MEN WHO CARE: HOW ORGANIZATIONS AND INDIVIDUALS NEGOTIATE
MASCULINITY, EMOTIONAL CAPITAL, AND EMOTION PRACTICE IN
NURSING

A Dissertation
Presented to
The Graduate Faculty of the University of Akron

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Marci D. Cottingham
August, 2013
MEN WHO CARE: HOW ORGANIZATIONS AND INDIVIDUALS NEGOTIATE
MASCULINITY, EMOTIONAL CAPITAL, AND EMOTION PRACTICE IN
NURSING

Marci D. Cottingham
Dissertation

Approved: _______________________________ Accepted: _______________________________
Advisor Department Chair
Dr. Rebecca J. Erickson Dr. Matthew T. Lee

Committee Member Dean of the College
Dr. Kathryn M. Feltey Dr. Chand Midha

Committee Member Dean of the Graduate School
Dr. Robert L. Peralta Dr. George R. Newkome

Committee Member Date
Dr. Clare L. Stacey

Committee Member
Dr. Janice D. Yoder
ABSTRACT

This dissertation addresses issues of masculinity and emotion among men in nursing in the U.S. Integrating gender theory on men and masculinities and the sociology of emotion, the results advance understanding of the distinct ways that health care organizations and individuals operate within the current gender system. Both organizations and individuals “mobilize” available resources, synthesizing dynamic and embodied masculinities through their everyday conscious/nonconscious social practice. Health care organizations mobilize hegemonic and alternative masculinities through ideological gendering practices in order to dispel stereotypes and recruit boys and young men to the the nursing profession. Counter to prior theory and cultural beliefs concerning men and emotion, individual-level findings suggest that men possess and cultivate emotional capital, emphasizing their capacity for compassion, empathy, and their ability to provide care to others. As one facet of their emotion practice, male nurses activate/embody their emotional capital through emotion management strategies in order to provide high quality nursing care to their patients. Integrating masculinity and emotion management theories, this dissertation shows how gender discourse shapes organizational and emotion practice in distinct ways for men in nursing who care for a living.
DEDICATION

I dedicate this dissertation to the men who participated in the study and those in my life who’s honest self-reflexivity bolsters my hope for social change.
ACKNOWLEDGEMENTS

I would like to acknowledge the intellectual, social, and financial support of those in my life who helped make this research possible. Becky, thank you. You inspire and challenge me. May our work together continue to evolve in “loving complexity.” I thank the loved ones who have supported me: Peter, Leon, Chris, Kay, Eve, Lindsey, Rick, Mom, and Dad. I thank my colleagues and friends in the Sociology Department at the University of Akron and the rest of the sociology faculty for providing such a vibrant and supportive environment. I want to specifically thank my writing group friends and colleagues who have helped strengthen this research: Dani Jauk, Austin Johnson, Kelsey Risman, Corey Stevens, Jessica Headley, Ruthie Walker, and Will LeSuer. I also thank the CARMA project team members for indulging my need for structured meetings and providing feedback on my work: Jim Diefendorff, Janette Dill, Eric Fritz, Allie Gabriel, Veronica Liebchen, and Mike Steiner. I thank Pat Martin, Clare Stacey, and Kathy Feltey for their feedback on various drafts and I thank my dissertation committee for their feedback throughout the proposal process.

The research reported here uses data from a larger study, “Identity and Emotional Management Control in Health Care Settings,” funded by the National Science Foundation (SES-1024271). Participant compensation and research travel was made possible through the financial support of the Barbara J. Stephens Dissertation Award. Chapter II of this dissertation was awarded the 2012 graduate student paper award from the Society for the Study of Social Problems, Health, Health Policy, and Health Services.
Division, and was presented at the Society for the Study of Social Problems 2012 annual meeting in Denver, Colorado. Chapter III was awarded the 2013 Alpha Kappa Delta graduate paper award and the 2013 American Sociological Association, Sociology of Emotions Section graduate paper award.

Finally, a special thank you to the American Assembly for Men in Nursing for their warm welcome and interest in the research, particularly Susan LaRocco and Bill Lecher, as well as the anonymous men who helped make this research possible by sharing their experiences and insight.
TABLE OF CONTENTS

LIST OF TABLES ...........................................................................................................xi

CHAPTER

I.  INTRODUCTION .......................................................................................................1
    Dissertation Format and Overview of Chapters...................................................4
    Men and Masculinities .........................................................................................7
    Theorizing the Sociology of Emotion:
    Management and Social Practice Approaches...................................................8

II. RECRUITING MEN, CONSTRUCTING MANHOOD:
    HOW HEALTH CARE ORGANIZATIONS MOBILIZE MASCULINITIES
    AS NURSING RECRUITMENT STRATEGY ............................................................11
    Abstract ................................................................................................................11
    Introduction ..........................................................................................................12
    Literature Review and Theoretical Framework ...................................................14
        The Contradictory Male Nurse ...........................................................................14
        Hegemonic Masculinity and Gendering Practices Theoretical Framework ...........15
    Data and Method ..................................................................................................20
    Findings ...............................................................................................................25
        The Context of Nursing Recruitment...............................................................26
        Mobilizing Hegemonic Masculinities...............................................................27
        Constructing Alternative/Non-Hegemonic Masculinities.................................32
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Recruitment Materials</td>
</tr>
<tr>
<td>2.2</td>
<td>Frequency of Hegemonic and Non-Hegemonic Masculinity Codes (Percentages in Parentheses are for All Codes, n = 287)</td>
</tr>
<tr>
<td>3</td>
<td>Participant Pseudonyms and Demographics</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Imagine a nurse chatting with a patient, administering medication, and then gently touching the patient’s shoulder to convey concern, compassion, and warmth. Imagine the patient’s face relaxing, eyes slowly closing and mouth exhaling the pent-up fear and stress of a hospital stay. Our imaginary nurse enters detailed information into the patient’s electronic file and begins to wheel the portable computer out of the room, but not before glancing back to confirm that the patient is comfortable and content. Working a typical shift, our nurse will go on to repeat this process for 12 hours, meeting the needs of several patients and rarely taking a break to eat or use the restroom. The work is physically and emotionally taxing, requiring both technical and emotional expertise—including a nearly endless supply of empathy and compassion for others in need.

