

**IS IT POSSIBLE TO CARE FOR
THE "DIFFICULT" MALE?**

**A Study Exploring the Interface Between Gender Issues,
Nursing Practice, and Men's Health**

By

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Abstract

This thesis is about caring for males, especially those males who could be considered “difficult” to care for through their use of behaviours such as silence, anger or defensive humour. This thesis is positioned in the view that these behaviours are often expressions of distress, which typically distance males from those who attempt to care for them. Hence the word “distress” more accurately reflects the theme of the thesis and is used throughout the work.

This thesis explores the interface between gender issues, nursing practice and caring for males. It is informed by a review of relevant literature and data gathered from a focus group of nine registered nurses. The analysis is framed by questions that are developed from a series of reflections on my personal and professional life. Critical social theory, with its emphases on dominant dialogue, power and emancipation is used to inform and guide this analysis. What is most obvious is the contrast between themes arising from the literature and those arising from the focus group. It appears that the literature, in the main, is critical of males in regard to concepts of masculinity, issues related to gender, and men’s health. Males are portrayed as arbitrators of their own misfortune, as deliberately choosing a lifestyle that reflects poorly on their health, their self-expression, and communication with others. Concepts such as power and control over others, both at a societal and individual level, often feature. Conversely, the literature is noticeably lacking in regard to information about the health related experiences of males and about caring for males. In contrast, the participants of the focus group frame their discussion in the positive. For example, they suggest that males are interested in their health but require an environment that supports this expression of interest. They support this by identifying a range of behaviors they believe are effective in caring for males. The participants also suggest that it is the registered nurse rather than the male who manages issues to do with power and control.

The thesis concludes that creating and sustaining an environment supportive of, and sensitive to the needs of males, is an activity that requires considerable thought, skill and experience. These areas are not adequately addressed in academic dialogue, research activity, or in the education of registered nurses. The thesis suggests that this situation is inconsistent with an ethic of care and that nursing should make a priority of broadening its research and knowledge base to better understand and care for males.

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Introduction

This thesis is about caring for males, especially those males who could be considered "difficult" to care for through their use of behaviours such as silence, anger or defensive humour. This thesis is positioned in the view that these behaviours are often expressions of distress, which typically distance males from those who attempt to care for them. Hence the word "distress" more accurately reflects the theme of the thesis and is used throughout this work.

In another sense, this thesis is about the ability of registered nurses to create and sustain an environment where care for distressed males, who use the behaviours mentioned above, can effectively occur.

These two perspectives identify the central tension that this thesis explores, the interface between gender issues, nursing practice and caring for males. The first perspective grounds the source of the difficulty in the behaviour of the male. The second perspective grounds the source of the difficulty in the skills of the registered nurse.

This thesis is deliberately situated in the second perspective. It explores the question "Is it possible for registered nurses to care effectively for "difficult" males?" Literature informing nursing and nursing care for males is reviewed and then compared and contrasted with the opinions of a small focus group of registered nurses. The analysis is framed around a number of key questions developed from my personal and professional reflections.

Chapter one provides an overview of the study. It backgrounds my interest in the research topic and sets the scene for the development of the thesis. My personal and professional history is outlined and as the chapter progresses, connections are drawn with the overall focus of the thesis. Finally, the assumptions the thesis is based on as well as the specific aims of the research are identified.

The Beginnings of a Thesis

I originally completed a hospital based nursing programme and registered as a psychiatric nurse in 1972. I then trained and registered as a general nurse in 1976. Otherwise, I practised as a psychiatric nurse in a range of acute and longer-term psychiatric areas (moving around a range of areas was a common experience of clinicians in those times). Following this I spent several years as the nurse manager of a unit where women with enduring mental illness resided. It was then that I applied and was accepted for a position as an academic staff member (tutor) in a polytechnic-based undergraduate nursing programme. This was a small school with approximately 60 students accepted for enrolment each year. The school itself has experienced a number of structural changes over the past ten years. However, the only noticeable changes in the student group has been an increase in the number of more mature students.

I consider that the writing of the thesis is a remarkable personal achievement. I find myself in quite a different place from where I stood at the beginning of postgraduate study. I now view the future with optimism, having a strong faith in the ability of nurses to access those areas of their souls where the seeds of care are embedded.

Completing a thesis has allowed me to glimpse a range of opportunities, such as in my relationships with family and friends, as well as in professional practice. It is important to note that for a considerable period of time prior to this more recent study, the situation was quite different.

I studied at undergraduate level between the years 1978-90. I found the process tortuous, uninspiring and expensive. As a distance student I felt isolated and generally unsupported. Personally my partner and I were struggling with the tensions involved in establishing a relationship, a family and a home. The tensions were unlike any we had faced previously and this was compounded by an extended family network whose location was distant.

As a registered nurse working within a psychiatric institution I was part of an industry that was grappling with the slow but steady decline of a culture that had persevered for decades. Psychiatric services were being restructured and this process meant a very uncertain future for all those involved. Roles that I had taken for granted seemed to be becoming redundant. I was also part of an education system that I believed had never really supported my learning. My life at university had not altered this view at all. The rather powerful culture within which I was studying was paternalistic and resistant to critique. The tutorial processes seemed uninspiring and the content did not relate at all well to the realities of my life at that time.

Professionally I was a male in a female dominated profession. In many ways I had found this difficult to manage, especially in maintaining a sense of identity as a male. This was not related to my work as a nurse. There I felt I shared a common culture. It was in the more informal networking that I found it difficult to contribute especially in regard to the preferred topics.

One exception to these rather negative experiences was while studying a paper titled "Sociology of Education" at undergraduate level. It was here that I became aware of inquiry from a critical social perspective. Through reading reports of research conducted from this perspective I became aware of socio-political forces and how they impact on socialisation processes (Freire, 1972; Willis, 1980). It was as if a door had been opened for me. I was now beginning to be aware of a perspective that not only allowed me to analyse my professional world, but also my life as a whole. With this came a beginning ability to explore and critique rather than experience confusion and a sense of powerlessness in my life. Two years after completing a Bachelor of Arts degree I applied for enrolment in the Master of Arts (Applied) programme at the Department of Nursing and Midwifery, Victoria University of Wellington. I took this initiative partly because of the demands of my role as a nurse educator, but also because of a thirst for a more complete understanding of the profession of which I was a

part. Through the M.A. (Applied) programme I have had the opportunity to explore and reflect upon the topic of males and their health, and especially on what informs professional practice in this area. My study has stimulated and supported my developing interest in the relationship between males and nursing. While my interest had been based around my experiences as a male practising as a nurse, I also became aware of the difficulty male students had in finding a place where they felt valued within nursing and the difficulties colleagues (of either gender) had in facilitating growth in male students. I also became aware at a deeper level of issues surrounding the topic of men's health. My study has, in the main part, been grounded by my own professional practice, earlier as a registered nurse practising in psychiatric areas and more recently as a nurse educator. In both areas I have been saddened by what I perceive to be the poor attention to, and lack of understanding of, men's experience of ill health.

The first year of post-graduate study provided the opportunity and also the challenge of exploring new ways of expressing self. The second year was one of personal catharsis, an outpouring of emotion that had been present for many years, gradually building yet finding no opportunity for expression in any meaningful form. The third year was one of reading, discussion, reflection and a sense of real progress. Various issues were identified, literature carefully studied, and various perspectives explored with growing confidence. In addition, a sense of responsibility for the area of nursing and men's health was developing. The fourth year has been one of concentrated and focused work. However, without the patience, support and encouragement of my family, my colleagues, my fellow students and my teachers during those first three years, this could never have happened.

A growing sense of responsibility

At the beginning of 1995 while studying the first paper in the MA (Applied) programme (Nursing Knowledge, NURS511), I was asked to journal and reflect on

my work as well as share aspects of these reflections with a mentor. This proved to be a significant experience for me. Themes quickly became apparent and I chose to explore one particular theme, "men and nursing", for the remainder of that year. With this growing awareness came frustration. This frustration was due mainly to my inability to clearly articulate my concerns. There seemed to be so many, so complex, and so deeply felt. I now believe I needed that year not only to develop an intellectual understanding of an issue that had had the effect of silencing me over many years, but also to vent some of the frustration that had accompanied this silence.

The next year was one of exploring the area of males and nursing in more depth, through reading, reflection and discussion (Barkley & Kohler, 1993; Wood, 1993). However, it was the dialogue I had with others that has proved to be the most productive source of information. It was not only the information itself that proved so important but also the energy, feedback and critique that accompanied this dialogue. As a personal journal entry commented,

My peers have been a source of strength, challenge and encouragement. It was only as I became more aware of the issues (that I originally had only been confused about), that I was able to articulate these issues in a manner that my colleagues could understand.

Mitchell, personal communication, 1996.

In my role of teaching undergraduate nursing students, one issue of concern was to do with what I felt to be the minimal attention paid to issues that affect males. Several of my teaching colleagues supported the development of strategies for facilitating an increased awareness of the relationship between males and nursing. A colleague and I managed this by identifying and supporting students' awareness of, and contact with, male (nursing) role models during their learning experiences, as well as the increased use of male guest speakers. A journal entry at the time comments,

This exploration and development was carried out in an atmosphere of trust and openness quite beyond my expectations. Of the one or two staff members who I sensed were more sceptical, their reserve was a useful counterbalance that I found encouraged me to be more careful in my critique than I perhaps would have been otherwise.

Mitchell, personal communication, 1996.

My manager shared most if not all of my concerns about these issues, particularly those in regard to male students. We spent some time during that year discussing the topic and exploring strategies that would hopefully prove positive. For example, by supporting male students as a group and also through the teaching of a paper concerning 'Men's Health Issues'.

This same year, my management team and colleagues supported my attendance at a men's health conference in Australia. This was of special significance as it exceeded the usual level of support that was available to staff members for conference attendance. The men's health conference took place at Toowoomba, Australia and was organised by the Darling Downs Region Health Promotion Unit.

The conference proved to be something of a turning point in my thinking about men's health. I was surprised that there was little information in the presentations that had direct application to caring for males. Most of the conference papers, both in terms of keynote speakers as well as in the concurrent sessions I was able to attend, seemed to involve criticism and critique of men's socialisation and how this impacted negatively on the health of males. These presentations were often based on anecdotal information, case study or the presenter's own personal opinions. To me, there seemed to be only two presentations out of those I attended that addressed the subject of caring for males with a strong sense of empathy, sensitivity or respect (Connolly, 1995; Hock, 1995). Both presentations involved people who had actually talked to men about their needs and they had developed their presentations around understandings they had interpreted from these conversations.

Sadly, through reading, dialogue and extended study, my sense of a prevailing criticism of males has only been reinforced since that time. Dialogue and themes that emerge through newspapers, magazines and other popular literature as well as more academic work seems in conflict with concepts such as sensitivity and empathy (Lewis, 1990; Wood, 1993). This is also in conflict with my own belief in the power of creativity of caring. Since this time, it is still only occasionally that I find information where males are consulted about their views. These concerns have become the impetus for the development of the thesis.

The Personal Can Be Professional

I have become convinced that the personal can not only be professional but that it is an absolutely vital ingredient in professional endeavour. Initially this caused some concern, as the various resources I was using to guide the development of the thesis seemed rather rigid, having a structured and inflexible feel about them. In contrast, the energy and drive for my area of interest is grounded deeply in a myriad of personal experiences from throughout my life, especially those related to my family. The passion I have for exploring this interest at times seemed in danger of being constrained by the tools I used. As my writing at the time said,

The study has been quite emancipatory for me. It has been empowering, a catharsis really in terms of a lot of issues that have been racing around in my head but I was hardly aware of... Issues about men's health, my own place as a man within nursing, a range of issues that were a concern to me. As I've moved through the course I've found that I've begun to be more articulate, more informed about these. A very empowering experience, yet that empowerment isn't really reflected in the development of my thesis. The thing that was missing was the passion I feel for this area personally.

Mitchell, personal reflection, 1998.

Adding to this perspective is the position that the “I” is central; that our accounts of the world can only be constructions, made up from the language, meanings, and ideas historically available to us” (Jones, in Middleton & Jones (Eds.). 1992, p18). Jones viewed the “old distant voice of the objective observer/writer (as) fiction, and as a mechanism of power which ensures the domination of certain accounts” (ibid). To manage these tensions and create what I believe to be a more meaningful approach to presenting this thesis, I have attempted to weave a more personal voice wherever possible. This is in the form of personal reflection and conversations. As such it is written in the first person. This may differ from what is generally regarded as proper for thesis presentation, but I believe it is important to convey the interrelationship of various influences on my life, my thinking and my development in pursuing the overall aims of the thesis.

The aims of the thesis

The previous sections have detailed the personal and professional background that has shaped the development of this thesis. The thesis has also been shaped by my attitudes, values and beliefs in relation to the concepts of power, knowledge, and caring and how they interface with each other in relation to the health of males. To arrive at specific aims within such a dynamic and layered environment seems quite difficult. However, critical social theory, as the methodology chosen to inform the thesis, can at least in part, acknowledge and give meaning to these issues.

The thesis is based on my own assumptions about the nature of masculinity, and also of nursing. For example, that males often respond to stress in a manner that differs from that of women, using “distancing” behaviors that challenge the attempts of others to develop a caring relationship with them. Added to this I believe there are a variety of constraints (related to social and gender issues) that compromises the ability of others to care in these situations. I also believe that

experienced registered nurses recognise and manage these challenges in a variety of ways.

It may seem odd to regard registered nurses as a homogenous group, ignoring issues related to gender that exist within the profession. The intention is not to decontextualise nursing in this regard but to explore how registered nurses, as a professional group, manage their practice in the area of men's health. This is not to ignore the possibility that there may well be gender differences in the manner in which registered nurses express care. However, to explore this as an added variable seems outside of the scope of this thesis. Therefore, the aim of this thesis is to explore, find answers, and perhaps develop new understanding in relation to three broad questions. Firstly, is it possible for registered nurses to care for "difficult" males? Secondly, if it is possible, what particular understandings and skills do registered nurses use? Thirdly, where do registered nurses learn these skills? Again, it should be understood that by "difficult" it is meant those males who use behaviors such as silence, anger and defensive humour as a way of managing their distress and also as a way of creating "distance" between themselves and others.

The development of the thesis is outlined below.

Chapter outlines

Chapter two explores published and unpublished understandings that relate to working with males. Included is a review and critique of the literature that informs professional practice. There is a considerable amount of literature related to the subjects of males, nursing and caring. In order to manage this volume, the literature is reviewed using four categories. These being, "aspects of masculinity", "issues related to gender", "the health of men", and "caring for men". These categories were chosen quite arbitrarily but I believe they give a sense of coherence and organisation to the chapter.

Chapter three details the theoretical, professional and personal justification for the thesis. It includes aspects of my personal and professional history, building upon that discussed in chapter one, and is aimed at grounding the thesis firmly in my lived experience. This work takes the form of reflections and exemplars from which key questions are identified. The chapter then moves on to detail the theoretical perspective, critical social theory, which informs and guides the progression of the thesis.

Chapter four provides justification for the choice of a focus group as an appropriate method of collecting data. It also outlines the organisation of the group, including information about the selection of participants and the particular methods and processes involved in setting up and facilitating the group. Also included are details about ethical considerations and how they were managed, as well as comment on the process of obtaining formal ethical approval.

Chapter five presents the results from the focus group. It details the responses of the group to the question, "What behaviours do you use that have proven effective in helping you care for "difficult" males?" Each response is discussed and supported by quotations from individual participants. The results of ranking these responses (in order of importance) are then presented. Finally, the responses of participants to the question, "Where did you learn these behaviours?" are discussed.

Chapter six analyses data gained from chapter two and chapter five using questions (developed in chapter three) as a framework. These questions relate to issues regarding the practice of registered nurses in caring for males. For example, do registered nurses still frame the behaviour of males who express their distress in ways that are difficult to manage, as antisocial behaviour rather than attempts at coping?; Are registered nurses constrained by their own socialisation in their ability to care professionally for distressed men?; Are there gender differences in the manner in which distress is expressed? And, if so, how

do registered nurses manage these differences. If at all? The results of this analysis are broadened into a discussion that is consistent with the aims of the thesis.

Chapter seven concludes the thesis. It includes overall evaluative comment, including the limitations of the thesis and recommendations for the future. A number of connections are also made between the results and nursing practice using the concepts of safe practice (including a connection with the concept of "cultural safety"), power and hegemony, as foci for discussion.

