

ORIGINAL RESEARCH

Clients with mental health problems who sexualize the nurse-client encounter: the nursing discourse

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Abstract

Title. Clients with mental health problems who sexualize the nurse-client encounter: the nursing discourse.

Aim. This paper is a report of a study of psychiatric nurses' responses to clients who were sexualizing the nurse–client encounter.

Background. Studies involving general nurses have reported incidents of 'unwanted sexual attention/behaviour' from clients. These behaviours have been identified, in the literature, as a form of sexual aggression and sexual harassment. Reported responses have included physically avoiding the person, ignoring verbal comments or adopting a no-'nonsense' professional approach.

Methods. A grounded theory study was conducted in 2005–2006 using tape-recorded unstructured interviews with 27 psychiatric nurses working in an urban mental health service in the Republic of Ireland. Tapes were analyzed, with the assistance of Nud*ist 4, Word documents, mind maps and memoing.

Findings. There were unwritten and unspoken professional expectations or norms that clients treated participants and nursing encounters in an asexual way. However, on occasions, clients transgressed these taken-for-granted norms and engaged in behaviour labelled 'sexualizing the nurse–client encounter'. In contrast to previous studies, our interviewees did not use the language of sexual harassment, but used the discourses of 'mad/bad' and 'inappropriate' to codify the behaviour. The tendency to view behaviour through the psychiatric discourse of badness and boundary violation gave rise to nurses either ignoring the behaviour or responding by using 'suppressive strategies'. Consequently, other possible lenses of understanding were pushed to the background.

Conclusion. Only when educators and clinicians view clients' sexual behaviours through alternative lenses of understanding will different actions and outcomes become possible and the rights of all, both nurses and clients, be respected.

Keywords: grounded theory, mental health nursing, psychiatric nursing, sexual harassment, sexuality, unwanted sexual behaviour

Introduction

There are unwritten and unspoken professional expectations or norms that clients treat nurses, and nursing encounters, in an asexual way, are appropriately modest and avoid verbal comments or behaviour towards nurses that could be construed as sexual. However, on rare occasions, both female and male clients transgress these taken-for-granted norms and engage in behaviour that is perceived by nurses as sexual. How they interpret and respond to such behaviour can either enhance therapeutic engagement, or become a source of anxiety resulting in disengagement from clients. In this paper we present some findings of a study whose aim was to explore how nurses responded to clients' sexuality in a mental health context. The emphasis is on nurses' responses to clients who were 'sexualizing the nurse–client encounter'. The nurses' responses are then discussed in the context of a number of possible theoretical lenses that might aid understanding of clients' behaviour.

Background

Sexual behaviour by clients towards nurses is a reality of practice for nurses working in both general and mental health care. However, the vast majority of research in this area has been conducted in a general healthcare context. Studies involving nurses (Finnis & Robbins 1994, Dan *et al.* 1995, Madison & Minichiello 2000, Celik & Celik 2007), nursing students (Kettl *et al.* 1993, Finnis & Robbins 1994, Celik & Bayraktar 2004), doctors (Schneider & Phillips 1997) and physical therapists (de Mayo 1997) have revealed incidents of 'unwanted sexual attention', 'deliberate touching', 'sexual propositions', 'unwanted discussions of sexual matters', 'rude jokes' and 'exposure of genitals' by clients in practice. These behaviours have been labelled in the literature as sexual harassment, in that they represent unwanted or offensive sexual attention, sexual coercion and/or gender harassment and perceived by the nurse as such. The frequency of reported 'sexual harassment' experienced by nurses has ranged from 37–91% (Kettl *et al.* 1993, Finnis & Robbins 1994, Dan *et al.* 1995, Bronner *et al.* 2003, Celik & Celik 2007). Only one paper was located that addressed 'sexual harassment' in mental health nursing. In a study involving 154 mental health nurses in London, Nijman *et al.* (2005) found that the majority of participants (68%) had experienced some form of sexual harassment in the previous year. In all the studies, female nurses experienced higher rates of sexual harassment than male nurses. However, Bronner *et al.* (2003), in a study of 478 nurses (20% men) working in five medical centres in Israel found that, in comparison with women, men were exposed to more severe

types of sexual harassment (26% women vs. 35% men), such as being forced to touch intimate body parts and suggestions to have sex against their will.