Apparent in the above description and the academic literature, nursing is an emotionally demanding profession centered on the care of others (Erickson 2008). As such, it is considered the purview of women (Bradley 1989; Evans 2004). In the U.S., however, odds are about one out of ten that our imaginary nurse is a man. The Institute of Medicine [IOM] estimates that men make up about 7 percent of the nursing workforce (2010). While a small percentage, this represents a marked increase over the 2-3 percent that constituted the profession in the 1980s (Christman 1980). Unfortunately, the increase
of men in nursing has not kept pace with the increase of women in medicine, who now make up nearly 30 percent of all physicians in the U.S. (Association of Medical Colleges 2011).

This trend in sex segregation in health care occupations mirrors occupational trends more generally. Occupational desegregation operates as “a largely one-way street,” whereby women’s movement into traditionally male jobs has out-paced men’s movement into traditionally female jobs (England 2010:155). A variety of factors contribute to this imbalance, including the devaluation of traditionally female jobs (England 1992) and the perception of men engaged in female work as effeminate, gay, and incompetent (Allison, Beggan, and Clements 2004; Hesselbart 1977). As a result, England (2010) calls for increased attention to the devaluation of female jobs so that the “gender revolution” might become balanced (“a two-way street”), with men entering female dominant fields at a similar rate to women’s entry into male dominant fields (162). Concurrently, Williams (2000; 2010) argues that challenging the “strong silent type” ideal of masculinity and men’s withdrawal from emotional life should be “moved toward the center of feminist’ agendas” because of its important implications for personal relationships and work (2000:203). The case of men in nursing, analyzed at both the organizational and individual levels, promises to offer insight into both of these contemporary feminist concerns. Examining the experiences of men in a female-dominated profession can inform the retention and recruitment of men to those fields, helping to balance current desegregation efforts. In addition, greater understanding of the conditions and processes involved in men’s negotiation of masculinity within the context of an emotionally demanding profession contributes to our limited scholarly knowledge
of men’s emotionality at work. Looking at men’s experience and management of emotion in nursing frames masculinity as both embodied and dynamic—features that Connell and Messerschmidt’s (2005) argue are lacking from current masculinities research.

Focusing on men and their work in the female-dominated profession of nursing, this dissertation integrates past research on men and masculinities and the sociology of emotion to highlight the tensions and contradictions that individual men and health care organizations confront. Starting at the organizational level, I examine how organizations engage in gendering practices that reproduce and contest dominant discourse on ideal aspects of masculinity. Moving to the individual level, I extend the concept of emotional capital in relation to the emotion practice of men in nursing and analyze areas in which men’s emotion management strategies overlap with discourse on hegemonic and alternative masculinities. The tensions and contradictions highlighted in the current study emerge from the dynamic and evolving nature of masculinities in the contemporary U.S. and the emerging occupation-specific emotional demands men must face within a service-based economy (Bell 1973/1999; Bulan, Erickson, and Wharton 1997). The case of men in nursing reveals how old and new forms of masculinity shape organizational practice, emotional capital, and emotion practice in this critical and growing occupation within health care (Bureau of Labor Statistics 2012).

To frame the dissertation, I overview its format and summarize the three article-length empirical chapters that constitute the main text. As each chapter contributes to the literature on men and masculinities and the sociology of emotion, I provide a brief description of these areas in this introductory chapter. Starting at the organizational level and moving to the individual, the three empirical chapters are presented in the following
order: Chapter II Recruiting Men, Constructing Manhood: How Health Care
Organizations Mobilize Masculinities as Recruitment Strategy; Chapter III Theorizing
Emotional Capital: The Case of Men in Nursing; and Chapter IV Learning to “Deal” and
“De-Escalate”: How Men in Nursing Manage Their Own and Patient Emotions.
Following these three chapters, I conclude the dissertation with a summary of the
findings, their implications, and a discussion of the limitations and suggestions for future
research.

Dissertation Format and Overview of Chapters

Unlike the common book-like format, this dissertation is organized into three
separate, stand-alone, journal-length articles. This format streamlines the publication
process, with one of the articles (Chapter II) already accepted for publication in Gender
& Society, forthcoming in December 2013. Another benefit of the three article format
was the ease with which I was able to develop and submit chapters to national graduate
paper competitions. Chapter II won the 2012 graduate paper award from the Health,
Health Policy, and Health Services division of the Society for the Study of Social
Problems. Chapter IV won the 2013 Alpha Kappa Delta graduate paper award and the
American Sociological Association’s Sociology of Emotions section graduate paper
award. I believe the format of the dissertation was a factor in this success.

Beginning at the organizational level, chapter II focuses on organizational
discourse and practice concerning masculinity and nursing. Using data from 32
recruitment items aimed at drawing men to the nursing profession, I analyze the visual,
textual, and audio content for themes surrounding ideal and alternative forms of
masculinity. The results suggest three types of nursing recruitment strategies used by health care organizations: full hegemonic co-option, partial hegemonic co-option, and alternative constructions of masculinity. Using these three strategies, I show how health care organizations mobilize alternative and hegemonic aspects of masculinity in recruitment materials with mixed results. In some cases, recruitment materials appear to devalue care in favor of hegemonic themes of autonomy, rationality, risk-taking, and emotional detachment. In other instances, the materials serve as an organizational critique of aspects of hegemonic masculine, showing how men can and do successfully nurture others.

In chapter III, “Theorizing Emotional Capital: A Case Study of Men in Nursing,” I use diary and interview data to extend the theoretical treatment of emotional capital. I offer three criticisms of prior work on the concept and illustrate how each of these might be addressed by using the experiences of men in nursing as a case study. Contrary to prior claims that only women hold emotional capital, the data suggest that men do possess capital but they mobilize or embody this capital through distinct forms of emotion practice. I further clarify the conceptualization of emotional capital as trans-situational resources that are situationally embodied and enacted through emotion practice. Finally, the results of my analysis of men in nursing suggest a need for refining the concept of emotional capital to include a consideration of primary and secondary sources of capital development. This distinction, in both the source and the features of capital, illustrates how emotional capital operates as a resource that men bring to the profession as well as one that men actively shape in order to meet the practical,
situational demands of their work. Developing this chapter for publication, I will target the journal *Sociological Theory*.