Conclusion

This chapter has outlined the background to the development of my interest in nursing and males. This interest has developed over many years from a complex mix of personal and professional experiences. Parallel to this interest I have developed a belief that what I am aiming to do may prove enlightening and beneficial to others as well as a catalyst for future action. Finding a focus for such a broad interest has proven difficult, but through a process of reflection, dialogue, reading and effort, the area of "caring for males" feels a suitable focus for my concerns.

In Chapter two, the literature review, I will identify areas of current knowledge, understanding and research activity around the general areas of gender issues, nursing practice and caring for males. The chapter develops further, identifying issues and interrelationships that I believe impact on the current environment surrounding the interface between the concepts of power, knowledge and caring, in the areas mentioned above.

Introduction

My first year of post-graduate study was a year of reading, reflection and discussion. During this time my initial concerns regarding the literature in relation to masculinity and men's health was reinforced. This was that the available literature was either critical of men or at best apologised for the activity of males (Bem, 1993; Griffin, 1993; Wolf, 1990). Until this stage I had only been able to find a small number of writings that explored the world of males with any sensitivity (Prestini, 1995; Ragg, 1995). Further exploration seemed necessary. There is a considerable amount of literature available related to males and also to the topic of men's health (Docherty, 1998; Harding, 1998; Lepore, 1998, cited in Lynch, 1998; North Health, 1995/6). In order to construct a review that is manageable and coherent, four distinct areas related to these topics have been identified: aspects of masculinity; issues related to gender; men's health; and, caring for men. Aspects of masculinity briefly explores the construction of the term itself and something of the debate that surrounds these constructions. Issues related to gender again briefly explores feminist constructions on the nature of masculinity and details something of ensuing debates. These two sections are intended as an overview only, setting the scene for a more detailed critique in the following sections. The section on men's health details morbidity and mortality data related to physical and psychological ill health, and also explores initiatives and areas of tension in this area. The section on caring for men explores research activity and other initiatives taken in this area with a particular focus on nursing practice.

Aspects of masculinity

Concepts of masculinity appear to be a fairly recent construct and are only a few hundred years old (Connell, 1995; Rafael, 1996). One suggestion is that this parallels the development of Christian and Darwinian thought, as the following quotation explains,

Through school textbooks, children's literature, philanthropic organisations and the churches, both the images and associated symbolic activities of both Christian and Darwinian "manliness" filtered down to the proletariat through an unrelenting and self assured process of social osmosis.

Mangan & Walvin, 1987, p42.

In one sense masculinity can be thought of as a relatively generic construct. However, more recent writing views masculinity as "an inner, psychological process intrically tied to an outer web of sex roles and gender expectations." (Sabo & Gordon, 1995, p6). This article moves on to explore multiple perspectives of masculinity (ibid, 1995). For example, Clatterbaugh (1990) suggests that males can be seen as conforming to eight categories of "masculinity". He cites these categories as Conservative, Profeminist, Men's Rights, Mythopoetic, Socialist, Gay, Afro Caribbean, and Evangelical man (Clatterbaugh, 1997).

Jock Phillips in his book "A Man's Country: The Image of the Pakeha Male – A History", explores themes related to men in New Zealand, tracking the history of the New Zealand male from colonial times until the present decade. This book makes an important contribution to an under-researched area. His comments, in regard to the Second World War, include:

The psychological injuries were perhaps as serious as the physical. Men afraid to admit weakness, fear or defeat suffered in silence or channelled their feelings into bitterness and self-contempt. Men, thinking it a weakness to express emotion, found it difficult to communicate and were locked into a lonely isolation.

Phillips, 1996, p289.

This quotation emphasises a lack of openness, a fear of failure, a lack of ability to express emotion, and difficulties in communication. It seems that these concepts seem to dominate perceptions of what it is to be male.

Males are said to take a "tough man" attitude in regard to their approach to life and its problems (Brannon, cited in Harding, 1998; Firn, 1995). The following description of the male role is an example of this common stereotype.

No sissy stuff: the need to be different from women. The big wheel: the need to be superior to others. The sturdy oak: the need to be self-reliant and independent. Give 'em hell: the need to be more powerful than others, through violence if necessary.

Brannon, cited in Harding, 1998, p19.

Risk taking is another concept that features significantly in the literature. Males are commonly said to indulge in high-risk activities such as very competitive sports, dangerous recreational activities and drug taking/abuse. In addition, employment options often involve high-risk tasks with males considerably more likely to work in hazardous areas such as the agriculture, forestry and construction industries (Harding, 1998; Higgins, 1998; Taylor, 1998).

The concept of masculinity as a social construction and not necessarily a result of biology has been debated at length (Biddulph, 1998; Taylor, 1998). Biddulph suggests that social determinism, the perspective that gender differences are due to socialisation processes rather than biological causes, has proven particularly popular over the past few decades. However, he suggests that biological differences do in fact exist, and need to be acknowledged. "There is a (growing) awareness to see that some differences do exist that are not socially created (and that) we can accommodate (these differences)," (Biddulph, 1998, p32).

It can be said that there are three positions that can be taken on this topic. Firstly, that the behavior of males is a result of their biology. Secondly, that the behavior of males is socially constructed. Thirdly, that social construction builds upon biologically determined events. These events that are not well acknowledged in the literature nor do they seem to be given much weight. However, as one writer suggests,

While feminist and critical social perspectives related to exploration of the dynamics of patriarchy have done much to enlighten, strengthen and transform the way we perceive gender roles, when men are mentioned (as they often are) it is to place them in a rather insupportable position.

The well-known author Dale Spender, in her often provocative yet very popular work, also follows this theme. The following extract describing the dynamics involved in patriarchal societies is typical.

In one sense a patriarchal society is organised so that the belief in male supremacy 'comes true.' If in a variety of ways a community can come to accept that males are superior, that they are more worthy and more deserving, then the whole community can find it sensible to provide the superior, more worthy, and more deserving sex with more resources, so that males do indeed have a greater chance of appearing superior.

Spender, 1990, p1.

Furthermore,

Males, as the dominant sex, have only a partial view of the world and yet they are in a position to insist that their views and values are the 'real' and only values; and they are in a position to impose their version on other human beings who do not share their experience.

Spender, 1988, p86.

These quotations can be viewed as painting a rather dismal picture of males as being combative, dominant and powerful. Distasteful and distant at best, selfish and arrogant at worst. While this may provide a perspective in regard to better understanding issues related to gender, it is but one perspective articulated from a particular worldview.

One much cited position that predominates in feminist literature is that males (because of their dominant position) have been advantaged by institutions,

Males are set hormonally and neurologically along certain continua, and that is that. If you are male you will surge with testosterone at 14 weeks gestation, at 4 years of age, and again at 13, in a way that never happens to girls, and your whole sequence of development will be changed by that. Your body will grow faster, but your brain will grow more slowly, you will read slower, have more trouble holding a pen.

Biddulph, 1998, p1.

Steven Biddulph, the writer quoted above, is becoming increasingly well known in Australasia since the publication of his books on the subject of "raising boys". In one sense he could be viewed as taking a moderate position in the polarities of the nature\nurture debate on the behavior of males.

As it can be seen, there are differing perspectives on the concept of masculinity, what it means and how it is constructed. The question of how it is experienced is one that seems to take a minor place in the literature, especially in terms of more scholarly work. Why this should be so is unclear. However, if true, this would seem to be a huge gap. Another area of debate that is linked to this topic, yet maintains a different position, is that on the subject of gender relationships.

Issues related to gender

Much of the literature about the way in which men relate to the world has developed out of feminist thought. The manner in which the work is presented varies enormously, from compilations of academic writing (Munns & Rajan, 1995) to research based in-depth analyses (Bem, 1993; Griffin, 1993), and to historical overviews of patriarchal influence (Ehrenreich & English, 1978; Wolf, 1990). Invariably, whether talking about gender roles in relation to politics, culture, employment, sexuality or communication, this dialogue is related to exploring the dynamics of power within societies bounded by a system of patriarchy and the impact this experience has had on the lives of women.

including that of health care, and that more support needs to be directed towards women. This view is common within nursing related literature as well, especially with regard to initiatives in women's health (Rafael, 1996; Russell, 1995; Smyth, 1992; White & Johnson, 1998). There are a number of health related initiatives that have been driven, at least in part, from this perspective, exploring areas of ill-health that have previously been constructed as primarily affecting males. For example, research into heart disease and how it affects women (Toobert, Strycker & Glasgow, 1998). The following quotation suggests that an even broader perspective should be taken in relation to the health of women.

A number of sociologists have commented on the trends in western societies in which more and more social and emotional problems are interpreted within a medical and psychiatric framework. This is particularly so for women.

White, 1991, p69.

A number of other writers support this inappropriate approach to the medicalisation of socially related problems affecting women (Busfield, 1996; Russell, 1995).

Parallel to this exploration, there was a new development in the exploration and perception of the culture on males. Literature following this theme has flourished, particularly in the form of personal stories and self-help/instructional books (Clay, 1989). It is aimed at allowing males an opportunity to reflect on, to explore, and to reconstruct harmful aspects of their socialisation. In relation to writing such a book, one author suggests,

Writing (the) book and testing out its new insights, skills and strategies has been for me a rich and fantastic journey. It has taken me to many heights, through many valleys and storms, into lands of sunshine, beauty, love and trust.

Gray, 1990, p47.

As a response to the rather negative focus that had been taken with the world of males, there is a small selection of popular writing that takes a rather reactionary stance in relation to contemporary writing on gender relationships (Farrell, 1993;

Lee, 1993). Mostly this work focuses on the negative impact of socialisation on males and how women often support this. The tone of this literature is often angry and pained and as such it is difficult to see the more helpful points amongst the anger.

Amongst, and perhaps developing from these conflicting perspectives, emerges another area of writing. Much is aimed at the popular reading market but there seems to be a growing amount of more scholarly work appearing. The general focus here is to explore gender *regardful* of the differences between men and women (Miles, 1989; Smith, 1990). As one author states "men and women regard the landscape from different vantage points" (Tannen, 1990, p44).

Deborah Tannen, a linguist, has become a successful author of books that address gender differences in communication (Tannen, 1990; Tannen, 1992; Tannen, 1994). While this work is aimed at lay readers, she has also become a controversial figure in more academic circles. As one writer explains,

(Tannen's) thesis was, and is, not that there are linguistic differences between men and women which are attributable to their different personal characteristics (eg. men dominate, are forceful and therefore use powerful assertive language) but rather that the differences between the sexes should be likened to the differences between speakers of the same language who come from different ethnic groups.

Davis, 1996, p71.

This position is in direct contrast to the more dominant position that differences in gender communication patterns are directly related to how males maintain their position of dominance in society. As the following extract explains,

Although researchers adopting a cultural difference approach do not deny male dominance or necessarily assume an essential biological difference between women and men, those writing for a wider, popular audience such as Gray (1992) Men Are From Mars, Women Are From Venus and Tannen (1990) You Just Don't Understand,

emphasise differences, minimise similarities and largely ignore unequal power or status.

Bergvall, Bing & Freed, 1996. p4.

These statements portray a debate that is polarised into two positions, that of gender differences based on culture, and that of gender differences based on power and privilege. The position that gender differences are based on power is one that predominates. In relation to males, what is perhaps most unhelpful in creating and sustaining an environment of empathy and respect (so necessary for care) is the negativity, blame and expectation of redress that so often accompanies this perspective. The literature reviewed may seem somewhat distant from the topic of men's health. However, this review is constructed in the belief that these perspectives provide the attitudinal and value base that may frame study in the field of men's health. Furthermore, the perspectives identified in this section tend to create an environment where informed, empathic critique of the world of males is compromised.

The health of men

The health of males has had a slow but steady rise in the public consciousness over the past decade or two. A defining moment in this was perhaps the edition of Time Magazine that featured a picture of the iron-jawed General Norman Schwarzkopf on the cover introducing an article on prostate cancer (Jaroff, 1996). General Schwarzkopf had achieved fame (or notoriety, depending on your perspective) as Commander of the allied forces fighting against Iraq in the Persian Gulf War. A no-nonsense, straight talking "man's man", he seemed to be the perfect conduit through which stories of vulnerability, pain and confusion could be communicated to and accepted by male readers. As the article pointed out, "most men shy away from exchanging information about any physical disorders, let alone problems involving their most private parts." (Jaroff, 1996, p44). Finding a man with internationally acknowledged leadership abilities as well as fitting the "straight

shooting, tough guy” stereotype seemed a major coup for not only Time Magazine but also the men’s health movement.

While the article was quite thorough it no doubt caused a great degree of unnecessary fear and disquiet in that it made little or no attempt to distinguish between differing types of prostatic cancer. It preferred to focus entirely on the most serious and devastating type while ignoring other, considerably more common and less life threatening types of prostate cancer. Why this should occur is unclear and public confusion on this issue of definition seems to continue. Nevertheless, an important contribution had been made to raising the awareness of the public, especially men, to a disease which has previously been surrounded by silence, ignorance and confusion.

In 1995/6, the Northern Regional Health Authority (North Health) developed a paper on men’s health, “The Health of Men – A Discussion Document (Te Hauora Tane – hei Putake Whiriwhiri)”. This discussion document was developed following a report commissioned by North Health and was aimed at “stimulat(ing) discussion about the kinds of services that North Health should purchase to deal with men’s health issues.” (North Health, 1995/6, p2). This initiative developed from the Ministry of Health’s 1995/6 “Policy Guidelines for Regional Health Authorities”. These included the belief that health gains could be made for adult males through such strategies as:

Targeting services to reduce disparities in health status within the population of adult men; addressing men’s lack of knowledge about health and disability issues and services; identifying ways in which health and disability support services can be more responsive to men’s needs (for example, by identifying barriers to men’s access to primary health care services and by ensuring services respond to cultural differences); and by stressing, within the context of personal health treatment services, preventive health measures (for example, about smoking, alcohol and drug consumption, diet, exercise, stress management, melanoma)

North Health, 1995/6, p3.

This growing awareness and interest in the health of males is timely (possibly long overdue) when the statistics regarding the health of males are considered. The following morbidity and mortality data is commonly reported internationally. In general, men die younger than women. In New Zealand the difference is an average of six years (in the period 1989-91). In comparison with females, males are twice as likely to die before the age of 65 years of age. This is most often from preventable conditions and situations such as; coronary heart disease, stroke, cancer, injury related to motor vehicle accidents, occupation and sport, violence, AIDS, cigarette smoking and alcohol consumption (Docherty, 1998; Harding, 1998; North Health 1995; Prenesti, 1995).

The situation regarding the mental health of males is also cause for concern with conditions such as alcoholism, schizophrenia and depression already high (in comparison to women) and rising. Indeed, the health status of Maori and Pacific Island males is of particular concern in regard to these conditions (North Health, 1995).

The rate for youth suicide in New Zealand has reached such a level of concern that there are concerted national initiatives being developed, the most recent being the publication "The prevention, recognition and management of young people at risk of suicide - development of guidelines for schools" a report commissioned by the Ministry of Education and the National Committee on Health and Disability (Beautrais, Coggan, Fergusson & Rivers, 1997). This was one of a series of national initiatives that reflect a strong level of public concern for the rate of youth suicide in New Zealand. That this country has one of the highest rates of youth suicide in the world is generally well understood. The figures presented in Table 1 (p22), taken from the New Zealand Official Year Book, 1998, portray a particularly worrying picture, not only in respect to youth suicide, but also in respect to the overall figures for suicide.

Table 1. Deaths from Suicide and self inflicted injury

Age group	Male	Female
0 - 14	4	2
15 - 24	122	34
25 - 34	96	20
35 - 44	67	18
45 - 54	55	18
55 - 64	29	8
65 - 74	35	7
75 and over	<u>19</u>	<u>9</u>
	427	116

Source: Department of Statistics, 1998, p191.

That there is a growing awareness of the high rate of youth suicide in New Zealand is commendable. However, in regard to the health of men, this growing awareness seems to be from a particularly narrow perspective. For example, what is less well known and certainly less well addressed, is that suicide in older males is also a major problem. While the figures in Table 1 (above) for the 15 - 24 year old group do make worrisome reading, 301 other males took their own lives. Little is known of these people.

The 1998, Television New Zealand Documentary programme "20/20" produced a programme on males and masculinity in New Zealand. The impetus for this programme was based on the findings of a recent international research study on men. One particular comment should be noted here,

New Zealand men emphasise being natural, self-sufficient and sober in personality. They are lost By the time they reach their 40s they are implicitly lost.

TVNZ Programme "20/20", 1998.