In exploring strategies used by female nurses ($n = 10$) to respond to 'sexual harassment', Dan *et al.* (1995: 571) found that female nurses in the USA most commonly responded by physically avoiding the person, ignoring verbal comments or adopting a 'no-nonsense professional' approach. Similarly, passive strategies of ignoring the behaviour and leaving the scene were reported by Bronner *et al.* (2003). Evans (2002), in a qualitative study of eight male nurses working in a variety of Canadian healthcare settings, identified six strategies used by participants to protect themselves from being wrongfully accused of 'inappropriate touch' by female clients. These included taking time to build trust, maintaining formality, wearing a white uniform, working in teams with female colleagues, delegating intimate care to a female colleague, and modifying procedures to minimize client exposure. In addition to transferring care to a female staff member and using a chaperone, Inoue *et al.* (2006), in a similar study ($n = 12$), described how Australian male nurses also used suppression of personal feelings, focusing on care as a procedure, humour and leaving curtains open to protect themselves when providing intimate physical care to women. Lawler's (1991) ethnographic study, involving interviews with 34 nurses, in Australia also highlighted the ways in which general nurses managed their embarrassment when caring for the physical body by adopting a professional matter-of-fact manner, minimizing the size or severity of an event or comment, and by wearing a uniform.

The vast majority of research in this area has focused on nurses working with clients who require intimate physical care and where nurses are continually negotiating what Lawler (1991: 151) describes as the 'socially delicate' aspects of invading bodily spaces. This paper focuses on the strategies used by mental health nurses where provision of intimate physical care is not a primary focus.

The study

Aim

The aim of the part of the study reported in this paper was to explore the responses of psychiatric nurses' responses to clients who were sexualizing the nurse–client encounter.

Design

A grounded theory study was conducted (Glaser 1998, 2001). Grounded theory involved the systematic generation of

theory from data and is typified by concurrent activities of data collection, organization and analysis (Glaser 1998). Emphasis is placed on letting problems emerge from the participants' perspective as opposed to predefining the problem, or 'fitting' the problem into a pre-existing theoretical framework.

Data collection and analysis

Using tape-recorded unstructured interviews, data were collected in 2005–2006 with 27 mental health nurses (ten men and 17 women) working in a mental health service in an urban area of the Republic of Ireland. At the time of interview, participants were employed as staff nurses or clinical nurse managers in a variety of community and residential mental health settings. Their clinical experience in psychiatric nursing, since qualifying, ranged from <1 year to over 20 years, and ages ranged from the early 20s to late 50s.

Interview tapes were transcribed in full and data were analyzed, with the assistance of Nud*ist 4, Word documents, mind maps and memoing. In line with the principles of grounded theory, the concurrent processes of coding, conceptualizing, theoretical sampling and constant comparative analysis were used. The core category to emerge from the data was 'Veiling Sexualities'. A more detailed account of the core category and an overview of the theory produced has been published elsewhere (Higgins *et al.* 2008). Aspects of the theory concerning clients who sexualize nurse–client encounters are the focus of this paper.

Ethical consideration

The study was approved by the relevant ethics committees. Detailed written and oral information was given to the participants, and interviews took place at a time and location of the participants' choosing. All participants signed a consent form and in all engagements emphasis was on fostering a collaborative dialogue, accepting comments without judgment, and being sensitive to participants' fears and anxieties. Emphasis was also placed on engaging with consent as an ongoing 'process' as opposed to a once of event.