In chapter IV, “Learning To ‘Deal’ and ‘De-Escalate’: How Men in Nursing Manage Their Own and Patient Emotions,” I focus more closely on emotion management as one aspect of men’s emotion practice in a caring profession. Emerging from in-depth interview and diary data, men’s personal and interpersonal emotion management in nursing suggests five distinct strategies: (1) reframing the nursing role, (2) distancing, (3) relinquishing control, (4) personal management as patient management, and (5) education as patient management. I contextualize these strategies within research on men and masculinities, noting the ways in which management strategies affirm or contradict hegemonic ideals. Strategies overlap with the ideals of emotional detachment, rational/technical competence, and control over others, but these ideals are used in the service of emotion-based goals—to calm and relax patients, as well as manage personal emotions of grief and helplessness. From the findings in chapter III, we see that men are adamant about their capacity to empathize with and care for others. Chapter IV shows us how they then activate their emotional capital through masculine strategies of personal and interpersonal emotion management. The target publication outlet for chapter IV is the journal *Sociology of Health and Illness*. A common thread running through each of the chapters centers on the tensions between ideal and lived masculinities, between discourse and everyday practice.
Men and Masculinities

Each of the three empirical chapters contribute to the literature on men and masculinities. Individual men and health care organizations exist within the particular gender system (or “gender regime,” Connell 1987) of our current socio-historical context. Constituting this context in the U.S. are interconnected beliefs about what it means to be a man and a woman (Ridgeway 2011). Within this relatively new field of study in the sociology of gender, scholars have begun to examine men and masculinities as distinctly gendered phenomena. Critical to the development of masculinities scholarship is the concept of hegemonic masculinity (Connell 1985; 2005). Hegemonic masculinity refers to the idealized forms of masculinity within a specific socio-historical context. Rarely do men embody this ideal type of masculinity, but it serves as the standard against which men’s constructed selves and situational behavior are judged (Hanke 1992). Men may actively seek to embody aspects of hegemonic masculinity, including rational/technical competence, athleticism, hyper-heterosexuality, independent autonomy, risk-taking, and economic success (Connell 2005; Pascoe 2005; Peralta 2007; Pyke 1996). But they may also eschew aspects they disagree with or cannot attain by developing alternative constructions. In so doing, tensions between hegemonic and alternative masculinities are likely to arise.

The tensions and contradictions highlighted in the current study emerge from the dynamic and evolving nature of masculinities in contemporary society. For example, in Gerber’s (2001) study of men and women in the police force – a distinctly male-dominated profession – the complex structure of the self is not reducible to a static set of gendered personality traits, but rather emerges from interactions and experiences.
Similarly, organizational practice and men’s emotion practice emerge out of complex socio-historical locations. Tensions between hegemonic and alternative constructions of masculinity are seen throughout the empirical chapters of the dissertation. These tensions stem from complicated frictions between the ideal of an independent, purely rational man and the “affective requirements” that underlie many occupations within today’s service-based economy (Bulan, Erickson, and Wharton 1997).

Theorizing the Sociology of Emotion: Management and Social Practice Approaches

This dissertation also draws on prior work in the sociology of emotion to integrate emotion management perspectives (Hochschild 1979; 1983) with Bourdieu’s (1990) theory of social practice. Emotion management theory focuses on the social nature of emotion, specifically attending to how emotional experiences and expressions are actively managed by individuals within particular social contexts. This management is largely dictated by structural and contextual emotion norms—the rules governing expected feelings and expressions. In developing this approach, Hochschild (1979; 1983/2003) synthesizes Marxist (Marx 1978) and Symbolic Interactionist theories (Goffman 1959; 1967) in order to show how emotions (and selves) in the public sphere are shaped by capitalist interests in ways that lead to new forms of exploitation and alienation.

Parallel to Hochschild’s work in the sociology of emotion, Bourdieu’s development of a broad social theory uniquely synthesizes Marx, Weber, and Durkheim through a distinctly poststructuralist, postmodern lens. Attempting to transcend dualisms of objective/subjective, structure/agency, and conscious/non-conscious, Bourdieu’s work
has been widely used in the sociology of education (Gillies 2006; Reay 2004) and in studies examining the reproduction of class inequality (e.g., Lareau 2003). Bourdieu’s theoretical approach centers on three key concepts: field, capital, and habitus. “Fields” refer to the social arenas in which institutions and individuals operate, complete with unique rules that structure interactions as well as forms of valued and rewarded capital. The religious, political, and educational arenas are all thought of as distinct but interconnected fields. Within social fields, individuals draw upon differentially available capital as resources. Counter to Marx’s reduction of inequality to economic forces, Bourdieu (1986) broadens the concept of capital to include economic as well as social and cultural resources. These three forms of capital combine to make up one’s symbolic capital—one’s social prestige and overall reputation relative to others. Operating within a field, an individual is constrained by structurally-shaped, embodied dispositions, preferences, and values (Bourdieu 1992). Taken together, these form an individual’s habitus—one’s practical, conscious and nonconscious way of being and doing within various social fields.

Bourdieu’s (1992) work grapples with social practice broadly. For this dissertation, emotion management theory informs Bourdieu’s social practice approach to further develop the concept of emotion practice. Extending Erickson and Stacey (2013), emotion practice refers to the situationally enacted/embodied emotional capital by which individuals meet the practical needs of everyday living. Similar to social practice, it engages the habitus by operating at both a conscious and nonconscious level, drawing upon trans-situational, emotion-based resources known as emotional capital. Like the individuals they partially constitute, emotional capital and practice are distinctly
gendered. Hence, interrogating the capital and practice of men in nursing requires the gendered lens provided by contemporary theory on men and masculinities.