Indeed, the area of depression in males is taking on an even more serious tone. The results of an American study of adolescent males by researchers at McLean Hospital and Harvard Medical School that found that those in the study were experiencing significant confusion, anxiety and sadness in relation to their developing role as men. As the following quotation explains,

We have written off normal boyhood disconnection as being okay when in fact it is indicative of a deeper sense of loneliness and isolation that boys experience as they move through adolescence towards manhood..... The findings carry massive implications for what appears to be a larger national crisis, one that we are now seeing can cause serious violence (towards oneself and others) in less well-adjusted or privileged groups of males.

Lepore, cited in Lynch, 1998, p1.

This information suggests that the health of males is considerably more compromised than most would believe.

Caring for men

I believe it is becoming more evident that for the health of males to improve there needs to be more attention paid to this area and also to developing a philosophical base that supports a more empathic approach in regard to caring for males. As one writer suggests,

For the men's health movement to move past the sort of victim blaming which seems to come from some proponents it needs to look harder at the causes of men's behaviour,

keeping in mind that not all behaviour occurs on the basis of rational choice

Ragg, 1995, p24.

Prenesti (1995) added to this position when he talked of creating an environment that is essentially more "male friendly". Furthermore, that traditional health promotion activities have proven unsuccessful for males because of a lack of understanding about their needs.

(In regard to) health promotion, it seems how and where it is presented for them is the key. Nurses have an obvious role to play in improving health outcomes for men. They need to recognise the problem and not reinforce the same sort of socialisation that men grew up with by saying, "he'll be right, he'll cope with that".

Prenesti, 1995, p23-24.

Health promotion is noticeable as an area where there has been sustained activity in regard to meeting the needs of males. For example, in areas such as preparing males for parenthood and issues to do with HIV (Bok & Morales, 1998; Polomeno, 1998; Robertson, 1998).

Jonathon Hoch, as part of an undergraduate project, interviewed 45 young men about aspects of their health. He suggested that the dynamics involved in communicating with young males were quite different to those involved with communicating with females. In this study he found that,

It is possible to talk with and listen to young men about their mental health. While such work may be difficult, in that young men often respond with anger, withdrawal or defensive humour when challenged with emotional or self-reflective matters, it is vital that pioneering work proceeds at the interface between mental health and the socialisation of gender.

Hoch, 1995, p75.

The research activity in the area of men's health in relation to nursing care is meager (Clatterbaugh, 1997; White & Johnson, 1998). What has been done makes some interesting points that confirm there are very real differences in how males and females express and meet their health needs and also how they respond to care (Dibble, Padilla, Dodd & Miaskowski, 1998; Foster & Mallik, 1998). For example, in a small study exploring gender differences during recovery after coronary artery bypass surgery, it was found that men's anxiety focused on the more immediate physical recovery and on long-term issues such as returning to work and activity. Women focused on who would care for them during recovery and where this would take place. The author concluded that "an understanding of these gender differences (is vital to meet) the specific needs of women and men" (Moore, 1995, p46). The situation becomes even more complex when one considers the following,

Clients who are male (and traumatised) are not only healing internal psychic wounds but they are also struggling against a society that invalidates their trauma, discourages them from seeking help and squelches their painful emotions. (ie. "real men don't cry")

Draucher & Petrovic, 1996, p325.

It seems that caring for males is potentially compromised on two levels. Firstly, in relation to their specific health needs not being adequately addressed, and secondly, that expressions of vulnerability in relation to ill-health are not regarded as legitimate by society in general.

A sense of hope and optimism is provided with the statement "Gender issues stalk the workaday of many professionals - lawyers, physicians, engineers, and even sales personnel. In nursing, any stereotyping pales before the rich experience that both men and women know together" (Hems, 1994, p14). However, literature reviewed in this paper suggests that the environment of awareness, value and respect for what it is to be male is not a concern of nursing today (Clatterbaugh, 1997; White & Johnson, 1998). Indeed, there is a suggestion that many health care workers (at least in some settings) are reluctant to engage with males because of

their own conservative and stereotypical views on masculinity (Robertson & Williams, 1998).

When the situation is related to distressed men, the scene becomes more complex. Breeze & Repper (1998) considered the views of clients who were considered to be "difficult". The discussion involved the concept of power and how it is managed within the nurse/client relationship. In contrast to much of the literature, power was talked about as being held and mediated by nurses.

Power over (the client) was considered by the patient informants to be unhelpful ... "Power to" consists of the ability to return some control to the patient and offer care and support which the patient recognises to be skilful and therapeutic.

Breeze & Repper, 1998, p1309.

This position is further developed in the following quotation,

An alternative construction of the view of men is that far from the power figures portrayed in feminist literature, the majority of men are in a powerless position, with strong feelings of vulnerability. This may be seen as a weakness in relation to the hegemonic view of masculinity promoted in the media. If this facade is broken down and the "true" feelings emerge, then the researcher will need special skills in supporting the respondent through potentially painful experiences.

White & Johnson, 1998, p45.

This position indicates, that because of the nature of socialisation, nurses require special, quite distinct skills and understandings in relation to working with this group of people. This position extends well beyond that which is taken by other literature that has been reviewed to date.

Conclusion

What became apparent in the early stages of this research was that the literature review was also another area of "data" gathering. Rather than being an exercise in reviewing the current literature for background information and to identify gaps in understanding, the literature review became an exercise in uncovering themes to do with dialogue and dominant discourse. What essentially has occurred is a critique of the literature, which will eventually form an important aspect of analysis.

This critical review has revealed that the literature on masculinity paints a picture of males as being combative and isolative, unable to relate on an effective interpersonal level with his fellows. This literature on gender creates a picture of males as supporters and perpetrators of a patriarchal society that continues to discriminate against women. The literature on men's health is largely based in physical medicine whereas there is growing evidence of men's emotional health being severely at risk (Lepore, cited in Lynch, 1998). The literature on caring for males indicates that effective caring for this group of people requires quite distinct knowledge and skills (White & Johnson, 1998). The situation where males present with more stereotypical "distancing" behaviors creates even more of a challenge to care.

These issues raise questions that yearn for answers. Firstly, is it possible for registered nurses to care for "difficult" males? Secondly, if it is possible, what particular understandings and skills do they use? Thirdly, where did they learn these skills? The following chapters will be aimed at answering these questions.

It should be noted that most of the dialogue so far has been about caring for males. This thesis is being focused on how nurses themselves care for males, hence nurses and nursing practice is also a key focus of the study.

Introduction

Chapter one detailed some of the personal beliefs, experiences and concerns that form the basis for the direction of this thesis. That is, whether nurses are able to care effectively for distressed males.

In chapter two, the literature review indicated that there is a paucity of research and general understanding of caring for males. The position is taken that the literature portrays males as the authors of their own misfortune, especially in relation to health.

It is my belief that further exploration in this area is warranted. The question is how should this exploration proceed? Exploration and inquiry do not proceed in a vacuum. These activities are always situated in particular understandings of the nature of the world and also in particular understandings of the nature of knowledge. The first part of chapter three (in regard to these ontological and epistemological points) aims to identify my concerns through the use of personal reflection and narrative. The second part of this chapter connects these concerns and questions with the theoretical and methodological perspectives that will guide and support the method selected for data collection.

Reflection as voice and guide

Throughout my childhood and early adulthood I was responding to the trauma involved in being reared in a dysfunctional family setting. My parents separated very early in my life. Alcohol and violence were a major factor. I believe that for my first 20 years I was despairing and grieving. It is only since then that I've started to heal in a noticeable manner and I believe this process will go on throughout my life. A personal journal entry noted:

Through these early years I expressed my turmoil in all sorts of ways that are socially unacceptable. I was labelled delinquent. I failed miserably through school. I was

assessed for my slow progress. I was sent to hearing specialists because of my inattentiveness in class. All through this experience there were only a couple of people who connected with me and actually showed some interest and concern (in a manner I could recognise). From what I read, I'm not confident that anything has changed (for youngsters in similar situations). (In addition) I don't see anything in nursing education that addresses this in any way for young men who express their despair in antisocial behavior.

Mitchell, personal reflection, 1998.

Apart from my mother, the only people that I felt connected to in a real sense were two men, one a teacher, the other a sports coach. What they actually did to connect with me is forgotten. What is still clear is the sense of connection, empathy and care that these men communicated. There does not seem to be anything "special" in what they did. They spent some time with me, listened to what I had to say uncritically, and gave advice. However, in another sense, what they did was quite unique in that they cared for me in a manner that was all too uncommon within my life at the time.

As previously stated, my behavior was generally construed as antisocial, by my mother, family friends, teachers and (occasionally) the police. With my friends, I challenged social norms in many ways. Always in a group, we shared many interests and activities that most adults would believe to be "high risk". To us the activities were seen as challenging and exciting. It was common for others, especially adults, to view my behavior as being deliberately antisocial, intimidating to themselves, and potentially contaminating their loved ones. This was never my intent. Indeed, the degree of misunderstanding involved still amazes me.

The limited work I have done with youth, as a parent, as an adult, and as a mentor/coach, gives me no confidence that this situation regarding young males from traumatic backgrounds has improved. I am left wondering, are we still framing the behavior of males who express their distress in ways that are difficult to manage, as antisocial behavior rather than as attempts at coping?

As a parent and partner the situation I find myself in is quite complex. As our children have grown their need for me seems to have shifted position whereas their need for their mother seems to me to have remained relatively constant. I wonder about my role. I am torn between a belief that I should be addressing these concerns in an open and direct manner, and a belief that I should be adapting in a more stoic, independent and capable way. One or two halting attempts to discuss this with my family have not met with great success as the following personal journal entry describes.

When we were with some friends I made what my children considered to be a blunder. What this "blunder" was I can't really remember. What I remember clearly is the profound sense of frustration I experienced in attempting to explain what I thought to be perfectly reasonable and considered behavior on my part. My attempts at explanation were met with ridicule and great humour at my expense. In itself, this situation could (perhaps should) be seen as one of those rather classic family exchanges. However, the frustration and turmoil I experienced was related to much more than this. It was related at a deeper level to my role as an adult male, a father, and as a partner.

Mitchell, personal reflection, 1999.

If one accepts the view that men need to communicate their concerns more effectively with others, it would seem that, with my own situation there is a very real contradiction between my attempts to achieve this, and my own expectations of stoicism and independence that have been so much a part of my socialisation. In addition, I believe this contradiction is experienced by my family as well. That is, their own belief that males should communicate effectively, contrasted with an expectation of the more stoic and independent behavior of males.

Could it be that people's ability to respond appropriately to males who do genuinely wish to express their feelings and/or distress may be severely compromised by their own socialisation, their own values, beliefs and attitudes?

I am left wondering, are health professionals constrained by their own socialisation in their ability to care professionally for distressed males?

As a clinician I have practised in a range of clinical settings and met many interesting and insightful people. In relation to caring for males, one particular conversation persists in my memory.

I was particularly taken with a story told by a nurse who worked at a health clinic attached to a boy's high school. She noticed that often when the adolescents presented they were gruff, monosyllabic and quite difficult to connect with in terms of talking about pain and comfort levels - especially at an emotional level. This behaviour was exaggerated even more if anybody else was present. She described how she attempted to make the environment "male friendly" by paying more attention to privacy, her body language (she found mirroring the adolescent's movements helpful), and initially talking only about physical matters. She found that by doing this it didn't take long for most boys to begin to express themselves more openly.

Mitchell, personal reflection, 1998.

In my view, this nurse has responded to what she has seen as a gender difference in communication styles. She was unaware of these issues prior to commencing work at the clinic. Her sense of achievement seemed related to her discovering: something "new"; something she hadn't been taught; something she had discovered for herself essentially through trial and error; and, something that had worked for her and her clients. While I had always assumed gender differences in the expression of distress, this woman seemed to be considering this as a new possibility, something she hadn't contemplated before. In addition, her actions were entirely of her own creation.

As a nurse educator I have the privilege of working with nursing students to explore areas of nursing care. The following exemplar details just one of these experiences.

A student related a situation she had recently been involved in as part of her practical experience. It involved a rather tragic family situation in which an elderly woman had been experiencing ill health requiring hospitalisation. The need for hospitalisation was disputed by the woman's husband to the extent where he was expressing anger. Those present felt intimidated and thought that there may be a potential for violence. The student expressed her thoughts that it was odd that while the clinicians she had been working with expressed considerable concern for the woman, her condition and her family situation, the concern they expressed in relation to the husband was for their own and the woman's protection only.

Mitchell, personal reflection, 1997.

In my experience this type of situation is not uncommon. In terms of health and coping skills I believe people, including health professionals, have considerable difficulty in recognising and valuing the use of anger as a legitimate and healthy means of self-expression. Instead it seems that expressions of anger are viewed as being a potential for violence requiring intervention that is focussed on restraint and isolation rather than interventions focussed on patience and understanding. Certainly the safety issues that are involved are often very real. However, the clinical decisions that are necessary to manage the tension between safe care of the client and safety of others are usually not that difficult, especially where the decisions are made by experienced and skilled registered nurses. Indeed, the potential for healing and growth in these situations may be considerable. This leaves me wondering, are there gender differences in the manner in which distress is expressed? If so, how do registered nurses manage these differences; if at all?

As I reflect on the concept of caring, I am aware of the range of perspectives that our society makes of its meaning and enactment. I see the term being used by groups of people as varied as car salespeople to registered nurses as a way of indicating their ability to meet the needs of their clients, communicating a sense of intimacy and trust in relationships that may not be found elsewhere.

However, on closer examination, the concept seems bedevilled with difficulties in definition and understanding as well as in continued debate about its place within nursing. While celebrated nurse theorists (Leininger & Watson, 1988), have developed new understandings of care and have stood these in a central place within nursing, other writers (Morrison, 1992; Phillips, 1993) point to the difficulties with defining caring and also critique the right of nursing to claim caring as its own. It is further suggested that the concept of caring developed by the more contemporary nurse theorists mentioned above are developed from a narrow vision of where nursing practice occurs. As one writer suggests, "there is a dearth of information relating to care from different areas of nursing practice ...Clearly nursing has more strings to its bow than just bedside nursing." (Warelow, 1996, p657).

However, in a more general sense, nursing scholars have explored and continue to explore aspects of the concept of care in ways that not only inform nursing practice, but also give nurses a greater sense of identity and purpose as well as the increased confidence that enhances their own professional development (Rafael, 1996). As with any change, there are many implications, as the following exemplar describes.

I had just had the opportunity of observing a (nursing) student assessment. The assessment involved a student demonstrating the use of effective skills in therapeutic communication with a client (a role player) who was experiencing a high degree of stress in his life. The student had been assessed as not only meeting but also well exceeding the expectations of the assessment. The assessor explained she felt the student had demonstrated excellent use of a wide range of techniques in therapeutic communication – both verbal and non-verbal. In addition, she was said (by the assessor) to have demonstrated an ability to care in a difficult situation. She was present and empathic. There was a sense of real "connection" with her client.

In contrast, when the role player gave his feedback he said that he felt more confused and distressed the more the student made efforts at "connecting" with him.

The student and assessor were upset and confused by this feedback. How could such technically excellent and heartfelt nursing practice have such an effect on the client?

Mitchell, personal reflection, 1998.

As this exemplar suggests, what were viewed as skilled and genuine expressions of care may not be appropriate in all situations. The situation as it developed in the exemplar is not uncommon in my experience, especially in regard to the practice of students of nursing or beginning practitioners when they are working with distressed males. To me, there seems to be something akin to a hegemonic process in the manner in which caring practice is understood within nursing. Hegemonic, in that one particular interpretation of the nature of caring seems to dominate because of the power of one particular worldview (Roberts & Taylor, 1998). One writer suggests that this view seems based in understandings developed from exploration of childbirth, child rearing and nurturing within the context of a dependent family (Warelow, 1996). This understanding seems similar to the picture of the enveloping wings of an angel, protecting and nurturing of the vulnerable person (whether this be a client, a patient or a child). It is verbal, close and very intimate.

I am left wondering that if current (nursing) understandings of caring are based in an ontology that is female, are there other ways of understanding and enacting care that are not known and/or valued within the profession?

The scenarios and reflections presented above give an overview of a range of personal and professional situations that have shaped my understanding of factors influencing the care of males. Included are situations and people who have not only influenced my thinking but also have provided the impetus for a deeply held concern for those males who are suffering, yet for whatever reason find it difficult, perhaps impossible, to express their distress in an open and constructive manner.