Findings

There were unwritten and unspoken professional expectations or norms that clients treated participants, and nursing encounters, in an asexual way. However, on occasions both female and male clients transgressed these taken-for-granted

norms and engaged in behaviour labelled as 'Sexualizing the nurse–client encounter'. When this occurred, nurses tended towards either ignoring or suppressing the behaviour. The emphasis appeared to be on protecting themselves and colleagues as opposed to engagement and exploration with clients. Although younger inexperienced participants reported clients' behaviour as more personally distressing, their responses tended to mirror those of experienced participants. Gender difference in nurse–client relationships influenced the findings. Female nurses were more concerned with personal safety, whereas male participants feared an erroneous accusation of sexual impropriety.

Sexualizing the nurse–client encounter

Similar to other studies, the most frequent sexual behaviour experienced by participants included comments, questions and/or physical touch. Comments extended from subtle, sexually suggestive remarks about participants' physical body shape or appearance to overt requests for sexual contact. Suggestive remarks ranged from 'Your bum looks nice in those trousers' (13 F), 'You have beautiful eyes' (18 M), to, 'Asking you about your sex life' (15 M). Although not frequent, some clients did make overt requests for sexual contact, such as recounted by this nurse:

He (client) had a thing about me, and he started telling people he wanted to have sex with me... and he said he got an erection and I was mortified...it was really upsetting me because I just wanted it to stop (13 F).

Female participants also recounted situations where male clients talked about sexual hallucinations in a manner which led them to believe that their professional interaction was being used as a source of sexual stimulation:

One man he said the voices were telling him that he wanted to stick his penis up me and touch my breasts... I felt he was getting some kind of sexual gratification out of it, out of telling me, I could be wrong, but that is how I felt (21 F).

He would talk about what the voices were telling him to do... very vivid pictures he would be describing to me, that he had to masturbate because the devil was in him...I did think to myself, he is just getting a satisfaction out of telling me things like that... to get some sort of pleasure (17 F).

Physical touching included 'touching you up in a sexual way, giving you a tap on the arse or trying to grab your breasts' (13 F) and 'stroking your arm and trying to kiss you' (22 M). Although some male participants did mention what they called 'inappropriate touch' from female clients, being

touched in a sexual way by male clients appeared to occur more frequently to female participants. Both also recounted incidents of male clients exposing their genitalia in a sexually suggestive manner:

When I am doing the injections... in the past some of them would say, 'Get a load of this', they shake their willy [penis] at you, and say hold that (penis) for me...instead of seeing you as a nurse, they see you as a young woman (4 F).

I have had one gentleman, he took his penis out and asked me for a hand job [to masturbate him] ... I said look that is not on at all, look you can't be asking anyone for a hand job' (15 M)

Sexualized behaviour that nurses perceived was unmotivated by any personal gain, but the result of impaired judgments or insight because of illness, was viewed more benignly. Where participants judged that clients were seeking personal gain or exerting power over them, their behaviours were classified at the malevolent end of the continuum. Similarly, the term 'bad' was used to denote awareness and conscious intent for personal gain, with 'mad' being used to denote lack of insight because of illness:

You do rationalise it and say it is part of the illness, but sometimes it is somebody that is bad rather than mad, it is not a psychosis or confusion, they are not suffering from mania' (27 F).

If there was no badness behind it, they were not well, ...they were not trying to take advantage of me, or trying to make me feel uncomfortable, trying to use me for their own satisfaction...that's different from the person who knows what they are doing, they are just doing it out of badness... to get some gratification out of it for themselves' (17 F).

Not surprisingly, if behaviour was considered malevolent or 'bad', participants reported 'feeling vulnerable' and had greater fear and concern for their safety. Feelings of vulnerability were related to clients' gender, with participants feeling more vulnerable with those of the opposite sex. When a male client engaged in sexualized behaviour, female participants were concerned with bodily and physical safety, as one commented: 'I was quite afraid, terrified actually, when I think about it [client who was making comments] afraid of what he might do to me' (F 23). In contrast, male participants were concerned with their reputation and professional safety, and were particularly fearful of being the subject of an erroneous or vexatious allegation of sexual impropriety from female clients. They believed that even if the accusation was subsequently found to be erroneous, the suspicion among colleagues would continue, ultimately destroying their reputation and career. As one said:

As a male nurse you are vulnerable, because females [patients] may make an allegation of sexual misconduct, then you are gone out the door...I have seen it happen, any question, doesn't even have to be a written complaint and you are out that door, until it is investigated, so you see you have to be careful with female patients (6 M).