Taken as a whole, this dissertation addresses issues of masculinity and emotion at the individual and organizational levels within the nursing profession in the U.S. The results advance our understanding of how individuals and health care organizations operate in distinct ways within the current gender system. Both organizations and individuals “mobilize” available resources. Health care organizations use masculine ideals and alternative constructs to counter the stereotypes that deter men from entering the profession. Individual men cultivate and use their capacity for empathy and compassion, emotion management knowledge and skills, in order to provide the best nursing care to their patients. Integrating masculinity and emotion management theories, the findings extend our understanding of how gendered discourse shapes organizational and emotion practice in distinct ways for men who care for a living.
CHAPTER II
RECRUITING MEN, CONSTRUCTING MANHOOD: HOW HEALTH CARE ORGANIZATIONS MOBILIZE MASCULINITIES AS NURSING RECRUITMENT STRATEGY

Abstract

Despite broader changes in the health care industry and gender dynamics in the U.S., men continue to be a minority in the traditionally female occupation of nursing. As a caring profession, nursing emphasizes empathy, emotional engagement, and helping others – behaviors and skills characterized as antithetical to hegemonic notions of a tough, detached, and independent masculine self. The current study examines how nursing and related organizations “mobilize masculinities” in their efforts to recruit men to nursing. Analyzing recruitment materials, I assess the mobilization and construction of masculinities in the context of textual, spoken, and visual content. Results reveal how organizations simultaneously mobilize aspects of hegemonic and non-hegemonic masculinities through ideological gendering practices. I identify three distinct types of mediated mobilization: full hegemonic co-option, partial hegemonic co-option, and alternative construction of masculinities. Empirically, the study illustrates the content of nursing recruitment material aimed at men and the ongoing contradictions endemic to men’s entry into caring professions. Complementing existing structural and interactional
approaches, the study advances theory on how the mobilization of masculinities operates as an ideological gendering practice at the organizational level.

Key words: masculinities, nursing, gendering practices, health care organizations

Introduction

As a historic and contemporary issue, occupational gender segregation is an important topic for scholars interested in understanding the devaluation of work typed as female (Baron and Newman 1990; England 1992) and the barriers women face when entering traditionally male jobs (Acker 1990; Williams 2000). Controlling for labor market variation, researchers argue that women’s work is devalued and women in traditionally female occupations suffer from lower wages than men in traditionally male jobs (Cohen and Huffman 2003; England 1992). As a result, recruiting men to traditionally female occupations has been a difficult task, despite the fact that service sector jobs—with an increasing number of “affective requirements”—have been on the rise since the latter part of the twentieth century (Bulan, Erickson, and Wharton 1997).

As greater occupational gender integration benefits women through increased gender pay equity, decreasing occupational segregation is a worthy aim for feminists invested in bettering the economic standing of women (Cohen and Huffman 2003; Cotter et al. 1997).

Occupational gender segregation is particularly evident in nursing, where men make up a small minority even as the profession highlights projected staffing shortages and concern for diversity (Bureau of Labor Statistics 2012; Institute of Medicine 2010). Thirty years ago, an early advocate for the recruitment of men to nursing criticized the
profession for failing to recruit more men (Christman 1980). Since then, the number of men in nursing has increased from the modest 2-3 percent when Christman wrote, to about 7 percent today (Institute of Medicine 2010) – an increase of over 100 percent, but far from the gender parity for which he had hoped. Over the last ten years, nursing organizations such as the American Assembly for Men in Nursing (AAMN), health care systems, hospitals, and corporations have attempted to address the number of men in the field through recruitment posters, videos, and brochures.

Drawing on recent scholarship on gendering practices (Martin 2001; 2003) and masculinities (Connell 2005, Connell and Messerschmidt 2005), this study advances theoretical and empirical understanding of how health care organizations in the U.S. mobilize masculinities as an ideological gendering practice to recruit men to nursing. In analyzing recruitment materials, two primary themes emerge: (1) across content, both hegemonic and non-hegemonic masculinities are mobilized, with (2) each item (video, poster, and brochure) employing a mobilization strategy of full hegemonic co-option, partial hegemonic co-option, or alternative construction of masculinities. Results suggest a portrait of men in nursing that is neither wholly hegemonic nor wholly alternative. The study extends the gendering practices approach and advances our theoretical understanding of how ideologies of masculinity are simultaneously reproduced and re-constructed through mediated materials that work to reconcile the cultural contradictions of the male nurse.
Literature Review and Theoretical Framework

*The Contradictory Male Nurse*

The male nurse is characterized as “a contradiction in terms” (Bradley 1989:195). The current structure of health care in the U.S. is predicated on gender distinctions that stretch back to nursing’s formation as a profession (Gordon 2005). Florence Nightingale’s efforts to professionalize nursing as a white, middle-class, and feminine occupation exaggerated the disconnect between “caring” and “curing” in order to mirror Victorian sex roles (Bradley 1989:193-95; Evans 2004). Women were and continue to be seen as naturally adept at caring (Lewis 2005), while men, with their technical skill and knowledge, are assumed to be better suited for curing. Nursing’s distinct “care” component emphasizes a nurse’s ability to nurture others and provide emotional support (O’Lynn 2007a), with nursing rated high on a scale of nurturance (England, et al. 1994) and associated with femininity (O’Lynn 2007a).

Unsurprisingly, then, men have a small presence in the field of nursing, making up only 7 percent of the U.S. workforce (Institute of Medicine 2010). With an aging population, increasing rates of chronic disease, and implementation of health care reform, the Bureau of Labor Statistics (2012) projects the demand for registered nurses to grow much faster than most occupations, and employment in nursing to increase by 26 percent through 2020. Furthermore, health care organizations emphasize efforts to increase workforce diversity (American Association of Colleges of Nursing 2012), making nursing an attractive occupational choice to a more diverse group than the white, middle-class women who have traditionally entered the profession.
Previous research on men in nursing has investigated men’s reasons for entering traditionally female jobs, their financial and promotion outcomes (i.e., the “glass escalator,” Williams 1992; Snyder and Green 2008), and the racial dimensions of these outcomes (Harvey Wingfield 2009). This work has shown that men in female-concentrated occupations are acutely aware of the problems posed for constructing a masculine self (Cross and Bagilhole 2002; Heikes 1991). For example, Simpson explores how men in caring professions negotiate masculinity (2007), finding that men emphasize technical competence and rationality. Despite the benefits men gain, they must negotiate contradictions between hegemonic masculinity and their work in a caring profession, often segregating work and non-work presentations as well as de-emphasizing the caring aspects of their job.

