

The Pennsylvania State University

The Graduate School

College of Education

**THE SOCIALIZATION OF MEN TO THE NURSING PROFESSION:
A SYMBOLIC INTERACTIONIST APPROACH**

A Dissertation in

Adult Education

by

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Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Doctor of Education

December 2009

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ABSTRACT

The profession of nursing is composed, primarily of females. Hence, the profession becomes gendered due to the persons who primarily engage in the work and the characteristic that is primarily associated with the profession – caring. When men enter the profession, they are challenging the gendered image of the profession. Those individuals who socialize men to the profession are primarily females. Research informs us that males have special needs when being socialized into what are considered the “female” professions.

To date, although there have been studies on males who enter female professions from the male’s perspective; there have been no studies which explore the females who socialize men to these professions. This study used the theoretical lens of symbolic interactionism to study the interactions of female nursing instructors as they socialize men to the nursing profession.

Basic qualitative was the research type used to guide the study. Methods of observation and semi-structured interviews were employed to unearth the symbolic nature of interactions. Participants were observed while interacting with male students within a patient care area. Results were coded and themes emerged from the data that identified instructors view male students having special needs that, to some extent, set them apart from their female counterparts. Notably, most of these perceived needs of male students involve assisting the male to cope with role strain experienced when socializing to the nursing profession as well as assisting the male in learning how integrate and navigate in a female dominated profession.

The instructors in this study utilized strategies which they have learned via experience. Based on the findings, a discussion regarding the impact of gender on professional role socialization of men to a female-dominated profession with implications for educational practice is presented.

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ACKNOWLEDGEMENTS

I acknowledge the Father, who created me; the Son, who challenges me; and the Holy Spirit who strengthens and guides me. Without the gifts that God has bestowed on me and given me in the form of family, friends and colleagues I would have never embarked on or accomplished this journey of doctoral studies.

In addition, I would like to thank Ed Taylor, who has guided me, mentored me, supported and tolerated me for the last five years. Daniele Flannery, my initial advisor and support person in this project, thank you for your guidance and constant encouragement. Rae Brown, Patricia Cranton and Kamini Grahame for agreeing to be on my committee, offering your time and talents to assist me in meeting my goals, you are each a true asset to your fields.

To my husband, Ed, who has supported me, never complained about a tuition bill, took on the role of single father, and encouraged me to keep going in spite of events neither of us could have imagined, I will be forever grateful. Why you were so supportive of me, I will never fully understand. To my children Ellen, Alison and Josh, I hope that you will be able to forgive me for the times I have spent at school instead of with you. I realize that you have never really known a mother who is not either at work or doing a project for school. To the newest addition to our family, Kate, who inspired me to complete this chapter of my life and start a new one.

To my parents, Henry and Rita (Duffy) Mullen, I know that this is the last thing that you ever expected me to accomplish; however, you supported me even though you had your doubts. To my brother, Henry, and sister, Mary-Jo, thanks for all your encouragement, you are the best siblings a person could hope to have in life. And last, but certainly not least, my friends from the 2004 cohort for creating a learning community that made me feel safe and welcome.

Chapter 1

INTRODUCTION

This chapter provides an overview of a qualitative study that seeks to understand the symbolic nature in which female nursing instructors socialize male students to the role of the professional nurse. Gender is socially constructed whereas sex is biologically defined. This study examines gender and its impact on the socialization of men to the nursing profession. The discussion begins with how gender plays out in everyday life and the influence of gender on occupations. A brief summary of the status of males within the nursing profession and the issues males face as a minority, as well as the problems that arise when choosing work counter to the expectations of society due to its gendered nature, is presented. The purpose, research questions, theoretical framework, and significance of the problem follows. The chapter concludes with definitions of key terms, as well as the limitations of the study.

Background to Problem

Gender- being a man or a woman; masculinity or femininity; acting like a man or behaving like a lady; a “man’s man” or a “girly-girl” - these are some examples of phrases we use to delineate and define the two sexes. Gender is ingrained in everything we do. Gender influences how we interact and communicate, how we dress, even the type of hygiene products we use. In labor and delivery rooms across the nation, the first question asked is whether it’s a boy or a girl, even prior to determining the physiological stability of the child. In fact, many times parents opt to find out the sex of the child prior to its birth so that they can prepare for the new arrival by purchasing pink decorations and clothing for girls and blue if it will be a boy. At the time of birth, a pink cap is placed if it is a girl, and blue if it is a boy; a symbolic gesture representing the child’s sex. From this moment on, the future of the individual, from what types

of play they engage in to what career they choose is heavily based on this qualifier (Goffman, 1977; Leaper & Friedman, 2007).

After a child is born, friends and family will come to visit. If this is a first boy for the parents after having more than one girl, this comment may be made: “You finally did it *right* this time and got a boy” or if the situation is reversed: “Did you have another child so that you could “*get*” a girl this time?” Often parents will make plans for the child. A parent will dream of their son becoming a football hero, or their daughter becoming the homecoming queen, further symbolizing gender roles more so than simply a sex category. Gender is the trait we associate with the two sex categories of male and female. Important to this concept is sex. Sex is not the same as gender; however, there are many assumptions about a person’s gender, and their role in society, based on their sex (Leaper & Friedman, 2007). Gender becomes much more complex to define, as it has a meaning which goes beyond the physical characteristics of being a boy or girl. From a sociological viewpoint, the definition of gender is the totality of meaning attached to the two sex categories (Kramer, 2005).

Gender is the delineation of roles, traits and characteristics assigned to each of the sex categories which humans take on as they are socialized. It also influences behaviors and one’s sense of identity (Howard & Hollander, 1997; Leaper & Friedman, 2007). Socialization to a gender is facilitated through a number of channels. Parents, society, and popular culture all reinforce what is considered appropriate gendered behavior for each of the sexes (Leaper & Friedman, 2007). Appropriately gendered behavior would include males as football players and girls as the cheerleaders, and this influence flows into the eventual choice of one’s vocation. Males are encouraged to become engineers, doctors, auto mechanics, and all occupations that build and repair. The practice of medicine, although a helping profession, has a strong emphasis

on healing or repairing of the body, sharing this masculine association. Although times are changing, jobs in teaching, secretarial work, social work, child care and nursing are traditionally associated with females. Nursing, which often is referred to as an offshoot of medicine, focuses not on curing illness, but rather on four major areas: 1) promoting health and wellness, 2) preventing illness, 3) restoring health, and 4) caring for the dying (Berman, Snyder, Kozier & Erb, 2008). Noticeably, these occupations emphasize caring and nurturing. Therefore, certain occupations have been defined as “gendered,” such as nursing (Williams, 1989, 1993, 1995). This gendering of an occupation tends to lead to an occupational appeal to only one-half of the population.

Nursing as a Gendered Profession

Nursing became one of the professions along with teaching, secretarial work and others known as appropriate work for females. The women’s movement of the 1960’s changed the traditional prescribed roles for women, opening doors to fields that were once closed. Many women started to move into various fields once dominated by men. Unfortunately, the trend did not go in reverse for men entering traditionally women’s fields. Doors that were opened to women as a result of affirmative action did not go in the same direction for men entering schools of nursing, as men were not a protected class under anti-discrimination laws (O’Lynn, 2004).

Although currently considered a “woman’s profession,” historically, care of the ill was performed by males within the monastery systems of the early Catholic church. The monastery system is the religious communities of men and women in the form of monks, Christian brothers and religious sisters. Due to social and political changes associated with the Protestant reformation, resources for the education of health-care providers shifted to medicine (curing) and away from nursing (caring). There were two major elements involved with this shift in

perspective: the growth of the scientific method and the decline of church social capital in England. The growth of scientific method moved the focus away from caring of the ill and toward the cure of disease process and hence, to the science of medicine (Jensen, 1950; Seymer, 1933 & 1954). Medicine, based on the scientific method, was taught in the university, and was considered to be a role fit for educated men only. Women, who were educated during this time, were instructed in the arts and humanities, but not math or science. The decline in church capital came about as a result of the political activities of Henry VIII in England. When the Roman Catholic Church refused his divorce from his first wife, Catherine of Aragon, Henry VIII joined in the Protestant reformation, acquiring church property in England and destroying six hundred monasteries (Jamieson & Sewall, 1944). As a consequence of the destruction of these monasteries, the inns and hospitals that cared for the sick also were destroyed (Jamieson & Sewall, 1944).

This trend continued until the advent of formalized training of nurses, which was facilitated by Florence Nightingale. Nightingale, who came from an upper-class background, was one of the few women of her time to be educated in math and science as well as the humanities. This focus on math and science was due heavily to the influence of her parents. With her educational background, Nightingale was able to utilize statistical data to validate the importance of environmental conditions on the health of individuals. Nightingale essentially founded modern nursing education. Her philosophical stance was that nursing was an extension of a woman's role (Nightingale 1859/1991), thus setting the stage for what in modern times has been considered a women's profession. From Nightingale's time to present, the image of the nurse has been a female (Kalisch & Kalisch, 2004).

Males and the Nursing Profession

Ironically, males maintained an active role in the health-care professions, although their roles have been distinctively different. Males who entered nursing in the early 1900's, for instance, were segregated into nursing programs designed exclusively for the training of male health-care providers (O'Lynn, 2007). Therefore, the expectation was that if males did enter the field, their roles and education would be distinctively different from their female counterparts. The men who did enter the nursing profession faced a myriad of stereotypes, ranging from questions of their sexual orientation, intellectual abilities, masculinity and moral character, to name a few (Blankenship, 1991; Evans, 2002; Evans & Blye, 2003; O'Lynn, 2004). These stereotypes are still evident today.

The nursing profession is currently suffering from what is considered by many a critical shortage of registered nurses. In order to correct this problem, the profession has turned to recruiting from some atypical populations. The word atypical is used because in the last 200 years, nursing has been dominated and exclusively thought of as a white women's profession. In order to remedy the problem of the nursing shortage, the profession has turned to focusing a large part of recruitment efforts toward attracting more men as well as minorities. Currently, men make up less than 6% of nurses (Yurkovich, 2006). Adding to the nursing shortage is the fact that an estimated 7.5% of newly graduated male nurses will leave the nursing profession within the first four years of graduation, as compared to 4.1% of female graduates (Yurkovich, 2006).

Male Recruitment

Recruitment of men into the nursing profession is considered to have two positive impacts. The first is to relieve the nursing shortage by marketing the profession to 50% of the population who, otherwise, may not have considered the profession due to the female image

associated with the profession. Secondly, the influx of men in nursing is felt to raise the professional value of nurses within the health-care field. Men are thought to bring with them a certain amount of power and prestige, which in turn will help raise nurses' salaries and improve working conditions within the field (Yurkovich, 2006).

In addition to the impact on salaries, men's participation in nursing education and the nursing profession has been studied from many different viewpoints. Throughout the research it is clear that when men enter the nursing profession, they face advantages as well as disadvantages (Anthony, 2004; Brady & Sherrod, 2003; Evans, 2004; Kelly, Shoemaker & Steele, 1996; Okraniec, 1994; O'Lynn, 2004; Soerlie, Talseth & Norberg, 1997, Williams, 1989, 1993, & 1995). What has been concluded from this research is that men, while in nursing education, do face marginalization due to their gender. This comes across in nursing texts when the nurse is always referred to as "she," or instructors address their classrooms as "ladies," instead of ladies and gentlemen. Men have also found that although they are on the margins as far as numbers, they also enjoy privilege in the form of being elevated to positions of status in the profession. The elevated status of men, therefore, does not begin as they enter the working environment but rather starts within nursing educational programs. Men who participate in nursing education programs report being nominated and elected to leadership by their female student colleagues (Soerlie, Talseth & Norberg 1997). The female colleagues, who are in the majority, tend to step aside for this minority population, allowing them to take over as the leaders.

Role of Nursing Instructors

Nursing instructors have been cited as an important influence on male nurses' choice of career paths within the profession as well as reinforcing male privilege, and disadvantages

(Evans & Blye, 2003; O'Lynn, 2004; Soerlie, Talseth & Norberg, 1997; Stott, 2003). The instructor of nursing is an influential person in the socialization of the student to the professional role, and the direction students take in their careers (Soerlie, Talseth, & Norberg). As part of this socialization process, the instructor is charged with finding learning opportunities that will assist the student to develop professionally. The literature refers to the professional responsibilities of the instructor on the clinical unit as necessitating that the instructor forms a close working relationship with the student (Tang, Chou & Chiang, 2005). The effectiveness of nursing instruction is based on the instructor's attitudes toward the student. This attitude can have a significant influence on the student's feelings of success or failure in their ability to be clinically successful. Unlike the classroom setting, in which most communication is one-way with the teacher standing in front of a classroom full of students and speaking while the student passively participates as the observer, listener, and recipient of information, the clinical setting involves more one-to-one, intimate dialogue and interaction between student and instructor.

As part of this close relationship between student and instructor, students look toward instructors to point out their strengths as well as weaknesses in a way that is supportive and displays a positive attitude toward the student (Tang, Chou & Chiang, 2005). With this aspect of instruction in mind, men have reported a lack of knowledgeable advisors to guide them in career decision-making (Gilchrist & Rector, 2007). Men have been encouraged and expected to not just go into the high-tech areas, but to also fulfill roles in the clinical area such as dealing with the aggressive patients and doing most of the heavy lifting (Gelchrist & Rector). These are just some examples which have led to an encouragement for female nurses, especially instructors, to engage in some "gender awareness training" to develop an awareness of the male student's needs (Gelchrist & Rector, 2007; O'Lynn, 2004). Having accurate information from an instructor could

make the difference in a male choosing a field such as pediatrics, rather than intensive care. In order for an instructor to determine the true strengths and weaknesses of the student, the instructor must assign the student to a variety of patient care situations. This cannot occur if the instructor has underlying assumptions or biases regarding a student's capability due to their gender. An example of this would be not assigning a male student to a female patient, or not assigning males to patients who require a great amount of personal care. Favoring or insisting that male students be assigned strictly to male patients or female patients who are relatively independent in their ability to meet their activities of daily living (ADL's) is counter-productive and places restrictions on students' experiences, limiting the opportunities that the student has to develop their skills.

Challenges to the Nursing Instructor

The importance of examining the socialization of males to nursing is two-fold. The first issue addresses the goals of educational experiences for males as well as females. Dickson, Walker and Bourgeois (2006) speak to the agreed-upon perspective throughout the nursing literature as to the goals of the clinical experience: "skill acquisition, integration of theory with practice, application of problem solving skills, development of interpersonal skills, socialization to the informal and formal norms of the profession, acclimatization to the protocol and expectation of professional practice and exposure to the socio-political health care area (p. 417)." The clinical instructor, therefore, becomes a facilitator of the learning experience, through providing time with a student as well as focusing the interaction and guiding the process of education (Dickson, Walker & Bourgeois, 2006; Lambert, 2005).

The second issue deals with professional development. "Male students look to faculty to provide opportunities and support for learning" (Anthony, 2006, p. 228). Types of clinical

experiences do not solely reinforce theoretical information, but also expose the student to various types of nursing care. This becomes important to the student in formulating an idea of what type of nursing they may desire to engage in after graduation. Students should be encouraged to go into areas that complement their strengths, not those that fit into what is assumed will be their area of strength because of their gender. Not only does the instructor aid the student by pulling together theoretical information and pointing out its use in the clinical setting, but also in assisting the student nurse in identifying his or her place within the profession.

A person finding their “place” within a profession is strongly influenced by the individual who is instructing them to the role. Within nursing, this person is primarily an instructor found in the clinical setting. Part of what is influential on a student’s socialization is the student’s positionality within the larger group. The next section of this paper describes what is meant by positionality and how this concept affects the teaching-learning environment.

Positionality of Male Nursing Students

The adult education literature is replete with literature regarding the topic of student positionality and its effect on the learning environment (Brown, Cervero, Johnson-Baily, 2000; Johnson-Baily & Cervero, 1998; Merriam, Johnson-Baily, Ming-Yee, Kee, Ntseane & Muhamad, 2001). Positionality refers to existing social structures and how those structures affect the student in the learning environment. For example, males are the outsiders within nursing educational programs. This has been referred to as the insider/outsider status when discussing student positionality within adult education (Merriam, Johnson-Baily, Lee, Kee, Ntseane & Muhamad). Insider/outsider status exists when one’s positionality in terms of gender, class, race, sexual orientation, and/or religion offer one either advantages or disadvantages, depending on how this individual is similar to or different from the dominant group. In terms of

gender to the nursing profession, being a female provides a student “insider” status and a male “outsider” status within the classroom and clinical situations.

The student-teacher relationship, as far as the social location of the student in terms of gender, has been studied to some extent within the adult education field (Brown, Cervero & Johnson-Baily, 2000). Brown, Cervero & Johnson-Baily (2000) found that the social location of a teacher impacts the dynamic in the teaching and learning process. Nursing offers a unique look at the concept of overall social privilege and how it can spill over into environments where those who hold power in society (men) are now the minority and those who hold lesser social status (women) are now those within positions of power. Do social factors of what is considered masculine and feminine affect the way in which nursing instructors interact with and socialize the male student? How does a female react when placed in a position in which they have authority over males? Does the social status of men affect the way in which instructors interact, advise, and utilize corrective action in the clinical setting?

Problem Statement

Men in non-traditional occupations, such as nursing, challenge society to rethink and reevaluate what is considered appropriate work for men and women. The image of the nurse as a female is obviously challenged. Does this image reversal bring with it a process in which the female nursing instructor needs to renegotiate for herself what is thought of as appropriate work for men and women when recognizing the student is a male? Recalling that the nature of clinical instruction is a highly interactive process in which the teacher is socializing the student to the norms and expectations of the profession; does the nature of these interactions reflect an internalized perception of gender on the behalf of the instructor? If the image of the nurse is that of female, how do instructors manage this difference from what is typically the gender of their

students? Men who enter the nursing profession recognize women, including their instructors, as being important support persons in their adapting to the nursing role.

This study examines the nature of professional role socialization of male nursing students by female instructors. Looking at the nature of the socialization of males requires the researcher to utilize a perspective that accounts for gender when looking at the nature of interactions between male students and female instructors. Specifically, the role of the female nursing instructor within this process is analyzed through a gendered lens to ascertain what influence being a gender minority has upon the teacher/student interactions.

Purpose of this Study

The purpose of this study was to identify the nature of interactions between female instructors and male students to identify how gender influences teaching and the socialization of males to the registered nurse role. The study explored the interactions between female faculty and male students with particular emphasis on the socialization process to the registered nurse role. Specifically, the female instructors were studied to analyze what expectations they have in a clinical setting of a male student and how these expectations are lived out within student-teacher interactions. It was thought by looking through the symbolic nature of these interactions, a greater understanding would be obtained of how nursing educators socialize men into a profession that has been socially constructed as a gendered (female) profession.

Theoretical Framework

This study involves the investigation into socialization of male students within a clinical setting by female nursing instructors. The subject of how gender influences interactions and how this plays out specifically in instructor/male student interactions is the focus of the study. A theory from the field of social psychology that brings understanding to the nature of interactions

between these two groups of individuals is symbolic interactionism (SI). Symbolic interactionism has as its foundation the question “What is the common set of symbols and understandings that has emerged to give meaning to people’s interactions” (Patton, 2002, pg. 112)?

Symbolic interactionism provides a strong theoretical grounding and gendered lens for this study because of its disciplinary roots in social psychology. The internalized adoption of identification of one’s self as being either male or female can be thought of as occurring in either psychological or sociological fields. Psychological approaches primarily look at the individual, rather than the social, context and emphasize the “intra-psychic processes” as the basic unit of analysis (Bussey & Bandura, 1999; Howard & Hollander, 1997). The sociological approach to understanding gender emphasizes the social dynamics and how social contexts shape our cognition, emotional experiences and behaviors. The primary focus is the prevailing social norms, with an emphasis on the social construction of gender and what is occurring at the institutional level (Bussey & Bandura, 1999; Howard & Hollander, 1997). Social psychology draws from both of these traditions to analyze the relationships between individuals and their social environments. Social psychology is thought to be helpful for the purposes of this study when looking at how male students are socialized by their female nursing instructors into the role of the nurse. How the instructor views male nurses is important, but perhaps more important is how this is observed and/or evidenced in patient care situations.

Symbolic interactionism offers a depth and richness to understanding how gender roles emerge within social interactions, which other theories of social psychology do not adequately address. Gender, although one characteristic that comprises an individual’s sense of self, plays out within all aspects of human interactions (West & Zimmerman, 1987). To discover if there is

an “unwritten curriculum” within nursing that may be promoting male privilege or creating a bias against males, a framework is needed which examines how cultural norms of what is expected reproduce within the educational setting.

West and Zimmerman (1987) coined the term “doing gender” to refer to how women and men produce gender through a “complex of socially guided, perceptual, interactional and micro political activities that cast particular pursuits as expressions of masculine or feminine natures” (p. 126). Gender, therefore can be seen as a sociological reproductive phenomenon in which the symbolic action of placing a pink or blue cap on an infant in the delivery room becomes but one of many symbolic gestures throughout a person’s life which reinforces gendered beliefs regarding what it is to become a man or woman.

The SI perspective looks at gender as being but one of many things that emerge from a person’s self and play out in how they interact with others. Symbolic interactionism can be understood as having three basic premises- meaning, language and thought- developed from the work of Herbert Blumer (1969):

The first premise is that human beings act towards things on the basis of the meaning that those things have for them. Such things include everything that the human being may note in his world....The second premise is that the meaning of such things is derived from, or arises out of the social interaction that one has with one’s fellow. The third premise that these meanings are handled in and modified through an interpretative process used by the person in dealing with the things he encounters (p. 2).

Although there are many approaches one can take to addressing a problem through the SI framework, all approaches share these three premises from the work of Blumer as foundational to this perspective. For instance, Erving Goffman’s (1959) dramaturgical approach to SI

describes the interactions between individuals as humans acting and reacting toward one another as actors do on a stage. We take on roles and play these roles as we have internalized them.

We live in a patriarchal society; although nursing as a profession is female dominated, males still occupy positions of higher power and prestige in society. The socialization of males to the professional role occurs within schools of nursing. Nursing instructors are an important influence in this process. In terms of gender interaction between men and women, symbolic interactionism can explain, or at least theorize, how gender is produced within roles in the nursing clinical area. For example, a female instructor, when dealing with a student assigned to a complicated case, may interpret a male student with many questions as inquisitive. On the other hand that same instructor may interpret a female student with many questions as unprepared. This may be in part due to her own personal meaning that she has of herself as a woman, and how she takes her personal meaning and place in society and brings it into her interactions with students. This is to say if being a male carries with it an implication of being more technically savvy, the instructor uses this impression in making decisions regarding the male student's patient assignments and how the instructor may evaluate the student. Using this theory, she appraises the student partly on her internalized meaning of herself as a woman.

Guiding Research Questions

The questions that will provide focus for this study are:

- 1) How do female nursing instructors perceive the role of the male nursing student?
- 2) What symbols are present in the clinical area which represents an instructor's perception of the role of the nurse?
- 3) How does a student's gender influence the instructor's clinical assignments?
- 4) How does a student's gender influence an instructor's perception of the nurse's role?

- 5) What are the symbols which emerge within the clinical setting when instructors are confronted with a male student and what are the meanings of these symbols?

Overview of Methodology

Symbolic interactionism calls for the interpretation of the objects, gestures and language within interactions within a context in order to grasp the symbolic meanings within the interaction. It requires a research method which allows the researcher to understand the meaning of the world from the outlook of the other. Taking on the position of the other is a concept of *Verstehen*, or, in other words, “sympathetic introspection,” which means at some level one is able to imagine themselves in the role of the other in order to gain this understanding (Herman-Kinney & Verschaeve, 2003). In order to capture the essence of the view of the other, a qualitative methodology allows for exploration of both the external actions as well as the internal dialogue we have within ourselves, which will require a dual approach to data collection.

The nature of qualitative research calls for the collection of information-rich data for depth of analysis, which will illuminate the questions under study (Patton, 2002). Historically speaking, qualitative research developed from the fields of sociology and anthropology. The essence of qualitative research was to capture individuals in their natural setting in order to study the customs and habits of another society or culture (Denzin & Lincoln, 2000). Qualitative research has expanded to include various approaches to data collection and analysis. The methods used in qualitative research have expanded to include not only observation, but also the use of case study, personal experience, interviews, visual texts, life story and artifacts (Denzin & Lincoln, 2000).

There are various types of qualitative inquiry. Some types seek to investigate a phenomenon in order to uncover new theory, such as the case with grounded theory (Merriam,

1998, 2002). The type of qualitative research used in this study is basic qualitative. Basic qualitative research focuses on interpreting what is actually going on in a situation, specifically 1) how people interpret their experiences, 2) how they construct their worlds, and 3) what meaning they attribute to their experiences (Merriam, 2002). Therefore, the incorporation of basic qualitative research with a symbolic interactionist lens takes key ideas from symbolic interactionism, the I and the Me specifically, to investigate how internalized constructions of gender play out in the interactions between female instructors and male students.

Since the purpose of this study was to determine the qualitative nature of interactions between male students and female nursing instructors, a small purposeful sample was used. The sample consisted of 8 full-time faculty members from a diploma school of nursing located in eastern Pennsylvania. All participants met the requirements of having two years of teaching experience, were female, taught in the clinical setting and had male nursing students in their clinical groups. Instructors could have been teaching in any area of nursing, including maternal-child, medical-surgical, pediatrics or mental health nursing.

The methods of data collection employed for this study consisted of a dual-method approach to data collection. The first phase of data collection consisted of an observation of the instructor on the clinical (patient care) area. The observer had an advantage within these settings because she was a recognized member of the hospital community. It was not unusual to see her on the patient care area. Therefore her presence was not as obtrusive as a person who is an unknown. Performing observation in the clinical setting was valuable to this study because it was during this time that instructors are engaged in more individualized instruction. Part of this instruction took the form of structuring the experience so that the students were engaged in the professional role. It is also during this time that the student was engaged in activities that

required a great deal of physical care to individuals. These two aspects of nursing education as well as the images of what a nurse is, play out in the form of symbols and the interactions between the student and those he comes in contact with.

In order to record the symbolic nature of these interactions as well as other aspects within the clinical area, the use of field notes was employed. The use of field notes was challenging in terms of recording what was occurring within the clinical area. The use of guiding areas on which to focus assisted the researcher in focusing attention on key areas of interest in order to identify if there were symbols within the student-instructor interactions. General areas of focus were: the types of patient assignments, the way in which verbal feedback was provided, the type and amount of questioning done between student and instructor.

Symbolic interactionism also calls for recognition of the meanings which are attached to symbols in addition to an internal dialogue that goes on within individuals, either consciously or unconsciously as they interact within society. To capture this internal conversation, the second type of data collection was in the form of semi-structured interviews. Semi-structured interviews were employed as a means to engage the participant in reflection of the events and interactions observed by the researcher during the clinical observation in order to understand the instructor's point of view, thoughts, feelings and "internal dialogues" which may have driven her actions. In order to understand if there was a symbolic nature behind the student-teacher interaction, the researcher needed to identify the internal dialogue of the instructor while these events were unfolding.

Significance of the Research

"The power relationships that structure social life do not stop at the classroom door" (Brown, Cervero & Johnson-Bailey, 2000, p. 273). Women and men throughout the world are socialized into societies that teach them what it is to be female or male. They learn through

socialization what characteristics are considered to be male or female as they identify with one's gender. Similarly, types of work become identified with certain genders. In other words, depending on the skills required, certain jobs are considered to be more likely associated with men (such as construction work) and female (such as nursing). Williams (1993) describes how interactions between males and females change depending on social characteristics such as race and class (2006), and gender (1993, 1995). While researching how gender affects the work of male strippers, Tewksbury (1993) noted that:

Men modify interactional norms and status expectation when they occupy traditionally female occupational roles. Not only is the occupational structure itself reconfigured, but the interactions of those within the occupation are also altered. When men cross over, traditionally female occupational roles are modified by incorporating traditional masculine ideals and sociostructural elements of patriarchal privilege (p. 179).

Likewise, the literature is replete with reports of males being provided privilege in terms of professional advancement and leadership (Bradley, 2000; Coulter & McNay, 1993; Evans & Blye, 2003; Herbert, 2000; Rozier & Hersh-Cochran, 1996; Soerlie, Talseth & Norberg, 1997; Stott, 2003), suffering less disciplinary action (Evans & Blye, 2003; Stott, 2003) and increased professional respect (Ellis, Meeker & Hyde, 2006; Luciak-Donsberger, 2003; Rozier, Raymond, Goldstein & Hamilton, 1998) when entering female-dominated professions.

All of the research that has been performed regarding what is known about males in female-dominated professions has been performed from the perspective of the men themselves. Regardless of whether the research has dealt with struggles with role expectations, attrition of men from educational programs, or issues of power and positionality within the educational/professional setting, the voice which has been represented has been that of the male.

This study adds to the research of gender socialization by providing a perspective of how gender socialization, as well as cultural norms, manifest within the interactions between teacher and student in an adult education setting, via the female perspective.

The issue of gender to the field of adult education has been considered significant from the perspectives of inclusion, positionality, power, and teacher-student dynamics (Brown, Cervero & Johnson-Baily, 2000; Johnson-Baily & Cervero, 1998; Merriam, Johnson-Bailey, Lee, Kee, Ntseane & Muhamad, 2001). As the field of adult education has evolved, issues of social justice concerned specifically with knowledge construction, power, positionality, identity and voice have emerged as important themes impacting the field (Kaufmann, 2001). The positionality of a teacher within a classroom is an important factor influencing the educational environment (Brown, Cervero & Johnson-Bailey, 2000). Factors such as gender have been found to be influential factors in a student's learning. Within nursing, the assumption is that the nurse is female, and has been historically linked to a female's role. Thus, when a male enters such an environment, he now is in a world in which he needs to learn the traits, roles, and values of a profession which has been structured by women.

This study focuses on teacher-student interaction, adding to the work already completed in adult education related to the impact of gender on adult education specifically dealing with how instructors negotiate the unwritten curriculum when confronted with a student who does not fit the typical mold of a nurse. A unique aspect of this study is having men, who hold positions of power and privilege culturally, enter an educational setting where they are now the minority. Likewise, women who typically lack power in a patriarchal culture, are now in control. The nursing instructor is challenged with being in a position of trying to socialize men to a profession typically associated with females. Instructors of nursing are not immune to the socially

constructed perceptions of gender. This study looks at how women, as instructors, interact with men who are stepping outside of what is considered culturally normative work for a male.

The significance behind investigating these interactions was to identify if culturally defined roles for men and women play out in the educational setting for male student nurses. As Ellis, Meeker & Hyde (2006) state, "Nursing school is the first place men are likely to experience nursing in the professional sense and serves as the first route to socialize new nurses into the profession" (pg. 523). Female instructors are a key set of individuals whom the student looks toward in order to be taught professional roles and responsibilities, as well as to socialize the student into this professional role. The female instructor is challenged to socialize the male student to a role that is viewed by the greater society as one in which women inherently possess the qualities needed for the profession. The instructor is the product of this same society that socializes males and females into specific gender roles. When the female instructor is faced with a male student in a profession that has been associated with females for well over 200 years, what are some of the internal issues/challenges the instructor faces in socializing this student? Since most males within nursing programs are older than their female peers, as well as entering nursing as a second career, the situation provides a context in which to glean rich data for adult educators. This study provides insight not only for nursing instructors, but also for any female who may be teaching a male within a field predominantly made up of women such as teaching, home economics, and social work. By exploring instructor-student interactions, one may be able to determine if there is an unwritten, symbolic nature within these relationships.

This study can add to the field of symbolic interactionism by providing additional information as to the meanings gender imparts to nursing instructors and how these meanings play out in symbolic ways. The symbolism of these acts inform the understanding of adult

education by adding to what is known about adult educators and how they socialize students who do not fit the typical gender demographic of their field. The study of the female instructors' interactions with a group, such as male students, may demonstrate how beliefs and values from the greater cultural transfer onto the educational interactions.

Assumptions

This study has assumptions related to the theoretical framework and design:

- 1) There is a culture within nursing which delineates between male and female nurses. This study assumes nursing faculty has to some extent taken on these cultural values, and this will be demonstrated within their interactions.
- 2) This study assumes nursing instructors socialize their students to the professional role, going beyond simple technical skills. The emphasis each instructor places on various roles and responsibilities of the nurse will vary, depending on the student she is interacting with.
- 3) This study assumes female instructors will notice on some level that they are interacting with a male, and this will have some level of meaning within them as to what professional roles these men would be best fit.
- 4) The symbolic interactionist perspective derives from the field of social psychology, which assumes the individual has the internal mind (I) acting on the internal thought patterns of the here and now, as well as the Me, which is the part of the mind which uses past experiences in order to make decisions and judgments regarding the present. This study assumes there is an internal dialogue going on within the instructor's head, directing their actions either consciously or subconsciously.

- 5) It is assumed there is a difference in the way in which female nursing instructors interact with males. Since there are no comparative studies of male to female nurses, it is the assumption that there are some differences in the socialization of the male student.

Definition of Terms

The following definitions of terms used throughout this study are important to identify:

- 1) Positionality: “The ways in which people are categorized in a Western hierarchical society” (Brown, Cervero & Johnson-Baily, 2000).
- 2) National League for Nursing (NLN): This is the professional organization for nursing faculty in the United States. Its mission is to promote educational excellence in nursing education programs.
- 3) National League for Nursing Accrediting Commission (NLNAC): The organization in the recognized accrediting agency for all post secondary and higher degree nursing programs.
- 4) National Council Licensure Examination for Registered Nurses (NCLEX-RN): an examination all graduates of nursing programs must successfully pass in order to achieve the title and licensure practice of “Registered Nurse.”
- 5) Diploma education: A two-to three-year course of study that prepares a student nurse to sit for the NCLEX examination. These programs are regulated by the NLNAC, are typically affiliated with a hospital and grant a diploma in nursing rather than an associate’s or bachelor’s degree in nursing.
- 6) Clinical: The actual application of skills and theory taught within the classroom setting. Clinical experiences are typically done in an actual patient care area in a health-care institution such as a hospital or nursing home setting. However, clinical experiences are also gained through the simulated laboratory setting.

- 7) **Simulated Laboratory:** Learning environment in which the instructor develops a learning experience that replicates the patient care area. This is typically performed in an area outside of a health-care institution, in which a training mannequin acts as the patient or students take turns acting as the patient.
- 8) **Psychomotor skills:** Skills and techniques utilized when assessing and providing care to an individual. Examples of psychomotor skills include auscultating a blood pressure, changing a wound dressing, inserting a urinary catheter or administering an injection.
- 9) **Medical/Surgical Unit:** Nursing care unit which focus on the care of individuals who are suffering from disorders which are physical in nature and typically are defined by major bodily systems such as: cardiac, endocrine, musculoskeletal, etc.
- 10) **Mental health nursing:** Care of the individual from a psychological and spiritual perspective. Nurses care for individuals experiencing psychiatric disturbances such as schizophrenia, depression, bi-polar dysfunctions, etc.
- 11) **Maternal-Child nursing:** Care of women before, during and after the childbirth process. This also includes the care of the pre- and full-term infant.
- 12) **Pediatric nursing:** Care of individuals under the age of eighteen years of age.

Definitions related to Symbolic Interactionism:

- 1) **I:** The part of ourselves which will react to others in a social situation, and consequently changes the community based on his/her reaction to the community (Mead, 1934).
- 2) **Me:** The part of the individual that becomes aware within the person's memory which will recall the "I" of the moment in which the individual interacted with society.
- 3) **Mind:** A concept which focuses on the internal dialogue individuals have with themselves regarding the meanings of objects and other people.

- 4) Society: The “interpretive process by means of which human beings, individually and collectively, act” (Blumer, 1969, p. 89). Humans are responsible for creating society through these interpretive acts.
- 5) Culture: A shared “consensus” of the group arising out of a series of conflict resolutions which have been worked out over time (Charon, 1995).
- 6) Social interaction: A view which sees the interaction between individuals as significant in that it is seen as what forms human conduct, instead of being simply an expression of human conduct (Blumer, 1969). Therefore, the interaction itself becomes an important piece in understanding how society, and subsequently culture is formed and how, in turn, the important aspects of culture are played out between individuals.
- 7) Symbols: Gestures, actions or inanimate objects within a social situation that communicate or stand for a particular meaning to the individuals. This meaning may be different from what the gesture, action or object was originally intended.

Limitations of the Study

Typically, with qualitative research, and this being no exception, there are limits within the data collection, analysis and application of findings:

- 1) There are limits of generalizability. The use of a small sample size, in addition to the exploratory nature of the research, increases the depth and richness of the data. However, this also limits the ability of the research to be generalized across other populations. The sample consists of entirely female instructors, who may or may not share the same types of interactions with male students as male instructors have with male students.
- 2) This research is limited as far as the scope of inquiry. The goal is not to explain how situations occur, but that they do occur. The purpose is to provide insight into the

symbolic nature of the interactions and glean insight as to the meaning of these interactions. The theoretical lens utilized does not provide for examination of how interactions occur, but rather investigates the symbolic meanings of interactions for the individuals involved. The context of the clinical situation is dynamic; therefore, the interactions themselves may be charged with emotions which may originate from reasons other than the gendered nature of the interaction.

- 3) The presence of an observer may influence the actions of the instructors in ways which may be unknown (Patton, 2002). The assumption with the observation of instructors is that they are behaving in ways identical to their behavior when not being observed. In addition, the observer may have been looking for one set of actions and inadvertently ignore an entire set of gestures or acts which present themselves.

Chapter Summary

This chapter has covered the key highlights of what will be the significance and guiding theoretical framework and methodology for the implementation of this study. The purpose, research question, guiding research questions, limitations and assumptions were also provided. Chapter 2 will go on to discuss the background literature which provides the foundation and infrastructure for this work. Chapter 3 will provided an in-depth, detailed description and rationale of the methodological applications which will be utilized when carrying out this study. Chapter 4 will provide narrative descriptions of each participant. Chapter 5 will present findings of the study. Chapter 6 will be the final chapter, within which the implications for practice and suggestions for future research will be presented.

Chapter 2

REVIEW OF LITERATURE

The purpose of this study was to identify the nature of interactions between female instructors and male students to identify how gender influences teaching and the socialization of males to the registered nurse role. Specifically, the female instructors were studied to analyze what expectations they have in a clinical setting of a male student and how these expectations were lived out within student-teacher interactions. It was thought that by looking through the symbolic nature of these interactions, a greater understanding would be obtained of how nursing educators socialize men into a profession which has been socially constructed as a gendered (female) profession. Although males in female dominated professions are a topic covered in research, the interactions between the females who teach and socialize them into these professions has never been studied.

This chapter outlines the foundational pieces used to construct and carry out this study: theoretical framework, historical context of nursing, males in the nursing profession and men in other female dominated professions. The theoretical portion emphasizes symbolic interactionism (SI), the theoretical framework for the study. The historical context of nursing piece provides an overview of nursing, paying particular attention to the role of males in the care of the ill. This is followed by an extensive review of the current literature that focuses on experiences of males in nursing, as well as men in other female-dominated professions.