Responding to behaviour: suppressive and protective strategies

Responding to sexual behaviour posed a major challenge to participants. To cope with behaviour that was considered 'bad' or 'inappropriate', they responded by using a number of strategies including 'erecting professional boundaries', 'using humour', 'communicating disapproval', 'increasing visibility', 'transferring care', 'putting on record' and 'tipping off'. The focus of these strategies was on suppressing the behaviour and protecting themselves and colleagues.

Erecting professional boundaries

In situations where clients asked questions that were perceived to be of a personal or sexual nature, participants reminded them that the relationship was a 'professional' one. Responses appeared to be shaped by what O'Shea (2000: 9) calls 'therapeutic correctness', whereby participants made reference to professional prohibition against personal disclosure and intimacy in the relationship:

You would get a few that would ask you about your sex life or have you a girlfriend and with them, I just go, Ah sure I am not here to talk to you about that, I can't really discuss that with you (15 M).

There are boundaries...what I would tell the students is that if they are being very inquisitive about where you were last night, are you living together, I said, You can gently distract them and say well actually we are told we really shouldn't discuss that kind of thing (27 F).

Some writers have suggested that self-disclosure is an important dimension of therapeutic relationships as it promotes trust and genuineness and demonstrates to clients how to undertake self-disclosure effectively, thus encouraging reciprocity (Ashmore & Banks 2001, McCann & Baker 2001). Clients with mental health problems ($n = 25$) in Jackson and Stevenson's (2000: 379) study also expressed a wish for professionals to be able to move away from the 'professional me' to the 'ordinary me' domain and share personal information with them. However, in our study, participants tended to stay in the 'professional me' domain, allowing clients little insight into the private self, as some viewed self disclosure as creating personal and professional vulnerability:

The more information we give away...the more vulnerable we are...people can become unwell and they can say things... they can throw it back on you (18 M).

Using humour

Participants also deflected the line of conversation through humour, which was perceived to be less offensive to clients:

Somebody might say something like asking you out and we might say something like, Ah I would cost you too much money or what ever, we make some kind of joke about it (24 F).

If they said, Have you a boyfriend or are you living with him, I would say, Oh, I have myself and the dog and that is enough, I would laugh it off, I just wouldn't give out that information (11 F).

Communicating disapproval

In situations where gentle distractions and humour did not work, nurses' responses tended towards informing clients that their behaviour was considered 'inappropriate':

You try to be sensitive and without being confrontational say, it's not appropriate, those famous words. Not appropriate is a kind of a word that can be used without causing offence, because you are saying it so many times about everything else (22 M).

When I am doing the injections and some of them [male clients] would say, Get a load of this [point to genital area]...I would say that's not appropriate, that's not on (4 F).

By labelling behaviour as 'inappropriate' and subsequently communicating that to clients, participants did not have to think or speak about these issues. Despite the obvious sexual nature of the client's request in the next scenario, the participant went about completing the 'clinical task' without reflecting on possible meanings behind the behaviour which would, in her perspective, negatively affect her practice. Thus, over the years, clients' sexuality became eroded and lost in the ritual of labelling behaviour as 'sexually inappropriate':

Participant:

We have a patient in the service, he has schizophrenia you know and they haven't found anything that works and that...[impotence] was a big problem for him, and one day...he asked me could I hold it [penis] before I gave the depo [intramuscular injection], so I said, I can't do that, you know I can't do that, that's inappropriate, turn around there, so I can give you the depo, and that was that.

Researcher:

What do you think his request was about?