From the reflections in this chapter a number of questions arise. To recap,

- *Do we frame the behavior of males who express their distress in ways that are difficult to manage, as antisocial behavior rather than attempts at coping?*
- *Are registered nurses constrained by their own socialisation in their ability to care professionally for distressed men?*
- *Are there gender differences in the manner in which distress is expressed?*
- *If there are differences in the manner in which distress is expressed, how do registered nurses manage these differences, if at all?*
- *Are current (nursing) understandings of caring based in an ontology that is female?*
- *Furthermore, are other ways of understanding and enacting care known and/or valued within nursing?*

These questions have been shaped by three overriding insights and/or beliefs. Firstly, I have a growing awareness of the historical and social forces that sustain oppression of groups of people. Secondly, I have a growing confidence that change can occur. Thirdly, I hold a belief that (given the opportunity) the creativity, humanness and ability of people to care for each other is boundless. My primary interest in undertaking this research project is to investigate how to care effectively for males.

The second part of this chapter connects these concerns and questions with the theoretical and methodological perspectives that will guide and support further development of this thesis.

Theoretical and methodological considerations

A methodology has been variously described as a plan of action, an overall strategy, and a guide to meet the overall outcomes or goals of any particular project (Crotty, 1998). Critical social theory has been chosen as the guide for this thesis.

Critical social theory aims at the critique and transformation of the social, political, economic, ethnic and gender structures that constrain and exploit humankind (Cheek & Rudge, 1994). In this regard, contrary to the expectations of positivist research, the assumptions of the researcher do influence inquiry. Indeed, they are expected to. The investigator and the investigated are assumed to be interactively linked with the values of the investigator inevitably influencing the inquiry (Guba & Lincoln, 1995).

Thus critical researchers enter into an investigation with their assumptions on the table, so no one is confused concerning the epistemological and political baggage they bring with them to the research site.

McLaren, cited in Denzin
& Lincoln (Eds.). 1994, p140.

It seems somewhat presumptuous to describe this project as deliberately pursuing the goals mentioned above. This project is small and exploratory in nature. However, the vision is indeed one of eventual change. One hope for this thesis is that the findings may provide a small but valuable insight, perhaps even a catalyst, for further studies and other initiatives.

Marxism, with its focus on economic forces shaping the nature of consciousness, could be thought of as being the beginning of critical theory. Critical social perspectives are commonly thought of as having developed through a group of writers connected with the Institute of Social Research at the University of Frankfurt (McLaren, cited in Denzin & Lincoln (Eds.). 1994). This perspective

of philosophical and social thinking developed in the context of the social devastation in Germany between the First and Second World Wars with the group's dissatisfaction with positivism and its inability to manage the major social issues of the time. Known as the Frankfurt School, this group is considered something of a watershed in regard to critical thinking. More recently Habermas situated our understandings of "consciousness" within relationships, as having a more individualistic approach to its nature. He talked of the seeds of emancipation and autonomy being strived for through verbal communication, but that people are constrained in this search through hidden oppression. Furthermore, that it is only by exploring, becoming aware of, and confronting these forces that people can have an equal chance of participating in dialogue and hence in society (Fulton, 1997). Later Foucault went further, looking at a more dynamic relationship between power, language and time, stating:

I believe one's point of reference should not be the great model of language and signs but that of war and battle. The history which bears and determines us has the form of a war rather than a language; relations of power, not relations of meaning.

Foucault, cited in Papps
& Olssen, 1997, p27.

This thesis is a small exploratory study that is informed by critical social theory. It is exploratory in that currently there is a paucity of information in the area of caring for males. It is informed by critical social theory in that there is a vision (held by the researcher) of a need for change. Critical social theory has been described as a paradigm that "shares the common goals of generation of knowledge which contributes to emancipation, empowerment and change" (Berman, Ford-Gilboe & Campbell, 1998, p3).

A critical researcher has been described as one who attempts to use their work as a form of social or cultural criticism and who accepts certain basic assumptions. For example, that all thought is mediated by power relations that are socially and

historically constructed and that language is central to the formation of subjectivity (that is, both conscious and unconscious awareness). Furthermore, that certain groups in any society are privileged over others, and although the reasons for this privilege may vary widely, the oppression that characterises contemporary societies is most forcibly reproduced when subordinates accept their social status as natural, necessary or inevitable (McLaren, cited in Denzin & Lincoln (Eds.). 1994).

Of central importance to this thesis are the concepts of power and hegemony. Power is defined by De Vore (1995, p32) as "the ability of its holder to exact compliance or obedience of other individuals to his will on whatsoever basis". De Vore talks about how power can become institutionalised within social structures. Indeed, a case could be made that societal institutions are essentially organised systems of mediating power. Foucault goes further. He views power and knowledge as being inextricably correlated, that they exist with each other as a dynamic entity (Papps & Olsen, 1997). These perspectives also define the manner in which hegemonic processes occur and are maintained in society and in groups in general. Hegemony has been described as:

not the passive acceptance of the dominant group ideologies but the active consent to them. (This active consent is given) by oppressed groups that consciously support the ideas and beliefs of the dominant group in their everyday lives. Herein lies the beginnings of false consciousness (where) the ideas and beliefs of the dominant group become frozen or fixed as permanent social norms, rather than socially constructed realities which are able to be deconstructed and reconstructed.

De Vore, 1995, p36.

As explained previously, critical social perspectives expect the outcomes of the research to be influenced by the assumptions of the researcher. This view varies considerably from other research perspectives in that the process of inquiry is not linear, exploring in a direct and predetermined manner an original concern or hypothesis. Rather, the research process is dynamic, one part being linear, but

this is overlaid with another perspective that acknowledges the serendipitous and is not afraid to allow these insights to alter the direction of inquiry.

Horkheimer used the term "critical theory" to distinguish this form of theory from the prevailing logical empiricist account of scientific knowledge and to characterise a different form of knowing, one anchored in both reflection and practice.

Peters, Hope, Marshall, &
Webster (Eds.). 1996, p7.

As the thesis develops my thoughts and understandings change. Indeed, in a sense, the process of writing and reflection becomes a method of data collection and analysis in itself. This begins during the literature review. Reflecting upon theoretical underpinnings continues throughout the research process. As a personal journal entry noted:

It seems entirely appropriate to expect this change. Indeed the assumptions and processes of critical perspectives seem to demand that this process occur. Alternatively, to expect that tensions and issues remain constant during the research process seems ridiculous, life doesn't stand still.

Mitchell, personal reflection, 1999.

The impression here is one of personal evolvment and change. The thesis is, in a sense, a record of evolution and change. However, as with all attempts at generating new understanding, the path (or methodology) that is chosen will have certain advantages and disadvantages. Issues related to this point are explored in the following section.

Questions related to validity and reliability

The research activity associated with this thesis is qualitative in nature. Qualitative is a general term with researchers "studying things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, cited in Beanland, Schneider, LoBiondo-Wood & Haber, 1999, p238). Qualitative research seems to be bedeviled by its inability to be subjected to the rigors of statistical analysis that is expected of other forms of research effort such as quantitative research. As one author has suggested, "analysis in the social science literature is clouded in mystery. The social science discourse has contributed to this mystery by a reluctance to explicate how data analysis is done" (DeLaine, 1997, p209). Whereas issues to do with reliability and validity are paramount in quantitative research, these two concepts seem to "refute the philosophy upon which qualitative inquiry is grounded in the first place" (DeLaine, 1997, p272). This writer goes on to suggest that with refinement of qualitative processes and perhaps more confidence, researchers have come to suggest that credibility, trustworthiness and dependability are more appropriate concepts by which qualitative research can be evaluated and that we have to develop confidence and trust in tools or methods that differ from those traditionally used in research.

Some analysts argue that validity may be an inappropriate term in a critical research context, as it simply reflects concern for acceptance within a positivist concept of research rigor. Trustworthiness, many have argued, is a more appropriate word to use in the context of critical research. It is helpful because it signifies a different set of assumptions about research purposes than does validity.

Denzin & Lincoln (Eds.). 1994, p151.

This study is a small project and no attempt will be made to generalise findings more widely. However, the findings may well provide new understanding at the interface between gender issues, nursing practice, and men's health. It is also expected that the thesis may well point to future endeavours that might prove

enlightening and beneficial to the environment surrounding nursing and the care of males.

Conclusion

This chapter began with exploring a range of my personal and professional experiences. These included reflection on personal experiences from my childhood, and from my roles as a parent and as a partner. It also included reflection on my roles within nursing, both as a clinician and as an educator. These reflections raised a number of questions related to males, nursing and caring (eg. Are registered nurses constrained by their own socialisation in their ability to care professionally for distressed men?). As these questions are absolutely central to the thesis, it has been decided to use them as points for analysis in a later chapter. In a sense these questions are the link between the concerns that have generated the energy for this thesis and the generation of new understanding that is the aim of the thesis. This seems entirely consistent with research endeavour, especially research that is informed by critical social theory. These understandings are related to concepts such as power, dialogue and change, concepts that are becoming more central to this thesis as it develops.

In this chapter, something of the history and nature of critical social theory has been outlined, especially from the position of how these perspectives might act as a guide for the development of this thesis. However, while I believe these perspectives will prove extremely valuable, they give no direction as to how information is to be collected and collated. These points will be covered in the next chapter.

Introduction

Chapter three discussed the personal and professional experiences that underpin this thesis. Also outlined was the methodological choice that was made to give shape to, and guidance in, exploring concerns that arose from reflection upon these experiences. Critical social theory was chosen because of its focus on concepts such as change, emancipation, power and dialogue; concepts that have featured in exploring the underpinning of this thesis. Critical social theory was also chosen as it supports the dynamic, even serendipitous nature of inquiry, points that are expected to feature as the thesis unfolds. The choice of methodology tends to suggest a range of differing research methods that are more suited to that particular methodology. However, methods are not prescribed by a particular methodology, in fact the same method can often be useful across methodologies. Indeed, multiple methods are gaining popularity (Berman, Ford-Gilboe & Campbell, 1998). Berman et al (1998, p2) develop this theme by examining “how it is possible, even advantageous, to employ the use of differing research methods within (defined research paradigms)”.

While it has previously been acknowledged that the literature review was a method of gathering data, this chapter details the choice of a focus group as being what I consider to be the principle method of data collection for the thesis. The chapter begins with details of the place of focus groups in generating information and in research activity. Included are advantages and disadvantages of focus groups and the reasons for choosing a focus group for this study. Included in this section is a discussion on why it was that registered nurses were chosen as the participants. It then details the preparation for the group session, and then the actual process of the focus group. Finally, ethical considerations related to the project are discussed and the process of obtaining ethical approval is detailed.

Focus Groups

A focus group was chosen firstly for convenience, ease of management, provision of rich data in a short timeframe, and being able to complete the project reasonably quickly. Secondly, although the topic involves a range of complex issues, none were expected to involve any disclosure that could be considered personally challenging. If this were the case, individual interviews would be considered more appropriate. Thirdly, and perhaps more importantly, is the synergistic effect of focus groups, the belief being that the information gathered from the group would prove to be of greater depth than that which would be achievable through individual interviews.

The history of focus groups as a distinct research method is relatively recent. While group interviewing has been practised in some form or another for many years, several authors (Delaine, 1997; Morse, 1994; Stewart & Shamdasani, 1990) credit Robert Merton with coining the term "focussed interviewing" during the 1940s and 1950s when he and his colleagues "used the term *focus group* to apply to a situation in which the interviewer asks group members very specific questions about a topic after considerable research has already been completed" (Morgan, 1995, p44).

Various writers (Carey & Smith, 1994; DeLaine, 1997; Denzin & Lincoln, 1994; Happell, 1996; Kruegar, 1990; Morse, 1994; Stewart & Shamdasani, 1990) describe the advantages of focus groups. For example, their inexpensiveness; their ability to provide "rich" data through access to relatively large numbers of people (at least in regard to qualitative research design); their ability to provide a stimulating atmosphere; and, their ability to aid recall through such things as increased dialogue and opportunities for clarification between participants. This "synergistic" effect is often mentioned where participants are able to build their responses upon the perspectives of others. As one writer states, "Focus groups involve the explicit use of the group

interaction to produce data and insights that would be less accessible without the interaction found in a group" (Morgan, 1995, p12).

Focus groups have a number of disadvantages. One author suggests that "group interactions provide a social environment and comments must be interpreted within that environment. Care is needed to avoid lifting comments out of context and out of sequence or come to premature conclusions" (Kruegar, 1990, p46). This point could be considered contrary to what is mentioned above as an advantage. This contrast is perhaps an indication of the different ways in which the method is perceived and discussed by different researchers.

Other disadvantages include the considerable variation in terms of group comparability and cohesiveness necessitating considerable skill in the interviewer. Another disadvantage is the inability to generalise the findings from focus groups to a wider population, although this takes away the need for representativeness as a criteria for selection of participants. However, it should be noted that the participants should be representative of the issue under consideration, an example perhaps of disadvantages being reframed in the positive.

One major disadvantage is the ability of the focus group to be easily biased by the facilitator and/or dominant individuals. This pitfall can have a significant conscious or unconscious censoring effect. Given the importance of the facilitation of focus groups it is not surprising that there is a considerable amount of discussion in the literature related to this area (Carey & Smith, 1994; Morgan, 1995; Sim, 1998).

The skills of the interviewer have been described as being very much the same as those considered beneficial for individual interviews, with qualities such as flexibility, objectivity, empathy and effective listening skills being mentioned as important (Denzin & Lincoln, 1994). However the group interview requires the interviewer to be able to mediate group dynamics in order to provide for the most representative flow of thoughts possible from the participants. The following

quotation, although rather tongue-in-cheek, perhaps gives some picture of the art involved in group leadership by stating,

the best facilitator has unobtrusive chameleon-like qualities; gently draws (consumers) in to the process; deftly encourages them to interact with one another for optimum synergy; lets the intercourse flow naturally with the minimum of interventions and remains completely non-authoritarian and nonjudgmental.

Karger, 1987, p52.

There is another vital point that must be acknowledged. Focus groups are often used from a critical perspective. In this situation the positioning or grounding of the interviewer is pivotal to the direction of the group and to the analysis of results. "Underpinning critical (research) is an unambiguous and overtly political intent to facilitate change. The critical researcher holds interpretive interests but also has an interest in revealing the interests underlying culture" (DeLaine, 1997, p204). Focus group technique is said to be especially useful for studies of complex issues involving many levels of feelings and experience such as studies of beliefs and attitudes. Morse (1994, p226) describes this as "richness at a reasonable cost". This seems particularly relevant to the aims of this thesis.

Selection of participants

The focus group was made up of nine participants. All were experienced registered nurses. Those with over two years' clinical experience since registration were deemed to be "experienced". There were three males and six females. Although it may well prove interesting for future study, the participants' gender was not considered as a variable for this project. While this action may seem odd considering the importance of gender in regard to the client group, this decision was made primarily in the interests of ease of analysis and for issues to do with confidentiality, as making the gender of the participant

known may well have compromised their identity. In addition, the central issue under study was nursing care itself.

Three registered nurses practised in acute mental health areas, one in an in-patient setting and two in a crisis intervention team working in the community. Two registered nurses practised in areas caring for clients with enduring mental health problems, one worked in an in-patient setting and another in a community outreach programme. Two registered nurses were from acute medical services, one from an emergency department, the other from an intensive care setting. One registered nurse was from a nursing education setting and the remaining participant practised in an occupational health setting. This mix of participants was perhaps skewed towards an under-representation of general, medical and gerontological services. However it was felt this would not disadvantage the project.

While the participants for the thesis could have been anybody who worked closely with males, experienced registered nurses were chosen for a variety of reasons. The first being that of convenience. As a registered nurse myself, I felt more comfortable approaching and working with this professional group especially in terms of understanding and not having to learn something of a new professional culture and language. I believed that the registered nurses needed to be relatively experienced in their area of practice so that dialogue was informed by both variety and depth of experience. There was no conscious attempt made to dictate what particular areas of practice the registered nurses were involved in as I was looking for a generic approach to gaining knowledge about caring for males. Apart from these reasonably pragmatic reasons I had an overall belief (and hope) that registered nurses would be able to consider the central concept of care from a more informed and insightful position than other professional groups.

The process of selecting participants for the focus group began with the application for ethical approval through the Regional Ethics Committee (details and issues in

relation to this process will be covered under the section on ethical considerations later in this chapter).

The managers of a range of health care units that employed registered nurses were approached in writing and were asked to draw their staff's attention to an enclosed note seeking expressions of interest for participation in the focus group. The note introduced myself and my course of study. It also gave brief information about the focus group and contact details for obtaining further information (see Appendix 1). Any registered nurses who contacted me were given a detailed information sheet and consent form if they wished to proceed as a participant. These followed a formal format required by the Ethics Committee (See Appendices 2 and 3).