Section I: Gender and Theories of Social Psychology

One's gender goes much deeper than being a man or woman; it becomes scripted onto the internal sense of self, role and station in society (West & Zimmerman, 1987). When someone or something is gendered, there are assumptions and perceptions about that person or object from

both psychological and sociological viewpoints, which will, in turn, affect the thoughts, feelings, behaviors, or treatment of those who come into contact with that person or object (Howard & Hollander, 1997). Therefore, being masculine or feminine is thought to be interwoven in every aspect of our social and personal lives, including how we interact with others as well as within ourselves (Howard & Hollander, 1997; West & Zimmerman, 1987). This gendered interaction is an adoption of a socialized sense of being either male or female. Gendered interaction is thought of as occurring on either psychological or sociological planes. Within these planes, there is further debate on how exactly this phenomenon takes place. Psychological approaches look at the individual as the primary unit of analysis. Theories that fall into this category emphasize the individual's "intra-psychic process" as the way in which we accept the norms to which we are being socialized (Bussey & Bandura, 1999; Howard & Hollander, 1997). In other words, the element primarily responsible and responsive to gender socialization is that which resides within each individual's mind. Our minds, through cognitive processes working to organize the constant uptake of data taken in during our socialization process, are responsible for the adoption of a gendered sense of self, and come to expect certain gendered traits in others. This contrasts with sociological approaches, which view the society surrounding the individual as more important in the adoption of a gendered sense of self.

The sociological approach to understanding gender emphasizes the social dynamics and contexts that shape our cognition, emotional experiences and behaviors. The primary unit of analysis within this viewpoint is the prevailing social norms, with an emphasis on the social construction of gender and what is occurring at the institutional level (Bussey & Bandura, 1999; Howard & Hollander, 1997). Although the sociological viewpoint emphasizes the influence of society in the acquisition of a gendered sense of self, it does not account for the internalization of

these messages, which are found within the psychological approaches. An approach that takes into account both the social, as well as the psychological, processes is what is found in the field of social psychology.

Social psychology draws from the psychological and the sociological traditions to analyze the relationships between individuals and their social environments. Social psychology is interested in the effect of social groups on the experience and conduct of the individual member (Mead, 1934). Social psychology is thought appropriate for the purpose of this study because of the emphasis on the psychological element and the social dynamics that play out in the instructor-student relationship. Three primary theories from social psychology which best explain gendered dynamics are: 1) Social Learning Theory, which views human behavior occurring from a system of reinforcement and modeling; 2) Social Cognition, which emphasizes the ways in which one thinks about the social world, with a heavy emphasis on schematic processing and social roles; and 3) Symbolic Interactionism (SI), which has an emphasis on the everyday interactions and negotiations that constitute social life. Although each provide a unique view of how these negotiations and interactions take place, all three of these perspectives emphasize the reproduction of a gendered society in which social roles, interactions and behaviors reproduce themselves through both social and psychological processes.

All three of the views from social psychology could offer something to this study. The first two, social learning and social cognition, provide an explanation of how gender is reproduced within ourselves from a young age. Although these theories are interesting as far as giving insight into the learning of gender roles, they do not provide any organizing framework that would explain interactions that occur when a person is socialized into a gender-atypical role.

SI, however, sets itself apart from the others because it takes into account the process that we encounter as adults in reproducing gendered contexts. For this study, it was accepted that there are socially learned definitions of what it is to be a male or female. Although not addressing the socialization to gendered roles specifically, SI was utilized as a theoretical lens to examine how gender influences interactions of individuals in group situations such as education. What SI offers to this study is a way in which to investigate how internalized definitions of gender play out in everyday life. Therefore, the next section will focus specifically on SI, what it is, how it has evolved and what it can bring to the study of nursing instructors and male students.

Symbolic Interaction: An Overview

The main belief of Symbolic Interactionism (SI) is that people attach symbolic meaning to objects, behaviors and other people (Blumer, 1969; Howard & Hollander, 1997; Stryker, 1980). Building on the work of George H. Mead, SI does not focus simply on one element within society, but rather how individuals interact with one another and, more importantly, dialogue with themselves in order to analyze and interpret the behaviors of others. In this way, SI can be used as a guiding theoretical framework for this study. This section addresses the key elements of SI, including those individuals who were essential in the formation of this perspective. In addition, a brief statement as to the various viewpoints of SI is discussed. The majority of this foundational piece focuses on SI as viewed from the Chicago School, specifically the work of Herbert Blumer.

Although Blumer coined the phrase SI was developed and influenced by the work of various scholars. The philosophy of SI is rooted in pragmatics. Pragmatism emphasizes human agency, consciousness, meaning and process (Musolf, 2003). Pragmatics in the social sciences started with the works of scholars such as William James and John Dewey, who were in turn

influenced by the Greek philosophers Aristotle and Plato (Prus, 2003). The essence of Aristotle and social pragmatics in relation to how society is formed is essential to the understanding of what lies at the root of SI. Aristotle claimed that “people develop knowledge of concepts, generals and universals only through actual contact with the specifics” (Prus, 2003). The work of Aristotle informed the development of SI by the focus on human knowing as predicated on people’s capacity for sensory experiences (Prus). This knowledge is transferred through evolutionary aspects of human behavior and language (Prus).

However, SI has never been narrowed to one specific point of view. Consequently, a plethora of perspectives on SI have emerged (Meltzer, Petras & Reynolds, 1975; Reynolds & Herman-Kinney, 2003) in the literature. Reynolds and Herman-Kinney (2003) express this frustration when attempting to detail major varieties of this perspective: “There is simply not a great deal of consensus among interactionists concerning whether one can meaningfully speak of real varieties or schools of symbolic interactionism. Among those who feel we can, there is little agreement about just how many or what those schools are and about how they are best described” (p. 85). Many scholars were important in the development of the SI, including George Herbert Mead, John Dewey, William James, Charles Horton Cooley and William Isaac Thomas (Stryker, 1980). Depending on the use and interpretation, SI evolved into three main perspectives, all of which provide their own view on how SI can be used to inform the construction of society.

Development of Symbolic Interactionist Thought

The foundations of traditional SI thought evolved over time through the thinking of two men, Charles Horton Cooley and George Herbert Mead. The more influential of the two was

Mead. A discussion of both men's work is essential in order to understand the foundational pieces that are threaded throughout the various schools of thought regarding SI.

Charles Horton Cooley

Charles Horton Cooley was a student of John Dewey (Reynolds, 2003). As a sociologist, Cooley was one of the instrumental figures providing concepts key to the development of symbolic interaction. He shared in the development of this theoretical view by his contribution of two important principles to the understanding of society: the *primary group* and the *looking-glass self* (Reynolds, 2003; Stryker, 1980).

Primary groups: By primary groups, Cooley was referring to those “groups characterized by intimate face-to-face association and cooperation” (Cooley, 1962/1909, p. 23). Cooley believed that the individual existed within the imagination of the members within the society, and it was through the mental picture that we have of ourselves that society is formed (Reynolds, 2003; Stryker, 1980). When speaking of this primary group concept, Cooley felt that “human nature is not something existing separately in the individual, but a group-nature or primary phase of society, a relatively simple and general condition of the social mind” (Cooley, 1962/1909, p. 29). Cooley's contribution to the formation of symbolic interactionism is found in this perspective of the relationship between an individual and to the framing of society. To understand society and gain a true understanding of its workings, one first needs to unveil what is occurring in the imagination of its members (Reynolds, 2003). How we develop this imagination of ourselves and each other is the function of the primary group and looking-glass self. The primary group is referred to as the intimate face-to-face contact, and is responsible for formation of the social nature and ideals of self as well as other individuals (Reynolds, 2003). For most individuals, the family and peer groups serve as the primary group.

Looking-Glass Self: The concept of the looking-glass self relies heavily on an individual's imagination. Our social selves are made up of three components: 1) the way we imagine ourselves to appear to another person; 2) our imagining of the others' judgment of us; and 3) the individual's feelings of pride or mortification that arise from these two imaginations (Stryker, 1980). In Cooley's theory, the conception of society is dependent on the imaginations of ourselves and how we imagine others. Society is therefore a joint venture between an individual's action as a part of personal responsibility and the society that influences an individual's act. Or, to quote Cooley (1962/1909), "the active individual is responsible, and yet he only sums up the action of society at the given moment" (p. 158).

The criticism of Cooley's theory of how the imagination of the individual plays a part in forming society is that it infers that there is a separate society for each person within the society. In other words, if there are 50 people in a room, there are 50 different societies within the room. What is problematic with this concept is when it is applied to researchable questions, which seek to find true meaning and reality. Although Cooley provided these concepts, it was Mead who truly defined the theoretical foundation for SI.

George Herbert Mead

George Herbert Mead's most noted work in relation to symbolic interactionism is his 1934 work, *Mind, Self and Society*. Like Cooley, Mead was influenced by the pragmatics of John Dewey, and he read and challenged Darwin's theories of evolution and of behaviorism, specifically the stimulus response. Therefore, Mead neither looked at what ties social expressions such as smiling or grunting as primitive responses that eventually led to formalized language, nor did he look at society from a linear standpoint (X=Y). Instead he saw social expressions as the result of exchange among people, and looked at society as how the many elements within society

and the individual work together to create reality. Mead recognized the intrinsic uniqueness of each social act.

The social act is not explained by building it up out of stimulus plus response; it must be taken as a dynamic whole – as something going on – no part of which can be considered or understood by itself – a complex organic process implied by each individual stimulus and response involved in it (Mead, 1934, p. 7).

Key areas of Mead's analysis that informed the development of SI as a sociological perspective were the mind, the self, society. Included as part of these areas are concepts such as gestures, I and Me, the act, social interaction, symbols, objects, and joint action.

The Mind: The concept of mind deals with the central nervous system of our bodies. The mind focuses on the internal dialogue individuals have with themselves regarding the meanings of objects and other people. This concept came from the earlier work of Mead, who stated in one of his lectures in 1929: "Thinking is communication with yourself, and this is the basis, the essence of mind" (p. 154). It is the process of internalized dialogue with the self that takes place within the individual (thinking), during which the person may attend to one characteristic of a situation over another. This is a continuous process occurring within the individual; we are constantly having internal dialogues with ourselves about people and objects with which we come into contact. The mind is involved within all social interactions, because it is through the mind that one defines others and determines the universals held by the group (Mead, 1934).

The concept of mind, the reflective element of thinking, is also responsible for the ability of individuals to be able to "take the role of the other" in viewing the world and each other (Mead, 1934). Taking the role of the other is the process by which we try to imagine the view or position of others (Charon, 1995). In this SI perspective, other humans are objects; therefore,

they must be defined and have a meaning assigned to them just as all other objects (Charon, 1995). In order to take the role of others, we must be able to not only imagine how the other is interpreting the world, but also to internalize the point of view of others and conduct ourselves accordingly (Charon, 1995). Therefore, taking the role of the other is not simply imagining the perspective of others, but is also a process by which we come to a collective understanding of the meaning of their acts (Charon, 1995). This is done through the understanding of gestures and language.

It is also from the mind that we adopt and learn the meaning of gestures. These gestures, after a period of repetition, become symbols in our minds, creating a form of non-verbal communication (Mead, 1934). Through these symbols individuals come to understand and assume the thought processes of those who use them. Gestures, therefore, become symbolic of what is occurring within one's mind (Mead, 1934). Gestures will also become understood by the collective society through interaction.

Language is another social gesture within the mind. Over a period of time, vocal sounds become known to those who occupy the same social space. According to Mead, we learn words that also are symbols of communication through the collective understanding of the sounds produced (Mead, 1934).

Self: Mead's theory of self is that every human being has a self, and can communicate with self. The self is a separate element from the physiological organism (Mead, 1934). Self is one way in which Mead separates the view of social science from that of behaviorism. Behaviorism views the self as responding to situations through "scripting" appropriate behaviors. In the SI perspective, development of self involves a reflective process on the part of the individual (Blumer, 1969, Mead, 1934).

The self goes beyond the physical operations of a human body and involves a learning process that is much more reflective. The self is the individual's sense of who he or she is, and relates to personality formation. The self is learned by taking the response of others, and coming to develop a sense of "who one is" through these responses. In this way, a person needs to take on the attitudes of the generalized other to direct their future behaviors (Mead, 1934).

The I and Me: Foundational to the understanding and formation of the theory of symbolic interactionism is Mead's concept of the "I" and the "Me" in relation to the person and society. Mead's philosophy was the individual has various qualities that will play out depending on the situation in which one finds him- or herself. Mead explains this as follows:

What determines the amount of the self that gets into communications is the social experience itself. Of course, a good deal of the self does not need to get expression. We carry on a whole series of different relationships to different people. We are one thing to one man and another thing to another. There are parts of the self which [sic] exist only for the self in relationship to itself. We divide ourselves up in all sorts of different selves with reference to our acquaintances. We discuss politics with one and religion with another. There are all sorts of different selves answering to all sorts of different social reactions. It is the social process itself that is responsible for the appearance of the self; it is not there as a self apart from this type of experience. (Mead, 1934, p. 142)

Mead's theory was that it is difficult, if not impossible, to truly separate the self from the relationship/situation in which the person is involved at any particular point in time. The person takes on a chameleon-like quality, in which the qualities of the self that appear are dependent on the social experience and those who are involved within this experience. It is in the combination of being able to adapt one's interactions to the situation in which one finds oneself that

demonstrates the influences of Darwin and pragmatism on Mead's work (Stryker, 1980). As society develops into a system of interdependent parts, individuals then need to be able to adapt their behaviors in order to survive and create functional societies (Stryker, 1980).

Individuals adapting their presentation of themselves to the person with whom they are interacting comes with a delineation of the "I" and the "Me" within this context. Mead speaks about this selection of traits that are brought into the interaction, causing a resultant breaking of the personality into different selves (Mead, 1934). In Mead's thought, the difference between the "I" and the "Me" is found in the relationship of these two selves to the social process. The concept of "I" and the "Me" can be difficult to understand, but is important to the understanding of Mead's work, because these two elements are the essential elements found in each personality emerging within a social process (Stryker, 1980). The "I" represents "the responses of the person to the organized attitudes of others" (Stryker, 1980, p.38). According to Mead, the "I" of the personality is in constant dialogue with the Self in relation to the interaction it has with others. The "I" is the "self talk" that we have within ourselves. The "I" is the part of our self that will react to others in the social situation, and consequently changes the community based on our reaction to the community (Mead, 1934). The "I" is how humans will separate themselves from the society's social attitudes. It is through this element of separateness that an individual does not become simply a vessel to replicate what they have seen, but becomes an active participant within the formation of the attitudes of the society. The "Me" is the part of the individual that becomes aware within the person's memory and recalls the "I" of the moment in which the individual reacted with society. The "Me" of one moment was the "I" of the former moment. In Mead's own words, he explains the relationship between attitudes of others and the "I" and "Me":

The “I” is the response of the organism to the attitudes of the others; the “Me” is the organized set of attitudes of others which one assumes. The attitudes of the others constitute the organized “me,” and then one reacts towards that as an “I” (Mead, 1934, p. 175).

The “I,” therefore, becomes the active part of the self, whereas the “me” is more reflective in nature. Not only does the “me” act as a reflective portion of self, but it also assists in controlling the future responses and reactions of the “I.”

Society: Society could not exist without a mind and self. Society is the collective of individuals constantly engaged in a process of defining and evaluating themselves and each other. Within this society there is a constant advance of the existence of minds and selves (Mead, 1934, p. 227). Society exists in order for advancement and continuation of the species. As Mead (1934) states:

All organized human society, even the most complex and highly developed, is an extension and ramification of those simple and basic socio-physiological relations between the members. (pg. 229).

The Act: Mead ([1914] 1982) described an act of an individual as “a stimulus and response on the basis of an inner condition, which sensitizes the system to the stimulus and quickens the response” (p. 28). People do not simply respond to situations; they respond to a situation by acting out their wants and the expectations they have of themselves and others.

Social interaction: Mead identified two levels of social interaction: Non-symbolic and symbolic. Non-symbolic interaction is the direct response of individuals to gestures and actions of other individuals. In symbolic interaction, there is an interpretation of another’s gestures, and the act that follows is based on the meanings constructed.

Mead and Cooley offer the key ingredients from which SI is created. By looking at the processes involved in the ongoing relationships between individuals and their ideas, we are provided some perspective as to how interactions between individuals can be explained. What they offer is an explanation as to the connectedness between what individuals perceive and how they behave and how society is reproduced through past experiences of an individual, affecting the way in which a person acts in the present situation. Cooley inspires this study by offering an explanation through the use of the primary group and looking-glass self to explain the relationship between student and instructor. Instructors are constructing the relationship partly through their own view of how they see themselves in the instructor's role, as well as how they view the role of the nurse. This perception is formed through years of socialization, which reinforces the image of the nurse as a female. Mead's work takes the concepts of Cooley and applies them one step further to explain how the looking-glass self and primary group come alive within social situations. Mead, in his analysis of the "I" and "Me," provides an explanation as to what guides behavior and how our constructed images from past experiences are acted out in current situations.

Schools of Symbolic Interactionist Thought

The major schools of thought to which SI lays claim are the Chicago School (influenced by Herbert Blumer), the Iowa School (influenced by Manford Kuhn) and the Dramaturgical approach (influenced by Erving Goffman). Each school of thought provides frameworks in which to better understand human interactions. The perspective of SI that best incorporates the elements of SI that all the other perspectives share is found in the work of Blumer (Chicago School).

The Chicago School: Blumer

The term symbolic interaction was both coined and developed by Blumer. Blumer was a student of Mead's at the University of Chicago. Although Mead was not the only person on whom Blumer based his work, he was the primary source of inspiration for SI (Charon, 1995). Hence, Blumer and Mead, share common underlying assumptions. These common assumptions are found in the previous paragraphs related to Mead. There are tools of SI theory, developed by Blumer, that are threaded through most, if not all, views of SI, and are considered the key components of SI. Symbolic interactionism can be understood as having three basic premises that focus on meaning, language and thought, as described by Blumer:

The first premise is that human beings act toward things on the basis of the meaning that the things have for them. Such things include everything that the human being may note in his world. ... The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters (Blumer, 1969, p.2).

The influence of Mead is apparent in Blumer's work. Blumer took the idea of the internalized dialogue occurring in the mind and applied it to his first premise as being responsible for an individual's ability to make meaning from society. The influence of pragmatics on SI is evident when discussing meaning-making, because within the SI perspective, we make meaning not from the object itself or from pure psychological elements within the individual; meaning-making comes from the interaction between people and how others act toward the person in regard to the thing (Blumer, 1969). Therefore, "symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining

activities of people as they interact” (Blumer, 1969, p. 5). In Blumer’s view , individuals do not take all stimuli and react to it, but will selectively choose which elements of a social situation to attend to and process. Thus the person (organism) is in constant interaction with him- or herself and the environment in adjusting to the conditions of the world (Meltzer, 2003). We block out what we are not interested in, and pay our selective attention to a situation.

Blumer (1969) describes this process of self-reflectiveness as follows:

With the mechanism of self-interaction the human being ceases to be a responding organism whose behavior is a product of what plays upon him from the outside, the inside, or both. Instead, he acts toward his world, interpreting what confronts him and organizing his action on the basis of interpretation. (p. 63)

These meanings are interpreted and are used in order to achieve a sense of self. Through the development of a sense of self, we form a sense of identity. This identity formation can be likened to Blumer’s third premise, which deals with the modification of meanings. Identity can be defined as how we see ourselves, in addition to how we believe we are viewed by others. Due to the interaction of self within one’s self, self-interaction affects the character of the outward action within society (Blumer, 1969). Acts are constructed by the individual, and go beyond simply responding to a stimulus (Blumer, 1969).

Social interaction within the SI perspective is unique in its view of interaction between individuals as significant, because it is seen as what forms human conduct, instead of being simply an expression of human conduct (Blumer, 1969). Recalling from the discussion of mind, the images humans form of themselves and others, as well as society, is dependent on the meanings they make from the interactions they have with others. It is through this reflective process that we learn how to behave in different situations.

Blumer's first premise of SI also deals with the action of humans towards objects. There are two basic premises of SI, the first of which is people behave toward symbols not on the basis of the concrete properties of the object, but on the meanings they associate with them. The second premise is that meaning develops through interaction with those objects. Objects can be things, people, places or situations, depending on their place in the social interaction.

Symbols can be found in the gestures and actions of others within a given situation. Symbols can also be inanimate objects within a social situation. A gesture is "any part or aspect of an ongoing action that signifies the larger act of which it is a part" (Blumer, 1969, p. 9). When a person makes a gesture, he or she is doing so to communicate to another individual a plan of future action. If the receiver of this gesture responds in some way, then the gesture was considered significant, since both sender and receiver had a common understanding of what the gesture was meant to communicate (Blumer, 1969, Howard & Hollander, 1997).

Society can be linked to Blumer's third premise of SI. The emphasis of a SI view on society rests on the concept of social acts and gestures as creating society, rather than society creating itself (Katovich & Maines, 2003). These gestures and acts create society, but just as important is the interpretation that individuals give to the situations that confront them, which also forms society. Society is therefore defined by the "interpretive process by means of which human beings, individually and collectively, act" (Blumer, 1969, p. 89). Humans are responsible for creating society through these interpretive acts. Unlike other theories, SI views the human as a constructor of society, rather than learning society through a process of reinforcement, schematic processing or as biologically determined. It is through individuals acting in cooperation that society is constructed (Charon, 1995). The following tasks need to occur within a society in order to solve conflict: 1) ongoing communication, 2) mutual role-taking, 3) defining

the others as social objects, 4) defining social objects together, and 5) developing goals in interaction (Charon, 1995).

Culture, then, is formed from resolving conflict, which creates continuity over time and a shared perspective of how the world works. Culture, therefore, is a shared “consensus” of the group (Charon, 1995). Learning culture is a process of taking on the perceptions of the “generalized other” as previously addressed. Culture maintains society because people come to share and use the perspective of the generalized other. The more committed any society is to the cultural perception, identity or role performance, the more prominent it will be within society (Stryker, 1980).

Within nursing, there is an image that the nurse is female, and many identify the nurse as such. Blumer’s work provides a way in which to describe what is occurring within the student-teacher relationship in a clinical setting. The instructor is seeking to socialize a male to the profession, yet the cultural perception to which society is committed is that a nurse should be/is a female. This requires a renegotiation of the meaning of a nurse, which the female instructor has come to adopt as being part of the larger society.

The Iowa School

The Iowa school of symbolic interactionism was developed by Manford Kuhn, and has as its fundamental question “how is society possible” (Katovich, Miller & Stewart, 2003)? Kuhn started teaching at the University of Iowa in the 1940’s (Katovich, Miller, & Stewart, 2003). His approach to SI reflects the university’s attempts to develop the school of social science by creating educational programs that emphasized an approach toward research more grounded in the scientific method. This is not to say the Chicago school is lacking in this; however, the

approach of the Iowa school incorporated scientific methodology similar to what is found in quantitative studies.

Kuhn took Mead's social behaviorist theory and utilized it to establish a theory of self that was testable. Kuhn wanted to use methods that would allow for generalizations to explain human interaction. In essence, he wanted to find the patterns of human behaviors that could in turn be made generalizable to all behavior. The benefit of this was thought to be in the consequent ability to predict the future behaviors of others. In contrast, Blumer's methods involved observation to establish the underlying meaning behind the actions of individuals. Clearly, the methods within Kuhn's theory are very different from those of Blumer.

The methods employed by Kuhn explain behavior as constructed socially, instead of behavior as occurring partially from within the individual. In other words, although Kuhn utilized SI, he does not favor the ideas of the "I" and "Me" from the work of Mead as heavily as Blumer. Kuhn did focus on the self, particularly when investigation how individuals viewed themselves and on role-taking. The Iowa school does not focus specifically on the internalized dialogue of the actors, but rather on the on "social acts and how concerted action was linked with the social self. The focus of data derived from methodologies from the Iowa school emerge from the social interactions of the participants and look at the sequences of initiations of these social actions and the responses to these initiations" (Katovich, Miller & Stewart, 2003, p.123).

Kuhn's most noted accomplishment was in the development of the "Twenty Statements Test" (TST) (Katovich, Miller & Stewart, 2003). The purpose of this test was to measure the self in a way consistent with interactionist theory. Seven postulates formed the basis of Kuhn's test, and all revolve around statements in which the individual answers the basic question "who am I" through answering 20 questions on an examination. Because of the popularity of this exam, the

Iowa school came to be associated with research concerned with answering the question of self and self-measurement (Katovich, Miller & Stewart, 2003).

Kuhn's view of SI looked at human behavior in terms of roles being constructed and individual behaviors socially determined by the actor's definitions, particularly self-definitions (Meltzer, Petras, & Reynolds, 1975). The emphasis of Kuhn's work related to self, not surprisingly, has been linked to work that has been developed in the area of role theory. Kuhn's approach to SI "focuses on the concepts of self and of role-taking" (Stryker, 1980, p.100). What Kuhn's work lacked in terms of a connection to the original work of the Mead and Cooley is the interactional nature of society, and how this reflects back onto the individual. Again, Kuhn viewed human behaviors as socially determined by the actors' definition of themselves.

Kuhn's work could inform this study by providing a way in which to explain the learning of the role of the nurse by the student. However, what Kuhn's work lacks for this study is a framework for describing and explaining the interactional elements between student and instructor.

Dramaturgical Approach: Erving Goffman

The Dramaturgical approach, which takes as its metaphorical meaning of William Shakespeare's famous quote, "All the world's a stage," started from a philosophy in which society was seen as created by individuals acting out their social roles (Edgley, 2003). The person who is most frequently associated with this approach to SI is Erving Goffman. Goffman was both influenced by, and influential in, the development of SI (Charon, 1995). Although the most closely associated with SI, Goffman was not the original developer of this perspective. The Dramaturgical approach was first developed by Kenneth Burke in the 1930's to serve as a

framework for analyzing literature. This framework has been taken into the field of social psychology to become one of the standard views of SI (Edgley, 2003).

The Dramaturgical approach is much more reflective of Mead and Blumer's works than of the Iowa school. This view sees the meaning a person has toward an object or another person as behaviorally active, rather than a cognitive process. The focus that sets the Dramaturgical framework apart from the work of Blumer is the focus of meaning-making, specifically, how individuals make meaning within their lives. Blumer was not concerned specifically with how meanings are made, but rather how they emerge within everyday interactions. Thus, the foundational principle of Dramaturgy is "the meaning of people's conduct is to be found in the manner in which they express themselves in interaction with similarly expressive others" (Edgley, 2003, p. 144). Goffman was concerned with the meaning of the individual's conduct and how it emerged within interactions. Goffman differs from Blumer in that there is less emphasis on the internal dialogue, but rather how the surroundings of the present situation affect the interactions between individuals. Therefore, Goffman's perspective was described as being:

that of the theatrical performance; the principles derived are dramaturgical ones ... the way in which the individual in ordinary work situations presents himself and this activity to others, the way in which he guides and controls the impression they form of him, and the kinks of things he may and may not do while sustaining his performance before them. ... The stage presents things that are make-believe; presumably, life presents things that are real and sometimes not well rehearsed. More important, perhaps, on the stage one player presents himself in the guise of a character to characters projected by other players; the audience constitutes a third party to the interaction – one that is essential and yet the stage performance was real ... In real life, the three parties are compressed into

two; the part one individual plays is tailored to the parts played by the others present, and yet these others also constituted the audience. (Goffman, 1959, p.xi)

An individual learns to take on different views of the self and play them out within social situations. This is what Goffman (1959) called Dramaturgy, or impression management, which is Goffman's main contribution to SI. Humans will play out their self-impression of their role, depending on the situation in which they find themselves. Goffman compared this presentation of self to acting on a theatrical stage, in which we script for ourselves what we feel our place is within society (Goffman, 1959). Therefore, the interaction itself becomes an important piece in understanding how society, and hence culture, is formed, and how in turn, the important aspects of culture are played out between individuals.

Goffman's analogy to the world as a stage is extremely helpful in attempting to understand SI from a theoretical standpoint. The individual is, in essence, taking on a role. How those individuals internalize that role, as well as the individuals with whom they are interacting, will "set the scene" for what is enacted on the proverbial stage, which, in this case, is the social situation. Goffman defines a social setting as any area in which a person finds himself exposed to the immediate presence of another (Goffman, 1977). Specifically, Goffman studied gender as a criterion on which individuals make meaning. He refers to gender as a code, which establishes the conceptions individuals have of one another concerning their fundamental human nature (Goffman, 1977).

Goffman, however, does not place the same emphasis as did Blumer on the "I" and "Me" from Mead's work. He looked at social interaction as a way in which to observe the meanings that people have formed, but did not delve as much into the internalized processes within the individual psyche as did Blumer.

Symbolic Interactionism and the Study of Occupations

SI, as discussed, helps to better the understanding of meaning-making regarding oneself and interactions between individuals and their environments. In the SI perspective, individuals come to know and create a self-identity via their interactions with others. Gender is part of this self-identity. As West and Zimmerman (1987) contended, we “do gender” in everyday interactions as part of this identity. West and Zimmerman concluded that gender forms social arrangements, based on sex categories, which in turn legitimize ways of organizing social life based on these “normal and natural” categories. How this ties into SI is in the sustaining and reproduction of elements of social arrangements by way of individually constructing and playing out socially defined roles. West and Zimmerman state: “if we do gender appropriately, we simultaneously sustain, reproduce, and render legitimate the institutional arrangements that are based on sex category” (West & Zimmerman, 1987, p. 146).

Occupational choice is one avenue within which individuals express their concept of self and “act out” self-identification, through engaging in work (Shaffir & Pawluch, 2003). SI creates a way in which to study the impact of work on one’s construction of self-identity, place in society, and role identification. The interactions within the work setting give clues to the meanings individuals have regarding objects and events within that setting (Fidishun, 2002). Studies in SI have done this by looking at individuals who engage in the studied work and what meaning the work has on the person’s view of themselves (Fidishun, 2002; Hallett, 2007; Shaffir & Pawluch, 2003; Walsh & Gordon, 2008). For instance, if a person is a truck driver, the question the researcher may ask is “How does the individual’s view of truck driving affect the person’s view of themselves?” This may explain why so much of the work surrounding symbolic interaction and occupational choice involves what may be conceived as “dirty” or “deviant”

occupations. However, SI also has been used in the study of many different occupations, such as medicine, law enforcement, ministers, teacher, and realtors. What has been found by studying occupations using SI is, when being socialized to a profession, individuals come to take on the profession as part of their identity and learn the norms of behavior for that profession. This requires exposure to the profession at some point, in which the learner becomes actively involved in carrying out the functions of that profession (Shaffir & Pawluch, 2003).

The way in which individuals perform their work is reflective of their work identity. Individual work identity refers to a work-based self-concept, constituted of a combination of organizational, occupational, and other identities, and shapes the roles individuals adopt and the corresponding ways they behave when performing their work in the context of their jobs and/or careers (Walsh & Gordon, 2008). Creating a work identity is an integration of: 1) competencies of the employing agency and 2) defining values of the occupation. This is demonstrated in Williams' (2006) work related to toy store workers. The behavior of the workers within toy stores was constructed first by the employing organization's prescription of how clerks and customers should interact. The second element of worker behavior was influenced by customer characteristics, by which clerks would change the employing organization's guides for how to interact with customers. The third aspect of work identity was acted out in the ability to repair relations with customers when relations break down. In Williams' (2006) study, the influencing factors in the clerk's ability to effectively manage customer relations relied on the organizational expectations, as well as the influence of gender, race and class on the customer/clerk relationship.

The term "professional" itself can change the expectations of those involved with the work. The term carries with it a certain elevation in class status by the sheer use of the word

when associated with an occupation (Shaffir & Pawluch, 2003). The term brings a connotation that certain work requires a higher level of training and education. That those who join the profession have made a commitment to the respective field helps to identify not just what they do, but their social worth (Shaffir & Pawluch, 2003; Hallett, 2007). In Hallett's (2007) study of occupational changes within an organization, the influence of others' actions were studied. Hallett (2007) found that part of a social arrangement is the power of those who are engaged in the social exchange. Power was defined as characteristics giving one group or individual power or privilege over another. Within the social order, those who have what is, according to Bourdieu's term, "cultural capital," have more influence over the ability to control the social situation (Hallett, 2007). The roles of others are important in the process of education with specific emphasis on the socialization piece (Kawecki, 1994).

An occupation, regardless of the need for advanced education, requires some form of socialization for the newcomer. It is in examining this process that SI has made its greatest contributions (Shaffer & Pawluch, 2003). In occupational studies, in addition to forming work identity, the reproduction of appropriate behaviors, customs, rules and rituals are transferred via socialization. All occupations, regardless of being deemed socially appropriate or deviant, pass on and reproduce these professional traits through the socialization process (Shaffir & Pawluch, 2003). This is influenced by those who are charged with bringing the newcomer into the field. Impression management will be a piece of how the new person comes to know the profession, and how they make meaning of themselves within the profession. In nursing, the clinical area is where a great majority of the socialization process takes place and the student's work identity is formed. The nursing instructor is the individual who most heavily bears the weight and power within this process.

The female gender is associated with nursing, and therefore becomes a symbol of the profession. When the symbols change, the worker may need to re-assess their identity. As an example of this, Fidishun (2002) studied the impact of introducing computer technology into a library setting to interpret exchanges that occur within libraries as more information is being shared via technology in place of books. For the librarians studied, the book was a key symbol they associate with their occupation and place of work. On re-assessing the work they do and how they identified themselves in light of the incorporation of computers, the librarians viewed themselves as “people servers” or “information providers;” hence, they did, in fact, value computers within their jobs, even if it meant incorporating another form of media to the workplace.

Conclusion of Symbolic Interactionism

The study of gender and how it plays out within everyday life can be examined through many different lenses. SI provides a lens for looking at how gender plays out in everyday interactions. The philosophical view of SI can be traced back to early scholars, and has evolved into different schools of thought. However, all SI theory utilizes the conceptual underpinnings of: things that are left unsaid still play out within society. Expectations of people based on their gender could be one example of unexpressed ideas that are expressed within symbols and social interactions.

SI is a way in which to explore how individuals define themselves and create identities. These identities are influenced by the type of work and the environment in which the work is performed. The socialization process is a crucial piece in the adaptation of the individual to the work, and in development of their work identity. The person who is socializing the individual is highly influential in this process, and has power in the relationship. For this study, nursing

instructors were studied to explore the how gender influenced the socialization of males to a profession in which the members are socially viewed as females.

SI is being chosen for this study because it offers a perspective that combines the use of gendered roles and socialization. The use of SI will enable the researcher to examine the interactions of instructors and students, to identify if there is a symbolic nature to the interactions, and if so, what is the meaning behind these symbols. Notably, the underlying expectations related to gendered roles between men and women will be able to be explored by way of looking at the interactional nature of instructors, rather than relying on self-reporting of instructors alone.

Section II: Men in the Nursing Profession: An Introduction

The purpose of this study is to gain an understanding of how males are socialized into the predominantly female profession of nursing. This was accomplished through observing and questioning the interactions between male nursing students and female nursing instructors. Nursing is a professional world dominated by women. Therefore, because of their gender, men are considered minorities; hence they become marginalized members within the professional community. Current economical conditions, causing layoffs in many manufacturing and other types of employment, coupled with increasing nurses' salaries, have influenced many men to consider nursing as a career choice.

Currently, there is a nationwide shortage of nurses. In an effort to increase the number of nurses, the profession has sought to recruit more men into nursing education programs. This effort contributed to a 100-percent increase in males enrolling into nursing programs from the 1970's to the 1990's (Stott, 2003). Although this led to a tremendous growth in the number of men in nursing, this increase was followed by a 40- to 50-percent attrition rate of males out of

nursing education programs (Stott, 2003). The reasons for this trend have yet to be clearly identified; however, the literature gives a hint that there are different types of stress encountered by male students and professional nurses as a result of their gender (Baker, 2001; Brady & Sherrod, 2003; Callister, Hobbins-Garbett & Coverston, 2000; Ellis, Meeker, Hyde, 2006; Kelly, Shoemaker & Steele, 1996; McMillian, Morgan, & Ament, 2006; Meadus, 2000; Morin, Patterson, Kurtz & Brzowski, 1999; Okrainec, 1990 & 1994; O'Lynn, 2004; Porter-O'Grady, 1995; Smith, 2006; Villeneuve, 1994). Some of these differences, which are discussed in more detail below, revolve around differences in the educational experiences of men in nursing programs because of their gender. These differences, typically, arise out of the social position of males and what expectations/assumptions both instructors and students have related to gender and the nurse's role.

The adult student comes to the educational setting with assumptions based on personal life experiences. For white men, this is likely the first time they have been a minority group within an educational or professional setting. Regardless, there has been little research of the assumptions and expectations female nursing faculty hold regarding male students. The nursing research has dealt primarily with giving voice to the experiences of males.

The importance of this review is to determine how gender influences participation and experiences of men in the nursing profession. The main purpose of this review is to identify the contemporary themes that characterize men's experiences in the nursing profession. The field of adult education could benefit from this information because it provides another lens, particularly for faculty of nursing programs, through which to view how a student's gender impacts the educational learning process. As nursing seeks to recruit more men into nursing and becomes more diverse, it is important to be aware of how gender affects the experience of becoming a

professional nurse. In addition, it is important to have a nursing workforce that is representative of the populations served; therefore, understanding how diversity in terms of gender, as well as other characteristics, impacts the interactions between instructor and student is valuable. Under-representation of men in nursing programs causes a subsequent under-representation of men in the nursing workforce.

There are three main sections to this review concerning nursing and the experiences of male nurses. The first deals specifically with nursing history. The information provides the reader with some foundational knowledge of how nursing came to become known as a women's profession. In addition, this history provides the reader with some information regarding historical themes that have shaped the professional culture. The second major section specifically addresses empirical and some conceptual research regarding men in the nursing profession. This section outlines the current status of males, as well as issues specific to being a male in the nursing profession. The third section deals with men who work in other female occupations. The purpose of this section is to provide a broader understanding of males who engage in occupations traditionally seen as female-dominated and identify important similarities and differences to the nursing profession.

History of Men in Nursing

Throughout history, humans have had the need for health care. The provision of this care can, and has been, a joint effort by both men and women throughout history. Although in modern times nursing is portrayed as a profession suitable for both men and women, there is still an assumption that when care is provided, it is done by a woman. Nursing schools, although striving for change, are still attracting a disproportionate number of women into educational nursing programs. In popular media such as television, books, and advertisements, nurses are portrayed

almost always as women. The profession's history has been recorded by white women. The voice of the male nurse, as well as other minorities, has been left out of this history. This is evidenced in many of the nursing history books when the nurse is typically referred to as a female (Kalisch & Kalisch, 1984; O'Lynn, 2007). The purpose of this section is to trace the history of the profession from its earliest period to identify what role men and women played in the provision of health care; specifically, to what extent men were included and how their roles changed over time. This review is organized by time periods. Each time period covered addresses how health care was structured and what role men and women played in providing care. Resources used for this history discussion predominantly included a collection of historical texts outlining the history and trends of nursing, as well as a few current texts. These historical texts were published from as early as 1907 to as recently as 1966. The texts were obtained from the historical collection of one of the oldest diploma schools of nursing in Pennsylvania.