Research focused on the individual-level experience of men in nursing has been important for understanding gendered outcomes in traditionally female professions, but studies have not gone beyond the individual to address how organizational processes reconcile the cultural contradictions between the demands of nursing and the ideals of masculinity. By shifting from micro- to meso-levels of media representations, the current study provides theoretical insight into how gendering practices circulate within the sociocultural milieu as fluid combinations of cultural and ideological practices with the potential to contest and/or reproduce gendered structures of inequality (Howson 2006).

**Hegemonic Masculinity and Gendering Practices Theoretical Framework**

Conventional masculinity, or hegemonic masculinity, refers to the culturally dominant form of masculinity to which most men aspire but rarely achieve (Connell
2005; Connell and Messerschmidt 2005). Its Western contemporary form entails hyper-heterosexuality, control, technical/physical competence, autonomy, and rationality (Connell 2005; Lutz 1988; Pascoe 2005; Trujillo 1991). Hegemonic masculinity operates within a broader gendered system (or “gender regime”; see Connell 1987) as the norm against which alternatives, including femininities and alternative masculinities, are measured (Hanke 1992). Using normative cultural schemas, hegemonic masculinity assigns unequal value to such characteristics as technical/rational aptitude versus nurturance and, in so doing, provides an ideological basis for justifying the subordination of (primarily) women. Given its role in maintaining the gendered system, hegemonic masculinity can be viewed as both foundational for understanding gendered processes and a point from which to critique the current system (Howson 2006). To accomplish such critique, however, change must be seen “as a dialectic arising within gender relations themselves” (Connell 1985:263). In the case of the current study, this dialectic emerges from the circulating, mediated representations of men found in nursing recruitment materials.

Recruitment materials seek to reconcile the seemingly contradictory demands of nursing (e.g., giving physical and emotional care to others) with the hegemonic ideals of emotional detachment, hyper-rationality, and toughness. Held to different emotion expectations, boys are socialized to experience and express emotion differently than girls (Chaplin, Cole, and Zahn-Waxler 2005; Garside and Klimes-Dougan 2002). A detached, unemotional demeanor that conveys control reflects the dominant masculine ideal (Connell 2005; Lewis 2005; Lively 2000), while being supportive and congenial and showing empathy is considered feminine (Connell 1987; Lewis 2005). In and outside of
work, it is often women who are relied upon to provide practical and emotional support to men (Fletcher 1999; Martin 2001; 2003). Reconciling masculinity with the notion of care, then, is a formidable task for recruiting men to caring professions.

Beyond viewing gender as interactional and performative (West and Zimmerman 1987), scholars have increasingly conceptualized gender as an institution with its own, often rigid, practices that maintain structures of power (Lorber 1994; Risman 1998, 2004; Martin 2004). While interpretive work on the perceptions and meanings held by individuals is important for understanding the gendered work experience of men and women (Blumer 1969; Sayman 2010), a gendering practices approach embeds these meanings within the organizational level, illuminating the role of organizations in shaping subjectivities. Gender influences individuals, but its reach extends beyond them as it affects cultural norms and institutional policies (Risman 2004). Gendering practices operate as guidelines for performing gender at the interactional level, including the “plethora of meanings, expectations, actions/behaviors, resources, identities, and discourses that are fluid and shifting yet robust and persisting” (Martin 2003:344).

Studies of gender within organizations have largely emphasized the level of interaction, with less attention to how organizations themselves – through discourse and policy – engage in gendering practices (cf. Acker 1990; Sasson-Levy 2007).

Shifting the level of analysis from individual to organizational practice, the current study examines how recruitment efforts illustrate the gendering practice of “mobilizing masculinity” (Martin 2001). Originally conceptualized, mobilizing masculinity refers to men’s use of practices in the workplace that implicate, or “bring to bear,” masculinities in a given situation (Martin 2001:588). Extending this concept, I
suggest that individual men are not the only ones who utilize masculinities, but that organizations themselves also mobilize a plurality of masculinities through mediated representations. In the present study, the representation of men in nursing recruitment material is framed as a site for the organizationally based, gendering practice of mobilizing masculinities—meso-level ideologies that bridge performative and structural gender inequalities.

Media serve to circulate gender beliefs through cultural representations of men and women, including hegemonic and alternative constructions (Hanke 1992; Ridgeway 2006). Empirical work analyzing media and gender centers largely on women, as is the case in studies of women’s body image (Hesse-Biber 2006; Zhang, Dixon, and Conrad 2010) and the portrayal of women who “opt out” of careers in favor of motherhood (Kuperberg and Stone 2008). However, media studies focused specifically on men and hegemonic masculinity are not without precedent (Morrison and Halton 2009; Vigorito and Curry 1998).

Hegemonic ideals of emotional detachment, physicality, autonomy, and dominance are common themes found in the media representation of men. For example, Morrison and Halton (2009) find in their analysis of men in action movies that an ideal of masculinity symbolizing physical competence and toughness is pervasive. Furthermore, portrayals of masculinity are set in the context of sexual relationships devoid of emotional attachment. While Vigorito and Curry (1998) find that men and women are equally presented in the non-hegemonic role of parenting, magazines with a target audience of men rarely represent men as nurturing parents and instead they feature “dominance and control, and cool, even unemotional relationships” (1998, 148).
Nursing recruitment materials may expand upon or perpetuate definitions of masculinity centered on the ideals of emotional detachment, rationality, and autonomy. However, the ideals of hegemonic masculinity are heavily scripted within the current sociohistorical context (Trujillo 1991), and nursing materials are embedded within that context even as they confront the contradictions of men in nursing. In analyzing nursing recruitment content aimed at men, the current research was guided by the following questions: How do organizations recruiting men to nursing reconcile the qualities of dominant masculinity that seem at odds with the requirement that nurses provide physical and emotional care to others? More specifically, what qualities of hegemonic masculinities and non-hegemonic masculinities are represented in the recruitment material? Finally, using each recruitment item as a separate case, what type of mobilization strategy does each poster, video, and brochure utilize in an effort to attract men to the profession?