Participant:

I'm not really sure maybe it was to see could he get an erection... I don't think about it... I wouldn't be able to do the job if I did, so ...I suppose it's just familiarity as they say breeds contempt, you just get used to something and you don't think much about it, you just tell them it is inappropriate (5 F).

Physically avoiding clients

In situations where the sexualized behaviour was persistent, and where verbal strategies did not appear to be working, nurses spoke of disengaging from care to minimize opportunities for such behaviour to continue. When this occurred, verbal interaction was reduced to what one nurse called a 'superficial level':

I was inclined to step back, not be around him, and I wouldn't have got to know him as well as other patients because of that... you just say hello (14 F).

If you knew someone was at risk of doing that [making a sexual comment], and telling them that it was not appropriate didn't work...you know, just interact on a superficial kind of way (15 M).

Transferring care

In practice areas where participants carried an individual caseload or were allocated clients using a key nurse or primary nurse system, they disengaged by transferring care and making an official arrangement for the carer to be changed, frequently to a nurse of the same gender as the client:

If I believe that the person is misinterpreting or that the person is thinking that there's something else going on, I will stand completely back and I will say 'listen maybe it would be better if we had a different nurse looking after you...I would keep myself covered (7 M).

If I felt it was just to get off on the fact that they were talking about sex, then I put a stop to that, and redirected it to the male nurse and asked them to speak to them ...so you kind of transfer them (10 F).

Increasing personal visibility

In an attempt to increase personal visibility, participants modified the care environment by leaving doors of interviewing room open, by interviewing clients in a location with increased visibility, or by requesting a chaperone. Male participants, because of their fear of an erroneous accusation of sexual impropriety, were more conscious of remaining visible and requested a female chaperone:

I would never have a female in the office with the door closed...it is not worth it, it is not worth it for my own safety (18 M).

I didn't feel that comfortable around him, I would have another person in the room with me (13 F).

In situations where participants were concerned about visiting clients in their home, in order to increase visibility, they sometimes requested clients to come to a venue such as a community clinic:

Some people, I won't see in their houses, some men, because, if my gut tells me, I don't go there. I ask them to come to the clinic (5 F).

More senior participants also helped to protect junior colleagues from unwanted sexualized encounters by shadowing. This differed from chaperoning, as in this context the person was not present as a result of a request but rather was in the background vicinity, listening and watching the client's behaviour, ready to intervene should a junior colleague not know how to react to sexualized behaviour:

There is one gentleman on the ward that I would keep an eye on him ...in terms of the young student nurses... female students ... because sometimes they'll not say anything about it...so you keep around them [students] and watch (10 F).

Putting on record

Where behaviour was perceived to carry a high risk to participants, for example malevolent sexualized behaviour, they documented this in the nursing records in order to 'put on record,' or provide evidence of their concerns should they subsequently be called to account. One male participant was concerned about a letter he had received from a female client, addressed to his home:

I suppose the fear of accusations and allegations being made further down the line and I suppose with a view to transparency and openness was why I kind of declared my hand, I said it to the ward manager... recorded it...But, yeah, (pause) I felt that I needed to be a hundred percent above board to distance myself from the thing. I didn't want the problem to escalate (16 M).

Tipping off

Tipping off was the final process used to protect colleagues from perceived risk. Verbal communication in the nursing team about sexually-related issues occurred in an *ad hoc* and informal manner. When participants considered that a client posed a personal and professional risk to colleagues, they informally alerted each other to be cautious and careful around that client:

We got a patient referred who had a history of making an accusation, I was told watch your career, be careful, don't whatever you do be on your own... it was a kind of just telling you to be careful, kind of informal... (20 M).

The males [nurses] would be sort of made aware of this person's history, be careful, they have made allegations...but it wouldn't formulate an overall care plan, it would be reported informally in the team to each other (12 M).