Primitive Times

The earliest periods of human history, those referred to as the years prior to the birth of Jesus Christ, are what are considered to be "primitive times" for the purposes of this writing. Although there are various speculations as to the history of humankind and how we came to be (Creationism vs. Darwinism), humans have always had the basic need to survive. The care and maintenance of the human body in the prevention and management of disease is felt to be a primary need with which humans dealt even within these primitive times (O'Lynn, 2007; Nutting & Dock, 1907). How, and by whom, this care was provided is a matter of speculation. Although in current times nursing and medicine are thought to be two distinct, yet interrelated specialties, it is thought that at one point in time, they were considered one and the same. Modern health care has advanced to being an intricate network of diverse specialties working together to prevent and

manage disease states. Certainly, primitive humans dealt with injury and illness, as well as the basics of providing adequate nutrition and assistance with childbirth.

The field of nursing can be traced back to these earliest times of human history. The way in which societies structured themselves can be viewed as the first system of health care, because the major function was to ensure survival and the continuation of the species. This need to care for one another in order to assist with continuation of the species is not unique to humans, but has been observed in other species, as well. For instance, most animals engage in some form of self-care, care of the young and helping another in distress. Rats have been observed gnawing off the legs of another community member who is trapped (Nutting & Dock, 1907). It only makes logical sense that within primitive societies, humans learned of ways of surviving and healing when wounded. Human societies in primitive times were thought to consist of a tribal system in order to achieve health, survival and reproductive functions.

Tribal living consisted of men hunting for food while women stayed close to camp. Within these societies it is thought that men and women had different roles. Men were responsible for the provision of food. Women gave birth to children and cared for them, which provided for the continuation of the society. In addition to caring for children, women stayed close to the tribal camp, and if a person was ill or injured, assumed the role of nurse as well (Jamieson & Sewall, 1944).

As societies evolved, the curing of illness became associated with a type of magical power given by the gods. Medicine was considered either white or black magic (Nutting & Dock, 1907). White magic was associated with benevolence, doing good, and healing. Black magic was associated with evil spirits, poison and malevolence. Illness became associated with

negative spirits; the cure of illness took on a religious tone, and was thought to have been associated with the formation of the first religions (Leff & Leff, 1958; Nutting & Dock, 1907).

As tribes started to migrate to different lands, the system of healing became the basis of religions worldwide. In ancient Egypt, the temples also were hospitals, and the priest was really a “priest-physician” (Jamieson & Sewall, 1944). In tribal communities, healing was typically performed by the medicine man, who was well versed in the application of remedies in the form of baths, mixing drugs, and even psychotherapy (Jamienson, Sewall & Suhrie, 1966).

As tribes started to migrate to areas such as Greece, China and Egypt, the connection between the healing arts and religion maintained its strong bond. In ancient Egypt, healing was performed by the priest-physicians who held positions of high power in the community. The priest-physician was typically assisted by a temple woman who shared this position of high social authority (Janienson, Sewall & Suhrie, 1966). The role of the temple woman was in the carrying out of the treatments, similar to present day nursing tasks. The strong connection between religion and health continued in many other civilizations in the form of worshiping gods who could bring wellness, strength and healing (Jamienson, Sewall, & Suhrie, 1966).

Early Christian Era: 1-500 AD

As Christianity came into practice, the linkage between health care and religion continued. The care of the ill became a role of the monks and nuns of the early church. However, unlike the relationship between healing seen as a magical process bestowed through the intervention of a god, the provision of care took on a humanitarian effort performed by those who had devoted their lives to carrying out the teachings of Jesus Christ. This was a marked difference between the pre-Christian and post-Christian time periods. The love and service

toward one's neighbor were regarded as a duty commanded by Christ. Service was, therefore, following the words:

You know that the rulers of the Gentiles dominate them, and the men of high position exercise power over them. It must not be like that among you. On the contrary, whoever wants to become great among you must be your servant, and whoever wants to be first among you must be your slave; just as the Son of Man did not come to be served, but to serve, and to give his life – a ransom for many. (Matthew 20:25-28)

These religious orders, for the most part, took care of the poor as a service of charity (O'Lynn, 2007). The duties of care transformed from an elevated status of authority in the pre-Christian period to a status of service instituted by Christ. Therefore, the provision of care still had a very strong link to religion, but the motivation to care for another derived from very different philosophies. Caring and healing were no longer done for the continuation of the species, but rather to follow the command of Christ. Religion during this time became not just an important part of life, but what one's entire life centered around (Goodnow, 1938).

At this time, men, as well as women, were the providers of care. However, the places of care were controlled by the church and religious orders of the day within religious monasteries. Men, as monks, and women, as nuns in the monasteries and convents, provided care to the majority of the ill and infirmed. This is what is referred to in nursing history texts as the Monastic system. The early church, through the leadership of St. Basil, utilized much of its resources to build housing for travelers and the sick (O'Lynn, 2007). The church turned much of the leadership of these buildings over to the religious orders to manage. There was a tremendous growth in religious orders during this time (Nutting & Dock, 1907).

The Middle Ages

The Middle Ages heralded the formation of hospitals for the care of the sick. Unlike the early Christian period, during this time care was moved out of the monasteries and into institutions designed for the aged and the indigent. This is considered to be the period during which the birth of hospitals took place (Seymer, 1954). The care-giving was still provided by religious orders and controlled by the church; however, in addition to the religious orders, other, secular and military orders started to emerge. These secular and military orders, while sharing some traits with the religious orders of the time, had some unique characteristics which set them apart.

The military orders. The founding of the military orders came about as a result of the Crusades and of pilgrimages (Seymer, 1933). Most notably among these groups was the Knights Hospitallers of St. John of Jerusalem. The knights did not engage in battle, but were a group of men who cared for the ill (Seymer, 1933; Nutting and Dock, 1907). The monasteries at this time were declining in numbers, as many men were joining the Crusades. The church at the time was building hospitals, many of which were staffed by these “military monks,” who, although joined in the Crusade efforts, did so by engaging in the care of the sick (Jamieson, Sewall & Suhrie, 1966).

Secular orders. The secular orders were comprised of individuals, both men and women, who wanted to devote their lives to the care of the sick as a religious calling. However, unlike the nuns and monks of the day, these individuals did not take lifetime vows to a religious order (Jamieson, Sewall & Suhrie, 1966). The secular orders still had strong religious overtones, and those who participated did so with the desire to engage in humanitarian mission; however, the lack of vows did not bind the individual to a religious order.

One of the most noted persons who started his nursing mission within a secular order was St. Camillus. St. Camillus worked in a hospital, as a nurse, in Rome in exchange for care to heal a leg wound he had suffered. After his leg wound had healed, Camillus, on reflection of his work, decided to become a priest. After ordination, he continued his nursing work, founding the first home hospice. In addition to providing care to the dying, Camillus formed a special congregation known as the Regulars of the Sick. Camillus broadened the work of this group to extend into prisons, where his men would nurse those convicts condemned to death (O'Lynn, 2007). Camillus is but one of the many men who were engaged in nursing care through both secular and religious life during that era. Today, St. Camillus is considered the patron saint of nursing by the Roman Catholic Church.

The Protestant Reformation

The time following the Middle Ages marked a period of growth both intellectually as well as socially. The world had changed dramatically; new lands were discovered, America being one of these important discoveries. The world started to change on many levels, as people started to engage in trade with other countries. The church during this time also experienced significant changes, and started to split into different groups as theological views started to diversify. The first split was initiated by Martin Luther with the Protestant revolt in 1517. There were now two churches: Catholic and Protestant (Jamieson & Sewall, 1944). As time went on, the split between the Catholic and Protestant churches widened. Individuals started to pursue knowledge through the scientific method. More individuals left the Catholic Church. As a consequence, the numbers of people in the convents and monasteries declined; therefore, the availability of nursing care declined, as well.

It was during this time that most of the historical writings record a decline in the overall state of health care, particularly in England. Nursing was greatly affected by the Protestant Reformation, as well as the growth in the use of the scientific method. In England, more than 100 hospitals were closed as the movement of health care went from the control of the monasteries to the state and the lay sisterhoods (Jensen, 1950; Seymer, 1933 & 1954). The indigent and sick had no place at which to seek care. The movement of care into the hands of the laity within countries such as England led to a reduction in the social status of nursing. The provision of care was no longer seen as a principle of charity, but of social necessity. The honor that had been attached to this type of work was lost during this period (Jensen, 1950). The people who were hired to take care of the ill received poor wages, attracting those from the lower classes instead of the higher, more educated classes. “When a woman could no longer eke out a living from gambling or vice she might become a nurse” (Jensen, 1950, p. 40).

The withdrawal of the monastery system from providing care did not simply occur due to the growth of Protestantism and consequent decline of religious life. There was an active movement at the time to remove these systems by way of force. King Henry VIII of England, in response to the papal refusal to sanction his divorce, took advantage of the Protestant Reformation to acquire church property in England (Jamieson & Sewall, 1944). Henry VIII destroyed 600 monasteries in England; as a consequence, inns and hospitals were also destroyed. The care of the sick and poor, which was one of the main missions of the monastic system, was gone (Jamieson & Sewall, 1944).

During the Protestant Reformation, the teaching of medicine, which was originally controlled by the monasteries, moved to universities. Medicine found a place within the university system, which was primarily open to men only, particularly in the study of the

sciences. Medical science advanced, while nursing remained unchanged (Jamieson & Sewall, 1944). It was also, at this time, that nursing saw the decline of men in the provision of care. Suitable work for males at the time consisted of occupations such as teaching and secretarial work. Women were not viewed as equals, nor as entitled to education within the Protestant view; therefore, those women who did go into nursing were not as well educated as they were under the monastery system (Jamieson & Sewall, 1944).

Eventually, there was a widening gap in the class system. Manual work was not seen as appropriate for a wealthy female (Jamieson, Sewall & Suhrie, 1966). Formal education was not readily available to women, with the exception of the upper classes. Upper-class education of women was limited to poetry, romantic languages, and the arts. There were very few women who enjoyed an education that extended beyond these limited subjects. Florence Nightingale was one of the select women at the time whose education extended into the fields of mathematics and science (Jamieson, Sewall & Suhire, 1966).

Nightingale, against her parent's wishes, pursued nursing as her chosen vocation. For reasons stated earlier, the nursing profession was not considered appropriate for a young lady of her class, nor as a desirable profession across social classes. In fact, for those women who had to work outside the home, nursing was considered the least desirable of professions (Jamison & Sewall, 1944). By the latter half of the 1800's, the system of health care was at its worst within the Protestant-dominated countries such as England. The hospitals that had been run by the religious sister- and brotherhoods of the Catholic Church had been replaced with dirty, unsanitary buildings, becoming sources of epidemics leading to lowering, rather than extending, life expectancies (Jamison & Sewall, 1944).

Florence Nightingale Era

Although strongly discouraged by family and societal influences, Florence Nightingale pursued the work of caring for the sick. Her work established the foundation of modern nursing, and marks a turning point in the profession. The need for better trained nurses at this time was obvious, particularly in England, which had suffered a major downturn in terms of the provision of health care from the Reformation period.

Despite being from an upper-class family, Nightingale took care of soldiers during the Crimean War, and established the first training school for nursing education. Nightingale's contribution to the profession of nursing was groundbreaking; not only because she established education as an essential part of the profession, but because she created a perception of nursing as an independent discipline separate from medicine. "Miss Nightingale was the founder of modern nursing because she made public opinion perceive, and act upon the perception, that nursing was an art, and must be raised to the status enjoyed of a trained profession" (Seymer, 1933, p. 99). She also established the nursing role as exclusively feminine, and one which women should dominate.

Nightingale's famous book, *Notes on Nursing*, written in 1859, served as one of the first nursing texts which identified the nurse's key role in the provision of health care. Here, she described nursing as being an extension of a woman's domestic role. Nightingale conceptualized the art of care to be specific to a woman because her philosophy focused on the domestic nature of caring, in terms of providing an appropriate environment for healing to take place. Nightingale fought to establish nursing as a discipline independent from medicine, which was exclusively male-dominated, at the time. She viewed nursing as a profession in which women could engage

in self-governance and be independent from men. In a letter written by Nightingale in 1867, she stated:

Women are never governed by a man, except to their own detriment. When the government of the man interferes with that of the female head, all goes to ruin... The whole reform in nursing both current and abroad has consisted in this – to take all power over the nursing out of the hands of the men and put it into the hands of one female trained head, and make her responsible for everything. Scarcely a week of my life elapses that I have not to assert this principle (in answer to counsel sought) to some institution or other (as cited in Seymer, 1960, pp.32-33).

Ironically, Nightingale who is hailed as the founder of modern nursing, can also be credited with restricting nursing to being an exclusively feminine and domesticated profession. She did not envision men as being part of the profession, and in fact, specifically worked to remove medicine from having control over the profession. It is written, in historical texts, that prior to Nightingale, “nurses were entirely controlled as to discipline, routine of work, and plan of education by hospital directors and medical staffs ... to change this was her fundamental principle” (Seymer, 1933, p. 99).

To her credit, Nightingale can be viewed as the person who saved the nursing profession, particularly in England, from total destruction. She brought about a revolution in the field, which opened opportunities to women of the time to receive formalized education. The book, *Notes on Nursing* (1859), served as one of the first nursing texts which identified the nurse’s key roles in the provision of health care. The Nightingale school, which was founded in 1860, influenced the nursing profession worldwide. There were four features of the Nightingale school which made it unique in its approach to the teaching of nursing: 1) a matron in charge, who was supreme in her

own field, and elected by the hospital board; 2) the practice of having students live in a home with a “home sister” in charge (always a nurse); 3) emphasis on classroom teaching of the biological sciences, and 4) Ward Sisters, who were given a high status in the field and the responsibility of ward teaching (Goodnow, 1948). The graduates of this school went onto carry their education in the art and science of nursing to other countries (Goodnow, 1948). For this, the profession will always be indebted to Nightingale’s work, which was acknowledged first in the 1870’s in the United States, with the development of the first schools of nursing.

For the male nurse, Nightingale developed a system of education from which they were, initially, excluded. Men did participate in the provision of nursing care, but in a different capacity. Private nursing, which was provided in the home, was done by family. For a woman, it was considered improper for her to care for any man who was not her husband. Therefore, in private care, men were needed to care for other men. This trend occurred particularly after the Civil War, during which men had served in many hospitals at that time (Goodnow, 1948). The most famous of these male nurses who served during the Civil war was the poet, Walt Whitman.

Post-Nightingale to Modern Times

Due to the intimate nature of nursing care, as well as the reality of dealing with procedures which required strength and were physically demanding, the need for more male nurses was being acknowledged in the early 1900’s. Many hospital schools of nursing admitted men; however, the training for a male nurse was abbreviated to that of a female’s education. The schooling of male nurses typically consisted of a one-year course, and male nurses were referred to as “attendants” (Goodnow, 1948). The other area for the training of male nurses took place in the psychiatric hospitals. This training did not encompass the full complement of courses which

nursing schools at the time offered, and was limited to the determined role of a male in providing care to the psychiatric patient.

The Mills school of Nursing, under the direction of Fredrick Jones from 1921 to 1929, at Bellevue Hospital in New York, was the first school of nursing established specifically to train men in general patient care (Kalish & Kalish, 2004; Goodnow, 1948). By 1943, there were four schools of nursing for men only in the United States: the Mills school, New York; the Pennsylvania Hospital school of Nursing for Men ; and the two Alexian Brothers in Chicago and St. Louis. Seventy-five other schools accepted both men and women into their programs (Goodnow, 1948).

Although this small, yet significant, growth in nursing programs aimed at men may provided the illusion of acceptance of males within the profession, there was a strong contingency of groups within the nursing, medical and military communities, which sought to keep men out of the profession. Even though promising the idea of separate educational programs for men and women has an underlying tone that nursing is a woman's profession, and if men are included, it is in a different capacity. The movement during this time came from two major power structures: hospital administration and the military system.

Hospital Administration. Within any organization, there are systems in place to assure an organization is led effectively. In health care, one of the groups that holds power is hospital administrations. Significantly, in 1914, a manual on hospital administration commented on the value of male nurses. In the writing, males were seen as possessing some advantages: "There is no doubt that there is something more virile, more substantial, and certainly less finicky in the male nurse" (Kalish & Kalish, 2004, p. 373). However, in the same document, these administrators went on to characterize the male nurse as follows:

Has usually some overpowering failing, some inherent weakness that forbids his success in any permanent line of human endeavor. In other words, the male nurse has been nearly always “a failure.” Many times he has become a periodical drunkard. Sometimes he has been a bright young businessman or mechanic or clerk whose intemperate habits have brought him to the hospital, and, after repeated trials and repeated failures, he has found that his only safety lies in shutting himself out from the world, and subjecting himself to the discipline of the hospital or the institution. The most competent and reliable male nurse will often times go along for weeks or months, attending conscientiously to his duties, taking most efficient care of patients, until in some unlucky moment he finds the whiskey bottle in the medicine cabinet and takes “just a drop of steady his nerves.” The rest of the story is easily imagined. It has become a maxim that a trained nurse would not be a nurse if he were fit for any other occupation, and that is probably true.” (Kalish & Kalish, 2004, p. 373)

The above citation describes what, from those with the power to hire, fire and otherwise control the environment within the health-care system, and the work environment of nurses, accepted as truth regarding the male nurse. It can be assumed by this quote that, although men were seen to have some value to the nursing workforce, there were not as capable to hold down any other type of work and could not be trusted to function without being monitored for some unethical behaviors.

Military Nursing. Not only were male nurses fighting against the perceived notions of being less than fit to fulfill the role by hospital administration, they were also fighting the view of the U.S. Army. Although they had provided care during the Civil War, in 1901, men were banned from the U. S. Army Nursing Corps (Kalish & Kalish, 2004). This action was inspired by

a law that designated the U. S. Army Nurse Corps as a female entity. The establishment of the Army Nurse Corps as entirely female was a consequence of the demands of the American people on the government to assure a trained nursing staff to care for the soldiers during the Spanish-American war (Jamieson, Sewall & Suhrie, 1966). Prior to this war, nursing care was provided by primarily volunteers, consisting of individuals who lacked formal nursing education. As schools for nursing emerged based on the Nightingale training system, there developed a pool of qualified, trained persons to care for the troops. Necessarily, and socially approved, those who were recruited into the service for this purpose were women. This phenomenon can also be found in the history of military nursing in Canada, as well as England, during this time period (Jamieson, Sewall & Suhrie, 1966). Men who did serve in the army hospitals did so in the capacity of an orderly. There was not seen to be a need for male nurses in the military, and in fact, there was speculation that to allow males to function as nurses would lead to a diminished pool of candidates to serve as soldiers (Bester, 2007; Kalish & Kalish, 2004).

This limited utilization of male nurses in the military was closely scrutinized by males within the profession at the time. In 1941, H. Richard Musser, RN, wrote a letter that appeared in the *American Journal of Nursing*. In his writing, Musser described the struggles of males in the military as being problematic from two distinct areas. First, men were not being permitted to function as Registered nurses. Male nurses reported being given assignments that could have been performed by any lay person. They were barred from practicing at a level for which, clearly, their training had prepared them. Most male nurses serving in the military at this time were assigned to non-medical units. The second important issue raised by Musser's commentary was the failure of the U. S. armed forces to assign military rank to the male nurses befitting of a

person's with a nurses training and licensure. Males in the military, serving as nurses, were most frequently assigned the ranking of private, with little hope of advancement (Musser, 1941).

The barring of men from the military nursing corps continued through World War II. During the 1950's, the view held by many within the Army was that nursing is a role in which woman are much more adaptable to, and to allow men to enter the nursing corps would be problematic (Bester, 2007). Despite these views, President Dwight D. Eisenhower, on August 9, 1955, signed Public Law 294, which authorized the commissioning of males into the U. S. Army Nursing Corps (Bester, 2007).

Although this victory for male nurses within the military was the beginning of acceptance of males as nurses, there was still a view, which continues today, that men are an exception in the field. Within nursing texts researched from 1907-1966, the role of men in the nursing field has been categorized as separate. The themes that emerge are those of the male nurse as separate from women, yet forging into leadership positions in the field. In their text of nursing, Jamieson, Sewall and Suhrie (1966), explain the important role of the male nurse as providing care for the male patient, specifically. They also go on to say that, "in recent years, men nurses have been assuming leadership roles in the nation's nursing organizations. They have served on the American Nurses Association (ANA) Board of Directors, the National League for Nursing (NLN) staff, and have filled offices on of the associations" (p. 364). The ANA is organized to address issues regarding healthcare and practice issues on a national level. The NLN is the preferred organization for nursing educators and promotes excellence in nursing education.

What can be concluded from the above discussion is that it has taken the allowance of men into the nursing profession to be legislated, rather than simply accepted. Even with the allowance of males into the profession, men are still regarded as outsiders.

Section III: Current Status of Men in Nursing

Although it has currently been assumed that men are new to the profession, it is clear from the historical research that men have always had a role in the care of the ill since the earliest times of human history. The influence of the Protestant Reformation, Nightingale, educational structures, military policy and hospital administrative policies, have all had negative influences on men's participation in the profession. Consequently, men have needed to justify their place and contributions to the profession of nursing.

With the allowance of men into the armed forces, and changes that have taken place since World War II, it may be taken for granted that admittance will lead to acceptance of a group into a profession. The women's movement of the 1960's changed the traditional prescribed roles for women, opening doors to fields that were once closed. Many as a result, started to move into various fields once dominated by men. Unfortunately, the trend did not go in reverse for men entering traditionally women's fields, like nursing. Although the Civil Rights movement and affirmative action opened many doors which were once closed, such as medicine and engineering for women, the same trend did not occur in schools of nursing for men. This is because the rules of affirmative action did not apply to men (O'Lynn, 2004).

The men who chose to enter nursing were not only going against what was considered the traditional role for a male, but chose to venture where there was also no legal protection in place to assure that their civil rights were not violated. Nursing has not actively recruited men into nursing, holding onto an underlying discrimination toward male entry and inclusion of men in the profession, which has existed since the Protestant Reformation. A review of recent nursing literature shows that resistance toward considering the inclusion of men in the planning of professional and academic programs, recruitment of men into nursing programs, questioning

men's abilities to care, and failure to recognize the contributions of men to the profession (Anthony, 2004; Ellis, Meeker & Hyde, 2006; Evans, 2004; Meadus, 2000; O'Lynn, 2004; Tumminia, 1981). The participation of men in nursing challenges society, and nurses, alike, to rethink what is believed to be appropriate work for men and women, and provokes underlying assumptions regarding roles for men and women.

The next part of this review seeks to understand what is known about the experiences and the current issues which males face within the profession. Information regarding the demographics, motivations and personal characteristics is explored. Literature was gathered that dealt directly with men in nursing education programs, as well as graduates who are practicing nursing. A search was done utilizing ProQuest, CINAHL, ERIC, Wilson and GendeQuest. Search terms utilized included "Gender and Nursing," "Men and Nursing," "Men in Nursing Education" and "Male Nurses." In addition to an online search, an additional search was performed by inspecting the reference lists of retrieved documents for common titles and authors. The articles selected for review primarily consisted of studies, which explored issues and trends of men in nursing and male student nurses. Criteria for selection included both qualitative and quantitative research, as well as freestanding literature reviews.

Eleven conceptual pieces were chosen to provide an overview of influences and current issues involving men's participation in nursing. Empirical articles consisted of primarily, but not exclusively, qualitative, research pieces. Nineteen emerged as the primary sources, because they provided the greatest depth of information related to men's experience in the nursing field. Eleven major quantitative studies were also selected, which addressed the same issues and trends found in the conceptual literature.

Most of the literature used to inform this topic was written from the early 1990's, until current times. The topic is interesting, because it looks at gender issues from a very unique point of view; that is, men as the minority, rather than the majority. This issue is particularly applicable to health care, because the industry is female-dominated in many specialties other than nursing, such as radiology technology, physical and occupational therapy, nutrition therapy and social work. Much of what has been written about men in nursing revolves around main themes, such as men's experiences in nursing education (Anthony, 2004, 2006; Bell-Schiber, 2005; Ellis, Meeker & Hyde, 2006; Inoue, Chapman & Wynaden, 2006; Okaniec, 1989, 1994; Shellenbarger, 1993; Tumminia, 1981), recruitment (Hart, 2005; Meadus, 2000; Smith, 2004; Villeneuve, 1994), areas of specialty (Finalyson & Nazroo, 1997; Miller, 2004; White, 1983), and role conflicts (Callister, Hobbin -Garbett & Coverston, 2000; Evans & Blye, 2003; Grady, Stewardson, Hall, 2008; Jinks, 1993; Patterson & Morin, 2002; Patterson, Tschikota, Crawford, Saydak, Velkatesh, Aronowitz, 1996; Tummina, 1981).

The next section of this literature review seeks to answer some basic questions about men who are currently working in the nursing field: 1) characteristics of men who become nurses, 2) what are the major motivators and influences for becoming a nurse, 3) what are the major barriers they face from a socialization process, 4) how are males accepted into the profession by female nurses, 5) what are the major challenges for the male nursing student, and 6) are there privileges associated with being a male in a predominantly female profession?

Characteristics of Males who Become Nurse

Currently, 9.8 percent of registered nurses are male in the United States (U.S. Department of Labor, 2003). There is not a single piece of literature that has well documented the demographical data of the typical male who enters the field of nursing. Most of the descriptive

research is qualitative in design, and addresses the motivations of males entering nursing. Some quantitative demographics are available which, assist in profiling the typical male who enters nursing. Males who go into nursing are predominantly married, and older than their female counterparts (Fister, 2000; Jinks, 1993; Okranic, 1994; O'Lynn, 2004; Smith, 2004). The average age of a male student-nurse in most studies was more than 24 years of age, contrasting with females, who are typically reported as being less than 25 years of age. Many men who enter nursing do so as a second career (Blankenship, 1991; Kelly, Shoemaker & Steele, 1996). If a male chooses to enter into nursing, he is typically white, and comes from a lower- to middle-class, urban background (Okranic, 1994). Males are attracted to nursing programs with male faculty (Meadus, 2000). No studies compared men in nursing to other groups, such as women in nursing, or men in other fields. Therefore, it is difficult to assess how one or more of these demographic variables may be specific to influencing a male's decision to enter the female profession.

Several studies have been conducted to address the personality characteristics of males who enter nursing and other allied health professions (Fisher, 1999; Holroyd, Bond & Chan, 2002; Jinks, 1993; Lukken, 1987; Okranec, 1994). Although these studies were done internationally, one common trait that emerged was that males who enter nursing have a more androgynous personality than that of males in more typically male-dominated professions. Females were also considered to have androgynous personalities; however, they were ascribed traits, such as caring and empathy, more so than men.

The Holroyd, Bond & Chan study (2002), which looked at men who enter nursing in the patriarchal culture of China, illustrates the struggles of dealing with stereotypes regarding appropriate work for men and women. This study was of particular value because the culture

within China favors males as a group. In China, the profile of the ideal nurse is “closer to that of the typical Hong Kong female, being passive, restrained, nurturing and responsive” (Holroyd, Bond & Chan, 2002). For the Chinese males in this study, the characteristics of self-openness, extraversion and assertiveness were much higher than those of the typical male within the culture. In China, males who choose to enter a female-dominated profession may need to possess not only female qualities such as nurturing, but also some key masculine qualities to assist them in coping with the contradictions and expectations of being a male in a female profession.

Motivators and Influences on Entering Nursing

Influencing factors are those internal or external forces that affect a male’s decision to enter the nursing profession. Little quantitative data exists related to the reasons why men go into nursing. Most of the insight into motivation resides in the qualitative studies. There are few studies that directly compare men to women in terms of reasons for entering nursing. Influencing factors on men’s participation in nursing can be practical, as well as personal. Practical, in this context, is associated with a decision most likely to produce a positive outcome for the individual. Some examples of practical reasons for entering nursing are good pay, convenient working hours and job security. Personal reasons can be thought of as meeting some internal drive or need. Examples of a personal reason would be wanting to follow in a parent’s footsteps. For men, the decision to enter nursing also displays a shared interest with women, showing that they are able to take a chance by challenging society’s norms (Evans & Blye, 2003). The three key explanations found throughout the literature on men entering the nursing profession are: interpersonal relationships, personal motivations and practical motivations.

Interpersonal Relationships. Interpersonal relationships are those interactions which occur between two individuals, which can be positive as well as negative. A common trait

among many men who choose nursing as a career is a strong emotional attachment to their mothers or another strong female influence in their lives (Blankenship, 1991; Chou & Lee, 2007; Kelly, Shoemaker & Steele, 1996; Soerlie, Talseth & Norberg, 1997). For example, Soerlie, Talseth, and Norberg (1997) found that many men who enter nursing have a close personal relationship with their mothers, or with another female in their lives, who have offered them support and encouragement for their decision to become a nurse. Many men reported that they have a female friend in their lives who is a nurse, and who encouraged them to go into nursing. For married men, wives often become a source of not only emotional support, but also assume the role of breadwinner while the man is in nursing school. Women are more accepting and encouraging of a male's decision to go into nursing than other men. This is thought to be due, in part, to nursing being seen as appropriate work for women (Soerlie, Talseth & Norberg, 1997). Also reported were relationships with fathers that were described as poor or non-existent. Participants in their study either had a father who was absent for a prolonged period, or reported negative feelings regarding relationships with their fathers. These negative feelings included conflicting values, as well as having negative childhood relationships with their fathers. Chou & Lee (2007) found that acceptance of friends and family had an overall positive influence in men's decision to enter nursing.

Often, men experience a negative reaction from other males in their lives, including fathers and male friends, when sharing their decision to enter nursing (Evans & Blye, 2003; Fister, 2000; Kelly, Shoemaker & Steele, 1996). Examples of negativity from other males include fathers who express disappointment at the decision to go into nursing. Male nurses often need to defend their masculinity with other men. O'Lynn (2004) studied gender-based barriers for male students. In his study, a majority of male nurses (56 percent) knew a male nurse prior to

enrolling, and identified that peer support from other male nurses to be important in their educational experience.

What can be concluded is that support from those close to the male nurse is an important factor when choosing nursing as a profession. Most of this support comes from women who are close to males that are interested in pursuing a nursing career. Other males, with some exceptions, typically are not supportive of males entering a female-dominated profession, because the decision challenges societal assumptions regarding appropriate professions for males and females. Although this information is gleaned from qualitative studies making it difficult to generalize, the overall feeling is that women tend to be more accepting of males working in non-traditional occupations than men.

Personal vs. Practical Motivations. Motivations are factors that lead a person, male or female, to choose a profession. For male nurses, their motivations to enter the field can be divided into the personal or practical. For example, Finlayson and Nazroo (1997) studied, from a quantitative perspective, reasons for entry into nursing. They found that when participants were asked to rate various reasons for entering nursing, women were more likely to rate personal fulfillment higher than males as a reason for entrance. Men were more likely to state career opportunities and pay as more important motivators than their female counterparts. Another finding from the literature was career opportunities and job security are important factors for males who enter nursing (Ellis, Meeker & Hyde, 2006; Hart, 2005; Okranic, 1994).

Even though in the quantitative studies practical reasons seem to be the motivation behind men entering nursing (Chou & Lee, 2007; Okranic, 1994), altruistic motivations tend to be one of the main influences men will report when the issue is explored in a qualitative study. These studies reveal that male nurses almost always mention the desire to help others. Although

also having an altruistic desire to care for others, women are more likely to be younger, and hope to gain a sense of empowerment from entering nursing (Boughn & Lentini, 1999; Chou & Lee, 2007; Finlayson & Nazroo, 1997). Women also have less desire for career advancement than men, and did not state practical reasons such as job security and income (Boughn & Lentini, 1999). Okranic (1994) also reported differences between males and females in the career aspirations of male and female nursing students. Okranic's study noted that males chose to work in more fast-paced settings such as the emergency room. Females were more interested in working in obstetrics, pediatrics or newborn nursery. There were no explanations offered within the literature as to reasons for this trend.

It can be concluded from comparing the various studies that men and women share similar motivations for entering nursing, but in varying degrees. Men are more drawn to the positive aspects of job security and diversity nursing offers (practical reasons). Women are drawn to nursing primarily for altruistic fulfillment and feelings of self-empowerment (personal reasons). A basic question that was not addressed in the literature was how many men who choose nursing as a second career were terminated from their first career choice, and how this impacts their decision and future career satisfaction.

Challenges for Males When Socialized to the Nursing Profession

Once men enter into nursing, they need to adjust to being part of the profession. Due to being in a position in which they are not in the majority, one of the issues for males is how their female colleagues will come to accept and socialize them into the profession. The term "male friendly" is used in the literature to describe an educational setting that addresses the barriers men face (O'Lynn, 2004), suggesting that once a male has made the decision to enter a female-dominated profession, they must now exist and survive within this context. Miller (2004)

provided the term “male infusion.” This was defined as the process by which males merge themselves into the profession. For the male nurse, part of socialization revolves around defining one’s role and dealing with social perceptions of what is appropriate work for males. The clinical area can present obstacles for the male, particularly when caring for female patients due to gender role conflicts. Privileges are found in advancement, clinical experience, role expectations and the inherent advantages associated with being a male. The discussion that follows addresses various components of difficulties specific to males who enter the nursing profession. Specifically these areas are: role strain, feminization of nursing, the use of touch, and the maternal-child area.

Role Strain. One theme that is mentioned throughout the research on male nurses is the concept of role strain. Role strain is defined as a “felt difficulty in fulfilling role obligations” (Goode, 1960, p. 483). Jary and Jary (1991) defined role strain as “when an individual is likely to experience tension when coping with the requirements of incompatible roles” (as cited in Stott, 2003, p. 92). Role strain is commonly felt by male students while dealing with the multiple demands of work, school and family (Blankinship, 1991; Ellis, Meeker & Hyde, 2006). For the male nurse, role strain can come from a variety of sources, such as having their sexual orientation called into question, having their masculinity questioned, and the appropriate use of touch. Male nurses report greater amounts of role strain than females (Callister, Hobbins-Garbett & Coverston, 2000; Evans 2002; Evans & Blye, 2003; Fister, 2000; Kelly, Shoemaker & Steele, 1996; Soerlie, Talseth & Norberg, 1997). Although role strain may be significant for male nursing students, it has been shown to decrease as they progress in their educational programs (Baker, 2001). When empirical studies are explored, many aspects contributing to role strain

emerge: gender role issues, feminization of nursing, mentoring, and appropriate use of touch (the maternal-child rotation in nursing school, in particular).

Gender roles are the typical behaviors, attitudes and responsibilities associated with a person's gender; for instance, men are doctors, women are nurses. The male is the breadwinner of a household; the woman is the caregiver. Males experience role strain from both changing roles within the family as well as conflicts which arise from being in a female dominated profession (Blankenship, 1991; Kelly, Shoemaker & Steele, 1996; Tumminia, 1981) Research reveals that men fear the perception that they are unmanly, and many report the need to display their wedding ring to clarify their sexual orientation (Kelly, Shoemaker & Steele, 1996). In addition, males experience role strain from changing roles within the family. Some of the men report having to stop working in order to attend school (Blankenship, 1991). This change in their positionality in the family unit, as their wives assumed the role of primary breadwinner for the family, was also a source of role strain (Brady & Sherrod, 2003).

Feminization of Nursing. As stated earlier, historically nursing has been associated with women's work. This has been perpetuated, in part, through nursing education programs. O'Lynn, (2004,) addressed barriers to males in nursing programs from and listed the deterrents to males' participation in nursing education. One of the major themes is the assumption that a nurse is a female. Students reported this recurring in the nursing texts, and the faculty's use of the word "she" when referring to the nurse (Brady & Sherrod, 2003; O'Lynn, 2004). This theme repeats in the qualitative literature as well, but manifests itself differently. Within the qualitative literature, men often report the feminization of the profession has led to their educational needs not being addressed. For instance, men report feelings of isolation and challenges when providing care to females, which are often overlooked by their female instructors (Kelly, Shoemaker, & Steel,

1996; Evans & Blye, 2003; Milligan, 2001; Patterson, Tschikota, Crawford et al., 1991). The strain of the public assumption that the nurse is female contributes to a source of isolation for the male student nurse (Milligan, 2001; Morin, Patterson, Kurtz & Brzowski, 1999).

The field of nursing has become associated with the work of women from a long history linking the care of the sick to the extension of motherhood and nurturing. For many years, nursing was associated with being the profession of an ill-mannered, uneducated class of people. Men who enter the field are challenging, by their very presence, this long-entrenched perception of nursing as a female field which lacks a challenging educational curriculum. Consequently, their own sexuality and ability to be successful in other fields is frequently called into question (Callister, Hobbin-Garbett & Coverston, 2000; Evans, 2002; Evans & Blye, 2003; Fister, 2000; Kelly, Shoemaker, & Steele, 1996; Soerlie, Talseth & Norberg, 1997). One of the stereotypical characteristics of men who enter nursing is that they must be effeminate or gay (Chou & Lee, 2007; Hart, 2005; Meadus, 2000; Smith, 2006). One way in which males have learned to deal with these perceptions is through behaviors that reinforce hegemonic masculinity.

Hegemonic masculinity is a term used to describe the white, heterosexual, middle-class male as the dominant form of what is considered masculine (Evans, 2002). Evans and Blye (2003) reported that the defense of masculinity went beyond simply needing to display a wedding band. The males in their study felt the need to engage in activities that would either draw attention to or detract from their gender, depending on the individuals with whom they were interacting. For instance, when interacting with other nurses who were female, they found the need to not do or say anything which would highlight their gender. Men might try to avoid conflict with women to avoid being considered acting as a dominating male. In addition to the avoidance of conflict, many would avoid actions engaging traditionally sex-typed behaviors,

such as opening a door for a female colleague, because such an action highlights the fact men are different. When interacting with male patients, however, they needed to draw attention to the fact they engaged in activities outside of work that were considered manly. For instance, Evans (2002) found that many male nurses used humor with their male patients, stating they often made sexist jokes with their male patients to reaffirm their masculinity and avoid the stereotype of being a homosexual.

The Use of Touch. Nursing is considered a high-touch profession. Nurses are often required to come into intimate contact with patients. Intimate contact was defined to participants in Inoue, Chapman and Wynaden's (2006) study as the "removal of some part of a woman client's clothing and a procedure that involved touching her genital area during care delivery" (p.562). Men in nursing have reported they are discouraged from going into the high-touch fields such as maternal-child areas (Evans, 2002). When males are assigned to care for a patient, they need to deal with the patient's perception that the nurse is expected to be a female (Evans, 2002; Stott 2003). The stereotypical image of males as sexual aggressors creates an additional challenge to the male nurse when providing care (Evans, 2002). Inoue, Chapman and Wynaden found that even male nurses with five or more years of experience in providing intimate care still experienced difficulty with procedures involving intimate contact. Learning to provide care, therefore, is different for a male nurse than for a female nurse. How male nurses learn to perform hands-on care has been studied in the literature, and it is suggested that males need other male mentors in order to assist in adjusting to this demand of their role. This can be from other male nurses, as well as nursing instructors who are aware of this need (Evans, 2002; Stott, 2003).