The units these letters were addressed to included those attached to a general hospital, a broad range of psychiatric services, a number of community based services and nursing education. The initial response was disappointing with only one person expressing interest. It was discovered through a chance meeting that many registered nurses whom I thought would be aware of the project had not received any information. After a second approach to the units, several registered nurses expressed interest. Unfortunately, arranging a date suitable for all was impossible and several potential participants were lost for this reason. In the end, nine registered nurses were able to be present on one particular evening. The choice of venue was considered neutral to all but one participant. However, this participant did not feel that this was a disadvantage. Attention was paid to having an environment that was as free of distractions as possible, yet was quiet and comfortable. Light refreshments were made available.

The Focus Group

The process that I used for this focus group was one that I had been involved with previously (See Appendix 4). It is a process that I believe maximises the advantages discussed earlier in this chapter. These advantages include such

variables as inexpensiveness, the ability to provide "rich" data through accessing groups of people quickly, the ability to provide a stimulating atmosphere, and the ability to aid recall through such things as increased dialogue and opportunities for clarification between participants (the synergistic effect mentioned previously). The group begins with an introduction of group members including names and areas of employment. This is followed by a description of the aims of the project, the assumptions of the researcher and a description of the process to be followed. (Bearing in mind that these have all been detailed in information already received by participants). At this stage, issues to do with confidentiality are also repeated. Agreement is sought in keeping the identity and any identifying details confidential to those in the group. The group process then moves through three distinct stages; those of negative framing, positive framing, and ranking. This process could be considered more structured than would commonly be the case for the facilitation of focus groups.

Firstly, the participants are asked to identify negative experiences they have had with the area under discussion (ie. caring for distressed males whose distancing behaviours may be interpreted as "difficult"). They are asked to write the particular behaviors they have previously used that had not enabled them to care effectively for their clients. They are asked to work at this individually as group norming (or the development of synergy) of these more negative experiences is not wanted. The time spent on this process is at my discretion. When observing the group it is quite apparent that a lot of energy is expended for this exercise and care needs to be taken to give the group the time it needed to move through these thoughts. After this individual work the group is brought together to work on the second phase of the process.

Secondly, the group is asked to reframe their thoughts in the positive, identifying those behaviors/abilities that have assisted them to care effectively for distressed males. These ideas are written on a large sheet of newsprint that covers a wall of the room. Time is spent on discussing and defining these terms so that there is a reasonable degree of consensus on meaning. Facilitation

involves periodically re-emphasising that the discussion is related to caring for males and not caring for people in general. It is also emphasised that information giving should be in the form of brainstorming and subsequent discussion should seek clarification or assist others to clarify their thoughts. There should be no criticism or dismissal of the thoughts of others. Seeking clarification from others about their understandings is to be the focus. This stage takes by far the greatest amount of time as the clarity of definition is considered vital to the process overall.

Thirdly, the group is asked to rank which behaviors/abilities they feel best assists connection with their clients. Each participant has the same number of "points" to allocate. In this case they have six tokens to distribute amongst the identified behaviors. One token is worth three points, two tokens are worth two points and three tokens are worth one point. They are asked to allocate these points individually without any discussion. This is a very prescribed, organised process. In effect, the number and worth of the tokens is quite an arbitrary decision. What is important is ensuring that the group members are able to assign value or importance to the identified behaviors without their decision being influenced by myself as the facilitator or by dominant individuals within the group. As mentioned previously, a major disadvantage of focus groups is their ability to be easily biased by the facilitator and/or dominant individuals, either consciously or unconsciously. This can have a significant censoring effect (Sim, 1998). Following this the participants prioritise a number of concepts that they earlier identified as assisting in caring for distressed males. The points for each behavior are then totalled. The participants are then asked if these totals reflected their belief of the relative importance of each behavior.

The session is audiotaped for future reference.

Ethical Considerations

The consideration of ethical issues that might arise during the project began prior to the formal commencement of organising the focus group. In many ways the ethical issues related to focus groups are the same as for other forms of research. For example, issues such as informed consent (including knowledge of the aims and how results will be used), the right of refusal to participate at any time, and respect for confidentiality.

There are some issues peculiar to focus groups that should be mentioned. While privacy and confidentiality issues are common to research activity, the fact that information is shared with group members raises important considerations. Morgan (1988) suggests that there are two perspectives to this, the first being the attention that needs to be paid to addressing these issues with the group, particularly at the beginning and at the end of the process. The second perspective relates to the role of the facilitator in moderating their questions in order to avoid placing somebody in the position of being asked or expected to disclose information they would not want shared with others.

There was an added difficulty in my role as a nurse educator, which could potentially compromise my relationship with participants who may also be students. As a journal entry noted at the time,

I'm hoping to canvas registered nurses that are students in the Degree programme. There's an issue here about my role as a teacher and how to manage these issues; how I could potentially abuse these relationships or otherwise misuse my position.

Mitchell, presentation to
study group, 1998.

After discussion with my supervisor, it was decided that a prerequisite for participation would be that participants should not be students enrolled in any programme I was teaching. This was because of the potential for a perceived

power differential to negatively affect relationships within the focus group and also within the teacher/student role (as previously mentioned).

Obtaining ethical approval

The process for obtaining ethical approval was to obtain an application form and meeting schedule from the Regional Ethics Committee secretary. The completed application form was submitted. Following this, the committee replied by post querying several points. One particular point being that the committee was concerned about the potential for participants becoming distressed, asking, "What is your process if one of the participants reveals hurt due to a bad experience? How will you deal with this in a group situation?" (Letter from Ethics Committee, 1998). The reply was as follows:

This is always a concern and the range of situations that may occur is extremely broad. In my experience, working with "difficult males" almost invariably involves some degree of trauma for the nurse. Nurses manage and discuss these situations quite commonly, with the dialogue often being helpful and (in a sense) healing. I expect that this form of dialogue will occur within the group. If a participant reveals trauma (either personal or professional) that is more severe, the person's experiences will be validated (acknowledged). The group will be paused and I will talk to the person individually. We would need to discuss the advisability of continuation in the group and availability of appropriate support (eg. workbased OSH practices and/or professional counseling)

Mitchell, Letter to Ethics Committee, 1998.

Other areas which the committee required clarification on were the timing of the project (it was felt the timeframe was too short), and that there was no mention of a report being made available to participants.

The “National Application Form for Ethical Approval of a Research Project” is a comprehensive document clearly written with quantitative research in mind. This seemed inconsistent with the process of a small qualitative project, with many questions being related to drug trials and research involving other medical products. Qualitative research often involves small numbers of people with the information shared often being of a very personal and intimate nature. The very formal wording combined with the rather rigid guidelines for the construction of Information Sheets and Consent Forms (See Appendices 5 and 6) created a situation where the development of trust with some participants was compromised as they preferred a more relaxed and informal approach to the sharing of insights and experiences with others.

Conclusion

This chapter has detailed the development of focus groups as a research method, including advantages and disadvantages. Experienced registered nurses were chosen as participants mainly because of my familiarity with the culture of this professional group. Using a focus group of registered nurses as the primary method of gaining data for analysis seemed an exciting and creative way of exploring issues related to caring for distressed males. It was exciting in that there was the possibility of collecting a large amount of information that was an accurate reflection of the values and beliefs of the group at that time. It also seemed creative in that what might eventually be identified was unknown by any of the group at the commencement of the process. At a more practical level, the registered nurses seemed more amenable to being part of a research project when the method used was seen as pertinent and interesting, and was not going to take up too much of their time.

The process followed has been detailed in this chapter. It was a process with which I had previously been involved. As mentioned earlier, it was a process that I believed best maximised the many advantages of focus groups yet had

strategies that went some way to minimising the disadvantages inherent in this method. I had considerable faith that this was the most appropriate method with which to meet the aims of the thesis.

Ethical considerations proved a challenge to explore and accommodate. However, the professionalism and genuine interest of potential participants as well as others has proven enormously supportive. What has been most challenging is the process of formal ethical approval. While the intent of this formal process seems beyond question, that being adequately protecting and informing participants, the detailed and formal tools and processes used to grant approval seemed to create a situation of disquiet with some participants. These people were concerned with the detailed and rather authoritative wording for an exercise that they considered should be relaxed and reasonably informal.

My analysis and reflections on what actually occurred in the focus group are discussed in detail in the following chapter.

Introduction

This chapter details the findings of the focus group. In the interests of clarity these findings are presented in two sections. The first section is considerably more detailed than the second, listing areas that were identified in response to the question "What behaviors/abilities do you use that have proved effective in helping you care for "difficult" males" (It should be repeated here that time is spent in clarifying that by "difficult" is meant those males who use behaviors such as anger, silence or humour as a way of managing their distress). Ten specific concepts that the group identified are presented. This data is supported by quotations from individual participants in order to portray something of the discussion as the group attempted to achieve a consensus in their understanding. Parallel to this discussion, the process of how the focus group developed will be outlined as the group began to work more and more effectively with increasingly complex concepts.

Next, the process the group works through to decide upon the most important areas of the ten is outlined along with a description of how decisions were made.

Secondly, the participants' response to the question "Where did you learn these behaviors?" will be presented, again with supporting quotations.

Question one: "What behaviours/abilities do you use that have proven effective in helping you care for "difficult" males?"

The findings of the group

Humour was the first concept that was identified as aiding caring and connection with distressed males. How humour acted as a platform for the building of trust was explored. The sense here was that the participants were

very tentative in sharing their ideas with one another and that this was a relatively safe introduction. Humour was described as generally being non-threatening, acting as something of a stress release strategy especially at the beginning of a therapeutic relationship.

It doesn't work for everybody but when it does work it's great. When it works it's an icebreaker, it builds connections, builds trust and if it works well enough the person looks forward to seeing you again.

Participant 1

The ability of humour to assist connection was supported by several participants. Being "seen as one of them" and "being a safe way of connecting" were mentioned.

It might seem superficial to us but for the client it may seem very meaningful. Humour is generally non-threatening, a bridge. Humour's been a platform.

Participant 3

One participant added the thought that humour may not always be appropriate.

There are times when this wouldn't work... (you may be) seeming to be insincere and not taking the person seriously.

Participant 2

Being aware of and responding to body language was then identified as the second concept in connecting with distressed males. The group seemed to be moving into a slightly more complex area, although the discussion was still quite general. Here discussion was to do with issues of timing and physical distancing when communicating with males. Several participants mentioned respecting physical distance, sharing many of their experiences.

(Being aware of and responding to body language is) probably a lot more relevant with men where they're less likely to be telling you how it feels for them to be in that situation but they're probably showing you how it feels for them.

Participant 2

The importance of not being physically close to males was emphasised. It was notable that the "client's need for space" meant psychological as well as physical space. For example, the nurse's expectation of the time required to develop a therapeutic relationship with males was also pointed out. Suggestions such as "taking it quietly", "having no expectations of quick connections" and "don't engage real quick" were mentioned. The defence mechanism of denial was mentioned as providing a particular tension here.

We see a lot of it with denial, with coronary situations. (The men) keep reading books when there's obviously lots going on that they've never seen in their lives before but they pretend that nothing else is happening. We don't respond and give them information like the books tell you to.

Participant 5

Catching the moment was the third concept mentioned and was essentially a consensus that the group achieved after considering a range of loosely related ideas. The group now seemed to be working together, attempting to find common areas of concern and insight as well as attempting to find strategies for managing situations that arose. Examples of these loosely related ideas were "attempting to find a common ground", "engaging through activity" and the "sharing of self".

The ones who are difficult to engage are often able to engage through doing things. (it's a real bloke thing). Doing things together, going for a walk, just talking about sporty things. You engage at that sort of level.

Participant 6

"Catching the moment" was never clearly defined and is perhaps best seen as an introduction to the fourth concept. However, the discussion did re-emphasise the importance of acknowledging that caring for distressed males is quite a unique activity.

The **use of language** was the fourth concept. Participants offered a range of personal insights and experiences in support of this. There was a noticeable increase in sharing of ideas and experiences. It was here that I developed a sense that the group was beginning to work more closely together, developing a greater degree of trust as the session progressed. While participants acknowledged that the language used by the registered nurses was generally the same in regard to gender, there were distinct differences in specific areas. Firstly, that males respond to different verbal cues. Several participants mentioned a more "honest", "easy going" and "straight forward" structure to the language that was used.

The language I use with men is different perhaps. It's less flowery, more straight forward because I sense that they can relate to that easier than coming out with a whole lot of descriptive, emotional language. It is perhaps more easy for men to relate to more straightforward language.

Participant 2

The difficulties involved in communicating with younger males was acknowledged as being a special challenge.

I struggle to connect with young men, I really do. Even though I can understand where they're at, because I was difficult when I was young, very difficult. I don't have a clue sometimes I really get confused. But you find a way you do. You just keep trying and trying. There's something there (that) they're interested in that you know something about.

Participant 1

From another perspective the expectations of the nurse were considered an important variable. Nurses were thought to have (at least at times) an expectation that clients would respond in a positive, open manner to a concerned, sensitive and empathic approach.

And also the expectation you have of the language they will use. Sometimes we expect people to describe quite a bit of their emotions and sometimes with men that's not easy for them ... it doesn't seem that easy, and it kind of creates this awkward silence ... especially if you're expecting them to come out with all this stuff.

Participant 2

Listening was identified as the fifth concept. While this concept was in contrast to that of the former, the themes that emerged were remarkably similar, especially in relation to working with people from differing age groups. It was noticeable that the group was now entering into a deeper discussion involving more complex aspects of nonverbal behavior. The skills involved in listening were particularly noticeable in the opinions related to younger males.

There is a difference between (listening to) younger men and older men ... older men have longer stories, going off on a different axis. Younger men are usually more silent.

Participant 9

Similarly, it was agreed that while listening was important with all people, caring for males (in the opinion of several participants) required specific skills.

Knowing when it's time to finish talking. Listening skills are very important. Especially, in my line, we need to get a story from when they first come in and often these stories are very long and very involved. But you don't interrupt them because they like to tell you the whole story. So it's important to sit and listen, then you can lead on from there.

Participant 9

"Letting them go" and "letting the story out" were ideas that emphasised the importance of not interrupting males when they are talking.

Identifying areas of pain was identified as the next concept. The group began to conceptualise antisocial and often frightening behavior (for others) as symptomatic of distress. It was noticeable that as the discussion progressed the group was beginning to spend more time on each area, discussing, sharing and exploring differing perspectives with greater ease. It was certainly my impression that the participants were beginning to build and develop new meanings through their dialogue. An example perhaps of the synergistic effects of focus group method.

"Pain" was described as often being expressed through anger. There seemed to be a consensus that this was more typical of males, regardless of whether the anger was related to physical or emotional pain. The group discussed what they termed as "silent" and "overt" expressions of anger and that it was considerably more difficult to connect with those that expressed their anger silently. However, regardless of how the anger was being expressed, it was considered vital to attempt to understand and/or identify what was going on for the person.

There's something about identifying areas of pain or difficulty for the client, especially angry (client's). Whenever I find a client who is angry I hone in on that, depending on what the anger is of course psychosis or whatever, so I try to find out from them where the areas of, what is the problem "You tell me?" They might see a whole range of things that are the problem. I try to listen in a non-threatening way "Who are you angry with? What are you angry about?"

Participant 3

How anger can be an extremely effective distancing behavior was discussed. That males who are angry often do not recognise this feeling, let alone know what the problem is, was identified as an important factor. It was suggested that

not only does anger distance males from others but it distances them from themselves. Several participants identified one role of the nurse as being a person who helped the client find the words to describe his experiences and/or feelings.

There are times when you move into that other space where you actually have to question, you actually have to say, not always, but if you know your client quite well it could be vital to say "Hey, why, what is it with this anger", and he couldn't actually say. When he got really, really angry and I'd say, "Hey, what's going on?" It was pain.

Participant 8

Experience and intuition, while not exactly behaviors, were identified as the next concepts. Here the group was moving away from specific behaviors to more abstract concepts. Again I considered this to be an example of the group developing consensus and an ability to work together. The sharing of more detailed and personal/professional information continued.

Life skills, intuition, gut feelingknowing there's a problem, timing, all those things. (Experience and intuition) takes in all these thingsjust about.

Participant 5

If you're a new person to this game you won't know it. You learn through your mistakes. Doing nothing doesn't work. (In one situation) I did nothing and it didn't work. So what I learnt from that experience was that for me to work with people whose behaviors are something that distances them from me, I have to go and talk to them and I have to do it quickly. In fact people prefer that honesty, that straightforwardness.