Discussion

Sexualized behaviour by clients was an important issue in this study. As in other studies, the most frequent sexual behaviour experienced by participants included verbal comments or questions and/or physical touch. Responding to this behaviour posed a significant challenge. Participants responded by using a number of strategies including: 'erecting professional boundaries', 'using humour', 'communicating disapproval', 'increasing visibility', 'transferring care', 'putting on record' and 'tipping off'. Similar to nurses in Lawler's (1991) study, our participants were more understanding of sexual behaviour from clients when it was perceived to be a result of impaired judgement or illness, and less understanding if it was seen as exploiting a care-giving situation. To protect themselves and colleagues, participants responded using a number of strategies aimed at reducing the risk of unwanted sexualized encounters. In the case of male participants, the perception was that the strategies would help them to have evidence to support a repudiation of an erroneous allegation of sexual impropriety. Although the strategies did enable the participants to get on with their day to day work, like a double edged sword, they also caused them to disengage emotionally and physically from clients. Consequently, many issues were sidestepped and never discussed in the team or with individual clients.

There are many reasons why clients may transgress taken-for-granted norms and engage in behaviour that is perceived by nurses as sexual. An understanding of the meaning behind behaviour is central to therapeutic nursing. Sexual behaviour by men towards women is frequently viewed as a tool of social control and an attempt to sustain male power by treating women as sexual objects and as inferior (Bullough 1990, Robbins *et al.* 1997). In the context of nursing, Lawler (1991:203) suggests that exhibitionist behaviour by male clients in the form of exposing their genitalia to female nurses is not just a reflection of power and social attitudes of men towards women, but a reflection of a specific stereotype that female nurses 'tolerate such behaviour, and/or that their work involves sexual favours for the patient'. It could also be theorized that admission to a mental health service has a major impact on men's sense of power, thus challenging their sense of masculinity. With admission to a mental health service, men are positioned in a subordinate, order-taking position in relation to the higher status, and sometimes

What is already known about the topic

- Unwanted sexual behaviour by clients towards nurses is a reality of everyday practice.
- Research in this area has mainly focused on sexualized behaviour by clients in general nursing and strategies used by general nurses to counteract it.
- Research papers frame unwanted sexual behaviour in the context of sexual harassment.

What this paper adds

- In contrast to previous studies, participants used the discourses of 'mad/bad' and 'inappropriate' to codify sexual behaviour by clients.
- Participants tended either to ignore or suppress the behaviour, as opposed to engagement and exploration with clients, and younger, inexperienced participants reported clients' behaviour as more personally distressing.
- Women participants were concerned with personal safety, whereas male participants feared an erroneous accusation of sexual impropriety.

Implications for practice and/or policy

- Explanations other than 'sexual harassment' should be included in nursing education programmes, such as those of Foucault, feminists and recovery perspectives.
- Only when educators and clinicians remain open and view clients' sexual behaviours through other lenses of understanding will alternative actions and outcomes become possible and the rights of all, both nurses and clients, be respected.

younger, female nurses; thus, their masculine identity may be undermined. In the absence of other possible ways of constructing and sustaining hegemonic masculinity, such as sport, going to the pub or performing physical labour, they may seek other resources for constructing gender and validating their masculinity (Courtenay 2000). Therefore, reasserting masculine identity by resorting to sexualized behaviour may be viewed as a means of compensating for their subordinate status and as a way of reversing power positions by putting female nurses back in their place.

The writings of Foucault on power and resistance offer another perspective (Foucault 2001). According to him, being targeted by a professional discourse is a necessary condition for generating an oppositional discourse and further resis-

tance. Thus, it is possible to suggest that what participants were experiencing in the form of sexual behaviour by clients was a subversive reaction to the organizational, institutional and professional discourse that frequently ignores clients' sexuality (Higgins *et al.* 2006, 2008). By making visible a dimension of personhood that had been kept invisible by psychiatry and psychiatric nursing culture, clients were attempting to undo the discursive practices of professionals which constructed them as asexual, 'docile bodies' (Foucault 1973). Viewed from this perspective, discussions about how to respond to sexual behaviour moves beyond a focus on controlling individual clients labelled as deviant, to one that challenges mental health practitioners to explore how they contributed to this de-sexualization of clients. It also challenges every professional, from the levels of policy, management and education, to individual clinicians, to develop strategies that acknowledge the sexual rights of clients.