By answering these questions, the current study advances our understanding of gendering practices by extending the “mobilization of masculinity” process to include multiple masculinities utilized as ideologies at the organizational level. In doing so, the study’s findings illuminate three distinct mobilization strategies aimed at recruiting men to nursing: full hegemonic co-option, partial hegemonic co-option, and alternative masculine constructions. Theoretically, mediated representations of men serve as an important link between macro-level structures of gender inequality and the interactional/interpersonal level of gendering practices, with constructions of masculinity reproduced and reconstructed simultaneously within a hegemonic gender system.
Data and Method

To answer these research questions, I analyzed U.S. nursing recruitment materials targeted at men. Content analysis is particularly appropriate given the study’s focus beyond an individual level of analysis (Prior 1997:61) in order to address the gendering practices of organizations. As cultural texts, recruitment materials can mirror and reconstruct social reality, representing a pivotal site where “hegemony is enacted, contested, resisted, and challenged” (Hesse-Biber and Leavy 2004:305). By analyzing recruitment materials, I assess the common values that content creators hold concerning what it means to be a man and a nurse.

Recruitment materials were collected over the course of fall 2011 through summer 2012. The data include 2 brochures, 12 posters, and 18 videos, ranging in length from 31 seconds to over 10 minutes, for a total of 32 items. The total video footage is 68 minutes and 56 seconds (see table 2.1 for content details). I also analyzed relevant campaign reports, nursing webpages, and newsletters, totaling 39 items with 286 pages of text. These were located through organization websites and nursing newsletters and journals as supporting documents for understanding the goals of content creators, their intended audience, and the professional context in which the materials were produced. Individual men featured in the recruitment materials totaled 124.
Table 2.1: Recruitment Materials

<table>
<thead>
<tr>
<th>Item #</th>
<th>Affiliation, Title, and Link</th>
<th>Year</th>
<th>min:sec</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>American Assembly for Men in Nursing (AAMN) &quot;This is Our Story&quot; <a href="http://www.youtube.com/watch?v=5ADd0Gv6G4c">http://www.youtube.com/watch?v=5ADd0Gv6G4c</a></td>
<td>2011</td>
<td>2:47</td>
</tr>
<tr>
<td>2</td>
<td>Well Star &quot;Stephen&quot; <a href="http://www.youtube.com/watch?v=5ADd0Gv6G4c">http://www.youtube.com/watch?v=5ADd0Gv6G4c</a></td>
<td>2010</td>
<td>1:49</td>
</tr>
<tr>
<td>3</td>
<td>American Mobile Healthcare &quot;Men in Travel Nursing&quot; <a href="http://www.youtube.com/watch?v=7UDrC3YKcoY">http://www.youtube.com/watch?v=7UDrC3YKcoY</a></td>
<td>2011</td>
<td>2:01</td>
</tr>
<tr>
<td>5</td>
<td>Johnson &amp; Johnson &quot;Ed&quot; <a href="http://www.youtube.com/watch?v=VeDZrqKFaLE&amp;feature=relmfu">http://www.youtube.com/watch?v=VeDZrqKFaLE&amp;feature=relmfu</a></td>
<td>2010</td>
<td>3:25</td>
</tr>
<tr>
<td>6</td>
<td>St. Francis Health &quot;Hospice&quot; <a href="http://www.youtube.com/watch?v=ZOs6Y2dQy20&amp;feature=related">http://www.youtube.com/watch?v=ZOs6Y2dQy20&amp;feature=related</a></td>
<td>2010</td>
<td>1:57</td>
</tr>
<tr>
<td>7</td>
<td>Emory Healthcare &quot;Nursing and Research&quot; <a href="http://www.youtube.com/watch?v=li868PhTujU">http://www.youtube.com/watch?v=li868PhTujU</a></td>
<td>2009</td>
<td>0:40</td>
</tr>
<tr>
<td>8</td>
<td>Institute for Nursing &quot;Making the Men in Nursing Calendar&quot; <a href="http://www.youtube.com/watch?v=R6lABwUb1-U&amp;feature=related">http://www.youtube.com/watch?v=R6lABwUb1-U&amp;feature=related</a></td>
<td>2006</td>
<td>7:57</td>
</tr>
<tr>
<td>9</td>
<td>Johnson &amp; Johnson &quot;Romel&quot; <a href="http://www.youtube.com/watch?v=JyHcLsLvTTQ&amp;feature=relmfu">http://www.youtube.com/watch?v=JyHcLsLvTTQ&amp;feature=relmfu</a></td>
<td>2010</td>
<td>2:50</td>
</tr>
<tr>
<td>10</td>
<td>AAMN &quot;Professional&quot; <a href="http://www.youtube.com/watch?v=Ozwjt9kvYJU">http://www.youtube.com/watch?v=Ozwjt9kvYJU</a></td>
<td>2011</td>
<td>3:06</td>
</tr>
<tr>
<td>11</td>
<td>Well Star &quot;Chris&quot; <a href="http://www.youtube.com/watch?v=QSRUr6ZRXUc">http://www.youtube.com/watch?v=QSRUr6ZRXUc</a></td>
<td>2010</td>
<td>1:58</td>
</tr>
<tr>
<td>12</td>
<td>California Institute for Nursing and Health Care &quot;Men in Nursing&quot; <a href="http://www.youtube.com/watch?v=3rBEkKDe-2c&amp;feature=related">http://www.youtube.com/watch?v=3rBEkKDe-2c&amp;feature=related</a></td>
<td>2009</td>
<td>10:28</td>
</tr>
<tr>
<td>13</td>
<td>California Nurses Foundation &quot;Male Nurses in General&quot; <a href="http://www.youtube.com/watch?v=R6lABwUb1-U&amp;feature=related">http://www.youtube.com/watch?v=R6lABwUb1-U&amp;feature=related</a></td>
<td>2006</td>
<td>7:57</td>
</tr>
<tr>
<td>14</td>
<td>ConnectEd &quot;ER&quot; <a href="http://www.youtube.com/watch?v=R6lABwUb1-U&amp;feature=related">http://www.youtube.com/watch?v=R6lABwUb1-U&amp;feature=related</a></td>
<td>2010</td>
<td>4:26</td>
</tr>
</tbody>
</table>