Participant 7

Intuition and experience were not only related to developing insight and skills into what is effective in caring for males, but also involved knowing about

“self”. That is, being aware of the dynamics involved with behavior that is perceived as “difficult” and how this perception may be more about the nurse’s intrapersonal issues rather than those resident with the client.

Because experience has taught me that often these issues aren't really issues for the person, they're my issues. So it's good to get it out there and find that out.

Participant 7

That experience and intuition can also prepare a nurse for understanding and accepting that not all clients respond in a positive and grateful manner to caring behaviours, was also identified.

Sometimes, no matter what you do, it's not going to move you any closer to that particular person. Particularly if they don't want much from you. Or, what they want from you you're not going to give them. Say, somebody who's drug seeking, we see a lot of that. Just acknowledging, I use whatever skills I can, but don't expect any wonderful results from this.

Participant 6

Knowing your limitations was identified as the next concept. This was an interesting development as it moved the discussion to a different aspect of the therapeutic relationship. Here the discussion was being broadened to explore areas of the broader therapeutic environment. While discussion was brief, this concept was thought essential in maintaining safety for both the nurse and the client and (especially in regard to males) in building and maintaining trust.

I think there is a positive side to that. It's looking at your own limitations. I have a client who (my) passing onto somebody else is a positive move. They may get that (better) rapport, it's just one of those things. Some are better with other people's personalities than others.

Participant 8

Sharing power with the client, the next concept, opened an interesting dialogue. Here the discussion was detailed and reflective with the participants sharing their thoughts openly and freely with each other. The topic here involved the participants grasping and working with quite complex issues. Areas such as partnership, and safety and security in therapeutic relationships, were identified and discussed.

I think it is sometimes useful to talk about the interaction as a partnership, whatever the presenting problem of that client is. I'm very clear about what my role is in the partnership and it's really, I guess, giving the client freedom to figure out what their role is in it. I know what my role is and I'm quite clear about this. So my power is quite secure within me. If they want to latch hold of that, it's there but still giving them some room to kind of find their own power... and keeping some power over the situation too.

Participant 2

Discussion then moved to sharing power and assisting clients to find their own power. Also, how these actions impacted on trust, dignity and choice.

There's something about being in control. There's something about this that is securing. What I'm finding is that safety, feeling safe in my control ... not in a heavy sense, though sometimes it needs to be. But it's just that safety they feel with a solid team around them. It's how we invoke that (feeling). In my experience this builds trust and that's a bridge. That's really what it's about isn't it ... trust.

Participant 3

The situation of "power over" the client was suggested as being (at times) a very necessary aspect of nursing "care", although care in this sense was never elaborated upon.

I make it clear that when there's good reasons why, sometimes, power needs to be taken away (from the client), and it will be ...that it's needed. Sometimes people want to hear that too ... that if they get too out of control

there's somebody who is going to step in ... that they don't have to do that for themselves ... they can ... but there's a kind of, like, a bottom line.

Participant 2

Mirroring was the next concept identified. Mirroring has been described as the therapists ability to accurately reflect the clients real thoughts and feelings so as to provide the opportunity for them to regain contact, in a constructive manner, with their pain (Johnson & McMahon, 1996). As such, mirroring should be considered a complex skill where the nurse, both verbally and non-verbally, provides opportunity for the client to connect with their distress. Mirroring can find expression in quite a simple form such as the following example:

Sometimes for people to hear you say "pissed off" ... that can be an enormous relief to them. That you as a health professional are going to use that sort of language, or can use that sort of language.

Participant 2

However, there was a sense that the group was considering this concept as a complex blend of skill and understanding. Mirroring was discussed as having both verbal and non-verbal aspects and that both of these could occur on an unconscious as well as a conscious level.

It helps connect and it's a process that happens almost unconsciously. It won't always work with somebody who's very cynical and aware of it, but generally speaking it certainly helps. It's a way of connecting as long as it's done in a sincere and natural way. It becomes more natural with experience.

Participant 6

Regardless of the level of skill and the medium of expression it was generally felt to be an ability/behavior that was very effective in assisting connection with male clients.

Scoring

As mentioned in the previous chapter, the group were then asked to rank which concepts they felt best assisted connection with their clients. This was done individually, with participants being instructed not to communicate with each other while they made their own decisions re the weighting that they would give to the identified behaviors. Each participant had the same number of "points" to allocate, each having six tokens. One token was worth three points, two tokens were worth two points and three tokens were worth one point. The value for the tokens was a choice merely of convenience, the aim being to enable the participants to assign value to the concepts. The participants were asked to decide upon how they were going to allocate these without discussion. Once they indicated they had all reached a decision they were asked to attach their tokens to the newsprint alongside where the specific behaviors were written. Again, no discussion was entered into. At the end, the participants had prioritised a number of concepts that they earlier identified as assisting in caring for distressed males.

After allocating the points, the group was then asked to stand back and total the individual scores each concept had attracted. These scores and their ranking are listed in Table 2 (p65).

Table 2. Results of the ranking exercise

1. <i>Experience and intuition</i>	(28)
2. <i>Being aware of and responding to body language</i>	(12)
3. <i>Sharing power with the client</i>	(8)
4. <i>Catching the moment</i>	(7)
5. <i>Knowing your limitations</i>	(7)
6. <i>Listening</i>	(7)
7. <i>Use of language</i>	(6)
8. <i>Humour</i>	(5)
9. <i>Identifying areas of pain</i>	(2)
10. <i>Mirroring</i>	(0)

These combined totals were expected to portray the group's consensus. To obtain some degree of confidence in this assumption, the group were then asked whether these scores were something that they could live with. The group replied in the affirmative.

Following this exercise, the second phase of the group was begun with the following question being posed.

Question two: "Where did you learn these behaviors?"

The opinion of the group

In response to the question, "How were these skills/abilities learnt? Was it nursing education or any other formal process?", there was a round of rather derisive laughter. I took it that the laughter indicated an emphatic "no" to this

question, with the group viewing formal educational processes as being quite inept in this area. Conversely, stories of informal learning in this area were quite forthcoming.

When I worked in a factoryI worked my way up the ranks and learnt how to get the best out of people and how to problem solveI often draw (on these experiences).

Participant 3

It has previously been suggested that identifying intuition and experience as behaviors/abilities that have assisted in caring for distressed males was perhaps an error of judgement. Indeed, at the end of this discussion it was suggested that the categories should be altered. The following statement was typical of the discussion.

I'd almost like to see experience/intuition taken out, completely out of there, and have that as your main heading with all the other things coming under that, because all those things feed into that.

Participant 7

Although several of these points seemed valid it was felt that group consensus and synergy were the dynamics informing of the scoring. Having insisted that this be done individually it would then be incongruent to change the process in retrospect. However, the overall scoring does indicate the group's strong support for intuition and experience as being important in some way. Perhaps this can best be understood as the group's support of an approach to skill development and overall understanding that is quite distinct from formal educational processes.

Conclusion

This chapter has presented the finding of the focus group. It has briefly outlined details about the participants and about the introductory phase of the focus group. The chapter then went on to present the findings of the focus group in relation to two questions that were asked; "What behaviors/abilities do you use that have proved effective in helping you care for "difficult" males", and, "Where did you learn these behaviors?" There were ten concepts identified in response to the first question. Each of these were discussed until it was felt that as near a consensus on meaning was achieved. The group then went through an exercise of prioritising the listed concepts identifying those most important in the opinion of the group. There was a brief discussion in response to the second question with a very clear message received that understandings of how to care effectively for males were gained through life and clinical experiences rather than through those of formal education.

While not an aim of the thesis, the developmental process the focus group moved through as it began to function more effectively as a working group, was briefly discussed.

These results have identified some intriguing points. For example, points that emphasise specific communication skills and issues to do with power and its management as important considerations when caring for distressed males. However, what these mean in relation to the questions and issues that underpin the thesis remains unclear. These perspectives will be explored and analysed in the next chapter.

Introduction

In this chapter information gathered from chapters two and five will be analysed using a framework developed from the questions posed in chapter three.

To recap. Chapter two reviewed a range of literature related to masculinity, gender issues, men's health and caring for males. It also identified themes that appeared to relate directly to the discourse in these areas. For example, the literature on masculinity paints a picture of males as being combative and isolative, unable to relate on an effective interpersonal level with their fellows. The literature on issues related to gender creates a picture of males as supporters and perpetrators of a patriarchal society that continues to discriminate against women. The literature on men's health is largely based in physical medicine whereas there is growing evidence of men's emotional health being severely at risk. Finally, the literature on caring for males suggests that effective caring for this group of people requires quite distinct knowledge and skills. Also, that the situation where males present with more stereotypical, "distancing", behaviors creates even more of a challenge to care.

In Chapter five information that the participants believed were the key behaviours that had assisted them in caring for males was presented. Ten key concepts were prioritised to establish which ones the participants felt were the most important. For example, experience and intuition; being aware of and responding to body language; and, sharing power with the client. In addition, the group's response to the question, "where did you learn these behaviors?" was outlined.

Chapter three grounded the thesis in my experiences; experiences as a male, as a father, as a nurse clinician, and as a nurse educator. Reflection on these personal and professional experiences resulted in the following key questions: Do registered nurses frame the behavior of males who express their distress in ways that are difficult to manage, as antisocial behavior rather than attempts at

coping? Are registered nurses constrained by their own socialisation in their ability to care professionally for distressed men? Are there gender differences in the manner in which distress is expressed? If there are differences in the manner in which distress is expressed, how do registered nurses manage these differences, if at all? Are current (nursing) understandings of caring based in an ontology that is female? Further, are other ways of understanding and enacting care known and/or valued within nursing?

These key questions will now be used as a framework for analysis.

Question one

Do registered nurses frame the behaviour of males who express their distress in ways that are difficult to manage, as antisocial behaviour rather than attempts at coping?

From the review of literature regarding perspectives on masculinity and the behavior of males (especially in regard to their health care needs) it was concluded that little has changed over recent years. Males continue to be portrayed as isolative, needing to feel powerful and being generally uncommunicative about their emotions (Brannon, 1998; Phillips, 1996). At worst, male behavior is portrayed as being ill informed, irresponsible and antisocial. The following quotation is typical of this theme.

..... heavy use of alcohol, reckless behavior, the high accidental and deliberate injury and death rate. Even our unenviable teenage pregnancy rate and the growing number of young solo mothers reflect an avoidance of responsibility on the part of young men, and an inability to sustain relationships with the opposite sex.

Coney, 1997, p117-118.

There is a small and hopefully growing amount of literature that does talk of males more positively. When this occurs the picture is one of people that care deeply about their lives, their relationships and their health, (Parr, 1995; Smith, 1990; Tannen, 1990).

The different positioning of language in the literature is interesting here. There is a very noticeable tension between terms and how they are used. More recently, it has been suggested that when areas of health and general coping of males is compromised in some way the reasons are often related to issues such as inadequate knowledge, inadequate skills, and isolation from supportive networks (Biddulph, 1999). An interesting reframing of the dominant discourse occurs when words such as those quoted in the previous paragraph (ill-informed, irresponsible, and antisocial) are changed to those suggested by Biddulph (inadequate knowledge, inadequate skills, and isolation from support networks). I believe this rewording offers a language where the behavior of males can be explored from a more positive perspective. It is of concern that the amount of reviewed literature from this more positive perspective is almost non-existent compared to the vast amount that views males as perpetrators of their own misfortune (Firn, 1995; Phillips, 1996). Furthermore, it is concluded from the literature review that the positive framing of the stories of males occurs almost exclusively in more popular literature, with the more "scholarly" literature lacking in this regard.

In contrast to the negatively positioned literature, the discussion in the focus group was continually framed in the positive. While it can be argued that the facilitation of the group was positioned positively in regard to the central question (ie., What behaviours/abilities do you use that have proven effective in helping you care for "difficult" males?), the registered nurses seemed to have no difficulty in framing their discussion from this perspective. Indeed, the participants consistently talked of men's anger, silence, and other distancing behaviors as being expressions of ill health. It was as if these were expected and quite legitimate expressions of distress. While this was not stated overtly, all

dialogue was framed from this perspective. The following quotation is an example of this.

We see a lot of it with denial, with coronary situations. (The men) keep reading books when there's obviously lots going on that they've never seen in their lives before but they pretend that nothing else is happening. We don't respond and give them information like the books tell you to.

Participant 5

Similarly, the position that males are interested in their health was inherent throughout. A constraint on this being that males are not only unable to discuss the issues that arise for them, but that they do not possess the language or even the schema for this to occur. The following quotation supports this position.

(In regard to the language that is used) The language I use with men is different perhaps. It's less flowery, more straight forward because I sense that they can relate to that easier than coming out with a whole lot of descriptive, emotional language. It is perhaps more easy for men to relate to more straightforward language.

Participant 2

It was suggested males often needed a mentor to interpret and to otherwise facilitate discussion of health care needs. Several participants in the focus group saw this as an essential part of the role of a registered nurse. Again, this was not obvious in the dialogue but was inherent in the examples being cited.

Overall, there seemed to be a distinct contrast between how the behaviour of males is portrayed in the literature and how a small group of experienced registered nurses perceive of, and relate to males. The reviewed literature does appear to paint an overwhelmingly negative picture of the behaviour of males generally, and also in relation to the manner in which they attend to their health. Conversely, the discussion in the focus group was continually framed in the

positive. The participants seemed to have moved beyond that of the dominant discourse, recognising and responding to distress rather than to difficult behaviour.

Question two

Are registered nurses constrained by their own socialisation in their ability to care professionally for distressed males?

While not directly related to the background from which this question was developed, the concepts of "control" and "power" and how relationships are maintained between genders was commonly referred to in the reviewed literature on issues related to gender (Griffin, 1993; Spender, 1990). The oft mentioned position was of males maintaining their dominant position in society through a range of controlling and manipulating behaviors over others, especially women (Rafael, 1996; Spender, 1988). Nursing related literature does talk about institutionalised power and how this impacts negatively on the development of nursing as a profession (Bickley, 1989; Rafael, 1996; Thompson, 1987). However, in regard to caring within a nurse-patient context, it has been suggested that nurses "express discomfort with the idea of power. (As) caring is considered central to their practice it is perceived to be incongruent with the notions of power" (Rafael, 1996). Within the literature the concept of power appeared to be viewed mainly from these two perspectives. Either power was seen as an aspect of patriarchal influence, negatively affecting the profession, or alternatively was seen as being inconsistent with the concept of care.

The perspective that males use controlling behaviours in an attempt to maintain power was not evident in the focus group discussion. The consensus was that it was the registered nurse that was the person who made decisions about how to mediate power within the nurse (male) -client relationship. The concept of power was described in several ways. Firstly, in relation to language.

And sometimes I think we need other people to put that into words for them, because they can't. You do have to be sort of "leading", almost. They just get so caught up in the feeling of it; they do seem to have difficulty (with this). I don't know, but it does seem that you do have to put it into words for them.

Participant 2

Secondly, in terms of negotiating a partnership with the client

I think too, as far as this control thing goes, for us things are sometimes a little bit different in that I understand what you say about a client needing that feeling of security from you as a health professional. I think it is sometimes useful to talk about the interaction as a partnership, whatever the presenting problem of that client is. I'm very clear about what my role is in the partnership and it's really, I guess, giving the client freedom to figure out what their role is in it. I know what my role is and I'm quite clear about this. So my power is quite secure within me. If they want to latch hold of that, it's there but still giving them some room to kind of find their own power... and keeping some power over the situation too.

Participant 2

Thirdly, in terms of where power ultimately lay.

It's choice, but there's an element of "This is it, and this is how it will stay, no matter how out of control (the client) feels and they can rely on this.

Participant 7

What differs from much of the discourse on power is that the group viewed power as inherent within the role of the nurse, as an expected element of professional life. Indeed, there was a sense that the group viewed the mediation of power as a caring behavior. This idea is consistent with the concept of "empowered caring" (Rafael, 1996), which suggests power can be used in enabling growth in others. However, Rafael was suggesting this concept as a future vision for nursing. In contrast, here was a group of registered nurses actively using these concepts in their current practice.

It is the position of this thesis that the discourse in the literature related to gender places registered nurses in a situation where their ability to care for males in an empathic and sensitive manner is compromised. It is unclear why the contrast in the behavior of the focus group participants was so marked in comparison to the literature. However, it is clear that the participants considered that the insights they were describing and discussing were not informed by formal educational processes, theory or research. The following quotation describes one area of learning.