Viewing all behaviour in the context of power relations ignores the relationship between illness and sexual identity. A diagnosis and subsequent treatment can have a negative effect on a person's sense of sexual attractiveness, sexual identity and gender role performance, and it is reasonable to theorize that some of the sexualized behaviour participants experienced as boundary violations could be a search by the client for validation of the self as an attractive, desirable sexual being (Assey & Herbert 1983). Viewed through this recovery and validation lens, behaviour is no longer about power, oppositional defiance or merely 'inappropriate', but is part of a self-assessment exercise which starts with a subjective appraisal and then moves to a more objective search and confirmation from another person that one is sexually attractive. In this context, the focus of care needs to move from suppressive strategies, such as humour, communicating disapproval and transferring care, which are solely aimed at closing down conversation, to strategies that open up dialogue with clients. Care also becomes more focused on accepting the person as they struggle to re-evaluate their sexual self, with a view to exploring the possible meaning of the boundary violation and impact of mental health problems on the person's sexual self and identity.

Finally, in view of the fact that conservative estimates suggest that at least 30% of people who attend Irish psychiatric services have experienced sexual violence (National Counselling Service 2003), it is reasonable to suggest that some of the sexualized behaviour experienced by participants may be related to clients' confusion about personal sexual boundaries (Geanellos 2003). Viewing behaviour through this lens, nurses need to be sensitive to the possibility of a connection between sexualized behaviour and an abusive experience. Consequently, instead of

withdrawing from a client and erecting boundaries, nurses need to be more empathetic, with greater willingness to explore the possible meanings behind behaviour. In this way, clients may be helped to understand the nature of their boundary violations and learn how to regulate boundaries constructively in everyday interactions.

Study limitations

The study was conducted in the Republic of Ireland and therefore the findings may not be generalisable to nurses working in other cultures. Second, they represent self-reported behaviours as opposed to actual behaviours observed in practice; hence, there is a possibility they might have been different had the study included an observational component.

Conclusion

Many of the behaviours described by these participants have been described as 'sexual harassment' in the literature. In essence they were unwelcome and undesirable verbal, physical and written sexual contact that interfered with the person's ability to carry out their role. However, labelling all behaviour as harassment or 'sexually inappropriate' has implications for both nurse and client. First, there is a risk of demonizing all clients. Second, once labelled as 'harassment' or 'inappropriate' there is an automatic minimization of the need for a search for alternative understandings or further exploration of possible causes. We are not suggesting that nurses do not have a right to a safe working environment free from sexual harassment and innuendo, or have no right to use the strategies identified, or assertive communication skills. What is at issue is how the lens of 'inappropriateness', frequently gives rise to 'suppressive strategies', thus closing down therapeutic engagement and limiting other perspectives that may have given rise to alternative action and outcomes. Therefore, mental health nurses need to consider other possible explanations and lenses of understanding.

Many of the authors in this area focus their recommendations on the provision of education to nurses in the areas of right to safe working environment, legal issues, and assertiveness training specific to sexual harassment and procedures for reporting. We also recommend that educators include alternative explanations, other than 'sexual harassment' within education programmes, such as Foucault, feminist and recovery perspectives. It is only by educators and clinicians remaining open and viewing sexual behaviours of clients through other lenses of understanding will alternative actions and outcomes become possible, and the rights of all, both nurse and client, be respected.

Finally, in view of the limited research in this area within the mental health context, there is a need for further studies to explore, in greater depth, the issue of sexualized behaviour by clients, with specific emphasis on the meaning of such behaviour from both the nurse and client perspective. Understanding the motivation, rationale and context for sexualized behaviour may lead to more effective strategies for responding to such behaviour within practice.

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Author contributions

AH was responsible for the study conception, design and the drafting of the manuscript. AH also performed the data collection and data analysis. PB and CB supervised the study and commented on the manuscript.

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