Maternal-Child Area. One area in which a nurse's gender and role strain, related to the use of touch, is mentioned specifically in the literature as an issue is in the maternal-child area

(Callister, Hobbins-Garbett, & Coverston, 2000; Morin, Patterson, Kurtz & Brzowski, 1999; Patterson & Morin, 2002). All of the research specific to this states the intimate nature of the patient care involved with this experience as being the most problematic issue in this area (Patterson & Morin, 2002; Morin Patterson, Kurtz & Brzowski, 1999). Morin, Patterson, Kurtz and Brzowski (1999) studied the effect of having a male student nurse from the patient's point of view. Patients also showed some bias when it comes to having a male take care of them either during or after childbirth. Most of the factors that sway a woman to accepting or rejecting a male as a nurse in the maternal/child area have to do with the student's age, marital status, and if he is a father. Women in the post-partum area reported feeling more comfortable with an older male than a younger male. Also, attitudes of women toward having a male student nurse seem to stem more from the woman's feeling about herself rather than a negative feeling toward males who enter nursing. If a woman feels good about her appearance, she is more likely to accept a male student nurse. What did not emerge as a factor in having a male student nurse was that the patients thought the student would not be capable of providing quality care.

Four studies addressed male student nurses' experiences from the student nurse perspective (Callister, Hobbins-Garbett & Coverston, 2000; Ellis, Meeker & Hyde, 2006). Emerging in the findings are men's fears while on caring for women. These fears include their actions being misinterpreted by the females particularly when doing assessments and care involving personal contact. In many studies, men reported being afraid that the mothers or their partners will reject them and refuse to allow a male student to assist in their care during or after childbirth. Male students also reported feeling uncomfortable during their maternal/child rotation. This is due in part to the intimate contact and fear that the female would reject him as the nurse.

One of the key factors in making the experience on the maternal child unit has little to do with the patient or the student, but rather with the nursing instructor, and how that instructor supports the male student's learning endeavors. Males reported the importance of having an instructor who refers to them as a nurse and not a "male nurse" (Patterson & Morin, 2002), and who recognize issues unique to male students (Tumminia, 1981).

The maternal-child rotation seems to be the most identified area for inducing role strain for male nursing students. The importance of faculty and other members of the health-care team was noted as being an important factor in assisting the male nurse in coping with this issue. What is lacking in the literature is more information regarding clinical settings other than maternal-child. Conclusions that can be gleaned from the studies on role strain and the use of touch is that male nurses face conflict between what is required of them to provide patient care, and society's rules which govern what is appropriate contact between a man and woman. In addition to this, males are also challenged by the stereotypes associated with their gender as sexual aggressors. The maternal-child area provided even a more fertile ground for a sense of inappropriateness on behalf of the male student due to the young age of the majority of the clients (Inoue, Chapman & Wynaden, 2006).

Acceptance by Female Nurses.

An important part of socialization to a profession is inclusion and acceptance into the professional group. The persistence of the perception of nursing as a natural extension of the female's role has been questioned as to the implications for current professional environments. Newly graduated nurses, both male and female, hold onto gender stereotypes (Jinks, 1993). The attitudes and acceptance of male registered nurses by female registered nurses, in both rural and urban settings, indicate no difference between the acceptance of male nurses (McMillian,

Morgan & Ament, 2006). However, differences have been found in females' acceptance of a male nurse depending on the length of time the female had been working with males. From the statistics presented, there were some female nurses who do not accept male nurses, and still hold to the traditional attitudes of male nurses of being effeminate or gay, or not well suited to provide care (McMillian, Morgan & Ament, 2006). These studies suggest that the acceptance of male nurses is influenced either positively or negatively during either early socialization or the female nurse's educational program. The impact of socialization and time in the profession by females seem to have implications for the acceptance and perceptions of male nurses by their female colleagues.

Privilege

Privilege means being given certain exceptions, immunities or benefits because of characteristics one holds. From the above review, it is apparent that males have unique challenges related to their gender. The paradox of this situation is males actually have reported, and it has been documented, the advantage of being male in a female-dominated profession. Career advancement is one area in which men seem to move much more quickly than do women. Also, men report an advantage in the way of less disciplinary actions taken against them when an error occurs, as well as the type and quantity of work expected (Stott, 2003; Evans & Blye, 2003). Men find they may be better treated by physicians, seen as more stable employees and feel that their career paths are more plentiful with better chances of advancement (Ellis, Meeker & Hyde, 2006).

Furthermore, men typically find themselves practicing in certain specialties. These include: mental health, critical care, anesthesia, emergency care, and administration. What is common to all these specialties is they typically pay more, such as anesthesia, or they are low-

touch areas such as mental health and administration. When comparing the information from the qualitative research, it does not appear that men do this intentionally. Men seem to fall into these various specialties from the influence of their female colleagues and nursing instructors. This occurs from pressure from females to accept leadership positions, being readily offered transfers to areas such as the operating room and emergency care, and due to support from male physicians (Evans & Blye, 2003; Soerlie, Talseth & Norberg, 1997). Men were also found to have a more positive attitude toward their ability to succeed (Jinks, 1993).

Privilege emerges as a recurrent theme within empirical studies of male nurses. Stott (2003) reported that male students felt they were less likely to receive disciplinary action from their female nursing instructors while in nursing school when mistakes were made on the clinical unit. Mirroring these findings, Evans and Blye (2003) also found that the amount and quality of work expected from male nurses was not the same as it was for female nurses. Many of the subjects reported finding themselves in a position in which they were not expected to do as much of the “feminine” work. Males reported that often, female nurses would step in and perform their work for them, while encouraging these males to assume leadership positions. The varying treatment of male nurses by male physicians and by women colleagues was also noted by Evans and Blye (2003) as a reason why males have risen to roles within the health-care setting which afford them more influence.

Therefore, there may be a connection between the ingrained social structures that provide men with the expectation that they will take on leadership roles. Another influence may be that men have more confidence from the start of their career, providing them with the confidence that they can and will succeed. This sense of confidence may be lacking in females. This then

becomes reinforced if they are not receiving the amount of negative feedback that their female classmates may be getting from the nursing instructors.

From the above discussion, it's clear that men do face differences in their professional and educational experiences because of their gender. Some of these differences can be struggles, but other differences come in the form of privilege. However, the characteristics that may give males some types of privileges, such as not being corrected while on the clinical area, may not be a benefit to the student. It is further clear that men have need for role models and support in helping them to cope with some of the conflicting roles they have as a male in a female profession.

Section IV: Other Female-Dominated Professions

To provide for a critical analysis of issues facing males in female-dominated professions, a review of literature on types of work other than nursing was performed. The purpose of this investigation was to determine if there are overlapping themes that occur as men do work which is typically ascribed as "women's work." Teaching was one such field known to be female-dominated. In order to identify other professions considered to be "female-dominated," a search was performed using databases such as ERIC, CHINAL, Gender Watch and ProQuest, as well as the Pennsylvania State University's computerized catalogue system (the CAT). Search words included "female dominated professions," "male teachers" and "men in female occupations." Other professions identified as predominantly female can be categorized into six major fields: 1) teaching, 2) allied health sciences and social work, 3) domestic work and care giving, 4) library science, 5) secretarial and 6) stripping (exotic dancing). The research chosen was strictly empirical, and consisted of 13 studies on elementary education; 10 which addressed the allied health professions and social work; one on librarians; one on men in secretarial work; two that

focused on domestic work and care of family members; and one dealing with male strippers. Fourteen of these studies were qualitative and 14 were quantitative.

This section is not intended to be a complete review of every study done within all types of female professions. Rather, its purpose is to provide a sampling of what has been found within other female occupations to determine what are the major similarities or differences between the nursing and other types of women's work in which men might participate. The themes that emerge immediately regarding the dynamics of males entering female professions are similar to those found in nursing. The major themes found when investigating these diverse occupations can be divided into four major areas: historical trends, personality characteristics, motivations for entry, male privilege and role strain. These will be addressed in the following sub-sections with a synthesis of findings from the research studies examined.

Historical Trends. Historical trends indicate many of the female occupations originated as male occupations. Economics played a large part in education, as well as secretarial work becoming associated with being "women's work." Looking at men who participate in female-dominated work from a historical viewpoint, there are many themes similar to those found in the nursing literature, particularly in the field of elementary education. Women were historically considered better educators of the young by "God's design" (Gamble & Wilkins, 1997). Similar to nursing, elementary education is a field once male-dominated, but the men shifted out of the profession into different types of work. As this occurred, females moved into the profession, and hence the role came to be described as suited exclusively for females by nature of their gender. This is very similar to the process that occurred in the nursing field with the advent of the Nightingale training schools. Typically, shifts in the population of a profession occur as the

result of economic influences. As discussed, within nursing the shift to nursing becoming more of a female profession took place as wages and working conditions declined.

A similar phenomenon occurred with secretarial work. Keyboard and stenography were once positions held by men learning how to manage a business. These duties were typically incorporated into apprenticeship training aimed at learning how to manage a business. With the advent of new office technology and the climate of corporate business becoming more complex, the apprenticeship positions were replaced by an expanding middle management. Secretarial work became an occupation considered to be unskilled, hence poorly paid, and positions became filled by women (Pringle, 1993).

Personality Characteristics. Throughout the literature on female-dominated professions, there is evidence that when men and women are present within a situation, both sexes take on a more androgynous perception of themselves (Lukken, 1987; Rozier, Hersh-Cochran, 1996). When boys and girls are exposed to both male and female teachers in the elementary school setting, the children have less stereotyped attitudes of masculinity and femininity (Mancus, 1992). In addition, males in elementary education (Hebert, 2000), and men and women in the allied health sciences (Lukken, 1987), tend to have a more androgynous personality. These findings may indicate that when men and women are not segregated into certain jobs, those individuals seem to have less sexual stereotyping of masculinity and femininity.

Men who stay home to take care of young children found ways in which to intermix the feminine traits of nurturing children with the masculine characteristics of providing income and engaging in masculine activities. Doucet (2004) reported most males who have taken on the caretaker role for their children have found some type of part-time work to supplement the family income. In addition, males who take care of the household do so by fixing and remodeling

the living space, rather than engaging in cleaning of the living space. What this is indicative of is the ability of men who are engaging in the role of primary caretaker of children to balance the “female” role of nurturing children with the “masculine” role of fixing and building.

Motivations for Entry. When men enter a female profession, the process of how they made the decision does not typically flow from having a desire to do a certain type of work, but through rationalizing why they would want to do “female” work. The studies examined that addressed this decision-making process revealed men typically enter female occupations as a second career, or to supplement their income (Cushman, 2005b; McClean, 2003; Pringle, 1993). The reasons men provide for entering female professions varies according to whether the work is a paid occupation, which requires a certain amount of formal education, or if the work is of a voluntary nature, such as caring for a family member.

What was missing from the general literature on males in female occupations, and was evident in the nursing literature, was the female influence in encouraging the male into a female-dominated profession. This influence was not found to be of significance in other qualitative or quantitative empirical studies. In several studies on elementary education, helping others, needing a job, location of job, wanting to be of moral service and enjoying working with children were some of the reasons males provided for entering the field (Cushman, 2005a; Lewis, 2006).

When the job is an unpaid position, such as child care or elder care, the motivation to engage in this type of female work requires rationalization on the part of the male. In other words, men engage in this type of work not because they necessarily have some underlying yearning or lifelong dream, but because circumstances in their lives made the decision unavoidable, or was the solution to their life’s circumstance at the time. Many of the men who reported staying home with their children or ill family members reported doing so because of

practicality and a sense of duty (Applegate, & Kaye, 1993; Doucet, 2004). For men who chose to stay at home and take care of children or elders, the decision was based on the economical strain of paying for daycare (or nursing homes), managing the basic and/or special needs of children, and having a sense of duty to their family member (Applegate & Kaye, 1993; Doucet, 2004).

Male Privilege. Perhaps the most recurrent finding within literature on men in women's professions is that of privilege associated with being male. Tewksbury (1993), through his research on male strippers, noted that:

Men modify interactional norms and status expectation when they occupy traditionally female occupational roles. Not only is the occupational structure itself reconfigured, but the interactions of those within the occupation are also altered. When men cross over, traditionally female occupational roles are modified by incorporating traditional masculine ideals and sociostructural elements of patriarchal privilege (p. 179).

This means that although the work of men and women may be the same in terms of job title, the expectations change according to the gender of the worker. This is similar to the nursing profession, when the male nurses are expected to take on more leadership or high-tech roles.

In the literature reviewed from elementary education, males reported being expected to move into secondary educational settings or assume a leadership position such as school principle (Bradley, 2000; Coulter & McNay, 1993; Hebert, 2000; Simpson, 2004). Coulter & McNay (1993) found that when male elementary teachers stated they taught school, it was assumed by those in the public that they taught high school. The field of dental hygiene reported that the presence of males in the profession is felt to elevate the status of the profession in the public's eye, as well as increase funding for advanced education for all dental hygienists, both male and female (Luciak-Donsberger, 2003). In the physical therapy literature, a significantly

increased financial compensation for male physical therapists, when compared to female physical therapists, was evidenced even after adjusting for variables such as years in practice, full- and part-time work, etc. (Rozier, Raymond, Goldstein & Hamilton, 1998). Not only did males make more money in the area of physical therapy, but they were also more likely to be in independent practice instead of salaried employees (Rozier, Raymond, Goldstein & Hamilton, 1998), and more likely to hold managerial positions (Rozier & Hersh-Cochran, 1996).

The only research finding that showed an exception to the male privilege was found in the area of library science. Hickey (2006) found that men experienced segregation in the workplace due to their gender. The men reported dealing with an “all old-girls club,” meaning that not only was it easier to fit into the organization as a female, but also as an older female. The majority of the men in the study reported that most of the women they worked with were older, and did not include the males in socialization into the work group. In addition, males reported not being as well informed of career opportunities for advancement in library science.

Role Strain. Role strain was again found to be an issue when men did “female type” jobs other than nursing. Role strain often comes from the appropriateness of the work for a male. When men do female-typed jobs, the question arises as to whether they should be doing tasks required because of an underlying fear of sexual impropriety of the male. It was reported that discouragement from teaching at the elementary level stemmed from a perception that a male would be unable to meet the emotional needs of young children and a fear of being accused of pedophilia (Coulter & McNay, 1993; Cushman, 2005a; 2005b; Oyler, Jennings & Lozada, 2001). This is similar to the encouragement of males to go into the “low-touch” areas of nursing. Most of the negative reactions males encounter come from negative stereotypes held by society regarding men who engage in women’s work. Faust (1999) clearly stated that: “Men and women

have a 'place' in our culture and society, and when they step outside of that 'place,' people often react negatively (p. 141).”

For male elder caregivers, the inappropriateness of the work came not from those outside the relationship, but from the person who was requiring the care; specifically, those females who were being cared for by the male. In Applegate & Kaye's (1993) study of men who provided care for elder family members, females stated there were certain aspects of the role they did not feel was appropriate for men, such as assistance provided with intimate touch.

Although many similarities were found in the research on other female-dominated professions, some factors evident in the nursing literature were not found in other professions. The first is the stress of the educational experience. Men in other female-dominated professions did not identify the importance of instructors assisting with the stress of socialization. However, other female-dominated professions do not require the male to be involved with intimate care or perform in-depth physical assessments to the degree required of a registered nurse.

Section V: Conclusion

The major issues or trends of men within female professions, other than nursing, validate the information already found in the nursing literature. Privilege, motivational factors, as well as the feelings of being an appropriate fit for the work they are doing are linked to a central concept of hegemonic masculinity. Hegemonic masculinity is the foundation for the images, beliefs, and explanations of how men are perceived in a social setting. Hegemonic masculinity provides direction for how a man behaves, which may help to explain why males have difficulty when providing care requiring intimate touch. Women's reaction to hegemonic masculinity can lead to the reproduction of male privilege, even when women are in the majority.

From a historical standpoint, with the exception of caring for family members, most occupations considered to be women's work started as men's occupations. The transition of these fields to women only occurred after there was a shift that left the fields less lucrative, or holding less status.

In the nursing profession, unlike other groups that may be marginalized due to culture or religion, being a male in the profession is paradoxical, because it still carries with it some advantages. Most research studied identified the unique experiences and challenges of being a male nurse in the educational and practice settings. Men are marginalized, and sometimes ostracized, within the nursing community (Anthony, 2006; Evans & Blye, 2003). Also, men must confront stereotyping from the greater society when choosing to enter a female-dominated profession, which includes dealing with sex-role stereotyping (Evans, 2002; Evans & Blye, 2003; Stott, 2003; Villeneuve, 1994). Marginalization of men is demonstrated when the nurse is always referred to as a female in nursing texts and educational materials (Kelly, Shoemaker & Steele, 1996; Shellenbarger, 1993). The academic abilities of male nursing students are often questioned, which is particularly evident when men are asked why they chose the field of nursing instead of medical doctor? (Evans & Blye, 2003). Furthermore, male nurses sometimes are encouraged to act and behave in different roles than their female counterparts (Evans & Blye, 2003; Kelly, Shoemaker & Steele, 1996; Simpson, 2004). This is demonstrated when men are encouraged to participate in "non-touch" roles such as administration, or go into specialized "high-tech" areas such as critical care (Stott, 2003).

The gap in the research is in examining how women, female nursing instructors specifically, react to males who are entering a field in which females are the majority. What has not been asked is if females perpetuate males entering "non-touch" areas of specialization

through their interactions with male students. Identifying the underlying assumptions female instructors have when socializing their male students to the profession may narrow this research gap significantly.

Chapter 3

METHODOLOGY

This chapter begins with a brief overview of the purpose of this study. This is followed by a clear definition of the type of research (qualitative) which was utilized, and an explanation as to why this was the most appropriate type of research for this study. This is followed by an explanation of basic qualitative research and why that was the best approach for the purposes of this study. The following sections focus on the details related to guiding research questions, methodological procedures as to selection of research participants, and the background of the researcher. The chapter concludes with a discussion of how data was collected and analyzed, as well as methods which were employed to verify the findings.

Research Purpose and Problem

Although limited, the study of men who choose female-dominated professions has been studied from the viewpoint of those males who enter fields such as social work, teaching, and nursing. The view of those educators who have been identified as important in the transition and socialization of males into these female-dominated professions has never been studied. This is despite a body of research illustrating that males identify their instructors as being instrumental in their professional role development as well as overcoming stresses which result from being a male within a female-dominated profession. Blankenship (1991), in her study of attrition rate of males from nursing programs, identified socialization of men to nursing as an element that affects males' persistence in nursing programs. Therefore, the purpose of this study was to describe the symbolic nature of instructor interactions while socializing the male student to the role of the registered nurse.

Overview of Research Type

The quest for knowledge mandates a rigorous plan for the discovery of new theory, insights and conclusions. As humans have evolved, so have methods for scientific inquiry. Research paradigms are representations of how we think about the world, but which we cannot immediately prove (Lincoln & Guba, 1985). The essence of qualitative research is described by Merriam (1998):

The key philosophical assumption...upon which all types of qualitative research are based is the view that reality is constructed by individuals interacting with their social worlds. Qualitative researchers are interested in understanding the meaning people have constructed, that is, how they make sense of their world and the experiences they have in the world. (p. 6)

The history of qualitative research starts with the advent of the Chicago School of Sociological Orientation (Denzin & Lincoln, 2003). Scholars who were intrigued with the dynamics of group life often employed this method in order to better understand the customs and habits of another culture (Denzin & Lincoln, 2003). As time progressed, qualitative inquiry evolved and became a method which enhanced theory building, as well as knowledge acquisition, for fields such as education, history, political science, nursing, business, medicine and communications, to name a few (Denzin & Lincoln, 2003).

The term “qualitative research” has been described by Merriam (1998) as an “umbrella” concept, which can take several forms within actual practice. Naturalistic inquiry, interpretive research, field study, participant observation, inductive research, case study and ethnography are all terms that have been used interchangeably with qualitative research. Qualitative studies are

those that seek to gather rich data to uncover phenomena occurring at the microscopic level (Merriam, 1998; Patton, 2002).

Lincoln and Guba (1985) provide the five basic beliefs upon which this type of inquiry rests:

1. Realities are multiple, constructed and holistic.
2. Knower and known are interactive, and inseparable.
3. Only time-and context-bound working hypotheses are possible.
4. All entities are in a state of mutual simultaneous shaping, so it is impossible to distinguish causes from effects.
5. Inquiry is value-bound.

These beliefs set the basic foundation upon which to justify the use of this type of methodology. Qualitative inquiry seeks to uncover what is not readily measurable or acknowledged. It allows for a deeper level of understanding of what may be influencing a phenomenon. The usefulness of qualitative inquiry to this study was two-fold. First, this study sought to explore relationships which have been essentially unstudied prior to this point. Therefore, there were no known themes from other studies to serve as a basis for quantitative study. Second, qualitative methods enhanced this work because of the exploratory nature of the study. In its purest sense, the term qualitative implies an emphasis on “the qualities of entities and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity, or frequency” (Denzin & Lincoln, 2000, p.8). The exploration of the interactions between male students and female instructors required a method allowing for flexibility in methods, as well as openness to another’s point of view. Stated another way, qualitative inquiry allows

for: 1) the making sense of relationships and 2) interpreting a phenomenon from the meanings of those involved (Denzin & Lincoln, 2003).

Keeping in mind that inquiry is value-based, qualitative methodologies were essential to this study because of the need to look at not only the behaviors displayed within interactions, but to understand the nature of these interactions and the symbolism associated with them from the perspective of those observed. Therefore, the methods must provide a way in which data is gathered not to quantify interactions (e.g. how many times a person smiles), but rather to understand what was the underlying meaning behind the gesture, object or conversation. Thus, qualitative research was the method of choice in examining this research problem.

Research Type: Basic Qualitative Inquiry

There are many approaches to qualitative inquiry. One type of approach is basic qualitative inquiry, which employs a strategy that seeks to “discover and understand a phenomenon, a process or the perspective and worldviews of the people involved” (Merriam, 1998). The purpose of basic qualitative inquiry is to seek a basic understanding of the interactions that transpire between student and teacher. Merriam is one of the few scholars who has separated this type of approach from others found within the qualitative paradigm. The characteristics of basic qualitative inquiry are described by Merriam (1998) according to the following criteria:

- 1) Providing for description, interpretation, and understanding, allowing for more flexibility.
- 2) Identifying recurrent patterns in the form of themes or categories.
- 3) Delineating a process within a social context which emerges from the collection and analysis of data collected through observations, interviews, or document analysis.

4) Findings which are mixture of description and analysis.

The researcher within this approach is not only the data collector, but also the instrument of interpretation. This trait of qualitative analysis allows for the manipulation of data in such a way that the researcher can collect and uncover themes that may not be evident by other methods. However, the assumptions of the researcher can cause corruption of the data within the process. In order to safeguard against the underlying biases of the researcher leaving imprints upon the analysis, the use of a theoretical framework in designing collection and interpretation procedures was essential.

Qualitative Research: Relationship to Study

This study focused on female nursing instructors' interactions with male student nurses. This required an approach that allowed the investigator to uncover the underlying internal dialogue occurring within the individuals being studied. Working from the basic belief that entities are in a mutual simultaneous shaping, it is believed that the internal thought pattern emerges in symbolic ways within the student-teacher interactions. This study was designed to look specifically at nursing faculty, because socialization of a student nurse to the role of the registered nurse is one important aspect of nursing education. Male students report that their instructors are not only important for socialization to the role of the registered nurse, but also in supporting them through the adaptation to a role which has been associated with females (Evans & Blye, 2003). The climate that male students encounter as they enter the field through the doors of nursing schools is important to the learning within nursing curricula. Men who do not succeed within nursing programs cite the climate encountered while in nursing school being one of the reasons they did not perform as well as they expected they would (Blankenship, 1991; Medeus, 2000). These feelings on the part of the males, as well as the perceptions and consequent

interactions, form what is known as “constructed realities.” These constructed realities are the basis for qualitative research, and refer to an internalized process that requires a consensual language among the persons involved (Lincoln & Guba, 1985).

This study’s emphasis on the interactions between instructors and students during the professional socialization process lends itself well to the use of a basic qualitative approach. Lacking in the structural constraints found in other approaches toward qualitative inquiry, basic qualitative research relies heavily on the study’s theoretical framework to direct the study (Merriam, 1998). Using symbolic interaction as the guiding framework, the research needs a type of inquiry open to discovery in order to describe, interpret and understand these interactions (Merriam, 1998). Basic qualitative research seeks to provide a description and analysis of what is occurring.

Research Questions

Qualitative research seeks to develop a deep, rich understanding of the problem at hand. There is a challenge with this type of inquiry to achieve coherent results that enhance the understanding of the problem at hand (Morse & Richards, 2002). With this in mind, research questions are crafted in order to provide a framework for the study. Because the purpose of the study involved an exploration of nursing instructors’ perceptions of, and consequently the nature of how male nurses become socialized into the role of the registered nurse, a set of guiding questions was developed to aid in this process. The following questions guided this research study:

- 1) What do female nursing instructors perceive as the role of the male nurse?
- 2) What symbols are present in the clinical area that represent an instructor’s perception of the role of the nurse?

- 3) What influence does gender have on the instructor's clinical assignments, clinical teaching and the instructor's perception of the student nurses role?
- 4) How does the perception of professional nursing roles anticipated by the instructor play out within the interactions between the instructor and the student?

Background of the Researcher

When I was a young child (about four years old), I recall my friend's mother changing her little sister's diaper on day..I questioned the mother as to why moms change diapers. The mother explained that babies cannot use the toilet, as they are too little. "I know," I replied "But why is it that the *mother* needs to change the diaper, and not the dad?" My friend's mother just sighed, and said: "I guess it is just something mothers must do."

Although I was not aware of it at the time, this was my first recollection of realizing roles, jobs, and social expectations are divided along gender lines. These roles are not written down in some social book of instructions, but rather are scripted onto our lives in symbolic ways. For me, the diapers, dirty dishes, and the caring that took place when I was ill, all became symbols associated with the work of women. Likewise, watching my father take care of mechanical problems in our household, or talking to neighbors when there was a conflict or determining when we would eat dinner every night, became symbolic gestures of leadership and privilege which I came to associate with males.

Working within a profession predominated by women, my professional development has occurred within a woman-influenced environment.. I have worked in a gender-specific world that lacks diversity in terms of gender. In Consequence, I have had to make terms with parts of my profession that may not be in my best interest. This is evidenced, as an example, in the operating room, when a male surgeon will throw surgical instruments at the female nurse. Male surgical

nurses in the operating room have never communicated to me personally any instances of abusive behavior. This acceptance of inappropriate behavior on the part of male physicians is replicated on the nursing unit explicitly when a physician verbally accosts a nurse, and in non-verbal communication when there is a hesitancy to address patient problems with physicians.

I married a male nurse. During our courtship he attended the school of nursing in which I now teach. My husband insists that he found nursing school challenging, but that his gender was an asset to him in his clinical experiences. He states that he often felt instructors were much more lenient with him when it came to topics such as clinical dress, providing care, and overall performance expectations. He often states, "I would have never made it through if I was not a 34-year-old male." He sensed the girls in his class were treated with much more sternness, and were expected to perform at a different level.

He stated that this also played out within the classroom with his peers. When he was in his freshman year, my introverted husband was elected to class president, a position he did not even run for, nor was interested in winning. When I asked him why he thought he was elected, he just sighed and said the "girls" saw this as a male and figured he would make a good leader. (He was never elected to anything again after that year.)

I now hold a position in which I have become one of these entities to which the above scenarios apply. As an instructor of nursing, I strive to create a learning environment which is inclusive and respects the diversity of all who have entrusted their professional development to me. However, I am still a person who has grown up within a patriarchal society, and have taken on a perspective that there are male roles, and there are female roles. We come to expect certain behaviors, interests and traits to be associated with each gender, and we come to expect certain things of ourselves. As I grew up within a patriarchal culture, I came to expect less of myself

because I was a woman. I also came to expect and accept that men's contributions were of greater importance, and more valuable, than women's, simply because they were men. As a nurse, I often find myself, albeit not voluntarily, less critical of my male colleagues than my female ones. I believe that I may unconsciously look toward men to be the leaders, the critical thinkers and those who perform tasks that may require more physical strength. I expect them to protect me from sexual advances of male patients, be able to help with combative patients, and be better able to speak with physicians. Although I realize these assumptions are not immediately provable, they are the result of being socialized into a society in which men are held in higher regard than women.

As an instructor of nursing, it is my obligation to provide equal clinical experiences to all my students and to encourage each of them to use their strengths and work on their limitations. I find it difficult at times to socialize men into the nurse's role because the expectations of nurses, such as providing hygienic care, goes against the roles I have come to associate with men. I have worked in the nursing field for 15 years. I have worked with many men in the profession, and have come to respect what they offer to the profession. At the same time, I have noticed that often they are placed into leadership or other areas in which they may not have the aptitude to work. My experience tells me that women have a tendency to encourage males to take these roles based on their own gendered ways of perceiving the world.

My interest in this research, as a woman, was to not only study the socialization of males to the nursing profession, but also to better understand how women may or may not have to navigate, if at all, the effect of gender on their relationships with male students. It is acknowledged that, I entered this research from the perspective of being a woman. Accordingly, this is the main reason why observation-based analysis was so important to this research. The

observations were the starting point on which the interviews were built. As the observer, I wrote down what I observed, and asked the participants the meaning. I did not impose my interpretation on the observations. This said, it is equally as important to acknowledge the culture in which I have lived and been socialized. Although I would like to think I can be totally unbiased and objective, because gender is interwoven into almost all of our interactions, it is impossible to separate myself from the analysis.

Participant Selection Procedures

The nature of qualitative research calls for the collection of information-rich data for depth of analysis which will illuminate the questions under study (Patton, 2002). Since the purpose of this study was to determine the qualitative nature of interactions between male students and female nursing instructors, a small, purposeful sample was used. The research question addressed the interactions of female nursing faculty, within the same nursing education program; therefore, a purposeful sample was recruited in order to obtain the most in-depth information from individuals who fit the “typical” nursing instructor (Patton, 2002).

The location of the research was at a diploma-based school of nursing in Pennsylvania. The school’s current enrollment at the time of the study was 414 students, 47 of which were male. Therefore, males made up approximately 11% of the school’s student population. The school provides the opportunity for students to attend during the day, as well as the evening. Currently, there is almost an even divide between the male students attending during the day or evening, with 24 men attending during the day, and 23 attending during the evening. The school currently employs 30 full-time faculty members and one part-time faculty member. Of the 30 full-time faculty, two have roles which place them primarily in the simulation laboratory.

Nursing education encompasses a diversity of clinical learning experiences. Nursing students are exposed to the care of patients at all stages of the lifespan. Instructors who teach in the medical surgical areas, as well as mental health, mother/child and pediatric areas, were recruited to be part of this study to capture the full breadth of the teaching/learning interactions. As stated throughout this work, gender is part of what makes certain positions associated as masculine or feminine. Certain areas within nursing have become associated with being “exclusively female.” These specific areas include maternal-child, which focus on caring for women during pregnancy, childbirth and the period directly after childbirth. Pediatrics is another area in which the focus is on the care of children from birth to 18 years of age. These areas are associated with requiring a more nurturing approach to care.

Medical-Surgical and psychiatric nursing are considered to require more critical thinking, high-tech and analytical approaches to care. As a students progress through a nursing curriculum, they are exposed to all these areas of nursing; however, when they graduate they typically fall into the latter areas discussed, rather than the former. For, as diverse as the learning experiences are within nursing, the instructors who teach within nursing programs are homogenous in terms of race and gender; they are white females. These characteristics are typical of nursing instructors nationwide, not solely the instructors found at the location for this study.

Therefore, the criteria for inclusion were:

1. Female
2. Full-time faculty member
3. Full-time teaching experience of 2 years or more. It was thought that those instructors who had been teaching less than two years may still be a novices in their role. This

study sought instructors who were comfortable with and experienced with clinical instruction.

4. Must have had at least one male student nurse under their clinical instruction.

Since all participants were recruited from one school, a mass e-mail communication was sent out to all faculty requesting their participation in the study. There are no rules for appropriate sample size within qualitative research (Patton, 2002). It was known to the researcher that 12 of the 30 faculty members, although qualified, would not be able to be used because they were instructing on the patient care areas (clinical) during times the researcher was unavailable. Two of the 30 full-time faculty members, teach in the clinical simulation lab and did not have clinical students in the patient-care area. Although these two individuals had a great amount of student contact, student patient assignments was a key symbol of how nursing instructors socialize the student. Therefore, these two instructors were eliminated as possible candidates. To start, there were 16 anticipated individuals who met the criteria. It was hoped that at least eight of these faculty members would express interest in participating. This number was not reached; therefore, individual communication took place to request participation. The intention was not to coerce instructors to participate in the study. Rather, the intention was to clarify the purpose of the study and, accordingly, the participants' role. Also, it was anticipated that some of the participants might be intimidated by the piece of methodology which included observation, mistaking it for an evaluation measure of their teaching ability. In the recruitment process, it was important to reassure these instructors that the purpose of this research was not to evaluate their competence as nurses, but rather to observe how they interact with and socialize the male student.

Protection of Human Subjects

Since this research is being conducted at an institution outside of the Penn State system, Internal Review Board (IRB) approval was obtained through the hospital's IRB, as well as Penn State's system. In addition, approval of the director of the nursing education program was also obtained. A written consent was obtained from each participant and a signed copy of the consent was secured with the principal investigator. Each participant was given a copy of the consent for their records. All benefits and risks to the participant will be described on the consent. Although neither Penn State nor the hospital's IRB required a formal consent from the male student, the researcher did inform the male students verbally of the purpose of the study. None of the male students raised opposition to the researcher's presence on the clinical unit.

Protecting participants' confidentiality was of utmost concern to the investigator. The research took place in what was the participant's place of employment by an investigator who was a peer. The use of pseudonyms to ensure confidentiality was one strategy employed to maintain confidentiality. Each participant was allowed to choose their own pseudonym.

However, in so doing they were required to adhere to the following criteria:

1. Not assigning any name similar to their name in any way, including the first letter or using a middle name.
2. Not assigning the name of an immediate female family member, domestic partner, or in-law.
3. Not assigning the name of another member of the faculty or staff at the school.

In addition to pseudonyms, observations and interviews were done at a time in which the instructor was the only member of the faculty in the clinical area on that day. Interviews were

conducted as soon as possible following the observation in a conference room or another private room to ensure instructor anonymity.

Data Collection Procedures and Methods

Data collection for this study utilized two methods: observation and semi-structured interviews. This section provides a definition and description of these methods, followed by an explanation as to how these methods added to and were appropriate for this study. A description of the processes involved will examine how much time was spent in observation, how data was recorded and analyzed is discussed, as well as how informed consent was obtained from each of the participants. The rationale for each of these discussions is to not only explain and justify the methodologies, but to also to explain how confirmability, credibility/authenticity and dependability of the results were obtained.

Keeping in mind that the “method must follow the question” (Patton, 2002), this study used multiple collection strategies, which did not simply seek to describe the student-teacher interaction, but also to understand the meaning behind these interactions. Basic qualitative inquiry requires methods which would rely heavily on the study’s theoretical framework to direct the study (Merriam, 1998). Taking the theoretical elements of the “I” and “Me” from symbolic interactionism, this study utilized methods of data collection to examine what was happening in the real-life situation of the clinical setting (observation), to identify symbols which emerge. The symbolic meaning behind these observations was collected via interviews. Thus, the two types of data collection for this study included naturalistic observation of each participant on the clinical (patient care) area as well as semi-structured interviews as described below.

Observation

The analysis of an individual's interactions requires the use of observation in examining how each instructor interacts with their male students to identify if there were any themes/consistencies between the instructors. Naturalistic observation requires the researcher to be present in the field (Patton, 2002). Observation is classified according to three broad areas within field research within the naturalistic paradigm. They are 1) participant observation, 2) informant interviewing, and 3) enumerations and samples (Guba & Lincoln, 1981). For this research, participant observation was employed. Participant observation requires that the field worker (researcher) directly observe the setting, but also has the option to participate in the events to some extent. In this study the observer functioned in what was described by Lincoln and Guba, 1985, term "nonparticipant mode" (p. 274). In this mode, the researcher was present as an observer only, and not of a committed member of the group being studied. Observation was overt in that the participant was aware of the observer's presence. This familiarity may have added a comfort level to the situation, in that the participant was comfortable with the observer's presence. Naturalistic observation provides the researcher with an opportunity to examine the here-and-now experience in-depth (Lincoln & Guba, 1985). According to Guba and Lincoln (1981), the advantages to utilizing observation as a qualitative method are stated as:

The basic methodological arguments for observation, then, may be summarized as these: observation (particularly participant observation) maximizes the inquirer's ability to grasp motives, beliefs, concerns, interests, unconscious behaviors, customs, and the like; observation ... allows the inquirer to see the work as his subjects see it, to live in their time frames, to capture the phenomenon in and on its own terms, and to grasp the culture in its own natural, ongoing environment; observation... provides the inquirer with access to the emotional reaction of the group introspectively-that is, in a real sense it permits the

observer to use himself as a data source; and observation ...allows the observer to build on tacit knowledge, both his own and that of members of the group. (p. 193)

Thus the suggestion is made that observation adds a depth to qualitative research which goes beyond simply seeing what is occurring in the field, but to which the observer becomes part of the data itself. This is one of the arguments against using observation, since the observer can place his or her own perceptions and reactions into the data, therefore causing a “corruption” in the collection process (Guba & Lincoln, 1981). Although this may be a factor to consider, the researcher took steps to ensure truthfulness in data. Specifics of how this was achieved are discussed in the verification section of this chapter.

Specific to this research, the use of observation had distinct advantages. The first was found in the researcher’s ability to be open, discovery-oriented and inductive because of the need to rely less on prior conceptualizations and provide a broad range of inputs for the collection of data (Guba & Lincoln, 1981; Patton, 2002). Secondly, direct observation provided for the ability to discover important elements that might otherwise have routinely escaped the awareness of others (due to them being “second nature”) and to record these behaviors as they occurred (Guba & Lincoln, 1981; Patton, 2002). Instructors may not be aware of their own body language, gestures, language or routines. These may be only apparent to the person who was doing the observation. The third advantage was to provide insight into circumstances in which the people interacted (Patton, 2002). For the purposes of this project, when and how instructors chose to interact with their student, as well as when they intervened on a student’s behalf, were recorded. It was thought these interactions could also provide insight into the socialization process of the male nurse.