I learnt a lot as a barmaid ... and I've often made comparisons with being a barmaid and the work I do now. About talking, about listening with men who are distressed and who come somewhere wanting to offload. But it's also the anger thing, often fuelled by alcohol obviously...learning to sense when it's time to back off or when you're able to engage, to make some form of connection...a lot of these skills.

Participant 2

This quotation was typical of the conversation. There seemed to be unanimous agreement that nursing education, literature, and research contributed very little indeed to the professional issues the group often encountered in working with distressed males. The participants seemed quite unconstrained in their ability to explore and discuss complex areas of care with considerable insight and sensitivity.

Question three

Are there gender differences in the manner in which distress is expressed? If so, how do registered nurses manage these differences? If at all?

The literature reveals a considerable amount of work that explores women's experiences with health care (Rafael, 1996; Russell, 1995; Smyth, 1992). This information ranges from that aimed at the popular reading market (Coney, 1997), to that informing professional groups (Munns & Rajan, 1995), and to

academic research and debate (Griffin, 1993). From the review of the literature it is noticeable that there has been very little (of a qualitative nature) that explores the views and experiences of males and their health care needs. It is also of note that the reviewed literature regarding masculinity, gender, men's health, and caring for men, draws heavily on anecdotal and personal perceptions of relevant issues (Clay, 1989; Lee, 1993). Research activity, especially of a qualitative type, is noticeably meagre. Why there should be such a paucity of research in this area is unclear. One thought is that it could be to do with the position that as most research carried out in the past has been about and for males, as well as being carried out by males, more research is needed about women's experiences. (Rafael, 1996; Russell, 1995; Smyth, 1992). This position ignores my suspicion that most past research was positivist in nature tending to explore statistically significant information rather than listening to and exploring the experiences of males. In regard to research activity, the perspectives, stories and experiences of males were ignored as those of women were, certainly in relation to their health care needs. However, when qualitative nursing research related to males has been undertaken, the information gained consistently supports the perspective that males do experience and respond to health related situations quite differently than females (Hoch, 1995; Moore, 1995). Furthermore, that nurses need to understand these differences in order to provide effective, professional nursing care. Overall, the literature reviewed for this thesis was sparse in this area. Whether the question is interpreted to be in relation to the physical, emotional, social or spiritual environment, what was most noticeable was a marked absence of information.

In contrast, the participants in the focus group were quite emphatic that males do express their needs in quite a different manner to females and are indeed quite different to care for. The group appeared to accept this implicitly, supporting this idea by identifying specific communication skills appropriate to males.

That would be the key for me. If I'm with (a male) who I'm struggling with, having a difficult time with (in my terms) then the best thing I can do is to be straight "up-front"

with them and say what I think. Being really honest about how it's affecting me and getting on to some turf where we can talk about it. I'd probably do that for females, but I'd do it differently for men.

Participant 7

Indeed, the majority of the ten concepts identified in the focus group (ie. humour, being aware of and responding to body language, use of language, listening, identifying areas of pain, sharing power with the client and mirroring), are directly related to communication skills that are quite specific in managing the dynamics of caring for males. There were several occasions when the facilitator asked for clarification that the discussion was indeed related to males, and was not becoming a generic discussion on communication. The reply was consistently in the affirmative.

It is clear that whenever the topic is addressed, whether in the focus group or in the literature, gender differences in the manner in which distress is expressed are noticeable. Also, the registered nurses in the focus group were aware of, and practise a range of communication and other skills that assist the client to manage these tensions.

Question four

Are current (nursing) understandings of caring based in an ontology that is female? Furthermore, are other ways of understanding and enacting care known and/or valued within nursing?

It has become apparent that to explore concerns related to ontological perspectives in any depth is quite beyond the capabilities of a small exploratory study such as this research project. However, it is possible to make some general comment based on themes that have been identified from the literature review and concepts that have been identified by the focus group.

Only a small amount of literature related to caring was reviewed. The aim was to present something of the current dialogue on this topic within nursing. It was pointed out that while the perspectives of nurse theorists such as Leininger and Watson are well known within nursing, some writers are questioning the idea of the centrality of care within the profession (Morrison, 1992; Phillips, 1993), while others point to a perceived narrowness in the construction of the concept within nursing (Warelow, 1996).

The concept of caring was not specifically discussed within the focus group. However, the emphasis was on what assisted registered nurses to care for males. Caring was evident by the common use of terms such as "building connections", "sharing of self", "moving into that other space", "trust" and "acknowledging safety". Of particular note is that when the participants talked of partnership, they not only addressed this concept, but addressed it within an understanding of the tensions that arise in relationships of unequal power distribution. They explored these issues in depth and shared their understandings with considerable respect. Such was the degree of understanding that I was left with the thought that there was a consensus on what it is to care for distressed males. Furthermore, this consensus was built around ideas, insights and values that are common in the literature on caring.

Conclusion

This chapter has analysed aspects of the interface between gender issues, nursing practice and caring for males. Informed by a review of relevant literature and by the thoughts of a focus group of registered nurses, the analysis was framed by questions that were developed from a series of reflections on my personal and professional life. Critical social theory, with its emphases on dominant dialogue, power and emancipation has been used to inform and guide this analysis. What has been most obvious is the contrast between the themes

identified from the literature and the concepts gained from the participants in the focus group.

The literature was found, in the main, to negatively position the subjects of masculinity and issues related to gender and men's health. By this it is meant that males are more often portrayed as arbitrators of their own misfortune, as deliberately choosing a lifestyle that reflects poorly on their health, their self expression, and communication with others. Concepts such as power and control over others, both at a societal and individual level, feature frequently. Conversely, the literature was noticeably lacking in regard to information about the health related experiences of males, and also about caring for males.

In contrast, the participants of the focus group consistently framed their discussion in the positive. For example, taking the position that males are indeed interested in their health but require an environment that is supportive of this expression of interest. The participants also suggested that it was the registered nurse rather than the male who managed issues to do with power and control. Finally, the participants had no difficulty at all in identifying a range of behaviours that they believed were effective in caring for males.

In the final chapter, the overall aims of the thesis will be reviewed. In addition, there will be reflection and evaluation of the process of writing the thesis, as well as comments on the limitations of the research approach. Finally, comment will be made on future possibilities and challenges to do with the subject of caring for males.

Introduction

This thesis has involved the identification and exploration of themes from a critique of literature related to masculinity, gender issues, men's health and caring for males, as well as the findings from a focus group discussion. The thesis has been grounded in my personal and professional experiences. Answering the questions posed in chapter three has revealed a surprising, distinct and even paradoxical position between the "theoretical" knowledge of nursing in regard to caring for distressed males, and the lived experiences and understandings of the registered nurses in the focus group. It was expected that there would be a difference. What was unexpected was the extent of this difference. The contrast between the critique of the literature and the experiences of the registered nurses was so marked that comment should be made and further questions asked. These will be organised under the headings of "the overall findings", "towards safe practice", "nursing and the future", "the role of research", and "reflection on the research process". This chapter is an attempt to collate and explore these observations and make suggestions about future endeavours that might prove enlightening and beneficial to the environment surrounding nursing and the care of males.

It should again be acknowledged that this is a very small project and that the participants in the focus group were a convenience sample. Hence, no attempt is made to generalise the findings to the registered nurse population as a whole. However, the findings that emerged were validated within the group and I believe these may well prove valuable to the knowledge base surrounding the interface between gender issues, nursing practice and caring for males..

The overall findings

The aim of the thesis was to explore and find answers to three broad questions. Firstly, is it possible for registered nurses to care for "difficult" males?;

secondly, if it is possible, what particular understandings and skills do registered nurses use?; thirdly, where do registered nurses learn these skills? It should be repeated that by "difficult" it is meant those males who use behaviors such as silence, anger and defensive humour as a way of managing their distress and also as a way of creating "distance" between themselves and others.

In regard to the first two questions, the registered nurses in the focus group not only considered it possible to care for "difficult" males but were able to share insights and experiences of their care with a depth and clarity far beyond that which was expected. Indeed, with only a minimal amount of facilitation, these registered nurses articulated insights in relation to caring that went well beyond that which was accessed in the literature. Furthermore, the group had such an energy for this task that they appeared to have been starved of professional dialogue of this depth and quality. In contrast, the literature review consistently suggested that males do not articulate their concerns and do not seek assistance for them. The focus group reframed this perspective suggesting that males are often unable to articulate these concerns, as they do not possess the language that would enable them to do this. The registered nurses identified a range of communication skills that were considered important in connecting with distressed males, and also in assisting these males to recognise and understand their own distress.

In regard to the third question, the registered nurses talked of experience and intuition as the processes through which they had developed their understanding of caring for males. While these areas were not explored further, what was quite clear was the view that formal educational processes had very little part in informing their practice in this area.

Overall, I am left with the thought that this small group of registered nurses have insisted on practising from a deeply internalised ethic of care despite an environment that is largely unsupportive of this action.

Towards safe practice

The Nursing Council of New Zealand has published principles and guidelines that seem particularly relevant to the area of caring for "difficult" males. In their publication "Guidelines for Cultural Safety in Nursing and Midwifery Education" culture is defined as "the sharing of meaning and understanding." (The Nursing Council of New Zealand, 1996, p40). While the concept of cultural safety is based in the experiences of Maori (the indigenous people of New Zealand) the principles have been broadened to embrace those who differ from health care professionals, for example by such areas as age, sexual orientation and gender (to name a few). The guidelines specifically identify culturally safe practice as gaining insight "into the complexity of human behaviors and social realities." (ibid, p10). As the following writer explains,

Cultural safety is about power relationships in nursing service delivery. It is about setting up systems which enable the less powerful to genuinely monitor the attitudes and service of the powerful, to comment with safety, and ultimately to create useful and positive change which can only be of benefit to nursing and the people we service.

Polaschek, 1990, p453-4.

Culturally unsafe behavior includes "any actions which diminish, demean or disempower the cultural identity of an individual" (Hill, 1991, p5). A suggestion arising from the literature review is that this could well be argued as the situation facing males in respect to the limited attempts at meeting their health needs as well as the rather negative positioning of the literature. While it may seem at odds with the dominant discourse to suggest males as being in a less powerful position in regard to the delivery of nursing care, the literature review uncovered this possibility and the registered nurses in the focus group seemed to support this position absolutely.

Nursing and the future

While celebration of nursing's past must continue, nursing cannot rely on the ideology and values that have sustained it in the past to prepare and guide the profession for the future. It could be argued that nursing, as a predominantly female profession, identifies with knowledge framed in an ontology based in female understandings of the world. In relation to caring for distressed males, this thesis has gone some way to identifying a situation where the theoretical understandings of masculinity, issues related to gender, and men's health, support an environment that may be hegemonic in nature. The suggestion is that this environment may support practices that are discriminatory, even oppressive in nature in relation to caring for males. The following quotation provides some support for this position in relation to nursing.

There has been very little reflection in the nursing literature concerning the notion of feminist pedagogy or its practices. In many ways feminist pedagogy, as it is currently being practised in nursing education, is evolving into Foucault's (1980) 'regime of truth'.

Weyenberg, 1998, p345-50.

To provide professional protection and guidance in rapidly changing times, nursing needs to open itself to critique and to be proactive in ensuring this critique is rigorous and ongoing. Openness to sustained and rigorous critique of nursing and nursing practice seems absolutely necessary to identify and limit the potential for exclusive practices that may well discriminate against groups whose experiences differ from prevailing and dominant understandings. As the following writers point out,

Critical consciousness raising can be used by nurses in the 1990s to make explicit the power relations and structural oppression implicit in the nursing context ... injustices can be recognised as characteristic of oppressed groups in society, thus allowing for the opportunity of the development of a wider set of

possibilities for nurses and nursing by the challenging of taken for granted hegemonic discourses, and the validation of the richness of individual nurse's experience.

Cheek & Rudge, 1994, p60.

This quotation was from a journal article commenting on the need for nurses to become more political in order to address oppression facing nurses and women. In one sense, it may seem somewhat misleading to use this quotation in support of this thesis as this actions could be seen to decontextualise the focus of the article. However, in another sense, the perspectives expressed in this quote are entirely consistent with the findings of the thesis. A major point of this thesis is that nursing needs to broaden its understanding of oppressive practices to encompass the notion that nursing itself can be viewed as being a powerful professional group subject to the same hegemonic processes as are other groups. As Weyenberg (1998, p345) states, "Adopting a questioning stance, rather than merely proclaiming "all is bliss" in the feminist classroom, would benefit all who are involved in the construction of feminist pedagogy".

The role of research

The literature review suggested that the current knowledge base in nursing is extremely limited in providing information and guidance in caring effectively for distressed males. An example of this is revealed in a search of the Nursing Database "CINAHL" (the Cumulative Index for Nursing and Health Related Literature) with the descriptors "men's health" and "women's health" yielded 62 and 1858 references respectively.

The literature review revealed a theme that past research concentrated on males. Further, that males have largely managed research activity. This may well be true in relation to quantitative research, however the literature review also

revealed a lack of qualitative research in relation to males. The following statement this point.

That there is almost a total lack of qualitative nursing research in the area of men's health is beyond question. For nursing to meet it's goals this situation needs to change. At the present time there seems to be a lack of nursing research on health and ill health in relation to men. The impression is one of a neglected area. The evidence suggests that men's health is becoming increasingly problematic.

Adapted from White & Johnson, 1998.

When qualitative research has been carried out, differences in gender responses to health care situations have been shown to be marked (Dracher & Petrovic, 1996; Hoch, 1995; Moore, 1995). This thesis has gone some way in identifying a need for considerably more research activity in relation to the interface between the socialisation of gender, nursing and the health of males. This research activity needs to be rigorous and ongoing. Given the position taken in this thesis of an unsupportive environment surrounding caring for males it would seem that this research activity should be a priority. The current situation appears unsupportable.

Reflection on the research process

It seems appropriate to mention again at this stage that this project has a number of limitations. It is particularly limited in terms of its depth and scope. In terms of depth, the thesis has been compromised by the complexity of the area under study; that is, the interface between the socialisation of gender, men's health and nursing practice. In a project of this size I believe an overview of these areas is all that can reasonably be achieved. In addition, by utilising qualitative research methods as well as a focus group for the primary method of data collection, any hope of generalising the findings to a wider population is severely curtailed.

Concepts such as credibility and trustworthiness become the criteria by which to assess validity. Here, the professional judgement of the reader is paramount. While this is only a small exploratory project, I do believe it has the potential to make a contribution to nursing and to nursing practice.

In conclusion

The issues that have been explored in relation to caring for males are worrying and I believe need attention. Creating and sustaining an environment that is supportive of males, and sensitive to their needs is an activity that requires considerable thought, skill and experience, areas which this thesis suggests do not appear to be adequately addressed in academic dialogue, research activity, or in the educational preparation of registered nurses. This situation seems quite inconsistent with safe practice and should change. Considerably more research needs to be undertaken with males, registered nurses and members of other professional groups who work with and care for males. In particular, there is a need for research of a more qualitative nature that explores the lived experiences of these people. Research that will assist in increasing our understandings of what it is to be male in our society and of how best to work with and care for males.

My thoughts now turn to the participants in the focus group. Their contribution to this thesis is enormous and their professionalism and insight is inspiring. My one concern is that this group of professionals, who once shared so much, have now returned to an environment of increasingly heavy workload and demand. I suspect this environment cannot support the rich and detailed dialogue they shared in the focus group. I am left wondering why it is that experienced registered nurses, such a talented group of people and rich source of information so easily accessed and eager for dialogue, seem to be largely untapped. My hope is that this thesis has gone some way in acknowledging this source of professional knowledge.

Appendix 1 Letter of invitation to potential participants

Is it possible for nurses to care for the "difficult" male?

*An analysis of how nurses care for males who
use distancing behaviors (such as silence, anger and defensive
humour) as a way of managing their distress.*

I am researching this area as part of the requirements for a Master of Arts (Applied) Degree from the Department of Nursing and Midwifery, Victoria University of Wellington. Apart from this requirement, I also have a strong professional interest in the area and am keen to find out how registered nurses manage the tensions that working with "difficult" males create.

You are invited to take part in a small focus group of registered nurses (6 - 8 people) who are interested in exploring this question. In the focus group you will be asked to reflect on and share your experiences in caring for "difficult" males - what helped, what hindered and what informed your practice. What, when and how much you contribute is entirely up to you.

Although there will be set questions to be answered, it is hoped the session will be relaxed and informal.

It is expected that the group will meet in early February.

If you are interested in being part of this study and/or want further information please contact me on (03) 5483 931 (Home) or (03) 5462 472 (Work)

Yours sincerely

David Mitchell
Senior Academic Staff Member, Nelson Polytechnic.