1 Links are subject to change. Contact the author for any unavailable item.
<table>
<thead>
<tr>
<th></th>
<th>Title</th>
<th>Year</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Clover Park Technical College &quot;Nursing—It's more than a Job&quot;</td>
<td>2005</td>
<td>10:40</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.youtube.com/watch?v=5mniDlz9nnU">http://www.youtube.com/watch?v=5mniDlz9nnU</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>St. Francis Health &quot;Early Career&quot;</td>
<td>2010</td>
<td>2:21</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.youtube.com/watch?v=bU2zulSAWPs">http://www.youtube.com/watch?v=bU2zulSAWPs</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Whatcom Community College &quot;Men in Nursing&quot;</td>
<td>2011</td>
<td>10:47</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.youtube.com/watch?v=Xi9YsDv0SBc">http://www.youtube.com/watch?v=Xi9YsDv0SBc</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Johnson &amp; Johnson &quot;Name Game&quot;</td>
<td>2011</td>
<td>0:31</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.youtube.com/watch?v=2PVeq60GcA">http://www.youtube.com/watch?v=2PVeq60GcA</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Virginia Partnership for Nursing (VPN) &quot;Man Enough&quot; Poster (EBSCOhost)</td>
<td>2005</td>
<td>--</td>
</tr>
<tr>
<td>20</td>
<td>Oregon Center for Nursing &quot;Man Enough&quot; Poster</td>
<td>2003</td>
<td>--</td>
</tr>
<tr>
<td>21</td>
<td>AAMN &quot;Adrenaline Rush&quot; Poster</td>
<td>2011</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td><a href="http://aamn.org/posters.shtml">http://aamn.org/posters.shtml</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>VPN &quot;K-3 Grade&quot; Poster</td>
<td>2002</td>
<td>--</td>
</tr>
<tr>
<td>23</td>
<td>VPN &quot;4-8 Grade&quot; Poster</td>
<td>2002</td>
<td>--</td>
</tr>
<tr>
<td>24</td>
<td>VPN &quot;High School&quot; Poster</td>
<td>2002</td>
<td>--</td>
</tr>
<tr>
<td>25</td>
<td>University of North Carolina &quot;Nursing: It's a Man's Job, Too&quot; Brochure</td>
<td>2007</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td><a href="http://nursing.unc.edu/ccm/groups/public/@nursing/@oma/documents/content/ccm3_031123.pdf">http://nursing.unc.edu/ccm/groups/public/@nursing/@oma/documents/content/ccm3_031123.pdf</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Johnson &amp; Johnson “Charles” Poster</td>
<td>2011</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td><a href="https://www.discovernursing.com/resources/free-materials#category=posters">https://www.discovernursing.com/resources/free-materials#category=posters</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Johnson &amp; Johnson “Harold” Poster</td>
<td>2011</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td><a href="https://www.discovernursing.com/resources/free-materials#category=posters">https://www.discovernursing.com/resources/free-materials#category=posters</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Johnson &amp; Johnson “Scott” Poster</td>
<td>2011</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td><a href="https://www.discovernursing.com/resources/free-materials#category=posters">https://www.discovernursing.com/resources/free-materials#category=posters</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>AAMN “Up for Challenges” Poster</td>
<td>2012</td>
<td>--</td>
</tr>
</tbody>
</table>
I learned of nursing recruitment efforts aimed at men through the AAMN’s “20 x 20 Choose Nursing Campaign” (AAMN 2011), which aims to increase the number of men enrolled in nursing programs to 20 percent by the year 2020. It produced four posters and two videos. More recruitment materials were located through organizational websites, an online search engine (www.google.com), and EBSCOhost. I also used an online search engine and EBSCOhost to seek out professional newsletters, briefs, and reports that dealt with the issue of recruiting men to nursing.

The AAMN’s campaign to recruit men includes a distinct social media component, including a channel on the popular video sharing site YouTube (www.youtube.com). Using this site, videos were located through suggestions on the site and systematic searches for the keywords “male nurse,” “men in nursing,” and “recruiting men to nursing.” My sampling frame limited material to items endorsed or produced by an organization or institution such as the AAMN, or a specific nursing program or hospital (e.g., St. Francis, Emory Healthcare, etc.). All materials had to target men. Amateur videos and those portraying nursing students were excluded. Like other visual studies of “found materials,” I cannot assess the representativeness of these materials.
(Pauwels 2010:550). However, by using a variety of search techniques across multiple sites, the search for materials within the parameters of the study was thoroughly exhausted and yielded a range of affiliations, including multinational and national corporations, urban hospital systems, national and state nursing organizations, and community colleges. Northeastern, Southern, Midwestern, and Western regions of the U.S., as well as a multinational corporation, are represented in the material. To ensure access to the video content, I downloaded high-quality MP4 files of each video and stored them as permanent electronic copies.

Analysis of the content included attention to the text, speech, and visual elements of the materials (Rose 2004). Visual elements included facial expressions, body posture, and objects. Drawing from the literature on masculinities, I looked for themes relevant to hegemonic and alternative masculinities. In total, the analysis included four rounds of screening the video content. In the first round, I assessed the appropriateness of the item for the study. During a second round of screening, I documented emerging themes relevant to hegemonic and non-hegemonic masculine qualities. I developed a list of codes and re-analyzed the content in a third round of screening, noting the frequency with which they occurred in each brochure, poster, and video, revealing, to a degree, the emphasis a code receives (Rose 2004:362). Using a web based video analysis program (www.dedoose.com) I was able to select clips and elements of posters and brochures and then attach relevant codes to each excerpt. The software tracked code frequencies as well as the number of co-occurrences of codes, that is, the number of times that two codes were applied to the same excerpt. In a fourth round of screening I documented the number of men represented in the materials. Finally, I analyzed the content using each
recruitment item as the level of analysis to determine the type of mobilization strategy used by each (for multiple levels of analysis in content studies, see Kuperberg and Stone 2008).

In analyzing the data sources, I focused on the contradictions between hegemonic masculinities and the demands of a caring profession, looking for themes related to the notion of both hegemonic and alternative masculinities. Emergent hegemonic themes included competition, risk-taking/adventure-seeking, athleticism/physicality, emotional detachment, technical/rational competence, autonomy/independence, emphasized heterosexuality, and breadwinner/provider. Focusing on the care component of nursing, I analyzed the content for emergent non-hegemonic themes, or those that conveyed alternative conceptions of masculinity, including caring for/helping others, teamwork/collaboration, feelings of self-efficacy/gratification, and sense of purpose/making a difference. Following Vigorito and Curry (1998) I analyzed the visual signifiers of masculinity, including facial expression, body posture, and use of objects as props. These included sports equipment, motorcycles and gear, tattoos, smiling or not, arm positioning (i.e., crossed, at side, etc.), and posture (i.e., leaning forward or backward).