The collection of data during these observations took place on the patient care unit with the observer utilizing running notes in order to record data. Running notes make use of a straightforward, anecdotal or organizing data into categories at the time data is collected and recorded (Lincoln & Guba, 1985). When data collection occurred, the researcher quickly discovered that utilizing an anecdotal format was much more advantageous due to the variety and fast pace at which the interactions took place. During these observations, the researcher focused on the interactions that occurred between the male student and the female instructor only. The intent of this study was not to compare male to female, but to describe the interactions that occurred when a nursing instructor was faced with a male student. In order to guide these observations, some consistent questions the researcher asked herself to assist in directing the observations toward the purpose of the study, and stemming from a symbolic interactionist perspective, were:

- 1) What types of patient assignments are given to each student?
- 2) When giving directions, what type of wording, verbs in particular, did the instructor use?
- 3) What was the gender of the patient?
- 4) What types of personal care, treatments and assessments were required for the male student to perform? And if there were many, was the patient male or female?
- 5) How much assistance did the instructor provided to the male student when performing procedures requiring intimate touch?
- 6) What were some of the physical gestures instructors made when giving negative feedback to male students?
- 7) What were the physical gestures of the instructor when giving positive feedback?

- 8) Were there phrases, gestures, or objects within the interactions with students that recurred on a continual basis when interacting with male students?

These questions were not intended to serve to constrict the types of observations recorded, but to aid, the observer in directing her attention during the observation. Because of the open-ended nature of observation, any observations the researcher made and felt may have added to understanding the research question came as part of being present during the interaction were also recorded.

The recording of data during these observations required the use of taking accurate, fastidious field notes. The investigator engaged in observation for a period of two to two and one-half hours. During the time the researcher was physically present observing the instructor, she only recorded interactions between the male student and the instructor. Interactions were defined as the start of a physical or verbal exchange between student and instructor to the end of the exchange. The time each exchange started and the time each exchange ended was recorded. These field notes were an essential element of the study, since they became one of the main elements on which the interviews were centered. The participants were asked during the interview section to reflect on these observations and provide feedback to the researcher as to their thoughts, feelings and attitudes.

Semi-structured interviews

Although observation is the “purest” and most traditional form of qualitative research, it assumes a detachment on the behalf of the observer from the object being observed (Vidich & Lyman, 2003). Historically, however, this has not always been the case, and has led to observation being problematic in terms of ethical as well as practical problems associated with the outcomes of these studies (Vidich & Lyman, 2003). Therefore, in order to curtail some of

these issues, the process of semi-structured interviews was also utilized in this study. Further discussion of this issue takes place in the verification section at the end of this chapter.

The observations are the starting point on which the semi-structured interviews were built. As the observer, I wrote down what I observed, and asked the participants the meaning behind these observations. I did not impose my interpretation on the observations. Semi-structured interviews involve the use of some pre-formed questions but allow for further exploration and probing as the interviewer feels is necessary. These interviews took place the same day or within the same week after the researcher had observed the instructor on the clinical area. The purpose of interviewing each participant was two-fold. First, was to engage the participant in reflection of the events and interactions observed by the researcher during the clinical observation. As well as to allow the participant to give any other insights regarding other experiences they have had while socializing male students to the profession.

Interviewing is one of the most powerful ways in which to formalize our understanding of human beings (Fontana & Frey, 1998). Hence, the purpose of utilizing the interview process in this study was to understand the participant's point of view, including thoughts, feelings and "internal dialogues" which may have driven her actions. Drawing on Mead's concept of the I and Me from SI, the interviews sought to understand what was the internalized dialogue (I) which influenced the action observed (Me). This last sentence is referring to Blumer's (1969) first premise of SI, which is human's act toward objects and other humans based on the meanings these things have for them. This study looked at the interactions of the instructor with the male student nurse. In order to determine the meaning of the interactions, the researcher needed to find out what was the meaning of gender, as well as the meanings behind the interactions. To determine if there was a symbolic nature behind the student-teacher interaction, the researcher

needed to identify the internal dialogue of the instructor while these events were unfolding. Therefore, the interview was an essential aspect of this study.

Interviewing is the optimum method by which to obtain rich, detailed data about how individuals view their world (Rossman & Rallis, 1998). The type of interview that took place with each participant engaged a combination of informal conversation and the use of an interview guide. The informal conversational interview utilizes a serendipitous, open-ended approach to interviewing which allows for the maximum in flexibility in questioning (Patton, 2002; Rossman & Rallis, 1998). This allowed the researcher the ability to move the conversation toward seeking further clarification, or to pursue further information from what came about as a result of the conversation itself. The use of an interview guide provided for some solid, consistent information to be obtained from each of the participants. Interview guides require the researcher to develop categories or topics to explore, but still allow for the open, free exchange regarding topics the participant may bring into the conversation (Rossman & Rallis, 1998). The guide was written to address the interactions the researcher observed while in the clinical area, as well as to identify the meanings the participant attached to gender. The interview guide can be found in the appendix.

Because these interviews were intended to capture the symbolic meanings that underlie the interactions between student and teacher, the investigator attempted to conduct each of the interviews no more than 24 hours after each of the observations had taken place. Also, the order in which the investigator asked the participants questions proceeded from asking questions about the interactions which were observed clinically to more specific questions related to gender. All but one interview took place within 24 hours. The one which did not was due to the instructor's need to leave work early due to unexpected home requirements that day. .

Interviews were tape-recorded and transcribed. Transcriptions were kept securely in the possession of the principle researcher in a locked cabinet in the principle investigator's home. Once all data had been transcribed, all tapes were listened to while reading the transcript to assure accuracy of data. When the data was finished being transcribed and coded, and preliminary findings articulated, the participants were asked to recheck the findings for accuracy. This rechecking of data by the participants is termed member checking. This is further discussed in the following section on verification of data.

Data Analysis

In qualitative research data analysis consists largely of constructing interpretations of the data collected (Denzin & Lincoln, 2003). Data analysis consists of taking the volumes of raw data, in the form of field notes from observations and interviews, and transforming it into findings which provide insight into answering the research question (Denzin & Lincoln, 2003; Patton, 2002). Due to the structure of the multiple methods approach, it was anticipated, and found to be true, that there was a great quality of data in this study to be analyzed. Naturally occurring data, which was the majority collected, arises out of observation, tape-recorded interactions and written texts (Peräkylä, 2005). Since this research utilized a basic qualitative inquiry, data was transcribed, read and re-read to identify recurrent themes that emerged both within student-teacher interactions as well as within teacher explanations of these interactions.

The type of analysis most congruent with the data and the purpose of the study was content analysis, in order to search out recurring words or themes (Patton, 2002). Keeping in mind that the purpose of the interviews is to identify the underlying assumptions, thoughts, motivations and internalized dialogues instructors are having with themselves as they interact with male students, this process required inductive analysis on the part of the researcher.

Inductive analysis “involves discovering patterns, themes and categories in one’s data” (Patton, 2002, p. 453).

In this study, this occurred by way of the constant comparative method. The constant comparative method involves continually comparing one unit of data with another in order to derive conceptual elements of theory (Merriam, 2002). Originally utilized by Glaser and Strauss as a way in which to develop grounded theory, the method has been adopted as a way to analyze qualitative data with the intent of identifying relevant themes rather than theory (Lincoln & Guba, 1985; Merriam, 2002). Themes are constructs that investigators identify before, during and after data collection (Ryan & Bernard, 2000). Generating themes from qualitative data is “the most difficult, complex, ambiguous, creative and fun” (Marshall & Rossman, 1995, p.114). The constant comparative method is a way in which to sort through the raw data collected to identify if there are recurring themes throughout the observations, as well as data collected from the interviews (Lincoln & Guba, 1985).

The constant comparative method stems from the work of Glaser and Strauss, who identified four stages in the process of analyzing data (Lincoln & Guba, 1985). Those stages are 1) comparing incidents, 2) integrating categories, 3) delimiting theory and 4) writing the theory. Stages three and four are a reflection of Glaser and Strauss’s aim of theory development (grounded theory), which was the focus of much of their work (Lincoln & Guba, 1985). Since the intent of this study is to describe a phenomenon and not develop theory, a description of the first two stages is discussed in the following sections.

Comparing incidents

Comparing incidents applicable to each category involves the researcher identifying categories that “emerge” from the data. These incidents are then coded by the researcher. Glaser

and Strauss describe this process of emerging theories from the data using the coding method as not only coming from the data, but also from the researcher comparing incidents with those within the same and different categories (Lincoln & Guba, 1985). Glaser and Strauss described this in the following manner:

This constant comparison of the incidents very soon starts to generate theoretical properties of the category. The analyst starts thinking in terms of the full range of types or continual of the category, its dimensions, the conditions under which it is pronounced or minimized, its major consequences, its relation to other categories, and its other properties (as cited in Lincoln & Guba, 1985, p. 341).

The data took the form in this study, not only by the way in which each participant answered, but also the non-verbal symbols which came across in body language. The data collected via observations were analyzed to identify if patterns existed in the interactions between student and instructor. Using the guiding research questions as an organizing framework, the observations were analyzed to determine if there were patterns which arose from these interactions.

Integrating categories

Integrating categories and their properties involves a shift from comparing incidents with other incidents in the same category to comparing incidents to the rules that make up those categories (Lincoln & Guba, 1985). Therefore, the data analysis process changes from more of an affective “I feel like these things belong together” to a more precise judgment of “These things belong together because they all follow the same rules for this category.” The researcher needs to therefore make a move toward making thematic categories more coherent (Lincoln & Guba, 1985).

Within this research, the process of integrating categories took place after the major themes were identified. The researcher needed to ask the question: “What are the comparisons which set the context for each grouping of data, and how can these similarities be best expressed?”

Verification

Conventional methods of research, associated with quantitative research, emphasize the “truth value” of any given research study. The cornerstones of truth are found within the four criteria of 1) internal validity, 2) external validity, 3) reliability, and 4) objectivity (Isaac & Michael, 1995). The “truth factor” with which researchers are charged, requires an explanation as to how the aforementioned elements were reached. This discussion of how “truthfulness” is obtained within research is important because it is a strong indicator of the goodness or quality found within a study (Guba & Lincoln, 2005). Traditional benchmarks of quantitative (positivism) or qualitative (postpositivism) approaches to establishment of quality have been referred to as “rigor” or otherwise known as internal and external validity, reliability and objectivity (Guba and Lincoln, 2005). These concepts of validity, reliability and generalizability have been referred to as the trinity of questions to which all research can and should be judged (Janesick, 2003). In conventional, quantitative research the underlying assumption is there is an objective truth that can be found through procedural methods utilizing the scientific process of experimentation and replication (Guba & Lincoln, 1989; Lincoln & Guba, 1986).

The qualitative paradigm philosophically differs from quantitative in its assumption that “realities are not objectively ‘out there’ but are constructed by people, often under the influence of a variety of social and cultural factors that lead to shared constructions” (Guba & Lincoln, 1989). With this in mind, the use of the term “validity” has come under question as to the

appropriateness of its use in qualitative research due to its strong linkage with, and subsequent confusion with the quantitative paradigm (Janesick, 2003; Morse, Barrett, Mayan, Olson, & Spiers, 2002). The key element of quantitative research seeks to establish generalizability via validity, whereas finding validity in qualitative research focuses on the “description and explanation and whether or not the explanation fits the description” (Janesick, 2003, p. 393). Therefore, qualitative research focuses on the establishment of verification in order to ensure a study’s truthfulness (Isaac & Michael, 1995; Janesick 2003).

Rigor or trustworthiness are the term often used in qualitative research to refer to how a researcher should establish this accurate explanation for descriptions provided by the data as is found in conventional research through validation (Lincoln & Guba, 1986). Within the qualitative paradigm, the term validity has been replaced with verification. Lincoln and Guba established four criteria for the verification of qualitative research (Isaac & Michael, 1995; Morse, Barrett, Mayan, Olson & Spiers, 2002). These four criteria are: 1) Credibility, 2) Transferability, 3) Dependability and 4) Confirmability. Each of these criteria will be discussed individually to explain the meaning of each, and how these criteria will be met for this specific study.

Credibility

Credibility is analogous with the concept of internal validity within conventional research design (Isaac & Michael, 1995; Lincoln & Guba, 1986). In order to establish credibility, the researcher is charged with finding a way in which to answer the question “will the methodology and its conduct produce findings that are believable and convincing” (Isaac & Michael, 1995. p. 221) in order to establish truth value of the research (Lincoln & Guba, 1986). The methods of establishing credibility found within qualitative research are accomplished through using

techniques such as: 1) integrity of observations, 2) peer debriefing, 3) negative case analysis, 4) referential adequacy, 5) member checks and 6) audit trails (Isaac & Michael, 1995; Janesick, 2003).

Establishing credibility can involve any one of the aforementioned methods or, preferably, a combination of methods. For example, triangulation is the “process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation” (Stake, 2003, p. 148). The use of multiple methods is important for this process because it assures the work as presented has been investigated from different perspectives, and the same conclusions have been reached. In this study, there were multiple interviews of a purposeful sample of participants. Data were collected from these various methods and compared for similarities as well as differences.

Triangulation can also be achieved through using member checks as a way in which to check the data for truthfulness. Member checks take many forms, but perhaps the most commonly used within qualitative research is having the participants or an outsider read the field notes and interview transcripts to test if the investigator has adequately represented the data, interpretations and conclusions (Isaac & Michael, 1995; Janesick, 2003; Lincoln & Guba, 1986). In this research, member checks took place by having each participant read transcripts, review field notes and read the analysis of the data. In this case, participants were required to recall to the best of their ability what occurred on the clinical area, but also had access to the investigators notes.

The time in which I spent in the clinical area (two hours) allowed for sufficient time to perform persistent and prolonged observations, which helped to ensure integrity of the data collected. Persistence in observation is an “in-depth pursuit of those elements found to by

especially salient through prolonged engagement” (Lincoln & Guba, 1986, p 77). Prolonged engagement in the clinical setting provides for a “lengthy and intensive contact with the phenomena in the field to assess possible sources of distortion and to identify saliences in the situation” (Lincoln & Guba, 1986, p.77). Another advantage the investigator had is of being truly an insider, having worked at the clinical facility for 18 years, as well having a collegial relationship with the participants. Trust of the participants was easily established within this setting.

Credibility can also be established through the use of negative case analysis. This is a method of identifying the patterns that do not fit with the norm of the data that has been collected. Negative case analysis takes these insights, which differ from the typical, and adjusting the finding to fit these outlying, and unpredictable results until no other negatives are found (Isaac & Michael, 1995; Lincoln & Guba, 1986).

Transferability

Transferability deals with issues of applicability to other settings. This is analogous with generalizability or external validity when compared with conventional criteria stemming from quantitative methods (Isaac & Michael, 1995; Shaw, 1999). Transferability asks the question “To what other contextually similar settings can these findings be applied?” (Isaac & Michael, 1995, p. 221). Transferability can be obtained through the collection of “thick descriptive data” (Lincoln & Guba, 1986, p. 77). Thick descriptive data requires that the researcher describe in as much detail as possible the context in which the data was collected. Thick descriptions are an effort to allow the reader to have such a clear picture of what has been studied that they can observe through the writer what has been studied (Denzin, 1998).

Within this study, thick descriptions were collected as to the interactions between student and instructor during the follow-up interviews. The data was detailed as much as possible through the use of field notes. These observations were discussed within the participant interviews. These interviews were tape-recorded, transcribed and checked for accuracy.

Dependability

Dependability is analogous with reliability within conventional methods of research (Isaac & Michael, 1995). Establishing dependability requires the researchers asking themselves, "it this research was done over again, would it result in the same conclusions?" (Isaac & Michael, 1995, p.223). It is this element which methods of triangulation, or looking at a topic from multiple angles, become important, as well as a through audit of data (Isaac & Michael, 1995). The dependability of this research was found in the mixed-methods approach, which allowed for observations to be recounted within the interviews. The recounting of observations with the participant added to the assurance that the data is correct.

Dependability also is also assured by performing an external audit of the data collected. This external audit was achieved through an external peer reviewer examining the data collection procedures and process, as well as the conclusions arrived from the process. This is a process of "retracing" the data from collection to analysis to determine whether the same conclusions are reached. Hence, this will satisfy the criterion of performing an external audit trail (Guba & Lincoln, 1989).

Confirmability

Confirmability is analogous with objectivity within conventional methods of research (Isaac & Michael, 1995). Establishment of confirmability requires the researcher to ask "Are both the process and the product of the data collection and analysis auditable and be an outside

party?” (Isaac & Michael, 1995, 223). Confirmability is “the most ambitious and demanding of the four criteria which requires a full scale audit retracing the sequence of events from beginning to end” (p223). This requires the use of audits that trace data back to its sources. This audit was conducted at the same time as the dependability audits. Confirmability audits trace the conclusions gleaned as part of the data analysis back to the data itself in order to ascertain where the conclusions were drawn (Guba & Lincoln, 1989).

Within this study confirmability was obtained a number of ways. First, during the interview process, observations collected were checked against participants’ recollections, as well as their explanations as to what they were thinking when the actions took place. The interviews took place shortly after the observations were recorded, so that participants only needed to recall recent events. Confirmability was achieved through the use of keeping accurate records of interviews, internal and external audits as well as keeping accurate field notes. Confirmability in this study was obtained while doing the dependability audit, as well as rechecking the information obtained conducting interviews.

Summary

This chapter provided an explanation as to the methods and approach utilized in order to investigate female instructors’ socialization of males to the role of the registered nurse. Justification for the approach, as well as data collection procedures, including participant selection, were discussed. By taking the concepts from Blumer’s three premises of symbolic interactionism, the methods chosen focused on what is occurring when internalized dialogue is being acted out within student-teacher interactions in the form of language, objects, skills and gestures. By following the procedures as outlined, a complete and trustworthy investigation took place.

Chapter 4

PARTICIPANT NARRATIVES

This research sought to explore the professional role socialization of male student nurses by female nursing instructors. Symbolic interactionism, which allows the researcher to analyze interactions via a gendered lens, was the theoretical foundation for data analysis. In order to truly discover the interactive processes involved in the socialization of male to the nursing profession, both observations and conversational interviews were utilized. The researcher sought to look at the nature of interactions between the female instructor and the male student in order to gain a better understanding of what occurs within the student-instructor dyad and how gender influences the instructor's socialization of the male to the nursing profession.

Each instructor was observed on the clinical unit for a two-hour period. During that time the observer took copious notes regarding time spent with the student, patient assignments, body language of the instructor, terms used when referring to the male student, and how the instructor was interacting with the student. This process was then repeated at another time with the same instructor. Each of these two observational sessions was followed up with conversational interviews that lasted from 45 to 120 minutes. The researcher utilized the observations to facilitate discussion regarding the internal self-speak which drives the actions of those being observed.

There were a total of eight individuals who agreed to participate in the research. All were full-time faculty, all had at least 2 years of full-time teaching experience, and all had at least one male nursing student in their clinical group during the research. The participants ranged in years of nursing experience from 11 to 35 years in the profession and from 3 to 30 years of teaching experience. The next section of this chapter provides a brief, narrative overview of each of the

participants, giving a description of who they are, professional background and what they see as the main issues for men who enter the profession.

Participants

Name	Years in nursing	Years teaching nursing	Unit in which observed
Daisy	25	11	Medical/surgical
Grace	28	25	Medical/surgical
Hope	34	30	Medical/Surgical
Jillian	27	4	Medical/Surgical
Caitlyn	15	3.5	Medical/Surgical
Kelly	19	4	Medical/Surgical
Alison	28	5	Medical/Surgical
Helen	29	5	Labor and Delivery

Daisy

Daisy and I sit in a private conference room at the School of Nursing. She sits across from me appearing both professional and confident. Of her 25 years experience in the profession, the past 11 have been spent teaching nursing in both diploma and baccalaureate schools. Daisy is a nurse educator with a wealth of experience spanning her 25 years in the profession. She first became interested in the nursing field while in high school when a friend was severely injured in a motorcycle accident, and Daisy spent that summer helping her friend recuperate. It was during this time that Daisy was able to observe what nurses did and gain respect for both their work and their knowledge.

Although gaining insight and interest in the role of the nurse from this experience, Daisy was initially an undeclared major when she entered college. She thought she might try sports medicine, as she had a gymnastics scholarship to assist her with tuition. Her roommate at the time was enrolled in the nursing program at the same college. Daisy's interest was rekindled when her roommate shared stories regarding the nursing program and what she was studying. At this point, Daisy decided to transfer to another school, which offered an associate's degree (two-

year program) in nursing. Daisy secured her first nursing job on a medical/surgical unit at a community hospital where she worked in various roles, including medical-surgical, intensive care, progressive care, coronary care and float. In addition, she also worked in the community as a first-responder on an ambulance, was a first aid and CPR instructor and worked in an outreach capacity teaching health-related classes.

Although she had a breadth of experience in many different areas of nursing, one thing that remained consistent throughout her career was her interest and love of teaching and mentoring new nurses into the profession. Daisy went on to earn a bachelor's degree in nursing. Her first job in nursing education was as a clinical instructor, and she has continued teaching in various capacities for 11 years. Daisy now works as a full-time faculty member with both clinical and classroom responsibilities, and has also earned a master's degree in nursing. Daisy defines the role of nurses as one of patient advocate especially when collaborating with other members of the health-care team.

Daisy was observed during two different clinical days on a medical-surgical nursing unit that provides nursing care to adults. Daisy's general reaction to men in nursing is that they are different from women and have special needs when learning how to become a nurse. When socializing men to the clinical environment, it was noted during the observation, that Daisy utilized interrogative (why) questioning regarding what her students were doing. When asked about this, she stated she asks this of all her students, male or female, to help them to rationalize what they are doing in practice and facilitate critical thinking. Although being logical is a part of critically thinking, she sees the challenge of teaching males not in the rational portion of thinking but in the emotional and intuitive aspects of nursing practice. She expressed that it was this emotional side of the profession, the intuitive, the non-verbal side of nursing found within the

socialization of males to the profession, which makes their leaning a bit different. She was asked to complete a metaphor which asked to compare the socialization of males to the nursing profession to something else. She stated:

Socializing a male to the nursing is like – I've never really looked at socializing a male into being a nurse differently than socializing a female into that role of a nurse...The only thing that is different is addressing the issues of patients not wanting a male to care for them and giving them that guidance, to look at nonverbal cues, to be a little more compassionate. So in that respect, socializing a male to the nursing role for compassion is like teaching a duck how to fly, or a duck out of water, a fish out of water type of scenario. You have to take them step by step through that process of learning the compassion, learning to pick up on the nonverbal cues.

In spite of needing to teach the emotional aspects of the profession, Daisy expressed positive aspects regarding males, which help them in the social side of the profession. She stated that their way of thinking about and handling conflicts is much more direct, and they do not obsess over an issue. She explained:

Logical thinking, matter-of-factness, organization, and not being emotionally tied to their colleagues, and that they have a problem and they address it and they drop it. If a woman has a problem, they address it and they gnaw on it. They're like a dog without a bone and they can't let it go, but a male can let it go...They'll gnaw on it; they'll keep talking behind that person's back...They will keep after it and keep after it because they are emotionally tied to the event.

Furthermore, she stated this interpersonal difference in the way in which men and women interact is a major factor in preparing males to enter the profession. She has had males complain

to her regarding the way women will “cat fight.” She helps to prepare them for this by asking how they have dealt with these issues so far in their lives. She has found that most men will concur that women bickering amongst themselves is really nothing new, but that it becomes problematic for them because of the number of women with which they are now surrounded. The way Daisy reportedly handles these issues is to discuss the coping mechanisms the males have utilized in the past and reinforce those mechanisms.

Daisy was receptive to being observed, and expressed that through participation in this study, she has realized that male students may not always feel comfortable asking her questions about how to handle situations related to gender. She has come to realize that male students may have special concerns as a result of being a male in a female’s profession that she may not have thought about before this time.

Grace

Grace and I sit in a private conference room the day after her second observation and interview. She is a tall woman who commands a presence when she is in a room. She has been in nursing for 28 years, 25 of those years which have been in nursing education. She was drawn to the teaching aspect of nursing primarily through her own personal interest in learning and sharing of information. During our interview, Grace was very reflective on various experiences she has had throughout her career as a nurse as well as a nurse educator. Learning has always been a part of Grace’s life, and it is evident throughout our conversations that this is one of her core values.

Although Grace had always thought of nursing as viable career choice while growing up, when it came time for her to go to college, she did not choose nursing. This decision was

partially shaped by her observations of cousins and other family members who were in the nursing profession. She stated:

I was all set to become a nurse, but it just looked like a profession that was really... how can I say this?... wasn't going anywhere. It just seemed to be so confining.

Reflecting on this observation, Grace decided to pursue a liberal arts degree, which she did obtain. However, upon completion of this degree, and to her chagrin, there were no jobs available in her field, due to the country being in the midst of a serious recession. Therefore, she investigated going back to school for nursing. She was accepted to a school that would give her some credit for the course work she had completed during her liberal arts degree. Grace's interest and commitment emerged once again during this conversation as she recounted that the nursing school was willing to give her college credit for "life experiences." She declined this offer and said: "I don't want credit for life experience. Just give me credit for the four years that I've spent some place." Grace secured a place in the incoming nursing class at one of the local community colleges. By 1980, she had completed her coursework, earned an associate's degree in nursing, was employed, and started to work toward her bachelor's degree in nursing.

As she finished her bachelor's degree, Grace was offered an opportunity that had the greatest influence on her career direction. She explains an offer which was made:

I had just graduated...I was just about to graduate – it was April. I was about to graduate ... and the director of nursing was waiting for me in front of my building when I arrived at work that afternoon. She said to me, "How would you like to go ... for a Masters in ... nursing?" She said, "All expenses paid – a scholarship with a stipend." I said, "You got the money, I got the time!"

From there, Grace's career in nursing education began. Although not her first choice of paths with her master's degree, when the time came for her to graduate, there was no clinical nurse specialist position for her due to restructuring and cutbacks at her place of employment. So, she worked on the side as a family therapist in addition to her regular staff job. This became an unbearable workload, so she moved into the nursing education setting. She found her first job in nursing education to be challenging, but very rewarding. Mentors were key to her successful transition to the nursing faculty role.

From one nursing job to another, she progressed within the nursing education field as her lifestyle changed. Grace has remained true to the education components for nursing, whether working in nursing academia, patient education, or as a clinical nurse specialist. What draws her to her profession is the blend of art and science which makes nursing such a dynamic field. Teaching nursing, for her, is where the wellness component of healthcare is truly utilized for the individual and what makes nursing unique and valued. She does not think anyone stops being a nurse once they are licensed. The term "relevant" emerged several times during our conversations. The knowledge one gathers as being part of the profession is still relevant because of the wellness component which nursing brings to the overall health of the individual. Grace became interested in teaching nursing because she had always been interested in learning theory and sharing what she knew about things. Teaching nursing allows her to blend both the theory and practice and share her knowledge. She stated:

I like the blend of practice and teaching. I like that blend because it keeps me relevant in the classroom. Practice keeps me relevant in the classroom. It makes me real to my students. I think that, you know, if my examples are 30 years old, some of those examples will soon be 30 years ago, I have to coach them with... Well, this was what it was like in

1980 as a new graduate nurse. Now, that's not the reality today, but I know the reality today, too.

When discussing the role of men in nursing, Grace feels that the knowledge gained from the past influences the future. This led to a conversation regarding the history of nursing. Grace is somewhat a historian of nursing, so I asked her for her perspective on the past's influence on the present and future of nursing. She stated:

So, I think that we are just rediscovering....we've been slowly rediscovering a role for men in that and it's socially acceptable. I don't think that modern cinematography or modern Hollywood has made it real easy. There's a movie about um... the Folkers and their son-in-law who's a nurse. I don't think that that's a good portrayal. I think that we need stronger roles on/in modern television and movies where men have taken that role.

Grace sees men in nursing as not anything new, yet new to modern society. She sees her role in the socialization of men to the nursing profession as no different than socializing a female to the profession. However, she does recognize that there are some differences and challenges that are different for males in the profession vs. females. These differences are influenced not solely by impressions of male/female work, but also by generational differences within society, notably, when dealing with older female patients and in giving personal care to male patients. In Grace's experience, she has found that older females have a more difficult time with being assigned a male nurse than younger females. She views this as a generational difference for women who are in their 80's. She explained that older women are influenced by the rules of the society in which they lived. As the baby-boomer generation grows older, health care will need to make adjustments to the care environment to meet the expectations of this generation as well.

Grace has learned throughout her career as an educator that it is also important to recognize the rules of society regarding men's interactions with other men. When socializing males to the nursing profession, issues related to touching occur, not of females in this case, but of other males when providing personal care. Grace had one experience while instructing a man who had been in the United States Navy prior to his enrollment in the nursing program. During the morning of clinical, after giving his male patient a bath, Grace noted the student was out in the parking lot smoking. Grace asked the student about this when he returned to the clinical unit. His response was that when he was in the Navy there were strict social rules about touching other males. He said he would be okay, but that he just needed to take a moment. This correlates with the observations of Grace while on the clinical unit. She was frequently observed during the clinical day interacting with her male students while they provided personal care. During this time, she offered a great amount of verbal support to her male students.

Her interest in continual learning is evident within her teaching style. She views her role on the clinical unit as collaborating with the student in the experience rather than "standing over" the student, watching everything. Grace also brings much of her own professional experiences into the learning situation. She feels that her experience can assist the student by providing relevant information and guidance. Grace used the term "guide" to explain her interactions with the male student. She tries not to "reach in" and do, but rather mentor and guide the students through skills and decision making. She expressed, again in guiding the male student nurse through the process of caring for another, one of the greatest challenges she has faced is getting a male to touch another male. While placing a urinary catheter, the male student referred to the patient's penis as his "thing" rather than using the anatomical term. Grace explained she let this go because she knew this student was nervous.

Although Grace recognizes the nervousness a male may feel taking care of another male, as a woman she also does not go out of her way to assign males to female patients. She explains that she does not do this because of bias, but rather due to her own learned experiences and understanding of culture. She had an experience while in the military in which her privacy was invaded. Grace expressed that males bring something to the nursing profession that females cannot, particularly when caring for males. Grace gave one of her male students a difficult male patient, in terms of his attitude. The patient did not want to be in the hospital, was grumpy and did not express confidence in the nurses. The male student she had assigned to this older gentleman went into the room and “bonded” with this older gentleman in a way that the female nurses had not been able. Grace contributed this to the ability of male nurses to bring something to the patient care setting that females cannot. She feels that male nurses often will have common interests with male patients, and provided for the patient someone they can talk to about these interests.

Hope

Hope and I met in the conference room adjacent to the nursing unit she is on with her students. I interviewed her as she had her lunch. She looks much younger than her age. Hope has been in nursing for 34 years. Thirty of those years have been spent in the same school of nursing as an instructor. Hope’s career path started in the intensive care (ICU) setting. Her interest in teaching started during this time, working at the bedside. As she states “I always enjoyed teaching at the bedside.” From the ICU, she went on to become a nurse manager. During this time, Hope went on to earn her bachelors of science degree in nursing (BSN). This worked out well for Hope. Shortly after earning her BSN, a nurse educator position became available at the school of nursing affiliated with the hospital at which she worked; a position she “slid” right into

and has stayed at ever since. She stated the transition to the position of nursing faculty was smooth because she had obtained a BSN. From there, Hope felt it was necessary to pursue a master's degree to "maintain my position and improve my growth and my knowledge base and certifications."

Hope's interest in nursing started when she was a little girl. Her mother was a nurse, and Hope recalls:

My mother was a nurse. So, even as a little girl, I always band-aided my dollies and I put boo-boos on my dogs and cats. They all had bandages. I was always with a nurse kit and playing "nurse."

Hope expressed that she was very close to her mother, and that it was she who inspired Hope to become a nurse. This inspiration came to Hope via her mother's stories of what happened at the hospital and sharing pictures with Hope of what she looked like in her nurse's uniform. Her mother had a nurse's cap which Hope said she put on and "parade around" while wearing. As Hope stated, from a very young age she related the nursing with:

Caring, taking care of and bandaging and fixing. I used to put my mother's hat on. There were pictures in her photo album that we used to look at, and she would tell me about things that happened in the hospital.

As stated earlier, Hope enjoyed teaching patients at the bedside. In addition, her interest in teaching nursing students, specifically, started and was inspired by some of her own nursing instructors during her own education.. She provided the following description of one of these individuals:

I had one nursing instructor who I later worked with who was just the most kind and compassionate person, and the kind of person I would want at my bedside if I was throwing up.

Hope was observed during a busy day on a medical-surgical nursing unit. The majority of individuals on this unit were orthopedic patients who have undergone joint replacement surgery within the previous week. Hope had four nursing students on this particular day, one of whom was male. I stepped onto the unit to observe Hope with her male student outside the room of the male student's patient. They were discussing edema the patient was experiencing in her legs. Hope asked the male student many questions regarding the edema and what could be the cause. She stood 1 foot away from the student, keeping her eyes closed as he answered her questions. They were also discussing the patient's refusal to take some of her medications. Hope discussed reasons why the patient may be refusing, and if it was okay to allow the patient to refuse. At one point, she directed the student to recall for her what is known about the patient's lifestyle. Hope continued to keep her eye's closed during this time. When the student answers her questions regarding what the patient had told him about her lifestyle, Hope replied with the statement: "This is the softer side of nursing, the listening, the feelings side."

The patient the male student was taking care of was post-operative after a rotator cuff repair. Hope discussed the needs of the patient with the male student nurse. Her demeanor during this time was supportive to him. She asked many questions of the male student as far as the patient's medications, and what some of the assessments they had made might imply for the patient's overall condition.

Of the 2 hours I was present on the nursing unit, Hope spent approximately 45 minutes in total with this one student. She was very attentive to this student; however, it was apparent that

she kept her distance from him. This was apparent on both occasions that I observed Hope; she maintained a personal space of 1 to 2 feet.

When I first interviewed Hope, she stated that although generally she does not find issue with male students being receptive to her instruction, she has had instances in the past when male students were resistant to her teaching. When asked about challenges she has faced with male students on the clinical areas, she responded by stating: “Yes, absolutely. Smart-ass attitudes when they do not always want to listen to what the instructor is saying.”

When asked for further clarification, Hope went on to explain:

On two occasions it was men. I don't think these two men that I'm particularly thinking about were accustomed to taking orders or recommendations or suggestions from women.

It was in the first level and they are just not always accustomed to women and following directions of the woman.

Although she did not want to go into a lot of detail, she stated the issue was resolved with time and working with these particular male students.

One of the strengths Hope brings to this study is that she has been a nurse for many years, and has seen many changes occur in nursing. As far as male students, she can even recall the first time the school had male students. She can recall not really knowing what to do with them, and that she, herself, had a learning curve to overcome with recognizing that men can be part of the profession and need to learn the same things that the females needed to learn. This came across in one of Hope's interactions with her male student, when she was pointing out to him “the softer side of nursing.” Hope explained this interaction by expressing that the male student she was with was very science-oriented. She wanted him to understand that although the scientific facts

are important in providing care, a nurse still needs to listen to the patient and individualize care to fit the patient's needs with their personalities.

In spite of recognizing the need to learn and accomplish the same objectives, Hope is aware of the issues men may face as a result of their gender and social rules that may make certain aspects of nursing more difficult. An example of this emerges in her direction to the male student when dealing with the patient with a rotator cuff repair, who was also female. Hope specifically looked for an upper-extremity issue for this student because, first and foremost, Hope said she makes assignments looking to provide students with a variety of experiences. This student had taken care of individuals who had lower-extremity issues, but this is the first upper-extremity issue during his time with Hope. Hope, however, went one step further in her clinical assignment, and that was found in her discussion of the morning's pre-conference with the student when she made certain to tell the male student about how to take care of the axillary pit pad and how to assist the woman who only had use of one arm to accomplish bathing and dressing. Hope instructed the male student to get a female to assist with this because in her past experience, she knows taking care of a female with an upper-extremity issue is more cumbersome than a male patient because of the breast tissue. On this day, however, a Licensed Practical Nurse (LPN) came into the room while the male student was attempting to provide the patient with personal care and took over for the male student. Hope expressed disappointment that this occurred, because she wanted this male student to get this experience, yet she understood that bathing a female or helping her wash underneath the breast can be cumbersome for both the male student and the female patient. She felt the LPN jumped in a bit prematurely and took over from the student.

Hope expressed one of the key elements influenced by a student's gender, is the innate ability to know how the "fluff and puff" a patient:

Women typically, even though I'm sounding very stereotypical, know how to puff and fluff. They know how to tuck a person in. They learn how to give that comfort of squeezing a hand or wiping a brow or handing a tissue. Men may, over time they get there, but they're not quite as much, in my experience, fluffers and puffers. I've seen student nurses early on in their careers just grab a hand and squeeze it or wipe a brow or just put their hand on a patient. I see that and I hate to be stereotypical because I'm sure that there are men out there that do that, but typically I don't see that from my men. They grow into it, but much more quickly in my females, I see some of them be able to do it. Not across the board, but some are able to do it with very little instructor's suggestions. I don't know where that comes from. I don't know if that's rearing. I don't know if that comes from being comfortable with themselves as persons to reach out. We talk about therapeutic touch in the very beginning of Nursing and there aren't too many men that I have seen in my experience...I mean, they will do the care, but I don't see puffing and fluffing.

Hope likens the socialization of males to the profession to trying to separate the white from the yellow of an egg. What she went on to say is that one must very careful, proceeding with caution, so that the male is not "broken":

Yeah, you don't want to change them. You want to maintain all their masculinity, but at the same time, you have to temper some of that masculinity I would think. I'm trying to think of the men who took care of me as a patient in the hospital and what it was about them, or the men that I know now, what it is about them. It's, it's a degree of sensitivity.

We teach them the assessments, so it's not the assessments. We teach that and they grow into that. It has to be, and I hate to say "innate," but I think it's got to be innate for men and women. There's got to be something innate that you have about you and about who you are that is going to just make you a well socialized caregiver and nurse, whatever that means.

Hope views role modeling as a key element in socializing the male student, particularly when teaching them this softer side of nursing when providing personal care to the patient. Although Hope knows the male student needs to perform the same skills to either a male or female patient, she does recognize that the provision of personal care to a female by a male student may be uncomfortable. In these instances, she takes the opportunity not to do tasks for the student, but rather to go into the room and show the male how to do a skill or be present while he is doing a skill. Hope views the lack of males in the profession as a detriment to the male student, because she sees role modeling as an important aspect of teaching.

Although she has been challenged by male students, Hope does see males as contributing to the profession by increasing the diversity of the profession. She views this as particularly important to the care of men themselves. When interacting with male patients, Hope sees the male student possibly bringing a type of care to the males which women are not able to bring. Hope tries to use their gender difference to improve the care provided to male patients. She feels as though it improves care as well as providing the male student with an aspect of themselves that may increase their sense of self-efficacy in their role.

Jillian

Jillian and I sit in her office the day after she has been observed. She has a very soft demure about her. She is soft spoken and very reflective in her responses. Jillian has been in

nursing since 1981 (27 years). Her career background began in obstetrics (postpartum and newborn) then went onto gynecology (14 years), which led to Labor, Delivery, Recovery and Postpartum (LDRP) nursing (5 years). She spent 4 years as nurse manager of the LDRP and then began her career on faculty (it will be 4 years at the end of November). Jillian expressed wanting to be a nurse for as long as she could remember. She comes from a family which strongly valued service to others (church, ambulance, fire fighting, ministry, community organizations). Likewise, Jillian said that she, too, was drawn to the service professions. Nursing always appealed to her as a strong, honorable profession in which she could help others and support them during times of need.