Appendix 2 Information Sheet

Is it possible for nurses to care for the "difficult" male?

An analysis of how nurses care for males who use distancing behaviors (such as silence, anger and defensive humour) as a way of managing their distress.

Introduction:

I am undertaking this study to meet the requirements of an Master of Arts (Applied) Degree from the Department of Nursing and Midwifery, Victoria University of Wellington. In addition, this study could provide baseline information for future projects.

The study:

The study involves an analysis of information gained from 3 areas:

- a personal/professional reflection (of the researcher)
- a literature review
- a focus group of 6 - 8 registered nurses.

You are invited to take part in the focus group. This will take place in late January or early February and take from 2 - 3 hours. Light refreshments will be available. (See attached form for options of dates and times)

The focus group will involve:

- an initial discussion to clarify the nature of the study: background, aims and any other areas that may be of interest or concern
- identifying what has hindered your ability to care for males (who use "distancing" behaviors) in an empathic manner, and what has helped
- ranking those behaviors/abilities that have been most helpful to you in caring effectively for these males
- identifying where it was you learnt these behaviors/abilities

Inclusion/exclusion criteria:

Those taking part in the focus group will all be registered nurses with at least 2 years experience and have an interest in sharing their experiences in caring for males who use distancing behaviors.

Participants cannot be current students in any subject I am teaching in my role as a Polytechnic tutor. It is also important that all participants agree to protect the identity of others within the group and to keep the information that will be shared confidential to those within the group.

Storage of information:

No material which could personally identify you will be used in any reports on this study. Records will be kept in a locked, secure area. Records are required to be kept for 5 years when they will be destroyed by shredding paper and wiping digital information

The focus group will be audio-taped for use in summarising group discussion (if it is used at all).

Your participation in this study is entirely voluntary. In addition, if you do decide to take part you can withdraw from the study at any time without having to give a reason, or you can decline to respond to any of the questions asked.

Please note that participation in this study will be stopped if the facilitator feels it is not in the participant's best interests to continue.

Following completion of the study

- the conclusions of the focus group and a short report on the thesis will be made available to all participants
- the complete thesis will be available at cost to all participants

Please feel free to contact the researcher if you have any questions or require more information about the study

This study is being supervised by Ms Joy Bickley, Senior Lecturer, Department of Nursing and Midwifery, Victoria University of Wellington. Ms Bickley can be contacted on (04) 471-5363 Ext. 8497 if you have any queries about the study that you cannot attend to with myself.

This study has received ethical approval from the Nelson-Marlborough Ethics Committee. (The secretary of this committee can be contacted on (03) 546 6219)

Yours sincerely

David Mitchell
Senior Academic Staff Member
Nelson Polytechnic
Private Bag 19
NELSON

12 January 1999

Appendix 3 Consent Form

Consent form

I have read and I understand the information sheet dated 12 January 1999 for volunteers taking part in a focus group being part of a study designed to analyse the ability of nurses to care for males who use distancing behaviors (such as silence, anger and defensive humour) as a way of managing their distress.

I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect me.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I understand that I cannot be a current student of David Mitchell in his role as a Polytechnic tutor. I also agree to protect the identity of others within the group and to keep the information that will be shared confidential to those within the group.

I understand the compensation provisions for this study.

I have had time to consider whether to take part.

I know whom to contact if I have any side effects to the study.

I know whom to contact if I have any questions about the study.

I consent to the focus group being audio-taped. YES / NO

I hereby consent to take part in this study.

Date:

Signature:

Signature of witness:

Name of witness:

Full name of researcher: David Mitchell

Contact phone number of researcher: (03)548 3931

Project explained by:

Signature:

Date:

Please indicate below the dates and times that best suit you. Please indicate as many as you can so I can arrange a time suitable to most people.

January	26	1-4pm	6-9pm
	28	1-4pm	6-9pm
	30	1-4pm	
February	9	1-4pm	6-9pm
	11	1-4pm	6-9pm
	13	1-4pm	

The focus group will be held in Rm F209 of Nelson Polytechnic.

Could you provide a postal address here so that a report on the research can be made available to you.

Appendix 4 Notes for the Focus Group process

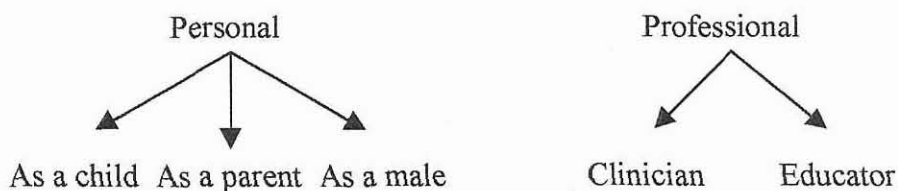
Focus Group Process

- Welcome

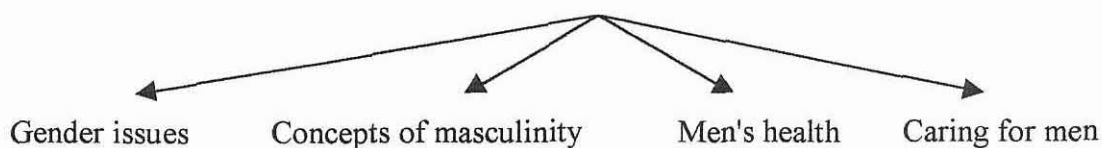
Introductions and review of issues to do with confidentiality.

- Overview (Write on whiteboard)

Underpinnings



Literature review



- Assumption underlying the project

1. This background creates a powerful stereotype for men
2. This also creates a situation where caring in a sensitive, empathic manner with men who are isolative and/or aggressive is difficult
3. That experienced RN's are able to manage these tensions in creative and professional ways
4. That these caring behaviors aren't informed by theory or research

- Stage One

What doesn't work when you have tried to "connect" with a male who keeps distant from you?

Write down, don't discuss

Rank these (if considered necessary)

1 = sometimes doesn't work 2 = often doesn't work 3 = never works

- Stage 2

What does work. What have you done that has helped you connect with men?

Brainstorm on newsprint - clearly define these terms and concepts

Rate these

1 = vital to do 2 = important to do 3 = helpful to do

Give out 3 * 1 2 * 2 3 * 1

- Stage 3

Take the top 3. Can they live with these as the top 3?

On separate paper, what has informed these behaviors.

- Stage 4

Farewells and thank yous

Appendix 5 Guidelines for the preparation of Information Sheets

GUIDELINES FOR THE PREPARATION OF INFORMATION SHEETS

Note: Information Sheets should be prepared on the appropriate letterhead of the researcher's institution.

1. GENERAL

The Information Sheet for participants in a study is very important. Not only does it set out the aims and methods of the study but it establishes the credibility and the responsibility of the investigator. It can be difficult to strike the balance between providing what the patient or participant should know and the mass of information that may be available.

Information should be written in a way that is helpful and clear. Not all people have the same command of the English language. Some for whom English is a second language may have special difficulties. The aim should be to produce documents that can be easily read by the participants.

The information sheet should be headed with the study title, in language appropriate for a lay person.

Obviously, all the details covered will not be appropriate for all studies. Paragraphs 5 to 8 inclusive raise questions that participants may wish to have answered. The information sheet does not have to be in question and answer form. If you have any questions about these forms, please do not hesitate to contact the Secretary/Administrator of the Ethics Committee, phone:

2. THE TEXT

Some methods for improving the comprehensibility of the text.

- 2.1 use positive phrasing. Negative sentences should be used only when emphasising actions to be avoided
- 2.2 avoid reassuring language in describing side effects
- 2.3 whenever possible, use active, rather than passive, sentences
- 2.4 use short sentences with only one or two ideas. Avoid sentences with complex and multiple clauses
- 2.5 avoid "jargon". If possible, use common words
- 2.6 place "inviting" questions before relevant parts of the text e.g. What are the side effects of the medicine?
- 2.7 group related items under sub headings
- 2.8 include the little words in the text. Omitting words such as "in, this, the, you" sometimes leads to misunderstanding
- 2.9 avoid abbreviations or use of initials for terms

3. LAYOUT AND TYPOGRAPHY

- 3.1 print size large enough to be read by all age groups
- 3.2 space appropriately
- 3.3 use Arabic numerals not Roman numerals
- 3.4 use bold lower case for titles as it is more distinct than capitals
- 3.5 indent the first line of a paragraph
- 3.6 numbers are easier to read as numbers than words
- 3.7 exclusion clauses should be in bold or underlined

4. THE CONTENT

Each page of the information sheet should be numbered and headed with the study title. The study title can be abbreviated for pages 2, 3 etc.

Title:

The study title should be in language appropriate for a lay person.

Principal Investigator:

Include full name, position, address and contact telephone number of principal investigator and/or contact person. (Include the supervisor if a student protocol)

Introduction:

The information sheet should begin with an invitation to take part ("You are invited to take part..."), a comment on the time available to consider whether to take part, and a statement on the person's right not to take part.

5. ABOUT THE STUDY

- 1. What are the aims of the study?
- 2. How were participants selected for this study, and who selected them?
- 3. How many participants will be involved?
- 4. Where will the study be held?
- 5. What is the time span for the study?
- 6. What will happen during the study - i.e. clearly explain what procedures will take place including the number and length of visits, number and type of samples taken, total time involved, other investigations (e.g. interview - how long will it take, how will it be recorded, what will happen to transcripts/tapes after the study), explain why the tests or procedures are necessary.
- 7. What will happen to samples after the study is concluded?
- 8. If participants are being randomised, explain what this means; e.g. 'chosen by the flip of a coin' or 'selected by chance.'

6. BENEFITS RISKS AND SAFETY

Explain all the following in lay terms

- 1. What are the benefits of the study?

2. What are the risks and/or inconveniences of the study? List all possible side effects of any medication or procedure which is part of the study and their likely incidence
3. Outline the inclusion and exclusion criteria
4. Is the study therapeutic or non-therapeutic
5. Will taking part cost anything, and will participants receive any payment, or reimbursement of expenses?
6. Are there other treatments available? What are the advantages/disadvantages of these?
7. If a placebo is to be used - explain, e.g. A placebo is a "dummy" medicine. If you are given a placebo while taking part in this study you will not get any benefit from the medicine that is being studied.
8. What happens if there are any ill effects from the trial. Is there any compensation?

Include a full explanation of the company's compensation cover for participants, including exclusions, and a description of the circumstances in which the participant would have to sue to obtain compensation.

7. PARTICIPATION

Include statements such as:

1. "Your participation is entirely voluntary (your choice). You do not have to take part in this study, and if you choose not to take part you will receive the usual treatment/care".

For non-treatment based studies, (or where appropriate) replace "you will receive the standard treatment/care available" with "this will not affect any future care or treatment."

Where there is a student/supervisor; or student/student relationship the following statement should be used "this will not affect your academic progress". If appropriate use "this will not affect your employment"

- 2 "If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your future health care/continuing health care/academic progress" (Insert only the phrase (s) which is/are most appropriate).

"Participation in this study will be stopped should any harmful effects appear or if the doctor feels it is not in the participants best interests to continue".

8. GENERAL

Include the following:

1. "Will my GP be told I am in the study?" (*if applicable*)
2. "What will happen at the end of the study?" (*include a comment on onward referral/future care if applicable*)
3. "Where can I get more information about the study?"
4. "If I need an interpreter, can one be provided?"

5. *For studies using interviews or questionnaires, state "You do not have to answer all the questions, and you may stop the interview at any time".*
6. In clinical trials include the statement " You will be issued a card to confirm your participation in a clinical trial. This card should be presented at the time of any medical treatment received during your participation in the trial".
7. If you have any queries or concerns about your rights as a participant in this study you may wish to contact a Health and Disability Services Consumer Advocate, telephone _____. *(Personalise this with the local advocates phone number).*
8. Details of any travel or accommodation allowance payable should be included.

9. CONFIDENTIALITY

Include the following statement - "No material which could personally identify you will be used in any reports on this study."

Explain what identifiers will be used to identify specimens. These should be minimal to protect participants' privacy. The consent of participants to identifiers should be obtained.

Information should also be included explaining how records will be stored to ensure details are kept confidential throughout the duration of the study, and also what will happen to records after completion of the study.

If the notes/results need to be checked by anyone else - e.g. the study sponsors (these should be listed) this should also be included on the information sheet and consent form.

10. RESULTS

How can participants get the results of this research, and where will they be published? Explain that there may be a delay between data collection and publication. Alternatively offer to discuss the outcomes with the participant.

11. GENETIC TECHNOLOGY STUDIES ONLY

In some research it will be necessary to explain genetic technology. The following has been suggested by an ethics committee. This wording is not mandatory.

"Each person has a DNA make-up (their genes) which is different from that of everybody else - except in the case of identical twins. This genetic make-up is a mixture of the genes of our parents. The precise way they are mixed varies from child to child within the same family, so having the same parents does not mean that two children will have exactly the same genes. We already know that some health conditions and disorders are definitely inherited through the genes (hereditary conditions), but we do not know how many conditions are explained by genetic inheritance. Inherited genes may explain why some people are more resistant and some people more prone to disorders which have not yet been identified

as hereditary. The research in which you are invited to participate will investigate genetic make-up to look for any link.

Because the research investigates genetic make-up, this identifies a participant and their particular genetic characteristics. This information is confidential and will not be disclosed or used in any way without the informed consent of the participant.

In particular the researcher/sponsor of the research will not claim any right, ownership or property in your individual genetic information or that of your kinship group, hapu or iwi, without having first sought and obtained your informed consent to the transfer of any such right, ownership or property. Your consenting to participate in DNA sampling of the proposed study will not be construed as creating any right or claim on the part of the researcher/sponsor to your genetic information”.

12. STATEMENT OF APPROVAL

Include:

“This study has received ethical approval from the
_____ Ethics Committee.”

For those studies involving groups of employees, include a statement such as
“the Manager/Supervisor/Director (as appropriate) has given permission for this study to be carried out”

Please feel free to contact the researcher if you have any questions about this study.

Appendix 6 Proforma for the Consent Form

PRO FORMA FOR CONSENT FORM

Please follow the pro forma below in your consent form which should be on the letterhead of the institution of the researcher. Note: The Code of Health and Disability Services Consumers' Rights requires written consent for all experimental health care procedures.

It is important that consent forms being used by researchers include the following information/phrases:

- 1 There should be a clear heading labelled "Consent Form".
- 2 Name of study in language that will be easily understood by the participants.
- 3 The points covered by the following phrases should be included in language able to be understood by the participants
 - 3.1 I have read and I understand the information sheet dated _____. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.
 - 3.2 I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my *future health care/continuing health care/academic progress/employment (insert only the phrases which are most appropriate)*.
 - 3.3 I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
 - 3.4 I understand that the treatment, or investigation, will be stopped if it should appear harmful to me. *(insert only when appropriate)*
 - 3.5 I understand the compensation provisions for this study. *(Insert for Form A and B trials)*
 - 3.6 I have had time to consider whether to take part.
 - 3.7 I know whom to contact if I have any side effects to the study.
 - 3.8 I know whom to contact if I have any questions about the medication or the study.
4. The following clauses, **if applicable to the research project**, should be included in the body of the consent form.
 - 4.1 I agree to an approved auditor appointed by either the pharmaceutical company or the ethics committee reviewing my relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study.
 - 4.2 I consent to the researchers storing a specimen of my blood (or other tissue) for its later use as a part of this study or other research
YES/NO
 - 4.3 I consent to my interview being audio-taped/video-taped.
YES/NO

- 4.4 I wish to receive a copy of the results
YES/NO
Participants should be advised that a significant delay may occur between data collection and publication of the results. Alternatively "I would like the researcher to discuss the outcomes of the study with me".
YES/NO
- 4.5 I consent to my GP being informed of my participation in this study/the results of my participation in this study
YES/NO
- 4.6 I am aware that the proposed study will involve analysis of my genetic makeup. I consent to such an analysis being performed
YES/NO
- 4.7 I understand that if I consent to such analysis, no rights will be created for the researcher/sponsor to my genetic information.
YES/NO

5. I . (full name) hereby consent to take part in this study. *(Refer to pages 19 and 20 of the National Standard where the participant is vulnerable such as children, patients under duress, unconscious patients and those with physical or mental disabilities).*

Date

Signature

Full names of Researchers

Contact Phone Number for researchers

Project explained by

Project role

Signature

Date

Signature of witness

Name of witness

(Note: A copy of the consent form to be retained by participant and (in the case of patients) a copy to be placed in the medical file.)

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