While on the clinical area, I noticed that Jillian stood beside her male student with her arms behind her back. When observing her body position, I saw that she remained behind her male student, keeping her arms behind her back until she entered the patient room. She was noted to do this several times on both observations. When asked about this, she explained that for a long time, she tended to reach in and do too much for the student. She wants the student to be involved in doing the care. When entering the room, however, in front of the patient, she prefers a more open stance with her hands in front because she wants the patient and the student to know that she is there to assist. She sees her role as the instructor as supportive and collaborative towards her students, both male and female. With males she really wants them to feel that they can be successful in the profession, and is very proud that more men are coming into the profession.

The elements of nursing Jillian said she finds specific to dealing with males is an internal struggle with wanting them to be able to accomplish the objectives of the course, yet fearing the male will be rejected by others. Specifically, she fears the rejection of males by female patients.

This makes Jillian uncomfortable, because she strives to instill a sense of self-efficacy within her male students, wanting them to feel as though they can do this type of work and be successful. Having women refuse to have a male student care for them is one of the fears Jillian has, and it does manifest at some point when making her clinical assignments.

Jillian admits she takes extra time to make sure that she is assigning male students patients of both genders. She explained that, because of negative experiences she has had in the past assigning male students to female patients, she has developed a natural inclination to assign male students to male patients. She explained:

I would like to think that I don't, but a lot of times, you know, for the male student... I have to not force myself ... but I, really have to remind myself to give them women patients. And, I think that's my own,, experience talking, because I did have occasion where I had assigned male students to females in the past.

A few years ago, the females just really didn't want...they wouldn't let the male do their bath... didn't want to let them do foley care...I wanted to, to protect the male students; I wanted them to be able to be able to feel that the patient would not say no to that kind of private care. And so, because I've learned that in the past, I'm still trying to get past that and I do remind myself and I to give males female patients. But it isn't something that comes naturally to me. I really have to remind myself to do that.

The second element in the socialization of males to the profession that emerges in the clinical setting is, to some extent, needing to undo some of the qualities society has constructed for males. In Jillian's area of experience, which is oncology, nurses are dealing with patients and families who are often going through the grieving and dying process. For the nurse taking care of these individuals, Jillian feels it is especially important for the male student to know that it is

okay to express emotion, meaning the fears, sadness and empathy that males often are afraid to express because they feel it would be inappropriate. Jillian has learned through her experience with male students in oncology that this is something to expect, and to be prepared to assist the male student to learn that what is acceptable in nursing is different from what may be acceptable, or unacceptable, in society:

I think what society tells men in particular about how they need to behave, they bring that along and they have to... that mind set sort of has to be changed, depending on what situation the male, the male nurse is going to be in. In the past, I have had men that were like.. “Oh my gosh, I almost cried; I feel like such a wuss I cried” So then I, I had to say, “Well to a patient or a family that is a good sign it shows that you really care. In nursing, that’s a good thing that you can cry with people and, and that you have that you really feel sad about what they’re going through” But what they bring with them is, is largely, the result of what they’ve been taught in childhood and their own families or else by society in general about how they need to behave and, and then I think we have to change what, what the typical behavior in nursing, that may not be the same as the behavior is in society.

The third challenge for Jillian when socializing men to the profession was a male whom she felt was very challenging to her within a classroom setting. On the one particular occasion, Jillian said she felt uncomfortable with this man challenging her in front of a classroom, partially because the student was a man. The classroom discussion was about some of the negative behaviors toward new nurses. The male student challenged the validity of what Jillian was saying and, because the student was a male, she took his negative remarks more personally than if the comments had been made by a female. That challenge also made her feel oppressed. It took

her back to her own childhood, which was very male-dominated in terms of power. In this case, Jillian felt that the male discussing the negative behaviors in what is predominantly a female culture made her feel personally offended and oppressed.

The negative behavior of nurses toward each other emerged again as an issue in the socialization of males to the profession. I asked Jillian to give a metaphor for what socializing men to the profession is like. She stated: “ It’s like introducing a new puppy into a house full of cats!” By this she meant that men may not be aware of how emotional nursing can be in terms of the professional interactions among nurses. Jillian states that she views males and females as having different communication and conflict management styles. She feels that not all men coming into nursing understand the culture of the profession, which has a strong female influence. In her metaphor, she went on to explain, one needs to introduce the new puppy (male) very carefully into the house of cats (females), because they just may not understand the ways in which females can interact with one another.

Kelly

Kelly and I sit in a private conference room the day after her clinical observation. Kelly has a stern look on her face as I ask her questions about my observations. She takes time to answer and reflect. As the conversation progressed, Kelly became more relaxed. Kelly has been a nurse for 20 years. After graduating from high school, Kelly went to college for a short time. She admitted that, at the time, she was unsure of which direction she wanted to take in life. She had thought about social work or psychology, but was not really focused. As time progressed, she started “floundering,” so she decided to drop out of school and go to work. After three years of working, Kelly applied for, and was accepted into, a local hospital-based school of nursing. She was inspired to go into nursing by her sister-in-law’s experiences as a nurse. Although Kelly

always admired the work of nurses, she said she did not think of going to nursing school until speaking with her sister-in-law.

Kelly thinks of the profession as having many opportunities. One of the more positive aspects for Kelly has been the flexibility in terms of shift work and being able to work around family demands. The work is demanding; but Kelly said she thinks that if a person is interested in the work, it makes these demands worth the difficulties. She is concerned that not everyone who is entering the field currently is truly interested in taking care of people, as much as they are in getting a steady paycheck. This may be a particular issue for men, because they tend to go into the profession as a second career choice. The desire to be a nurse, Kelly finds, is important to sustain a person in the profession. The types of work involved in nursing are sometimes unpleasant. Patients often need much time and attention:

The type of care we have to do- I mean dealing with bed pan with incontinent people, with people who are unhappy, people who need a lot of time and attention from us-it is not an easy thing to do even if it's what you want you want to do with all your heart. But if it's something you're doing just to get through the day, and to get a paycheck at the end of the week, I can't see, I can't see that it would be bearable to even do it, and I have to think that the quality of care that they give, and their attitude about it, is going to suffer.

The past four years of Kelly's career have been spent specifically in nursing education. She always thought that teaching was something she would like to do at some point, but never actively made a clear plan to enter education. Teaching opportunities came her way by chance, in the way of orienting new nurses to the units she was working. As time progressed, she found that she both enjoyed orienting new nurses to the unit and that it was one of her strengths. In addition to teaching new staff, she also enjoyed patient teaching. She was inspired to take the final step

and formally pursue teaching as her main role while speaking with one nursing faculty member who did some part-time work in Kelly's unit.

Kelly values the profession of nursing, and expects that those who enter the field will have the same values of high standards as she does. Currently, she feels the younger generation coming into the field does not have the same high standards of care. Kelly feels the participation of men in nursing adds to the profession in elevating the status and professional admiration from others on the health-care team.

Alison

Alison and I meet at the end of each clinical day she was observed. Alison is a very energetic nurse educator, who is always looking to ask questions of her students and push them to think critically. Alison pursued nursing as her career as soon as she finished high school. Her parents wanted her to receive her basic nursing education at a four-year college, but Alison opted to attend a three-year diploma program affiliated with a hospital school of nursing. She took this path because she felt the diploma program would give her a more intensive clinical experience. Her educational journey was very similar to Kelly's, in that she started at a diploma school, and then worked toward her bachelor's degree. Her experience in nursing is expansive in terms of variety of areas worked. Her first job was as a staff nurse in telemetry, intensive care, she also did emergency care float, high-risk obstetrics, normal newborn, post partum, labor and delivery. This variety of experiences is what led Alison toward wanting to work in education. She considers herself a generalist in the field; in other words, she has worked in a variety of areas and does not feel that she is specialized in any particular area of nursing. Alison always valued education, and had an interest in learning. During her clinical time, while working on her bachelor's degree, she took an elective in neuro-intensive care. Many individuals wondered why

she would take on such a challenge for an elective. Her response was that she loved to learn, and this was an area she did not know much about.

Alison has been a nurse for 27 years. She has spent the last four and one-half years in nursing education as an instructor teaching fundamentals, as well as oncology. Her inspiration for going into education came from her late husband, who thought that she had great knowledge stemming from all of her years in the nursing field. Being a professor of English, he recognized her natural abilities, and encouraged her to share her knowledge with those who would be entering the profession. Alison was not sure if she really wanted to leave the bedside in order to focus on nursing education, but she did give teaching a try and, in doing so, found herself in a place where she was able to share with students who she is and what she believes and values. She does this through pulling from her broad knowledge base to assist the students in finding answers to the questions they have about patient conditions.

Alison is known as the faculty “jokester,” even when interacting with patients, she has a way of putting individuals at ease with themselves, including males. In terms of teaching strategies, she finds this assists them to keep themselves calm and collected when on the clinical unit. She finds that students, male or female, learn better when they are relaxed and not feeling stressed or intimidated. She views males in the nursing profession as a positive, because males bring diversity to the workforce. Alison considers it a professional obligation to her male students to provide them with equal learning experiences and mentorship. She does not view any area of nursing as being “off limits” to males, including obstetrics. She views males in nursing as being challenged by stereotypes and double standards which would categorize male nurses as gay or unable to care for women appropriately.

Caitlyn

Caitlin and I sat in a quiet conference room for her second interview. Caitlyn, although not reserved, is quite. She is the youngest participant in the study. Caitlyn is unique to this study, because she has not been in nursing or nursing education as long as the other instructors. Her career started 15 years ago, and she has spent the last three and one-half of those years in nursing education. In addition to being a nurse educator, Caitlyn she works as a nurse practitioner. Caitlyn said she has always known she wanted to be a nurse. She was inspired by the nurses who took care of her when she had to be hospitalized for a medical condition during her childhood years.

Because she knew that nursing was where her passion was, when it came time to enroll in higher education, Caitlyn choose a college that offered nursing. She wanted to have the college experience, so she attended a four-year program from which she graduated with a bachelor's degree. As a new graduate, Caitlyn worked on a cardiac step-down unit. From there, she worked in a variety of areas, including trauma, operating room and pain management. She completed her master's degree in nursing in 2000. Her area of focus during her master's was clinical practice, not nursing education. Nursing education was not an area she actively sought out; she said it was really something she fell into when an opening presented itself as she was finishing her masters degree. My conversations with Caitlyn were short. Although answering all of my questions, Caitlyn did not take as much time to think about her responses. Hence, my data collection did not yield the same depth and richness as was the case in other interview.

Nursing, Caitlyn said, is a matter of taking care of another person in a competent fashion. She describes care as something that one does to another that one would want to do to oneself. She feels this is one of the most important elements to foster in nursing students: to care for

others as if they were a member of one's family. She also feels that nursing is a profession that is, or should be, non-discriminating as far as person's beliefs or appearance. Each person should be cared for in a non-discriminating fashion.

Caitlyn has worked with male nurses in varying roles throughout her career. She admitted that when she worked in the medical-surgical arena, there were not many men, in the operating room; however, there were many male nurses. When socializing males to the profession, Caitlyn really does not see any differences between socializing males versus females.

Caring is one of the elements that symbolizes nursing to Caitlyn. She feels that men, at times, can be seen as not having the same capacity to care as women can. Although she does not feel this way personally, she said she feels personality has more to do with one's ability to care than gender. She does not feel that she makes any distinction between males and females in the way in which she socializes students to the profession, with one exception, when she separated male students from female. This was done during a physical assessment course because of issues with men having to touch their classmates as a necessity to performing the assessments. She reported one instance where a female accused a male student of touching her inappropriately while he was listening to her heart sounds. That aside, Caitlyn said she does not see any difference in socializing males to the profession.

Helen

Helen and I sit in a private conference room the day after her observations. She is middle-aged, but looks very much younger than her years. Helen was the final participant in this study. She is an instructor, primarily in women's health. She has been teaching in a school of nursing for five years. She has had extensive experience in the area of maternal-newborn nursing, as she has worked in both staff and education roles for 29 years. Helen went to a large university, at

which she majored in nursing. After graduating from college, she started working in a community hospital as a float nurse. After a year, she obtained a position in the labor and delivery area of the hospital.

Her interest in moving into the academic setting was inspired by changes occurring in the labor and delivery area, which she said left her feeling not as fulfilled with her job. When the opportunity came to teach women's health in the academic setting, Helen changed career routes, and went into teaching. She found a new challenge that teaching which has given her renewed energy and a more positive outlook on her career.

She has a true nurturing nature when dealing with her students. She views her role in nursing education as fostering qualities of caring, compassion, honesty, a positive attitude and excellent communication skills. When dealing with men, she said she doesn't treat them any differently, than females, although she admitted that at times she senses men are too self-confident, and at times this has had issues with them taking on assignments that were not appropriate, or making decisions that were incorrect.

For Helen, working with male nurses was not something she was accustomed to, because there are very few male nurses who work in obstetrics, and none in the labor area in which she had worked. Given this, she does not feel that males make poor nurses in this particular area of nursing, but she acknowledged that she has dealt with staff who resist the inclusion of men into the field. She also tries to view the student not as a man or a woman, but focuses more on the individual qualities they bring to the practice. For men, however, the image of the nurse as a female is something she recognizes as prevalent and does feel a bit "protective," as she puts it, in terms of facilitating the relationship between the student and patient. She explained:

I don't have a problem with it. I feel, myself- and again you observed me- maybe I'm wrong, but I don't treat them differently. I try not to, because it being the "women's profession," we want to get them in there, and I have a number of students that were excellent, and there are a number of women that shouldn't be in it. You know, the men might be more empathetic, sympathetic than some of the women, so I feel I approach them pretty much the same way. I'm more — and I think I might have said this with the last interview-I think I'm more — I don't know if protective is the right word, because when I go up there, I don't ask permission from the patients, because I don't ask the guy's permission: "Do you mind if you have a female nurse?" Now,(sometimes) I'll come in and introduce them, and say, "This is a student; he's going to take care of you," and they say, "I really would rather not have a student." But I've had instances with staff where they were like, "I don't know- don't you think you should ask, 'this is a man?'" I said "Hey, she has a male doctor; don't you have a male resident?" I haven't had too much of a problem with that, and lately it's just been fine. So I think we are seeing more men and now they do have a male staff member.

Helen said she values men coming into the profession because she feels they bring unity to the profession. When asked to expand on this thought, she said she felt nurses do not always know how to pull together and advocate for themselves, particularly when lobbying for better working conditions and pay. Men are seen to bring these types of leadership skills to the profession, which are, accordingly, seen as inherent in them. According to Helen, men coming into the profession assist in raising the image of nursing in the eyes of the public. She explains:

Well I think, historically, we as a profession... we are a profession, but we aren't. I don't want to sound bad, you know, about talking against my own sex... but I don't think we're

as united as we should be, as a lot of the other professions are in what we want for our profession, and I think this comes back to growing up as a woman. You're there to help out — it's almost like you're there to do this — not for free, but because these people are sick and you should do this ...and not be fully compensated. We are definitely better compensated than we were when I first started working 29 years ago. But, I think the differences between male and female, the way they approach things, and there are differences - you read about it in research. I think that may ... bring maybe more power to us, because, you know, as a nursing profession, think we're larger than the AMA. (American Medical Association)

Helen expanded on this thought, explaining that she feels men, in general, have more power than women and are better able to assert themselves, particularly when it comes to dealing with physicians. This power goes beyond simply getting jobs, but also securing better-paying jobs, and being in control of family finances. Men, in Helen's view, have been socialized to be in charge and in power, and they carry these skills with them when they come into the nursing field. She states:

But yet, look at the power they have, because they know how to lobby. They know how to use that, and I don't know if that's being a man - that's always been that way because they have been the wage earners, they have been out there where women have traditionally been at home with the kids, and taught that — that's what their role in life is...and (in) the same way — I'll still hear nurses not what to confront the physicians and be the advocate. "Oh, I won't call him, it's 2:30 in the morning, he's going to yell at me." Tough, you know; and I don't think you see that as much with the males. They're not going to take that as much ... (although) some of them will.

Helen was observed for two hours on a post-partum unit. During that time, she spent 45 minutes total solely with her male student.. She was observed assessing a newborn with the student. She was very nurturing and caring with the student, and asked many questions to engage the student in thoughtful reflection in order to put theoretical information into practice.

Conclusion

Although each participant comes from a different educational background, and had different motivations for entering, they all had a commitment to the nursing profession. All had pride in the profession, and were welcoming of men. This chapter gave a brief introduction to the women who were brave enough to participate in this study. They all showed interest in having men in the profession, and wanting to create a comfortable learning atmosphere.

Chapter 5

FINDINGS

Nursing, like many other professions, has a long history and tradition. Many of the symbolic representations of the profession, such as the traditional cap, are formed from the assumption that the nurse is a female. In nursing education, many traditions, such as capping, were formed out of the Nightingale school, which viewed nursing as an extension of the female role. Nurse educators, themselves, are typically females. For men coming into a female profession, then, there are unique issues they face because of their gender.

In any profession, a person's perception of their role identity and work-identity are formed through socialization (See Chapter 2). In nursing, the student takes theoretical information and applies it in practice. Contact with patients and others in the health-care team occurs, primarily in the clinical setting. It is here where a great deal of socialization takes place. This study was undertaken in order to identify the symbolic nature of student/instructor interactions when socializing men into the nursing field. This research examines exploring the socialization of men to nursing by female instructors. The guiding questions for the research were:

- 1) How do female nursing instructors perceive the role of the male nurse?
- 2) What symbols are present in the clinical area that represent an instructor's perception of the role of the nurse?
- 3) How does a student's gender influence the instructor's clinical assignments?
- 4) How does a student's gender influence an instructor's perception of the student nurses' role?
- 5) Does the perception of professional nursing roles anticipated by the instructor play out within the interactions between the instructor and the student?

- 6) Does a student's gender influence the focus of the clinical teaching of the nursing instructor?

In order to answer the above questions, a dual-methods approach was used that included observation and interviews. Each instructor was observed on the clinical area for two hours. During this two-hour time period, the researcher took notes as to the start and end time of each interaction with the male student. An interaction was defined as an exchange of either verbal or non-verbal communication between an instructor and her male student. All actions, gestures, eye contact and dialogue occurring within the time frame of the interaction were recorded.

The data from the field notes were taken and reviewed by the researcher, who then engaged with the participant in a semi-structured, conversational interview. The data was organized according to themes. The following is a listing of themes and subcategories that emerged from the data:

1. Role modeling
 - a. Holistic care
 - b. "Softer side" of nursing
2. Fostering male self-efficacy
 - a. Avoid doing too much for student
 - b. Recognize one's own feelings of discomfort
3. Temperance of men's independence
 - a. Men too self-assured
 - b. Teaching men to ask for directions
 - c. Teaching men to collaborate
4. Breaking socially constructed rules

- a. Rules regarding masculinity
 - b. Rules regarding touch
5. Advocating for male nurses
 - a. Balancing patient rights and male students' needs
 - b. Dealing with homophobia
 - c. Prevention of female interference
 - d. Recognition of males as "the other"
 - e. Male nurses as mentors
 6. Valuing the presence of males
 - a. Improving status of the profession
 - b. Improved interpersonal working relationships
 - c. Drawing on their assets
 7. Emphasis on the student/instructor relationship is professional.
 - a. Language
 - b. Personal distance

8. It's all about gender

The following portion of this chapter is dedicated to describing the data on which each of these themes are based.

Role Modeling

Emerging again and again in watching instructors interact with students was socialization through role modeling. Role modeling takes place when the instructor performs an action for the student, while the student watches, with the hope the student will adopt the observed behaviors. Instructors were noted to do this in every observation, and spoke about it in every interview.

While observing the instructors, role modeling was observed where instructors joined in performing the daily aspects of nursing care modeling the traits expected of a professional nurse. The instructors role-modeled two major elements: 1) providing holistic care and 2) the “softer side” of nursing.

Holistic Care

Holistic care addresses not solely the physical, but also what is referred to as the psychosocial (psychological, social and spiritual), needs of an individual. For the majority of the instructors, the psychosocial aspects were the elements needed to be role-modeled to a greater degree for male students. For Kelly, role modeling is important in teaching the males the caring/emotional aspects of nursing. She states:

The woman spilled her coffee and it was a combination of her emotion center being hit by the stroke. Emotionally, she was spent because she just had a stroke, and had all this to deal with, and she was having some fine motor control issues.

So it was and everything that went wrong in the past three days came together when she spilled her cup of coffee, and she was crying, she was so upset over this. And you could see the male student was noticeably uncomfortable with it, and he just, he just kind of looked around and kind of patted her shoulder very stiffly and uncomfortably, with a look that said, “please save me” on his face and so, luckily, I had walked in just a moment or so after this happened and talked with the patient, and kind of helped to calm her a little bit, and I displayed to him, but I don’t know that he was really paying attention or kind of taking mental notes on how to handle this so much as he was just thankful I was there and “Oh my gosh can, I get out of here?”

Jillian referred to professional qualities that assist in assessing and addressing the psychosocial elements when she said:

I try to model. tolerance, compassion, the art of listening, as particularly today with that man, because he was he seemed to be irritated that we were bothering him and he wanted to sleep, and we wanted him to do things, so I was modeling patience, you know, patience meaning tolerance and ... being tolerant of what the patient's needs were. I was modeling that for him, and I thought I also wanted him to see that even though a patient can be sometimes not agreeable with what we want him to do ... that we could still be caring and we could still listen and we could still ... find maybe a way that he could have his way, and maybe take a little rest now, but that we would still like him to do what's best for him, which was wash up and walk and you know ... do all those things ... so that is what I was trying to model for him that, the tolerance of letting the patient's needs to come first.

Hope says she tries to model the caring behavior of empathy. She stated:

I definitely try to role model it. What I'm showing as role modeling may not be appropriate for what they deem appropriate, but at least they are seeing this behavior being executed. So, I will often run for a cold rag and I will wipe a sweaty brow, or I will frequently squeeze a person's hand and say, "You know, you really did a good job" or "This is the worst day it's going to be. Second and third day post-ops get better." I emulate the behavior I would hope that they would be able to adopt, and that is across the board. That's for men or women. I don't do anything different when I demo those empathic behaviors in regards to gender.

Grace described role modeling in teaching students how to decrease patient's anxiety

I was attempting to help Sam make the patient comfortable and I was role modeling how I approach male patients when I'm providing care. If I have a patient who seems a little antsy about getting an injection, then I will talk about how fine the needle is and that kind of thing, because that generally makes men more comfortable. And at some point, he was talking about.... He introduced the subject of guns. So I said, "Oh, are you a hunter?" He said, "No, I don't hunt anymore." ... But I have enough exposure to that through my husband that I'm able to kind of keep the conversation going.

In the above examples of holistic care, the nurse is responding to a variety of needs that may be expressed verbally or non-verbally from the patient. The knowledge of knowing what these cues are, and being able to pick them up from patients and intervene effectively, is what is known as the "softer side" of nursing."

Soft side of nursing

The "soft side" of nursing has been expressed as the intuitive ability to know what a patient's needs are or what they are feeling, even if it is not verbally expressed. This is sometimes referred to as "nurse's intuition." Daisy stated that men need more modeling related to picking up the non-verbal aspects of care, which include utilizing intuition as a way of knowing patients needs:

Pointing them out when you're in a room if it's something that they've overlooked. They go in, we perform care, we come out, and I might say, "Do you think your patient is in pain?" When I know they are, because of the grimacing or the subtle nonverbal cues, guarding their abdomen as you go to turn them or tensing up in the bed when you go to turn them. And a lot of times, they say, "No, I don't think they are in pain." They didn't think so. They wanted the confirmation of it. And I said, "Well, they tensed.... Facial

grimaces, they clenched their teeth. Did you see all of these nonverbal cues?" They said, "No, I didn't notice them at all." I have to point them out to them and make them understand the whole patient...

For Daisy, men need a great deal of role modeling in this area; she has seen that men do not notice the small clues and details from the patient that often the females will. Alison also expressed a difference between males and females in this area, stating that often females are better at addressing patient issues that go beyond those physical needs of the patient, but also that of a psychosocial and spiritual nature. Alison utilizes not only herself to model these behaviors, but also the other females in her clinical groups to model for the male student as well. She states:

The soft side of nursing, the art part of nursing, the caring, the anticipating of needs, the religious needs of patients, spiritual needs of patients; ... I think that women generally tend to see that a lot quicker than the guys, and once it's shown to them, then they're fine. Then they pick it up. If I were to ask the question to a guy... "Tell me the needs of your patient?" I'll hear from the guys..."Well he's got a bad heart, and he's got a bad this, and he's got a bad—we got to fix all this stuff."...And if I pair him up with a female student, the female student will say..."Yeah, he's got a problem with his heart, but it's really, really upsetting to his wife." The guy may just not pull that part of it in, that's why I want guys in my groups with my female students and I want females in with the guys. Maybe it's the way that people are brought up, ... for good or bad, there are differences, they need to be celebrated.

Kelly used the metaphor "re-teaching," because men don't come with the same experiences into the field as their female counterparts. They need to be taught the female side of nursing:

It's not like teaching someone from scratch; it's because often times they come with a lot of life experiences. It's more of building on what they know and correcting some of the stuff. So, sometimes, I'd say re-teaching. I feel I do a lot of re-teaching males. Paying attention to how the patient's reacting to their surrounding or to their situation, which I think they are less in tuned to than women are in general, not that there's not women who are oblivious – I think there are -- and there's men that are very in tuned to things, but for the most part seeing, a patient either look away or roll their eye or wince or draw their head back, it's something that a male is less likely to see or interrupt. They tend to be more task-oriented, not all of them ... but most of them ... are.

In Kelly's last sentence, she speaks of tasks and helping patients. From the above examples, the majority of role modeling is not on doing tasks, but rather the listening and feeling side of the profession.

Fostering Male Student Self-Efficacy

Self-efficacy means that the student feels confident, competent, and effective in carrying out the role of the nurse. Confidence means that a student feels that he or she knows what they are to do to the patient and can carry out their role in a safe manner. The student goes into an experience with the sense they will know what to do and their interventions will meet patient needs. Competency is doing no harm to the patient. What the nurse does is done correctly and appropriately. In fostering self-efficacy, the instructor helps the individual feel that he or she will be a safe, competent and effective nurse. The instructor helps the student to believe that he or she will succeed in the profession. This is accomplished by not stepping in and doing too much, and secondly, by acknowledging one's own feelings of discomfort.

Avoid doing too much for the student

Although the instructors had an emphasis on role modeling for their male students, there was also recognition that role modeling needs to be tempered. This means that there was an awareness of stepping in and doing too much for the student. While watching the instructors with their students, there was a pattern of gestures; notably, this came across in hand gestures. For Jillian and Kelly, for example, this was observed while watching them outside a patient's room with their male student, and then when they entered the patient's room.

May 6, 2008 at 0934:

Jillian was observed giving medications with a male student. She is standing behind him, looking at what he is doing, with her hands behind her back. Stating "all right" after he pours each medication. Jillian and the male student enter the patient's room.

Jillian stood with her hands behind her back while at the medication cart with her student. She explained why she does this:

I tend to overdo it. I tend to help them too much, students, in general. So the way I have gotten around not actually doing for them, or not actually involving myself in things that they should be doing for themselves, is I put my hands behind my back. So that I don't reach for things, or take things away from them that they should be learning. ... Today, what I was doing for him, I was really just focusing on his process, what he was doing, getting ready for meds, thinking to myself, to you know, evaluating him, that he was...I thought he was doing well, I thought he was being very careful, I thought he was, competent ... I was doing a lot of evaluation as I was standing like that.

Kelly was also observed performing the same kinds of gestures:

September 23, 2009 at 0907:

Kelly was standing at the medication cart 3 feet away from her student. She had her hands crossed in front of her so that they were out of the way. Kelly went back and forth, asking the student questions about medications. Kelly stood on the outside of the patient room as male student nurse went in. Male student nurse started to give patient her medications by doing patient identification. Kelly then enters the room, and engages with the patient, asking the patient to show Kelly her identification bracelet in order to assist the male who was having difficulty with the patient identification device.

Kelly described why she keeps her hands behind her back and maintains personal distance from the male student when interacting with him on the clinical unit. She recalled needing to recognize that she is not the nurse responsible for the patient, the student is, and that she needed to learn to step away from that role in order to allow her students to learn. Kelly states:

I found myself very quickly stepping in and doing their care, myself; rather than allowing my student, time or prompting my student to do it. I found I was doing it before I ever gave them a chance to react. So that was something that I needed to watch myself and check myself on.

The personal distance and hand gestures served to allow the student to do tasks for himself without interference of the faculty member. The faculty member was there for support and reassurance, but not to do tasks for the student.

Recognize one's own feelings of Discomfort

Specifically for the male student, his need to step away and allow him to perform skills can become additionally challenging because of the personal nature of some of the work required in nursing. Caitlyn recognizes the need to step away and allow the student to do tasks, but also is aware of the uncomfortable feelings she may have when the student is doing personal care. For

males, she feels that this may be a result of “picking up” these feelings from the male student.

She recognized that it is important to be present, but not to do things for the student. She states:

I can't say that I do anything differently, but the way I feel maybe different. I don't know that I show my feelings all the time. I'm hoping that I don't. But sometimes I do feel uncomfortable. I almost feel as if I am taking on their uncomfortable level. I have in the past met with them, asking them how they felt doing that bath, or wiping that lady's or gentlemen's, buttocks, Or putting in that catheter ... and sometimes they'll say...

“Yeah, I certainly felt uncomfortable doing that, but I was glad that you were there.”

I guess a lot of times I get more uncomfortable feelings from a male that I have than a female. I don't know that I would do too much different other than talking to them afterward seeing, you know, if they felt uncomfortable, how they felt about doing it, or giving them a hand if they needed a hand. “I guess my thought processes ... are ... that I get more uncomfortable feelings from males, than I have (from) females ... I don't know that I would do too much different ... other than talking to them afterward ... Seeing, if they felt uncomfortable, how they felt about doing it, or giving then a hand if they needed a hand.”

Fostering self efficacy of the male is facilitated by recognizing one's own feelings and how those feelings may be acted out in the patient care area. Although wanting students to feel a sense' of self-efficacy, this also needed to be balanced that men did not become overly confident.

Temperance of Men Being Too Independent

Although instructors feel the need to foster efficacy in the male student, there were also times when men have a tendency to be too self-assured when providing patient care. This can come across in the male not always accepting the assistance and seeking out the assistance of the

instructor perhaps in the manner in which they should. Men, at times, were seen as not asking for directions from the instructors as frequently as they should. In addition, collaboration was something that was viewed as something men needed to learn. Each one of these elements is addressed as sub-categories.

Men as too Self-assured

Self-assurance is feeling confident in one's abilities and knowing the correct way to perform in a given situation. Men, generally, were thought to be more self-assured at times than perhaps they should. Jillian ascribes this self-assurance to the independence and authority men feel when on the clinical area. She states:

I think men are a whole lot more independent in ... carrying out their nursing duties. He (male student) ... required me to sort of keep an eye on what he was doing because I knew he would be independent so much. I wanted to make sure that I was observing him because he felt just fine going off on his own. So, I think the independence that men feel or the confidence they feel, the authority that they feel manifests itself. And how I feel about this is that if it's appropriate, and it's safe, I take more of a resource guiding peer kind of role. If it is negative, then I need to deal with that. I make my expectations known and not allow them to really step too far out. I find that this week he was very safe, so I just stepped back and let him be independent.

Although Jillian's experience reflects the need to accommodate the independence men feel, this independence can lead to situations where clinical objectives are not met because a male went too far, and was too assured of himself. Helen has had experiences where males have made independent decisions that ended in the student not getting the clinical experience she had planned for him. She states:

I think sometimes men are a little more cocksure of themselves when they're not actually—know what they're doing. Boy, does that sound sexist. Well, yeah, maybe they're a little bit more self-assured, whether or not they should be. I had two instances. A patient went home, when the male went to get his assignment (and the patient was not there) he, never beeped me, just picked a patient. When I get there I said..... “Oh, I got to give you a patient.”..... “Oh, I picked one.”.... I said “Uh, oh, really?” I said “You weren't supposed to do that. I told you I would pick.”... “Well this is who I took.” And I said... “He really doesn't meet the objectives, but since you did your prep on him all right, I'll let it go and let's see how it goes.” He came to me and later and sat down and he said...”You were right.”

Hope has had feelings of frustration in the past dealing with males who simply do not want to listen to what she is saying or accept her authority. She states:

“Smart-ass” attitudes, when they do not always want to listen to what the instructor is saying. On two occasions ... I don't think these two men that I'm particularly thinking about were not accustomed to taking orders or recommendations or suggestions from women. It was in the first level, and they are just not always accustomed to listening to women and following the directions of the woman. I think it was just more their personalities, because I quickly cleared that up early on in the rotation, and over the 16 weeks in the Nursing 01 course, that kind of interaction got better. I needed to work hard to make sure that he understood that I was there as his ally and his support and his guidance, not someone just to tell him but I was there to assist him; and, early on, I had to say that because he didn't have that knowledge base.

Teaching men how to identify when they need help is a way in which to temper some of the independence men may feel. One way in which to accomplish this was to explain and encourage men to ask for directions.

Teaching men to ask for directions

Teaching men to ask for directions and seek out assistance when they need it emerged while observing interactions between male students and instructors. Hope was observed with her male student, who was having difficulty with retrieving discharge information from the computer. Hope was also having difficulty, so she asked another nurse for assistance. When finished, she turned to the male student and said, "What did I just teach you there?" During this process Hope reinforced asking for help several times. Hope explained why she did this:

Men typically don't like to ask directions. They like to figure it out themselves. If you've got a family who's chomping at the bit, ready to go ... we could have probably figured it out, but I wanted to get those instructions out and I wasn't getting them printed out. So I yanked in another nurse. Yet, I don't want to foster that because I want you to be able to think it through yourself. I could have wasted another 10 minutes. What I hope to do when I sit with him to close the chart out is I hope to go back over and say, "All right, let's do a Micromedex now on Lipitor. Pull it up, let's see if we can do it." Then, hopefully, I will learn also. I also showed him that the instructor doesn't always have the answers. It's okay for the instructors to ask as well.

Because the perception of males not asking for direction, Jillian feels she may spend more time with male students:

I don't consciously choose to do it. I don't feel the need to spend more time with them.

But if I make an extra effort, it's because I'm always concerned and maybe it's my own

perception that they won't ask me. I have to make myself available for them. I don't know if that's true. It's just my feeling. They wouldn't seek me out necessarily. I think if they needed help, they would seek me out or if they had a question, they would seek me out. I'm just thinking as general day-to-day, everyday nursing, you know, nursing care stuff, the things they are being evaluated by me. They want me to know that they're okay. Asking for directions and assistance required the male student not only to depend on, but to also to collaborate with, another as part of a team.

Teaching men to collaborate

The independence men bring with them was also expressed in teaching men to collaborate as part of a team. Collaboration is when a group of equally qualified persons work together on a project/work area, yet all may not be responsible for the same task. Grace was observed with her male student asking many questions that were not the "why" type questions typically observed, but those of a collaborative nature. Grace explained that she typically will ask these types of questions to all her students; however, she perceives that males "probably" are harder to teach collaboration. This she linked back to the way in which men and women are socialized:

Probably harder to teach men because collaboration is a female thing. We'll all get together and make dinner on Saturday night; okay, you bring the potatoes, I'll bring the salad ... we collaborate. I don't think men do that that much. Everyone shows up with their own box of tools (laughing).

Hope expressed collaboration as important when making decisions regarding patient management. Hope may instruct the male student on asking for help. I asked Hope to expand on

this a bit for further clarification. She expressed being respectful of the role of others as an important aspect of socializing men to the profession. She explained:

You've got to get used to it because in this profession, we rely on each other. You've got to get accustomed to getting second and third opinions and exploration of why opinions may differ. The more seasoned person is ultimately going to make the decision, and it's a matter of courtesy that you don't undermine the person who is above. I'm also teaching by emulating the behavior that I can go with an idea, but it's got to be explored with the person who's responsible.

The above category spoke to the need to teach men how to work on a team as well as teaching them to become less independent and depend on others for assistance. This leads into the next theme, which addresses men's need to break socially constructed rules.

Breaking Socially Constructed Rules

Socially constructed rules are rules men have learned and are associated with being a man. These deal with what is appropriate and inappropriate behavior for males. These rules male students have learned from a lifetime of socialization. Some of these rules need to be broken or renegotiated, or broken entirely, when socializing men to the nursing profession.

Rules Regarding Masculinity

Instructors are attuned to the social rules regarding appropriate male behavior. These rules include: "boys don't cry," men are not supposed to show emotion, men are not supposed to talk about feelings. Men are taught not to be emotional, and to do so, would be to be "unmasculine." The instructor who articulated the fear of demasculinizing males was Hope who, when asked to create a metaphor for socializing the male to the nursing profession, stated:

Teaching a person how to crack an egg and separate the white from the yellow.

An egg is fragile and it is possible to separate an egg, the white from the yellow, but you have to do it carefully. And you have to be careful when you socialize our men into this wonderful profession that you don't try to change them, that you try to bring them along and you don't break them. You dare not break them because that's not appropriate; you have to be careful. With the socialization process you have to be very aware of, very careful, and proceed with carefulness, gentleness, caution. You allow them to stay intact just like the yellow of the egg is going to stay intact, but also accomplish an end to become a good nurse. Yeah, you don't want to change them. You want to maintain all their masculinity, but at the same time, you have to temper some of that masculinity, would think.

During conversational interviews with the instructors, it was stated that often when dealing with a male student, the male needs reassurance that it is okay to show emotions such as crying, fear, sadness, and caring. Jillian said she has had this happen to her frequently when dealing with students who have connected with a patient who is dying. She stated:

And then they bring what society tells them, which is its not okay to cry ... or it's not okay to ... say that you're sad or ... what society tells men in particular about how they need to behave they bring that along, and they have to... and ... that mindset sort of has to be changed depending on what situation the male nurse is going to be in. In the past I have had men that were like, "Oh, my gosh, I almost cried, I feel like such a wuss, I cried so I had to say, "You know, to a patient or a family that is a good sign, it shows that you really care. In nursing that's a good thing that you can cry with people, and that you have that you really feel sad about what they're going through." But what they bring with them is largely the result of what they've been taught in childhood and their own families or

else by society in general about how they need to behave; and so I think we have to change what the typical behavior is in nursing, that may not be the same as the behavior is in society.

The emotional element of care was also an issue when teaching males to be supportive of patients' emotional state. The instructors spoke of needing to assist the male in knowing how to discuss patients' feelings. For Grace, who is also an educator in psychiatry, getting men to talk about and listen to the feelings of others is a challenge. She stated:

My experience in psychiatric nursing is that often I have to prompt my male students with the communication piece. Because, in general, I think men have a harder time talking about feelings, and that's my personal opinion. You mention the word "feelings," and most men will run away from you.

Assisting men with the emotional aspects of care was not the only social rule the male needs to break. In addition to openly expressing and discussing feelings, the male needs to touch patients, sometimes in very personal ways.

Rules regarding Touch

It is a requirement that the nurse physically touch others in ways that are considered personal, intimate, and in many other situations blatantly inappropriate. Teaching men to touch women and men in very personal ways was mentioned during the interview process. For example, Helen, being an instructor in the care of women during and after the birthing process, expressed more of an issue with men touching and assessing females in the post-partum period than during labor. The issues with touch were more apparent in this area because the post-partum assessments require the student to feel the woman's abdomen, check the perineal area and perform breast exams. In addition, women also require a great deal of teaching related to breast-

feeding, if they are choosing to do so. For Helen, the way in which she goes about assisting the male student, and many of her students, is to be present in the patient's room as they are doing their assessments for the first time. Helen was observed on clinical with her male student while doing a physical assessment on a newborn baby whom the mother had chosen to bottle-feed. was asked if gender played a role in the decision to assign a women who was bottle-feeding versus a breast-feeding woman to the male student nurse. She stated:

Yeah. To give him the bottle-feeding one. Yes it did, I did. I will honestly admit that. She went on to explain that she came to this decision not solely because the student was a male, but that this particular male was having a lot of anxiety with the entire labor and delivery experience, and to assign him a breast-feeding woman would be counter-productive to his learning experience. She stated:

And I knew he would just be like, "Oh, my God, what do I do?" I knew that this student was going to be totally uncomfortable with the breast-feeding, and I am glad I did not give him the one who was having issues with breast-feeding. This patient also had issues with depression and anxiety, and I think that would have been a problem. I don't know if there was a history of abuse, but I knew between her anxiety and his anxiety nothing would have gotten done, and no learning would have been accomplished.

This anxiety when touching another person comes out not only when men need to take care of women, but also when needing to care for other men. For instance, Grace recalls an experience she had with a male who had been in the military prior to entering nursing school. One mid-morning during clinical experiences, Grace looked out the window to find this student outside in the parking lot smoking a cigarette. When the student returned to the clinical unit, she asked him what he was doing outside smoking a cigarette. She stated:

He said: “Well, I had to wash my patient. ... “Yeah, that was the first time I had ever touched another man.” And he said, “I needed to go have a cigarette.” And I’m thinking, you know, four years in the Navy and, you know, the prohibition against touching other males and being in tight quarters on a ship, he needed to go have that cigarette to relieve his anxiety. He had to break the rule in order to become a nurse. He had to accept the fact that he was going to touch other men intimately, as a patient, and care for them. Of course, in the Navy he had worked in a boiler room, in the engine, on the engine. So, it was hot and tight quarters and “keep your hands to yourself.” So he had to change his perspective.

Showing emotion, coming in contact in close personal ways with men and women, and discussion feelings openly, are ways in which men need to break rules regarding what it is to be a man. These are the learned social rules that the male student needs to “unlearn” to some extent in order to become an effective nurse. In order to do this, the instructor needs to support and advocate for the male within the clinical area.

Advocating For Male Nurses

Advocacy is trying to assure the needs and rights of another are being acknowledged. Advocacy means that one person looks to serve the best interests of another. Advocacy can be manifested by speaking for another person who cannot speak for themselves. One of the roles of nurses, in general, is to act as a patient advocate. Nurses act as patient advocates when they address patient concerns with a physician, or question a physician’s order. For the nursing instructor, advocacy for male students was achieved by assuring the male had access to learning experiences that would enhance his adoption of the professional role. The main priority for the instructors was achieving a positive clinical experience for their male student. There are five sub-

themes that describe the way in which nursing instructors engage in male student advocacy: 1) balancing patient rights with male student needs, 2) dealing with homophobia, 3) prevention of interference of females, 4) needing more male nurse's to mentor male students, 5) recognition of men as "the other" in the field.

Balancing patient rights with male needs

In any health care situation, patients have certain rights. Some are explicit, such as written documentation given to the patient on admission to a health-care facility. There are other rights that are understood and legally protected, such as the right to refuse treatment. This means a patient is not forced to take a medication, or have any procedure done to them without their consent. With this is the unspoken rule – which is fairly well accepted and understood in health care culture – that patients have the right to refuse a health-care provider based on race, religion, gender, or if they are a student. When making a decision to assign a student to a patient who may refuse a male student, there were strategies instructors used to balance the patient rights with male student needs.

For example, Daisy related she does not call attention to the fact the student is male. When making the patient assignment for the student, she will go into the patient's room to meet the patient first. Instead of saying "I am assigning a male student to you," she will use a male name. She stated:

Sometimes I will go in and check with a female patient, introduce myself, let them know they are going to have a student nurse tomorrow and I won't say "It's a man." I'll say, "Scott will be in tomorrow, or Brad will be in tomorrow." Then they know the gender. If there is an issue with that, it comes up at that time, and I can reassign simply because I

want the student to have a good experience. I want them to be able to bond with their patient.

When a patient refuses a male student, the instructor is then placed in the position of having to comfort the student. For Jillian, she recalled past experiences of this led her toward unconsciously avoiding assigning female patients to males in spite of knowing males need this experience. Because of this, a strategy she has put into place is to record the sex of the patients she has assigned to the male students to assure that she is not unconsciously assigning only men to the male student. She explained:

And ... I do try very hard and I remind myself, if I have a student for ... a whole semester, I make sure I at least do assign at least ½ female and ½ male patients. Because I do know that they need to do both, and I understand the importance of them working with females too ... but I guess I still have in the back of my mind those couple of times that females would not let the male students do anything with them. And it is not so much to protect the patient, as it is I feel that I have to protect the male from being told that they cannot care for them, and ... it makes me feel protective of the students that they would be told that they can't do it. And I don't want them to feel that way.

Although it would seem assigning men to all male patients would erase gender issues for males, instructors also recognized homophobia as being another obstacle.

Dealing with Homophobia

Homophobia, for this investigation is defined as fear associated with homosexuality. Kelly has had times when the male patient refused having another male bathe him, as well as the student feeling uncomfortable giving another male a bath. She used the word “homophobia” when speaking of this issue. For both Kelly and Alison, who have had the situation of dealing

with a homophobic patient, they recognized that it may be uncomfortable for the student to have to deal with this type of patient. So they act as a guide and coach for the student as to how to react to these patient situations. They did this not by reassigning the student, but rather coaching the student in communication skills. For example, Kelly had to do this with a male patient who did not need personal care of any type, but just did not want a male nurse in his room. She stated:

With another case there was a male who was almost like the homophobia type. He didn't come out and say it, but that seemed to be what was going on. And I just said, "He is your nurse. If there is an issue, you let me know." And the nurse, the student, was a bit uncomfortable with it, but I said, "You're fine." ... (then, when speaking of the patient,) "Yeah, this person might be homosexual and he's in my room." ... If he had become abusive or very verbal about it, I wouldn't have forced (the issue), and certainly I wouldn't have wanted to put a student in that position. ... I just questioned him and kind of made him think about what he was saying and how he was acting, and he couldn't rationalize for being that way. He was just quiet and stayed to himself then.

Homophobia also emerges in student-patient interactions when male students are questioned regarding their sexuality by patients. Alison has had conversations with male students regarding the perception that male nurses are gay. She stated:

Well, we've had discussions about this and I ... you know, it is what it is. People are going to think what people are going to think. And not to take it personally ... if a patient lashes out at a student or at a nurse in anger, frustration, not to take it personally, because obviously they're sick, they're not at their best. Maybe they're going through the stages of grieving, shock, and a lot of anger. It may have absolutely nothing to do with them, and so if a patient, you know, says to a male student nurse, "You're gay, aren't you; you

must be gay. You're going into nursing and only gay men are nurses." ... either set them straight, tell them it's not open for discussion, just be frank. That's not saying yes or no. If you feel comfortable, and you want to admit to being gay, be my guest. You know, because it is what it is. If he says he doesn't want a gay nurse taking care of him, say, "No problem," and you find somebody else and switch up.

As was demonstrated in this sub-theme, not all patients are willing to accept care from a person they do not feel comfortable with. Therefore, instructors need to negotiate the patient/student nurse relationship. In addition, instructors find themselves negotiating relationships between the student and the nursing staff.

Prevention of Female Interference

Instructors demonstrated a great deal of advocacy for their male students when speaking about female staff nurses and their tendency to interfere with the instructor's plan for the male student experience. For example, staff sometimes overstep their authority or are "overly" helpful to the male student.

For example, Helen has had incidents of staff in the Labor, Delivery, Recovery, Postpartum (LDRP) area questioning her approach to making patient assignments for male students. She stated she has been questioned by female staff in the LDRP area as to whether she asked the female patient if it would be okay if a male student participated in her care. Helen has dealt with this by reminding the female nurses that the male student is a student, just like any female student. If a woman does not want him there, she will respect that, but she will not approach the women specifically to ask if a male student may take care of her. Helen has had to do a lot of education of staff regarding this issue. With male students, educating staff that nursing

is an acceptable role for men and that they can excel in the profession just as well as women, has been effective. For instance, she stated:

I don't know if protective is the right word, because when I go up there, I don't ask permission from the patients, because I don't ask the guy's permission: "Do you mind if you have a female nurse?" ... But I've had instances with staff where they were like, "I don't know, don't you think you should ask, this is a man?" I said, "Hey, she has a male doctor, don't you have a male resident?" I haven't had too much of a problem with that and, lately, it's just been fine.

Female staff was also reported to be somewhat of an obstacle for the male students in carrying out patient assignments independently. Female staff have shown a tendency to step in and do tasks for the male student. Typically, the types of things they will do involve helping with the personal care, homemaker types of duties. For example, with Kelly, the issue of female staff helping the male student has been something in which she has had to intervene, especially if the male student was personable. She stated:

This time I don't see it much, but last semester, the summer semester, the floor he was on had quite a few young nurses, several of whom had just graduated from the program within the past, maybe, one to three years; and then ... I had a male nurse who was a very charming type of guy; and he wasn't necessarily ... going to them, not that I ever saw, but they were constantly, whatever room he was in, I could almost guarantee there was going to be a female staff member in there with him if it was their patient or not. They were always in there helping him with stuff, wanting to show him stuff, and I had to intervene without being rude. I would say... I kinda was joking about it, "You know, I know how much you guys love to be around Ed; however, he needs to get the work done

himself, and you guys need to leave him alone so he can do the work, so I can evaluate him. If you're always helping him with stuff, then ... I have to evaluate that he can do it on his own." And I did it in a joking kind of way, to keep it light. I didn't want to chastise them. If I was the facilitator on that floor, I probably would have intervened or said something to them, but that wasn't my role to do.

Female assistance is not limited to female staff, but also extends to the female students in the clinical group, particularly when a male student is not doing well. Female students had a tendency to "follow" the weak male student and help him with his assignment. This help came across when observing Daisy with a male student. As Daisy was asking this young man questions, there was a female student in the room who would constantly answer for the male student. At one point, Daisy finally turned to the female student and said, "Hush," at which point the female turned and left the room. Daisy explained her response:

Because Tom is a little weak in his skills ... he needed to figure it out. He did not need to depend on somebody else, or Joan telling him the answers. I did not want her to respond. She could watch the student procedure, but don't give him the answers. You could see he was weak in that skill; it's a skill he obviously didn't practice before coming to clinical, like he should have. And I wanted him to struggle. I wanted him to know, "Man, I better get into that lab because I don't know how to do that."

She was trying ... I think the females in the group can pick up Tom's insecurities, and they cover for him. They want to help him succeed. That's what she was doing.

Although the helping nature of females may seem as if it would be a positive for the male student, the instructors recognize when this helping crosses over into interference with the

learning experiences. Therefore, the instructor steps into advocate for the student by pulling the female away.

Recognition of Males as “The Other”

Males as “the other” refers to instructors realizing that when men enter the profession, they stand out in the class; they are not the typical student. Instructors are very attuned to this difference, and recognize the student may feel somewhat different because of their gender. Daisy expressed this very clearly when she discussed how a male might feel when being rejected by a patient, or when a male is called the “male nurse” instead of simply “the nurse.” She explained:

They are the other. And that is something that’s difficult for me, because I have not felt that rejection from a patient. I have always been welcoming to my patients as their caregiver.”

Similarly for Jillian, this came across in her analogy (like introducing a new puppy into a house full of cats) of what is like to bring men into the profession. She stated:

And it’s something you have to prepare for, prepare them all for men and females, because I think there are more men coming into the profession now, which actually, I am very proud of, but I think it’s not something that you just sort of put them together and hope for the best; you have to sort of introduce them all to it, and culture them, assimilate them all to it, because nursing has its own culture altogether. And the things that we bring into it from different gender roles, putting that together isn’t always going to be easy for anybody. I think men coming from a problem-solving, take charge, let’s just get it done, let’s just take care of this problem ... I think if you just introduce that into a lot of females who want to think about it, want to talk about it, work it, see how it goes, and feel their way around it emotionally, I’m just thinking that all needs to be brought out,

and they have to all be introduced to the culture. And realize what this culture expects of them with those gender-type roles that they bring, which is something different altogether. Both men and females.

Instructors in this study were well attuned to being advocates for males; part of this came through in awareness of other instructors' non-advocacy of males. Caitlyn, who was the newest to nursing education, recalled one experience she had with another instructor, that led her to question whether gender does, in fact, affect objectivity in the evaluation process. She explained:

I had a male student last year, who then went to another instructor. He was wonderful; on the floor, he had a thirst for knowledge. I mean, he did above and beyond, and he had a lot of questions. A lot of times he would steer off the wrong end, and a lot of times I would have to bring him back. But she commented to me, "He will never be a good nurse; he's not fit for this." I was very appalled by that, actually. It was not what I had seen. I still did not see that, but it's very interesting, because it was the same student who was the one who initiated a MATT team on a patient, and then also received a letter from a patient who he took care of on the floor this semester. I guess because of his thought processes with nursing, she thought he was not really thinking the way a nurse should think and do.

Hope expressed empathy for the male student in being the other gender in having to learn to negotiate the female culture, and she described her own feelings when first faced with a male student:

Oh, God bless them. I think they are challenged a great deal because they are surrounded by women, including the instructors who are women. Most, not all, but most of the persons to whom they directly report, even in the chain of command, are women. So I

think they have to learn how to “talk our talk.” I think, and I hate to say it, in my experience, they also have to kind of, maybe, prove themselves to we women that are in this profession. I don’t think it’s any different than when my husband talks to me about females that are in drafting. Those women have a little bit of a harder time, perhaps, in getting into the drafting field. I don’t know for sure, but I suspect that may be the case, although we’re making great inroads. And I welcomed when I worked with my first student nurse that was a male. I was nervous about it. I said, “Oh my God, how do I do this?” It’s not different; it really is no different.

For the instructors, they realized that although men have the same learning needs as females, males may not have as many opportunities to find mentors who understand the needs of the male nurse.

Male Nurses as Mentors

The final sub-theme related to how instructors advocate for the male nurse is in recognizing their own limitations, as women, in understanding how a male feels when coming into the field. Mentors are individuals who have experience within a field who act as a guide and support mechanism. A mentor is a person who teaches the newcomer the often “unwritten” rules, and what is, and is not, appropriate behavior. The instructors in this study said they valued mentorship, but advocated for male nurses, preferably, to mentor male student nurses. Daisy said she found this was particularly important when assisting a male student who had a patient refuse him as a caregiver. She explained:

Hard to understand their position. It’s hard to understand his feelings of rejection. I understand he felt rejected. I understand why he felt rejected. But internalizing that, and then him thinking he’s a bad nurse, I could see that happening in his demeanor, in his

shoulder slumping, in his feeling like “I’m not very good.” That was a first year, first semester student. It was one of his first contacts with a patient. It wasn’t a happy one. So, we did talk about it and I did tell him, “Sometimes you just have to let the patient know, well, there aren’t any other nurses available. I will be your caregiver today, and I will meet every need you have.” And telling him he has to be very professional and nonjudgmental with that patient, and then go from there. I did also recommend that he talk to Joe and Henry who were on the floor, who are male nurses, and see how they interact with patients like that.

Daisy went onto explain that she will often use other male nurses as mentors for her male students, similar to the way in which Alison will find men in obstetrics for male students who are interested in that particular field. Alison acts as an advocate when she anticipates some of the assumptions men coming into the field may have regarding areas in which they can work:

I try to tell the male students, and I think I tell just about everyone, that OB (obstetrics) is not off-limits to you because you’re a male, and if anybody tries to tell you that, come back and see me, so that I can get you experiences or, you know, hook you up with some male nurses that I know who do OB.

The nursing instructors advocated for their male students as described above. In addition, the simple presence of males in the clinical setting was thought to be of value to the profession as a whole.

Valuing the Presence of Males

Although men are the minority in the profession, the female instructors valued the presence of males within the profession because they were thought to bring with them rights, privileges and positive behaviors currently lacking in the profession. In essence, males bring to

the profession valuable traits females lack, improving the overall profession. These traits include elements such as strength, better working relationships and enhancing the care of male patients.

Improving status of the profession

During the interview section of data collection the word “strength” was stated several times by several different instructors. Strength was mentioned as increasing the status of the profession in the health-care hierarchy. As Kelly stated in her interview:

I think that men coming into the profession will help raise the status a little bit. They'll help make it ... seem less like a subservient role. You know, when everyone thought of it as a female position. I think it will help to even the disparity between nurses and other members of the health-care team, because many of the men who come in, not necessarily my students currently, but some of the men I've had, who have worked in other professions in the past, saw no difference between them and the other people. (The males) never thought of themselves as being there to help. In our case, to help the doctor, not that I feel that way, but many nurses do. I think by having more men in the profession, the way they present themselves, and having less tolerance of being treated (as a subservient) when a male doctor looks at them, I think they (the doctors) see it differently, they're not seeing a women who is going to help them and run and get them something that they need.

Alison views the inclusion of men in the profession as important in raising the overall status of the profession, with the desired increase in nurses' salaries, thusly:

Okay ... it's in the eyes of society, not necessarily within the profession, but in the eyes of society. Male-dominated professions are better paid, and have more prestige. Okay ... it lifts the thinking of society about the profession in general.

This improvement in the status of the profession was also accompanied by a feeling that men improve interpersonal working relationships.

Improved interpersonal working relationships

Every instructor, with the exception of Caitlyn, stated the working styles between men and women are different, but that men, in general, improve the working conditions by decreasing the emotionality of the work environment between the nurses themselves. The most important element that men were felt to bring to the work environment was they are less personal in their relationships with their co-workers, particularly when it comes to handling conflict.

For Daisy, the element of conflict management was what she saw as the biggest difference when dealing with males:

Logical thinking, matter-of-factness, organization, and not being emotionally tied to their colleagues, and that if they have a problem and they address it and they drop it. If a woman has a problem, they address it and they gnaw on it. They're like a dog without a bone and they can't let it go, but a male can let it go. They can address the problem and say it's done and then be your best friend in 15 minutes. But a woman just does not have that. ... Not that way. They'll gnaw on it; they'll keep talking behind that person's back. They'll keep saying, "I can't believe she did this, I can't believe she did that. We talked about it, but she didn't address it the way I wanted her to or I wanted him to." They will keep after it and keep after it because they are emotionally tied to the event. The man is like, "Hey, I don't like what you did. Knock it off." They'll talk about it and then they'll have lunch with you or go out and have a beer with you, and its over.

Men were seen to not have many of the negative interpersonal behaviors women were thought to have. For many instructors, part of a male's socialization is not to change them, but rather prepare them for negative behavior on the part of females. As Jillian expressed:

Being with a lot of women in the workplace, there's going to be a lot more emotions. The way that females interact with each other is sometimes frustrating to men, I believe. You (women) don't often come directly at it like they (men) do. Women play games and that kind of stuff, I think that just annoys the heck out of men... but I feel that they need to know that's going to happen a lot Someone (a coworker) is going to talk behind your back, she's not going to up to you and say... "I'm really tired of you leaving all this work for the next shift." They're not going to say that. They're going to talk to someone else on their own shift about it. But men, for men it's just like... "Hey! I want you to know that this is upsetting, and it's got to stop." But that isn't how we as women relate.

In addition to lessening the emotionality of the work-place, males are thought to bring a better experience to the care of the male patient.

Drawing on their assets

On the clinical unit, I noted both of Grace's male students for two weeks were assigned men who were, as the students described, "Grumpy." I asked Grace about this assigning male students to these "grumpy" men. Grace told me that often she will assign males to difficult male patients because, in her experience, the male students are often better with these difficult male patients. I asked her if she thought having male students' help with providing more individualized care to the male patient. She replied:

Sure they do. When I have Hispanic patients – male or female – if I have a nurse of Hispanic background, I will ask the student, "How do you feel about caring for this

patient? Would you mind?" Sometimes I just go ahead and assign them because there is a cultural match there, not always. There may be a language match that will help that patient with their hospitalization because they have somebody who can speak to them in a language they know better than English. I look to match people up where I can. Up at St. Rita's, we used to get a lot of old ladies in the wintertime and they all spoke some Slavic language. We had a nursing instructor who spoke Romanian or a Chek/Slavic dialect – she spoke Yiddish. And, so...she was the darling of the nursing staff because she could make up posters that had words on with English equivalent. It just made the care of these elder women so much better. She could go in and explain the procedure in a dialect they knew or the words were kind of similar. Where you can do that, I think that's great and you don't have to use that interpreter.

Hope expressed that she will try to capitalize on the fact that men may bring something to a male patient's hospitalization that women cannot. During observation session #2 with Hope, it was noted that one of her male students was assigned to a male patient, who really did not have many skills or procedures involved with his care. The patient, however, had many emotional needs due to an uncertain diagnosis. Hope had specifically assigned a male to this patient case. She explained:

I thought maybe the student nurse and the patient might have something in common. Maybe they fish, maybe he knows about automobiles. I wanted to use some diversional activity to get the guy off his mind and off his situation. I thought that my male nurse...and I purposefully did this... although I'm sure a female could do it...I purposely did it because I was going without even knowing the patient, but knowing the student well from the week before, thinking now, this might be a nice link. It will give me

an opportunity to watch Sam, to see how he does and maybe there'll be something that the two of them have a communal male bond about.

I just felt that he might bring to the table a refreshing change for my patient who was in reverse isolation and going through all those issues with an inconclusive diagnosis. Being surrounded by women, let's give it a shot here. Let's expose this to something a little different.

Men change the dynamic of the nurse-patient relationship for male patients. Males bring another element of diversity to the nurse workforce.

Emphasis the Student/Instructor Relationship is Professional

There is an emphasis on the professional relationship between the instructor and the student. This came across in two ways; 1) the language used when addressing the male student, and 2) instructors expressing concern during the interviews of wanting to assure the relationships are not misconstrued by the male nurse as friendships/romantic interests.

Language

The use of the word "Sir," or using the male's first name, when addressing males was noted during many of the observations between students and instructors. Instructors were asked what this term meant to them, and they replied they use it as a term of respect. The use of the words "dear," "honey" and "girl" were used when referring to the female students. Instructors stated they called men "Sir" because they did not want to be inappropriate with the male. For Caitlyn, the use of "Sir" is to reciprocate the respect which is given to her as her students call her by her last name. Kelly states, the use of the word "Sir" for men and "Girls" for women was attributed more to characteristics associated with age. For young females, she sees them as more "girl like" and therefore has a tendency to call them "girls" or "dear" because they have a

tendency to become intimidated if she is too professional. Men, on the other hand, are typically older, well into their 20's, so she does not think of the men as being as easily intimidated by her, therefore she finds it somewhat easier to address men by a more professional term. She stated:

They (females) still seem very young and immature, and not very sure of themselves, and those are the students who I think become intimidated very easy. ... I don't think of them (men) as boys in particular, male students are men. Most of the ones that come to my mind are not 18 years old, right out of high school. Most of the male students we have had, have been well into their 20's, if not older.

In another example, Daisy was observed using the word "Sir" in different ways when speaking to her male students. In some cases she would use "Sir" to get a male's attention; in another instance, she was reprimanding a student. She used the word "honey" to get the attention of her female students. Daisy was asked about the meanings of these words when reprimanding a male student. She explained:

I was getting angry, almost kind of like, Mister. You know.... Kind of, who do you think you are sir? It's a very pointed word....I don't know. I was angry. Sir has a negative connotation for males, in that instance. But it has a very respectful yes or no sir to my elders; to someone that you know in authority, to a military person is very respectful as well. I think it's how I use it.

The term in which an instructor uses to address their student was noted during other observations and emerged during other interviews. Alison and Grace stated that one of the advantages a male may have in the instructor/student relationship is the instructor's remembering the male student's name, even after they are no longer their student. This, Grace stated is what she feels is an advantage. She explained:

Well, it's unfortunate because I think that ... I mean, I'll remember Tim's name after I get all of them through Psych and we get to graduation, I'll remember Joe and Sam and Jeff. I'll remember their names. I will stand there and I will remember the clinical performance of each one of those female students. I can see them on clinical. But darn, if I can remember their names.

Another way in which instructors maintained a professional relationship was through monitoring their body language with the student.

Personal distance

Instructors in this study were careful to maintain a personal distance from the student, which allowed them to hear what the student was saying and communicate, but not so close that the student would think that the relationship was personal in any way. Hope articulated what the meaning of her interactions was with her male students as far as this maintaining of personal distance. Her reply was that she did not want the student to misinterpret the relationship between him and her. She wanted to make sure the student knew the relationship was professional. Hope used the word "reserved" when discussing her relationship with her male students. She explained:

I am number one, not their friend; I'm their instructor, and I want to make sure that everybody, including them, knows that is our relationship. Did you catch that Josh touched me a couple times today? That happened at least twice. I have never ever said anything about it. I think it's a gesture and I'm not sure why. I wish you had noticed it. I want to be absolutely sure that I am giving the right impression that this is....I guess I never really thought about it, but this is a professional interaction and we can have fun, but this is not the moment that we're going to have fun. We might laugh and we might

have some fun during post conference, but boy in front of that patient, I'm pretty much according to the booklet.

Alison, as well, recognizes the need for personal space. She also keeps an appropriate distance between herself and her male students. Although she likes to joke, she also maintains a "matter-of-factness" sarcasm to her joking with males. Furthermore, Alison, has had to counsel male students in the past regarding professional behavior and personal space. She recalls an experience when a male student was consistently invading her personal space. Her way of dealing with this was to address it directly with the student.

I had a student two years ago, male. Big guy, bodybuilder, who did not seem to have a concept of personal space or honoring another person's personal space and I thought, "is this my imagination or is it because he's a guy." So I paid attention to it for a little while and then I had to pull him aside. I said "Look, I don't think I'm the first person who's ever said this to you so I'm going to be blunt. Your body language, especially with a woman, especially with a woman who is shorter, smaller, not as strong, it is intimidating." He said "You're right, this is not the first time I'm hearing this." Because I knew it was not my imagination and I said "You need to leave more space between yourself and women, especially those who are shorter." and he's like "Okay." I said, "This will stay between you and me. I will not say anything to anybody else.

Alison needed to, in a non-threatening way, approach this gentleman about his behavior because she knew, as a professional, his body language could be misconstrued by some of the females.

It's All About Gender

This theme speaks to an issue that crept up during interviews with instructors. It is reflective of the oppression many of these female nursing instructors have endured throughout

their lives as a consequence of their gender. They articulate the feelings of not being as valued or as privileged as males. It is something they expressed, not as much when they think of socializing men to the profession, but rather when they interact with men in general. For example, Jillian recognized this at one point when a male challenged her in front of a classroom of students. She stated:

I was telling the whole class, which was like 100 and some people ... awareness that we need to welcome people into the profession so that they stay. And, one student, a male student ... Sitting in the very back row, raised his hand and said: "Well, how come ... I'm not really seeing that on a personal level? How come when I'm working out there I'm not seeing people being very welcoming?" And I said... "Well I, I agree with you that's it's not where we want to be, yet. I'll agree it's not where we want to be, yet, I agree there's work to be done, but I also believe that we are trying to, we're coming, it's just in the fact that we're raising awareness, that's a step in itself." I was trying to say that to him, and ... I felt challenged by him and I don't know, I thought it was because of his gender, I don't think I don't think I would have taken it quite as personally if it would have been a female that did it. I don't know why that is exactly. But I felt maybe challenged by him because he was a minority, so to speak. Not a minority in his race, but a minority in his gender, coming into a female-dominated type of profession and he was really challenging the way that we behave, and I sort of took that personally as a female. And I took that very personally; I don't think I would have internalized it as much if it would have been a female saying it to me. I think I was put back into the role of the oppressed, somehow. I guess that's a throwback to the earlier days, when nursing was mostly women and physicians, and the people in authority were mostly men. It came

back to that with me, and I don't know why. I can't even explain to you, but it did; maybe it is my own upbringing, as far as being from a more male dominant/ female culture myself..... It put me back into that male-dominant situation again. ... on, on we ended up ... I don't want to say bonding with me, but we ended up working together at another point in time and ... whatever it was that was that day touched him as well, and he felt the need to ... verbalize that. I've never felt challenged on the clinical area in front of a patient by a male student.

Daisy, as well, recalled encounters when male physicians did not regard her assessments as valuable to the management of a patient. She felt that this had to do with her gender, because the male physician behaved the same way toward a female physician. She recalls a time in which she called a code on a patient, and a male resident came into the room annoyed a code had been called when he did not think it should have been called. She recalled:

Daisy: His look, his body mannerisms. And when I said, "I did," he looked at me like...."Well, who are you?" "I'm nursing faculty." "Oh." You know, it was very condescending, like "you don't count. You're not a doctor. Why did you call them?"

Rita: But this person's physician was a female?

Daisy: Yes.

Rita: So, she came in....did he have the same attitude with her?

Daisy: He did until she it was kind of obvious to me also that he really didn't have a lot of experience with sickle cell and acute chest syndrome and crisis. And, Um....she came in and she was like, "Holy smokes – we need to do this, we need to do that, get an ABG, make sure of his type and cross, we need to transfuse him immediately." She

recognized it for what it was. Once she started talking to him and she even said, “It’s acute chest syndrome.”

Additionally, Alison had expressed coming from a background in which her brothers had privileges she did not because of her gender:

When I was growing up, I experienced gender bias and that was from mostly my father but, I’d have to say my mother also, because they had a very cohesive front as parents when it came to dealing with the kids. I was the oldest, and I was treated differently because I was female. They had different expectations for me than they did my brothers. My curfews were earlier. I had more restrictions. I would say...”Why? Why is it that I have to come in at 11:00, but Henry can stay out until 1:00?” My father would reply: “Because you’re a girl.” ...and I’d say: “Well that blows, it’s not a good enough answer.”... I would go to my mother and say: “Mom, I mean come on.” She’s like “It is what it is, Alison. You know, he wants you in by 11:00, I want you in by 11:00.”... That’s probably why I try to ignore the gender and treat everybody the same as much as possible, I see gender bias as a negative. There might be positives to gender bias that I don’t see or recognize, but I see it as a negative because in my own personal life, I experienced it as a negative ... whatever it was, was because you’re a girl.

Conclusion

This chapter provided the findings from observing instructors on the clinical setting and performing interviews. It can be said from the data that instructors do realize that the gender of a student does not go unrecognized, and there are certain issues instructors have learned to be alert for, such as the interference of females. The instructors in this study value the male presence not only because of the perceived effect it has on the status of the profession, but also the positive

impact it has on the care of male patients. In addition, instructors expressed the need to come to terms with how being female has affected them when dealing with male students.

Chapter 6

DISCUSSION AND CONCLUSION

The purpose of this study was to examine the symbolic nature of the socialization process of males to the nursing profession. The study explored the interactions between female faculty and male students with particular emphasis on the socialization process to the registered nurse role. The significance of this study was important to the field of adult education, with an emphasis on nursing education. Ellis, Meeker & Hyde (2006) stated, "Nursing school is the first place men are likely to experience nursing in the professional sense and serves as the first route to socialize new nurses into the profession" (pg. 523).

The theoretical framework chosen to inform and guide the study was symbolic interactionism (SI) from the field of social psychology. Studies done with SI and occupations identify when learning a professional role, it is important the individual become socialized into the norms of the profession (Shaffir & Pawluch, 2003). In nursing, the professional role is learned primarily during the student's clinical experience. It is the responsibility of the clinical instructor to facilitate the socialization process.

In the SI perspective, individuals come to know and create a self-identity, gender being part of this identity, via their interactions with others. In the studies using SI when applied to occupations, individuals "act out" self-identification, through engaging in work (Shaffir & Pawluch, 2003). West and Zimmerman (1987) use SI to explain how individuals "do gender" in their everyday interactions as part of one's identity. Gender comes to be one element that expectations of one another are created. Some professions, nursing being one example, have come to be identified with the female gender.

The first half of this discussion will link the research findings back to what is known regarding men in female-dominated professions from the review of the literature. The purpose of this is to examine if there are similarities between what men in nursing have expressed, and what was found in this study when socializing men to the profession. The discussion will then analyze the research findings in light of the three premises of symbolic interaction as described by Blumer's Chicago school of SI. This better describes how the use of observations and interviews unearthed symbols within the instructor/student interaction giving meaning to the socialization of males. This chapter will conclude with implications for practice, limitations to the study, and suggestions for future research.

Discussion of Findings Related to Nursing Literature

This study produced findings indicating the socialization process of males into the nursing profession is affected to some degree by gender. Instructors expressed issues specific to male nurses while socializing them to the nursing profession. Many of the themes that emerged from the findings were reflective of issues that emerged from the literature on males in female-dominated professions. This next section will discuss the various topics that emerged from the findings as they relate to what is found in the literature on men in female professions, particularly the nursing literature.

Role strain

Role strain arises when males try to manage multiple demands as well as deal with issues of being a male in a female profession. The specific areas of nursing that cause more role strain for the male nurse are having their sexual orientation questioned, having their masculinity questioned, using touch in appropriate ways that do not get misinterpreted, feeling isolated when providing care to females, and by others drawing attention to the fact they are male (Callister,

Hobbins-Garbett & Coverston, 2000; Evans 2002; Evans & Blye, 2003; Fister, 2000; Kelly, Shoemaker & Steele, 1996; Soerlie, Talseth & Norberg, 1997). It is unknown if the instructors realized it or not, but there were many examples in the findings that demonstrate instructors' awareness, on some level, of these issues of role strain experienced by the male student. This awareness emerged during the interviews when instructors were asked about some of the behaviors that were observed, as well as general questions regarding socializing men to the profession. An example of instructors demonstrating a sensitivity to the role strain felt by males was when Daisy specifically stated she will refrain from using the term "male" when referring to the male student. When Daisy performs this behavior, she is trying to treat the male as no different from the rest of the staff. She is trying to demonstrate support for the male student by trying to balance the needs of the student with the patient's right to refuse a caregiver.

Alison expressed an awareness of role strain faced by male student nurses in her awareness of the stereotypes that male nurses are often thought of as being gay. She was aware that regardless if the student is gay or not, they feel as if their sexual orientation is in question every time they enter a patient's room. For her, the use of openly discussing with the male how to deal with these situations has been effective in providing support to the male in dealing with role strain related to his sexual orientation being questioned.

Male friendliness

"Male friendly" was one term used throughout the literature describing an education setting that addresses the barriers of the male student nurse (O'Lynn, 2004). Examples of "male friendly" environments include those that do not assume the nurse is female, have male instructors or role models, and support and address the special needs of the male when providing

personal care (Brady & Sherrod, 2003; O'Lynn, 2004). The instructors in this study demonstrated many qualities emulating male friendly behaviors.

For the vast majority of the instructors, male friendliness was articulated through the awareness and value placed on having male nurses become role models for their male students. Alison was particularly driven on finding role models for men interested in pursuing a career in care of women during childbirth. She demonstrates male friendliness by anticipating that males may be told certain areas are “off limits” to them because of their gender, and will take the time to arrange male mentors for the male student if requested.

Helen, who works in an area that has been addressed in the literature as particularly challenging for the male nurse, advocates for males students by educating the staff in the maternal-child area. Helen needed to educate female staff nurses that the care of women in the maternal-child area can be done as effectively by a male or female nurse. Using the example of male physicians who are obstetricians has been a useful argument for the appropriateness of male student nurses in the care of women during and after childbirth.

The literature states that males reported the importance of having an instructor who refers to them as a nurse and not a “male nurse” (Patterson & Morin, 2002). This behavior was articulated by Daisy, who instead of using the wording “your student is a male” instead opts for saying a male’s name. In this way she is not drawing specific attention to the student’s gender, creating an environment reflective of male friendliness.

Recalling that in the forming of work-identity, the reproduction of appropriate behaviors, customs, rules and rituals are transferred via socialization (Shaffir & Pawluch, 2003). It is the nursing instructor who is charged with the process of socialization to the nurse’s role. When dealing with the male student, these instructors sought out the assistance of male nurses.

Teaching a male the behaviors associated with nursing was not the area in which instructors felt men were lacking. Instructors felt that the ability to empathize with the male, to really understand what it is like to be “the other” in a world full of women, was where they sensed they were lacking. They articulated that other males in the profession should aid in the male students’ adjustment to the nursing role.

Fear of demasculinizing

Instructors demonstrated and expressed concern regarding the demasculinization of male student nurses. The profession of nursing has long been associated with the “art” of caring, referring to an extension of the women’s role as described by Nightingale (1859/1991). As a consequence, the work itself is considered feminine; therefore, men who enter the profession are at risk of being considered less manly or demasculinized. In addition, men’s undertaking a role traditionally occupied by women calls into question their sexuality and ability to be successful in other fields occupied by men (Callister, Hobbin-Garbett & Coverston, 2000; Evans, 2002; Evans & Blye, 2003; Fister, 2000; Kelly, Shoemaker, & Steele, 1996; Soerlie, Talseth & Norberg, 1997).

For the instructors, this feminization of the field poses somewhat of a challenge when socializing men. For instructors, there is a need to renegotiate within themselves how gender impacts the work of the nurse. For instance, the word nursing, has a feminine quality. For the instructors in this study, socializing men to the profession is introducing them to a new way of thinking and behaving in ways associated with femininity. The instructors are aware of men’s need to break certain rules they have learned while being socialized to their gender role, in order to become a nurse.

Dealing with emotions was one area male students where thought to need extra support from the instructor. Men come into the profession having learned that public displays of emotion, such as crying, are a form of weakness. Jillian expressed a need to teach men that some of these social rules need to be broken. She expressed that she needs to teach men that it is okay to cry. For Jillian, her male students express they are less of a man if they allow another person see them cry. Jillian needs to let the male student know that it is okay to display sadness by crying. However, this also calls into question how do nursing instructors define caring? Is it truly necessary to display caring in ways considered feminine in order to be successful in the field?

Through their interactions with male students, these instructors needed to allow males to express their fears of breaking these socially constructed rules regarding masculinity. The instructors communicated the need to give the male students time to express their feelings about breaking these rules. Nursing instructors' challenge is to let the student know it is okay to break these rules regarding masculinity. Therefore, the instructors in this study needed to provide a safe place for the male to express his feelings. The instructors, in this way, act as a counselor or mentor for the male rather than as an instructor. For Hope, by using the analogy of separating the white and yellow of an egg, she was trying to describe this process. As Hope expressed, she did not want to break the male student. She felt there is a need to be very careful not to demasculinize the male. Areas instructors felt that there was potential to demasculinize the male were found in teaching the emotional side, or "softer side," of nursing.

Teaching Men the Softer Side of Nursing

Recalling feminization of nursing as being one of the causes of role strain for the male student nurse (O'Lynn, 2004), contributing to men being considered the "other" and lacking some of the feminine qualities women naturally possess, instructors focused on teaching males

the softer side of nursing. The “softer side” was the more intuitive aspects of caring for another. Women who socialize men to the profession presume men need to learn the “softer side” of the profession, and that it comes to males more difficultly than females.

The symbols that expressed the instructor’s perception of nursing related to this softer side emerged in observing the instructors’ role modeling for the male student. Instructors had a strong emphasis on role modeling as a socialization method. The qualities instructors chose to role model were intriguing. The technical skills were not modeled as much as providing holistic care, and/or what was referred to as the “softer” side of the profession. The softer side of nursing was what was referred to as the caring, listening, and the psychosocial elements. Or, as Hope stated being able to “fluff and puff.” When interviewed, these were the same qualities that instructors associated with nursing. The modeling of these traits was seen to be of importance when socializing men to nursing. In this way, instructors were acting on what they perceived as characteristics men lack. The instructors are coming from a perception that nurses have an intuitive ability. They perceive men to be lacking in this, and feel that it is essential for men to learn. This is part of men being perceived as “the other.”

Teaching Men the Use of Touch

Nursing is considered a “high touch” profession. When a nurse takes care of a patient, it is necessary that he or she touch the patient. In addition, nurses use touch in order to show they care; for example, holding a patient’s hand during a painful procedure or when they are afraid. For most of the instructors, they recognize that for both men and women the student will have elements of discomfort and very possibly, fear. When socializing the male to the clinical setting, the aspect of how to deal with the special fears men may have, when on clinical, related to touch, was something to which each instructor seemed very sensitive.

The literature on men in nursing states that men struggle with issues related to the use of touch. Specifically, men have feelings of isolation and challenge when providing personal care, especially to female patients (Evans & Blye, 2003; Kelly, Shoemaker, Steel 1996; Milligan, 2001; Paterson, Tschikota, Crawford et. al, 1991). When socializing men to the profession, female instructors expressed a degree of discomfort with men doing personal care. Instructors learned strategies for helping themselves deal with their own feelings of discomfort. Jillian recognized that she may feel uncomfortable with men providing care to women. A strategy she uses is to record the gender of each patient to whom she assigns a male student, so that she is sure she is not unconsciously assigning only male patients to male students. Another instructor strategy when a male student is providing personal care is to be available, not to do for, but to simply be a female presence for reassurance. Having a female present for the male while he is doing personal care was seen as a way to alleviate some of the nervousness instructors felt men have when providing personal care. Caitlyn communicated she will often try to dialogue with the male student regarding his feelings after he provides personal care. What instructors are acting on is an underlying notion that teaching men to care for women and provide personal care is different when socializing men to the nurses role. This is not to imply that female instructors expect more or less in the way of performance from male students. Instructors do, however, have more feelings of discomfort when their male students are providing care to female patients.

The instructors recognized their own limitations as women in being able to fully understand the experience of being a male nurse caring for female patients in personal ways. Because of their recognition of their own limitations as women, they viewed male role models as valuable to the socialization of men to the profession. The instructors in this study recognized this to be a challenge, because it is a role they cannot fill as women.

For Daisy, other male nurses are essential not simply because they understand how the male student nurse might be feeling, but also in teaching them how to deal with some of the issues of rejection by females, as well as some of the stereotypes surrounding male nurses. Male nurses, therefore, are seen to be a kind of support network for the male student nurses in learning the unwritten rules that emerge due to gender. Females may not be aware of some of the hidden curriculum and how they impact the nurse. Unwritten rules are rules regarding behavior that are assumed. The male may not be aware of some of these rules because they are not part of the dominant gender group, which adds to males being considered “the other” when coming into the profession.

Awareness of Male Privilege

Privilege emerged as a recurrent theme within empirical studies of male nurses. Stott (2003) reported that male students felt they were less likely to receive disciplinary action from their female nursing instructors while in nursing school when mistakes were made on the clinical unit. Mirroring these findings, Evans and Blye (2003) also found that the amount and quality of work expected from male nurses was not the same as it was for female nurses. Male nurses reported women would step in and do much of the hands-on care while encouraging men to take positions of leadership (Stott, 2003). In addition, the literature reported the better treatment of male nurses by physicians and other members of the health-care team as a reason why men tend to rise to leadership positions (Evans & Blye, 2003). In reviewing the literature, it was noted that males, when entering female-dominated professions, whether nursing or other types, enjoy a certain degree of privilege in terms of females promoting them to positions of leadership, with females taking on more of the hands-on care, or less censure by instructors (Evans & Blye, 2003; Ellis, Meeker & Hyde, 2006; Stott, 2003). Therefore, there may be a connection between the

ingrained social structures that provide men with the expectation that they will take on leadership roles.

Viewing the findings from the aspect of male privilege, it is noted that female nursing instructors did not use the word “privilege” when discussing male socialization to the profession. Kelly, however stated, “I think men tend to get by on charm.” This attribute of “getting by on charm” could be interpreted as the underlying concern the instructors in this study had about a male student’s ability to accomplish the clinical objectives without the interference of females present on the clinical area. As stated in the findings, female nursing staff would covertly and overtly interfere with the male student’s clinical experience. Covert interference occurred when female nurses would innocently step in and do for the male student, either by performing basic homemaker skills or trying to rescue the male when he floundered on the clinical unit. This type of behavior on the part of females who surround the male while on the clinical nursing unit is reflected in the nursing literature. The nursing instructors felt the need to be aware of these behaviors from females and protect the male from this type of interference.

The instructors expressed a need to be vigilant of females doing too much or being too protective of the male student. They strove to keep the expectations the same, regardless of gender. Kelly was aware of men being “rescued” by female nurses on the clinical area, and found it necessary to intervene at times. She found that, at times, her male students were enjoying an abundance of assistance from female nurses. This led to her having difficulty with being able to evaluate whether the student met the clinical objectives. As the instructor, she needed to intervene when females helping turned into interference with the learning experience for the male. Therefore, these instructors act to protect the integrity of the clinical experience for the

male student to assure the male is having an authentic experience in patient care, and not being pushed aside by the female nurses.

Discussion of Other Findings

To this point the discussion has entailed relating the findings of the study to what has been previously discussed in the empirical literature. On reviewing the findings, there were other themes that emerged not relating directly back to the empirical data yet are worthy of further discussion. In this next section, these are discussed.

Men as “The Other”

As the interviews progressed during this study, the men started to be referred to as “the other.” This means that in nursing, men are not in the majority. They are, as Jillian stated, the “puppies in a house full of cats.” Women are established in the profession. Men coming into the profession are considered to be very different from the women because of their gender. These differences between men and women were felt to lie mostly in communication skills, as well as the ability to use the intuitive senses. The males were seen to bring strength and respect the profession is currently lacking. So therefore, females see value in the cultural capital that men’s gender brings to the profession.

As stated in the last section, gender’s impact on socialization of the male to the profession had little to do with learning the skills of the job. The impact of gender was felt more in teaching interpersonal communication. Instructors felt there was a need to prepare the male nursing student for differences between men and women in the work environment. Instructors viewed male students as unknowing regarding the catty, and at times dysfunctional, behavior of women. Cattiness was expressed several times by several different people as the way that women communicate with one another. This means dealing with conflict through indirect communication

with those whom one is having a conflict. Men were thought to have more direct communication. That is, if they are having an issue with another person, they go to that person and speak to them directly. Instructors felt the need to prepare the male student for these differences in communication styles between men and women. As Daisy and Jillian expressed, women often will not state the issue or problem they are having with a coworker, and/or they become emotionally tied to the event. Instead, they express their feelings of frustration to a third party and internalize it for a long period of time. Men were thought to have a more direct style when communicating, in that they address problems and forget about them, which is another reason for men to be considered “the other.” Instructors felt the need to prepare men for this difference when coming into a female profession. Recognizing this trait in women required the instructors to admit to, perhaps, a negative aspect of their own gender. For the women in this study, part of socializing men to the profession was recognizing the positives and negatives of each gender’s communication styles.

In assisting the males to deal with this, instructors dialogued with students regarding how men have handled this in the past. The instructors acknowledged this negative behavior of women with their male students. The instructors had hopes that the inclusion of more men in the profession will help to socialize women in the profession to better handle conflict. However, instructors felt men also could benefit from learning teamwork from women.

Teaching Men to be Part of a Team

The instructors expressed a need for men to temper some masculine personality characteristics. Independence was mentioned as one of the characteristics of men that interferes with their ability to effectively socialize into the nurse’s role. Independence of males was expressed as their tendency to make decisions and carry out a plan without the assistance of

another. Although this may sound stereotypical, the instructors expressed concern with the independence and self-assurance with which men behave. The instructors expressed that at times, some of this self confidence needed to be tempered, because instructors are afraid the independence could lead to males not asking for assistance or direction when they should. Hope was attuned to the tendency of men to be independent. Within her influence, Hope role-modeled how to ask for directions and assistance. Helen, as well, expressed that men have a tendency to be too “cocksure of themselves,” which has, at times, interfered with her ability to engage with them in the clinical setting. Helen expressed some frustration with males’ independence because, at times, they have not been receptive to her guidance in meeting their clinical objectives. Her approach to this is to allow the male to reflect on how his independence did not work to his advantage in allowing situations to play out, keeping in mind patient safety.

Grace expressed this independence as the difference between the way men and women work. Grace felt that women work more collaboratively together, but men work more independently. The instructors understood that males coming into the profession would have to shed some of these “masculine” ways in order to be successful in the profession. Hope expressed men need to learn to rely on others. Hope shares Grace’s view that men sometimes have difficulty working in a collaborative setting where everyone comes with the same skill set, however the work is shared. Hope characterized nursing as a “wonderful profession,” but feared that men may struggle with needing to shed some of their independence in order to be successful in the profession. To restate what Grace had said previously: “Everyone shows up with their own box of tools.” This independence can lead to them not listening, and perhaps not receiving messages sent from the instructor.

Protecting the Male from Negative Experiences

The female instructors in this study did show some elements of wanting to protect their male students from negative experiences. A negative experience is when something occurs on the clinical area that makes the student feel bad about himself or unwanted; first and foremost, negative experiences as a result of being rejected by a female patient. The second negative experience is found in the male being questioned as to whether he is gay. Instructors found a number of strategies to balance the knowledge that a patient can refuse to allow a male student to participate in their care. However, it is interesting to note they were much more tolerant and understanding of a female's refusal than they seemed to be of the homophobic patient.

Instructors' behaviors while in the presence of the patient and student were influenced by a male student's gender; specifically, instructors have learned a set of strategies when dealing with patients to not draw attention to the fact that the student is a male, yet do not deny it, either. This was to prevent the student from being rejected by a patient. The instructors in this study were heavily informed by past experiences dealing with male students and patients. The influence of gender on the decision to assign or not to assign a male student to a female patient may be more influenced by the instructors' own sense of uneasiness than anything else. This was demonstrated by Helen, who articulated that she does not feel comfortable assigning a male student to a female patient who was a victim of sexual abuse, emphasizing an element of men caring for women that is a taboo in her area, specifically in the care of women.

There were no strategies to protect males from the homophobic patient. For Kelly, as discussed in the findings, her way of dealing with male patients who are homophobic and do not want a male student because he may be gay, is to stand firm, unless the patient becomes abusive. Alison expressed an awareness that men might be asked if they are gay, and takes a more

proactive approach. For Alison, the use of discussion with the student related to what types of questions he does and does not have to answer is how she assists him. Regardless of the strategy used, the instructors expressed an awareness of negative experiences that may occur to the male student. They all tried to anticipate and be supportive of the male student if, and when, this occurred. In addition, they used strategies to help deflect unnecessary attention from the male students' gender when on the clinical area by attempting to be gender-blind.

Trying to be "Gender-Blind"

Instructors often were aware of how they felt oppressed at times in their life because of gender. Many expressed a knowledge that the perception of male dominance, and female oppression, has, at times, carried over into their education practice. Alison expressed a desire of equality, and, therefore, tried to remain vigilant that she was treating men the same as women. Alison expressed that she tried to treat everyone the same because she remembers how hurt she had been when being treated differently, and held to different standards because she was a girl. However, at some points equality struggled with equity. In other words, equality is treating every student exactly the same way. Although the "gender blindness" on the surface may seem optimal, these instructors gave many examples of how being gender-blind may not be in the students', or the patients', best interest. For example, Helen, assigning a male student to a woman who was bottle-feeding, took into account the issues the male student was having with providing personal touch. When the student came back from smoking a cigarette, Grace could have disciplined him for breaking the rule of leaving the clinical unit, but she recognized that the male needed to break even a bigger rule in order to become a nurse (see Chapter 5).

These instructors recognized that treating every student exactly the same way would ignore the unique abilities each of them brings to the patient care situation. Symbolically, this

comes across when instructors assign men to male patients. They recognize that providing care to an individual is much more than simply performing skills; there is a connection between the patient and nurse, where both individuals bring what they are to the relationships. For male patients, male nurses were thought to bring an element of brotherhood or common interests to the relationship. The instructors recognized diversity brings with it differences that need to be celebrated, and not suppressed trying to achieve equality. Another form of achieving appropriate behavior on the clinical is also found in setting boundaries.

Setting Professional Boundaries

Professional behavior, in terms of male-female relationships and the awareness of sexual harassment, was played out within interactions. Instructors were aware that the student was a male, and there was a chance that interactions could be misconstrued as flirting or sexual advances. Instructors are cautious in assuring the relationship between them and the male student remains professional at all times. The concern is that the student does not think the instructor is a friend, or that they may be considered a romantic interest of the instructor. The use of language in terms of addressing students ties in with the manner instructors use to build a relationship with the male student. There is a focus on maintaining a professional distance with the student, not just in language, but in non-verbal communication as well.

This was felt to be an issue for both the instructor and the student. Alison was aware that men could be accused of harassment, and counseled her male student on this issue. In addition, instructors such as Hope and Kelly, took precautions that their behaviors were not misinterpreted by the male students. In all of these instances, the overarching theme is that the instructors value the professionalism of the relationship, and do not wish to cause confusion with the male student

nurse. They are careful with language and non-verbal communication when dealing with members of the opposite sex.

By looking at the information gleaned from the findings and comparing it to the literature on men in nursing, the instructors in this study were aware on some level of the needs of the male student. The next section will look at the findings and analyze them in relation to symbolic interactionism.

Symbolic Interactionism

The theoretical framework used for this study was Symbolic Interactionism (SI). SI can be understood as having three basic premises that focus on meaning, language and thought, as described by Herbert Blumer:

The first premise is that human beings act toward things on the basis of the meaning that the things have for them. Such things include everything that the human being may note in his world. ... The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters (Blumer, 1969, p.2).

The main belief of SI is that people attach symbolic meaning to objects, behaviors and other people (Blumer, 1969; Howard & Hollander, 1997; Stryker, 1980). Using Blumer's premises of SI as a framework, there is a connection between the gender of a student and the way the instructors socialize the male to the profession. The image that is formed of the nurse changes when the student is male, and the instructor needs to determine what issues the male might need assistance with due to his gender. Building on the work of George H. Mead, SI does not focus simply on one element within society, but rather how individuals interact with one another and,

more importantly, dialogue with themselves in order to analyze and interpret the behaviors of others.

SI has been used in the study of occupations to describe how work-identity, customs, traditions, appropriate behaviors and rules are transferred (Shaffir & Pawluch, 2003). Many of these rules and traditions of the profession, particularly the interactions between the nurse and patient when doing hands-on care, have been formed from the tradition (and assumption) that the nurse is a female. For the female instructor, the feminine nature of the work is recognized when they are presented with a male student.

Although it seems obvious, Blumer's theory spoke to the meanings in which individuals have for the objects and people in which the individual is surrounded. For this analysis, I will address meanings that instructors have regarding the nursing profession, the meaning of nursing and how these meanings impact the socialization of men to the profession. The meaning of nursing for the instructors in this study was articulated during the interviews when the instructors were asked "What qualities symbolize nursing, in your mind?" There were many qualities stated; however, the emotional side of the work was what was mentioned most. Caring for another human is not considered simply meeting the physical needs of the patient. Caring was considered as also meeting the emotional needs. This emotional tie to the patient was viewed as important to the nurse's role. For the male student, teaching them to care for the patient in ways other than just the physical needs was valued and mentioned frequently in the conversational interviews. In socializing males to the profession, instructors acted on this value, for example asking a male to care for a male patient. Instructors felt it enhanced the care of male patients in terms of care being provided by an individual who shared the common trait of masculinity.

Blumer states that individuals will act on things based on the meaning those things have for them (first premise), meaning individuals act according to their perceptions and values. The instructors felt that men do not have the same ability to meet emotional needs, or to have the intuitive sense that females possess. From this meaning, lacking intuition and being able to meet emotional needs, the instructors behave in ways intended to teach the males these characteristics. For the instructors, the qualities of caring, compassion, competency, advocacy and the provision of holistic nursing care were concepts demonstrated and verbalized as the important behaviors to role-model for the male student nurse. Throughout the observations, the instructors were seen interacting with the patient, in the presence of the male student, in caring and nurturing ways. The instructors expressed this was to role-model caring for the male student.

Instructors in the study were concerned, above all else, that men coming into profession learn to care for an individual beyond the physical aspects. Role modeling as a teaching method maybe unrelated to gender. However, when looking closely at what was role-modeled, for the males in this study, all behaviors had to do with the emotional or intuitive aspects of care. Tasks and skills, although mentioned, were not the main focus of role modeling for the male student. Instructors expressed behaviors such as communication with patients, including non-verbal aspects, as especially important for the male student. This could be interpreted as the female instructors' attempt to infuse "femaleness" into the male's care-giving through role-modeling female behaviors, recalling feminization of nursing (O'Lynn, 2004) as being one of the frustrations men have mentioned when being socialized into the profession. Perhaps the frustration is not from an assumption that the nurse is female, but rather the males' struggle with adopting the feminine behaviors associated with caring. The need to teach males these "female" traits arose out of past experiences when dealing with male students. These experiences with

male students formed the instructor's perception regarding what men need to learn. The more experienced instructors were much more attuned to these issues.

Although the instructors valued caring as what they brought to the health-care team, they also expressed frustration that this aspect is not valued by others on the same team, specifically male physicians. In the conversations with instructors, add comma the physician was always assumed to be a man. Most of the instructors viewed men, regardless of whether physician or nurse, as having strength. This ties into Blumer's second premise, wherein he spoke of meaning as being "derived from, or arises out of, the social interaction that one has with one's fellows" (Blumer, 1969, p2). For the instructors in this study, the meaning they had for the male student, or any male, was that of strength and independence, as well as oppression.

Strength. Men were thought to bring strength to the profession by their simple presence. Kelly expressed this when comparing nursing to teaching. She felt that men are changing the way nursing is thought of in the health-care setting. Instructors felt that men bring with them the ability to change the way the profession is viewed by their participation in the field. West and Zimmerman (1987) would refer to this as a way that the instructors, through the value placed on men in the profession, are "doing gender." Whether they realize this phenomenon or not, there is a reproduction of the institutional arrangements based on sex category. In addition, not only are the instructors doing gender, but the male physicians in viewing the profession as less subservient are also doing gender, because they are changing their expectations of the nurse based on sex category.

Gender carries with it certain privileges and expectations. The term "cultural capital" is useful when trying to explain what is symbolically happening within the health-care setting when men are introduced as a nurse, and not as a physician. The status of the profession as a whole is

considered to be elevated. Cultural capital includes the characteristics within society that once possessed, gives an individual more ability to influence and control a situation (Hallett, 2007). For the instructors in this study, men were seen to elevate the profession. In addition, men were seen to have more ability to control their own experience on the clinical area because of their independence.

Independence. The instructors felt that when socializing men to the profession, the males have a tendency to be too independent at times. Not only was this problematic, but symbolically, the instructors' fear that the student would overstep his boundaries was acted out through the amount of time spent with the male student. Jillian spoke about the amount of time spent with her male students:

I don't consciously choose to do it. I don't feel the need to spend more time with them.

But if I make an extra effort, it's because I'm always concerned, and maybe it's my own perception that they won't ask me.

When socializing men to the profession, female instructors expressed concern that males will overstep their role in caring for the patient. They symbolically played out these concerns by checking on the male students, watching what they were doing, and liberally asking questions about the patient's condition.

Oppression. Oppression occurs when one group of individuals exerts power over another group. When socializing men to the field, instructors would be encouraged to participate in some self-reflection to expand awareness of their own feelings toward men in general. Many of the behaviors and feelings expressed by the instructors in this study were formed through past experiences, not only with male students, but men in general. For males coming into nursing, the impression would presumably be that they are the oppressed, because of their minority status.

However, when speaking to the instructors, elements of feeling oppressed emerged, even though they are in the dominant position in the profession. For most of the instructors, this comes from a history of socialization, whereby they were told, “because you are a girl ... that’s why,” into a male-dominated society that is carried into their adult lives. For many of the instructors in this study, there was a need to establish with the male student a position of authority over the male student. For Daisy and Hope, it was getting the male students used to taking direction and feedback from a female.

As previously mentioned, the instructors were heavily informed by past experiences with male students in guiding their interactions with current male students. Instructors create knowledge regarding the socialization process of males through their interactions with male students. In other words, instructors learn from experience the issues, the needs and challenges of bringing men into a profession composed of mostly women. This directly relates to the second premise of SI, in which meanings that instructors have formed when socializing men to the profession arise from past experience. Remembering that Blumer was influenced by the work of Mead, who spoke to the “I” and the “me” involved within social exchanges, provides an explanation as to what guides behavior and how our constructed images from past experiences are acted out in current situations.

The “I,” therefore, becomes the active part of the self, whereas the “me” is more reflective in nature. When observed, the “I” of the instructor was noted in the observations of the researcher. The “me” of the instructor was captured in the conversational interviews. In these interviews, the instructors articulated the need to role-model, not because of something they had learned sitting in a classroom discussing theoretical approaches toward teaching nursing students, but via the interchanges they had had with male nursing students throughout their

careers. Instructors have learned the needs of the male not by what they have been told, but rather by what they have experienced. This may explain why the individual who had the least amount of insights as to how gender influences the socialization of males to the profession was Caitlyn, who had been a nurse as well as a nursing instructor for fewer years than any other instructor. Instructors who had been teaching the longest, Hope and Grace, expressed more insight and experiences in the clinical setting as a result of students' gender.

Using the knowledge generated from past interactions, gender became an apparent element in instructor/student interaction, but not necessarily in a negative manner. The instructors in this study used gender as a way to assure patient assignments that were equitable, in spite of not always being equal. Equal assignments require each student to get exactly the same experience. Equitable assignments allow for some flexibility, where instructors make an assignment based on course objectives as well as individual characteristics of students. For instance Helen, recognizing the individual needs of the male student, was willing to negotiate the student assignment in light of the student's gender and anxiety, while still holding the male student to the same course standards. Hence, the male still needed to care for post-partum women (equal expectations); however, the instructor provided a learning experience that respected the student's individual needs (equitable).

This emerged as a result of instructors' realization that men, when socializing to the profession, need to break socially defined rules related to masculinity in order to adopt the work-identity of a nurse. For Grace, this was apparent in her approach when dealing with the male student who left the clinical area to smoke a cigarette. She recognized that this man needed to break a very strict rule he learned while in the U.S. Navy in order to be successful in the

profession. The meaning of the action needed to be taken in light of the context from which the student came, instead of a set of clinical rules set forth by the instructor.

Through looking at the interactions and interviewing the nursing instructors, gender is clear the gender of a student impacts the educational experience. The gender of a student leads to certain assumptions by the instructors as to challenges both they and the student will encounter. Gender socialization affects the manner in which individuals see themselves and others. By looking at the interactions and the reflections of female faculty, perhaps the independence men come into the field possessing is really a construct of how women view men. Men, therefore, are thought to be more independence and are encouraged to take on roles that encourage this trait. For example, Psychiatry, ICU and emergency are all areas that, typically, are not only high-tech, but employ a “primary care” model. General medical surgical units employ, at least to some extent, a team orientation to care. This is where nurses work in a collaborative fashion to provide care and responsibilities are shared.

The third premise of Blumer holds that “these meanings are handled in and modified through and interpretative process used by the person in dealing with the things he encounters” (Blumer, 1969, p.2). In other words, the individual will act on the setting based on how he or she interprets the situation. A male presenting himself into a clinical situation changes the behavior of the instructor. This comes across in subtle ways. For the instructors, the recognition of gender’s influence within the clinical setting caused them to institute strategies in order to manage or ameliorate the effect the male student’s gender may have on the student’s experience. As an example, acknowledging one’s own feelings related to a male caring for women was one strategy. For example, instructors stated they fear women rejecting the male student. Jillian, admitted that she may have a tendency to assign male student nurses to male patients; so, in

order to assure she was not subconsciously doing this, she tracked the gender of the patients assigned to her male students. For Daisy, her use of a male's name, instead of saying "male student," to a patient is a way of recognizing a male may be rejected, but not drawing attention to the gender of the student. Kelly, knowing females would step in and do for the male, prevents this by approaching the female nurses in a non-threatening manner and stating they need to let the male do his work.

In addition, when socializing men to the profession, and negotiating within themselves the needs and difficulties men face, instructors expressed difficulty with being able to understand how the male student really felt as a male in a female profession. In SI, this is known as "taking the role of the other," and is the process by which we try to imagine the view or positions of others (Charon, 1995). For the instructors, they acknowledged they have difficulty with this aspect when handling interactions with male students. This can be seen as the reason why so many female instructors look toward male nurses to assist in socializing the male student nurse. The instructors refer to male student as "the other," and realize as women, they lack the ability to truly empathize with their male students.

Implications of the Study

Adult education literature states the adult learner is affected by their positionality, both in and outside the academic setting (Brown, Cervero, Johnson-Baily, 2000; Johnson-Baily & Cervero, 1998; Merriam, Johnson-Baily, Ming-Yee, Kee, Ntseane & Muhamad, 2001). Nursing provides a venue to look at gender in a very unique way; that is, when men are the minority instead of the majority. This study provided this unique view of how gender affects the educational setting. The next section will provide implications for practice when training novice nursing instructors, as well as when working with male students.

Value of Experience

For nursing instructors, becoming more attuned to how issues of gender affect their practice changes with experience. With more experience, the nursing instructor gains insights into what challenges exist for male students. The instructors with more years in nursing education (Hope and Grace) were able to more clearly express how gender influences the socialization of men to the profession. This has implications for the value of retaining faculty members into entry-level nursing programs at the associate, diploma and baccalaureate levels. Because of the current faculty shortage, there maybe a tendency to hire nurses who meet the qualifications from an academic standpoint, but have not been in nursing practice very long, in order to “fill the position” within a school.

This research demonstrates the value of the educators’ experience, specifically in education, not just nursing practice, but also in identifying issues related to the male students’ needs. Nursing education goes beyond knowledge of educational pedagogies. Teaching nursing incorporates the affective (feeling) elements of the human and being in touch with how one’s values affect how newcomers are socialized into the profession. In order to teach students and socialize them into the field, the instructors must utilize the knowledge they have gained through being insiders in the field. This knowledge comes with engaging in the clinical setting with males over time, through experience, and not strictly through behaviorist approaches.

When new instructors come into the field of nursing education, addressing issues of gender in the clinical area and classroom should be part of mentoring new faculty. There were many insights the more seasoned faculty had regarding students’ gender on the clinical area and how it influences socialization of the student to the profession. These insights need to be shared with novice faculty. What biases a newer faculty member may or may not have are unknown;

however, part of socialization to any type of occupation is to challenge assumptions that the newcomer possesses. For the newer faculty, they may have many questions related to whether, and how, men should be socialized differently.

Awareness of Females “Rescuing” Males

When socializing the male student, it is advisable to the nursing instructor to be aware of the privileges men bring. These privileges in terms of bringing socially constructed worth in terms of strength and elevating the status of the profession, as well as perceptions that men are not as nurturing, can affect their clinical experience by females innocently and unconsciously stepping in and doing for the male student. Males must be provided the opportunities to practice and gain experience in the clinical setting. The instructor should have an awareness of female interference in order to effectively identify and/or prevent this from happening.

It must be noted that a male may receive assistance not only from female staff, but also the female students in his clinical group. This is protective behavior, where females try “rescue” the male they feel is in trouble. This is not to say this does not happen for females as well; however, in this study, females rescuing males on the clinical setting was a theme. One of the roles of the nursing instructor is to be aware of what is occurring in the clinical setting with each student and how the student is reacting to these experiences. This requires assessment, while keeping in mind assumptions that have been culturally learned.

Awareness of Cultural Assumptions

Culturally, men have a different place in society from women. Therefore, it is essential that each instructor of nursing perform his or her own self-evaluation of how he or she feels regarding men’s participation in the field. Culture changes over time. The feelings a female nursing instructor brings with her regarding men may affect the way she interacts with a male

student. Some female instructors were intimidated by males when challenged in the classroom by a male student, and/or surprised that males had difficulty taking care of other males. Female instructors, at times, assumed expressing feelings and crying with patients came naturally, and were surprised that men did not know how to express feelings. When the instructors in this study interacted with a male student, at times they needed to evaluate how gender has affected their lives, how they view gender and form the ability to integrate this knowledge when interacting with male students. In addition to being aware of one's own feelings and assumptions, it is equally important to be aware of how the student is feeling without assuming. The way to accomplish this is through communication with the male student.

Dialogue with the Male Student

Men are thought of as “the other,” in terms of not being part of the dominant gender group in nursing. The instructor may experience feelings of discomfort when men are providing personal care, particularly when caring for women. It is important to discuss with a male student how he feels when caring for men and women. Both the instructors and the students may experience some discomfort with the male giving personal care, as has been seen in the instructor interviews. In addition, men come into the profession having learned that they should not show emotion, and that certain types of touch are inappropriate. It is important that the male student be given a safe place in order to break some of the socially constructed rules he has learned.

In order for effective communication to take place regarding feelings of discomfort, instructors must create a relationship with the male student wherein he is able to express feelings of discomfort. The instructor should act as a mentor or guide to the student. However, the instructor also needs to be careful that clinical expectations are not altered because either the

male student or the female instructor feels uncomfortable in a situation in which men provide personal care.

In addition, the instructor should be aware of the need to set boundaries regarding the instructor-student relationship. In speaking about feelings, the female instructor should take care that her intentions do not get misinterpreted by the male student as interest in having a personal relationship. The professional relationship between student and instructor should be maintained at all times, while reassuring men that they are a valuable asset to the profession.

Embrace Diversity

In recent times, men have been seen as bringing diversity into the profession. This is viewed as particularly important to the care of male patients. Although it is important for male students to be assigned to a variety of patients, when appropriate, it is important to capitalize on the diversity male students bring to the profession. Perhaps a male student may share a common interest with a male patient; it is advantageous to allow the male to make good use of this common interest in meeting the patient's psychosocial needs.

Men coming into the profession need to "infuse themselves into the profession, whereby they relearn, perhaps, the habits of independence and individualism, and incorporate themselves into the "team" mentality under which patient care operates most efficiently. And, accordingly, it may involve rethinking traditional "masculine" thinking patterns." Part of the value that men bring, along with other minority influences, is that the profession becomes reflective of the population served. For the male student, there may be a better understanding of how male patients express their emotions. Although male nurses can significantly enhance the care of male patients, it is also important that males learn to work with and care for all patients.

If men are to learn the various aspects of the profession, they need to have a full complement of experiences. This includes taking care both men and women. Instructors should take care to assure this is happening, and they are not only assigning male patients to male students. If needed, the gender of the patient the male cared for should be recorded as part of the instructors notes, so as to ensure male students do not only get assigned to male patients.

Be “Male-Friendly”

Being “male-friendly” does not indicate setting different standards for males. However, an awareness of how behaviors may be interpreted by male students is important. Statements such as “He is a ‘male nurse’” may seem benign to the instructor, but may be interpreted by the male student as he is being held to different expectations, or, for a variety of reasons, is unwanted.

Instructors should take care to socialize the male that it is okay to express his feelings, but not to interpret the lack of emotional expression as uncaring. Communication is essential to developing effective socialization of males to the profession. It is optimal that the student know that if he is given a slightly different assignment, it may not be because their gender creates a deficiency because of gender. It is best that the male student know that a patient refusal of a male nurse is not a reflection on the student. Patients’ refusal of a student nurse indicates just that: the patient has a problem with male students, not that men cannot, nor should not, be nurses.

Be Aware of Stereotypes

It is of paramount importance to be aware of stereotypes regarding male students, some of which the male student may believe himself. Examples include ideas such as men should work in highly technical areas, they would prefer leadership positions or they cannot work in areas in women’s health such as obstetrics. Allow the student to experience all aspects of nursing without

bias toward his gender. Instructors bring what they have learned through socialization to their own gender role. Some of the best male students could become hospice nurses, a more caring and nurturing role.

Not all males need to be the leaders of the profession. Although they may carry privilege and status because they are male, they should not be responsible for “rescuing” the profession. Nurses, either male or female, should be responsible for elevating the status of the profession, as well as being accountable for their professional behavior. In this vein, the instructors expressed concern regarding the communication differences between men and women. Women were thought to be more indirect and emotional when communicating with one another. This is one area in which men were thought to add to the profession, given their direct communication style, but it still represents an area of struggle with when dealing with women.

Limitations to the Study

As with any qualitative study, there were limitations as far as the generalizability of the student to nursing education as a whole. This study only focused on the socialization of males to the profession of nursing. It did not compare men to women. In questioning the rise of men to leadership and higher paying positions in the profession, it is difficult to draw definitive conclusions as to how socialization may, or may not, impact this phenomenon when the socialization of females was not part of the study. Significantly, the methods used involved observation of the female instructors. The awareness of the instructor that she was being watched could have caused the observed interactions not to have been as “pure” as they might be if the instructors were unaware that observations were being performed.

The instructors who participated in this study were aware of, and had given consent to, participating in the study. What was interesting, and, possibly, a limitation, was these instructors

were open to the exploration of the socialization of males to the profession, and willing to be observed. Some of the instructors who were approached regarding being part of the study, who did meet the criteria for inclusion, were clearly opposed not only to being a participant, but to the entire premise of the study. They were opposed to, and refused to be part of, the study, because they were uncomfortable with any study that had the potential to document discriminatory issues. Therefore, one needs to call into question, and examine, the motives, and underlying beliefs, of those who did not wish to participate on this basis. The word “discrimination” was never used by the instructors who did participate. This leads one to question: Is discrimination present? And, if so, would the results have been different had instructors who had chosen not to participate been part of the study?

This study only looked at the way female instructors socialize men to the profession of nursing. The assumption is that there are differences that emerge symbolically between male and female students. This study did not include a comparison between men and women in that detail. That is a topic for further investigation. While instructors stated men need more role modeling regarding the “softer side” of nursing, perhaps they would have stated the same things if the socialization of females were being studied.

This study was undertaken in a diploma school of nursing. Diploma schools have been the traditional setting for nursing education, starting with, and strongly influenced by, Nightingale. This traditional method and setting for nursing education was structured from the Nightingale school, which assumed the nurse was female. It may be of interest to replicate the study using a variety of nursing programs such as associate or baccalaureate programs.

Suggestions for Future Research

Leadership positions typically require a direct approach to conflict management. Males have theretofore been thought to possess less “catty” behavior in terms of communication styles, which begs the question: Are women their own worst enemies? Do women spend too much time fighting among themselves that when men are brought into the environment they advance at a faster rate because they don’t spend as much time fighting between themselves? From this path of thought, the following suggestions are made for nursing and nursing education:

1. The study of conflict management styles between male and female nurses.
2. Male and female nurses’ definition of care in practice.
3. Explore generational differences between nursing instructors’ acceptance of males into the profession.
4. The affect of the patriarchal structure of health-care on nurses’ interpersonal behaviors.
5. Males’ adaptation to a female profession, while still maintaining their masculinity.
6. Replicate the study using an associate and/or baccalaureate school of nursing.
7. Replicate the study in another female-dominated field, such as elementary school teachers.
8. Research related to men in nursing utilizing theories of tokenism.

Conclusion

Do we “do gender?” I asked myself did the participants” do gender” in their interactions with male students? Yes, but not in a way to devalue the contributions a male could bring to the profession. They did gender in recognizing the fact that their student was a male, and there may be issues that arise on the clinical areas as a result of gender. It can be said that when Daisy

makes patient assignments and uses a male's name rather than saying, "you will have a male student," she is making a conscious decision to manage the gendered division. When instructors keep their distance to send a signal that they are in a professional relationship with the student, and not on a personal level elsewhere, they are directing their actions based on assumptions they have regarding the male. The communication between men and women is yet another way in which gender is acted out within relationships. We do come to assume different actions and behaviors from those we interact with, based on gender. For the instructor socializing the male to nursing, the challenge is to honestly identify these issues with themselves, and develop strategies for negotiating gender in the clinical environment.

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Appendix

- 1) I noticed when you were speaking to your male student you _____(describe behavior). Can you tell me what was going through your mind at that point.
- 2) How did you determine what type of patient you would assign to this male student?
- 3) When you were making the patient assignment, did you consider the student's gender?
- 4) What did you mean when you said _____?
- 5) What made you _____ (describe behavior)?
- 6) Can you tell me about a time when you were challenged by a student because of their gender?
- 7) Can you tell me what qualities symbolize nursing in your mind?
- 8) Can you tell me how gender influences the qualities which students bring to the profession?
- 9) Please answer the following: Socializing a male to the nursing profession is like_____?

Vita

Rita E. Mullen Wise

Rita E. Mullen Wise has been a registered nurse for eighteen years. She earned a Bachelor of Science degree with a major in nursing from the Pennsylvania State University, University Park, PA, and a Master of Science degree in Nursing from DeSales University, Center Valley, PA.

Rita has worked primarily in acute care. Her career started caring for post surgical patients as well as working in cardiac care. Her experience in the education setting began in nursing staff development providing education for hospital-wide in-services as well as special, unit based projects. Rita has participated in many committees to improve process at the institutional level. Rita has been on faculty at a diploma based school of nursing for the past seven years. During this time, she has had the privilege of teaching both traditional students, as well as adults, returning to school as a second career or as their first time in post-secondary education. She has been on many committees as part of this role including admissions, curriculum, as well as faculty evaluation and student recognition.

Rita has been active in community organizations such as the Girl Scouts and Boy Scouts of America, Autism Society of Berks County and various other philanthropic organizations.

Rita is a member of the Sigma Theta Tau International Honor Society of Nursing, American Academy of Medical-Surgical Nursing, and the National League for Nursing.