Findings

Results of the analysis show a mix of hegemonic and non-hegemonic codes across the recruitment material, with three distinct, emergent strategies for recruiting men to nursing. The first strategy consists of mobilizing hegemonic masculine ideals within the profession and among the men represented in the content. A second strategy pairs
hegemonic with non-hegemonic masculinities in a manner that polarizes these constructions. In a third strategy, alternative masculinities stand alone without recourse to hegemonic forms. This latter strategy focused predominantly on the value of caring for others and making a difference. Before discussing each strategy, I frame the context of recruitment efforts in terms of audience and goals. I then describe the most common hegemonic and non-hegemonic codes in the materials, providing examples for each. Finally, the three mobilization strategies are examined in detail.

The Context of Nursing Recruitment

Beyond meeting the projected need for nurses (Bureau of Labor Statistics 2012), recruiting men to the profession is motivated by broader workforce diversity interests (Institute of Medicine 2010). As echoed by professional reports and newsletters (Institute of Medicine 2010; Johnson & Johnson 2012; Robert Wood Johnson Foundation 2011), a diverse workforce that more closely mirrors the demographics of the patient population is expected to improve patient care. Materials are targeted at boys and young men likely to be in the process of choosing their career. Policymakers suggest that nursing be introduced to boys and youths early on as a viable career choice (LaRocco 2007; Meadus 2000). To reach this audience, materials are distributed to elementary and high schools, advising viewers to contact guidance counselors. Recruitment campaigns also aim to increase public awareness of men in nursing so as to lessen the stigma and stereotypes held by the public at large (Trossman 2003). To accomplish this, press releases announcing organizational recruitment efforts were aimed at the public and local communities (Anderson 2011; American Nurses Association 2007; Virginia Partnership
for Nursing 2002). For example, as part of the “Nurses Change Lives” campaign, the Virginia Partnership for Nursing (VPN) distributed posters “to elementary, middle school and high school students across the state to encourage interest in nursing as a career choice” while also informing the public through a press release (VPN 2002:para. 4).

In line with scholarly work (Allison, Beggan, and Clements 2004; Hesselbart 1977), nursing reports and newsletters note that men in nursing often face stereotyping concerning sexuality, gender expression, and competency, and are often assumed to be gay, effeminate, or lacking the intelligence and ambition for medical school. Previous campaigns tackled this directly with slogans like “Are You Man Enough to be a Nurse?” and “Real Men Choose Nursing.” The AAMN has tried to move away from this rhetoric, using the slogan “Choose Nursing” with the specific aim to “‘de-genderify’ nursing” (Anderson 2011:para. 6). However, as my analysis shows, this shift in rhetoric does not necessarily result in a corresponding change in the masculinities idealized in the recruitment material. Following theoretical critiques of the “androgyneous” and “de-gendering strategies” of early second-wave feminism (Howson 2006:6), efforts to de-gender nursing without detailed knowledge of hegemony’s specific characteristics in this sociocultural time and space fail to translate into professional transformation.

Mobilizing Hegemonic Masculinities

In the overall analysis, 14 hegemonic and non-hegemonic codes were applied 287 times to 248 excerpts. Hegemonic constructions of masculinity were used to define nursing and emphasize culturally ideal masculine qualities of male nurses. Table 2.2 displays the hegemonic themes that emerged from the analysis: rational/technical skills,
autonomy/independence, breadwinner/provider role, athleticism/physicality, and risk-taking/adventure. I discuss these primary themes in greater detail, drawing on the data to illustrate their use.

Table 2.2 Frequency of Hegemonic and Non-Hegemonic Masculinity Codes (Percentages in Parentheses are for All Codes, n = 287)

<table>
<thead>
<tr>
<th>Hegemonic Total</th>
<th>173 (60%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical/Rational Skills</td>
<td>35 (12%)</td>
</tr>
<tr>
<td>Autonomy/Independence</td>
<td>35 (12%)</td>
</tr>
<tr>
<td>Provider/Breadwinner</td>
<td>30 (10%)</td>
</tr>
<tr>
<td>Athleticism/Physicality</td>
<td>29 (10%)</td>
</tr>
<tr>
<td>Risk-taking/Adventure</td>
<td>22 (8%)</td>
</tr>
<tr>
<td>Emotional Detachment</td>
<td>17 (6%)</td>
</tr>
<tr>
<td>Heterosexuality</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>Competition</td>
<td>1 (0.4%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Hegemonic Total</th>
<th>114 (40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring For/Helping Others</td>
<td>53 (18%)</td>
</tr>
<tr>
<td>Making a Difference/Having Purpose</td>
<td>24 (8%)</td>
</tr>
<tr>
<td>Teamwork/Co-workers</td>
<td>17 (6%)</td>
</tr>
<tr>
<td>Gratification/Self-Efficacy</td>
<td>11 (4%)</td>
</tr>
<tr>
<td>Non-hegemonic Hobbies</td>
<td>6 (2%)</td>
</tr>
<tr>
<td>Parenting</td>
<td>3 (1%)</td>
</tr>
</tbody>
</table>
The AAMN’s (AAMN 2011) campaign poster, “Adrenaline Rush,” illustrates several hegemonic themes (see table 2.1 for links to all referenced content). The poster shows a white operating room (OR) nurse wearing a surgical mask next to an image of the same nurse wearing a mask for mountain climbing in extreme weather. Risk-taking/adventure, athleticism/physicality, and detachment from emotion are reflected in the image due to the emphasis on athletic and dangerous mountain climbing and masked facial or emotional expression. Similarly, the Oregon Center for Nursing (OCN) and Virginia Partnership for Nursing (VPN) developed posters in the early 2000s titled “Are You Man Enough?” that clearly emphasized hegemonic masculinities, including athleticism/physicality (evidenced by showing a snowboarder, marathon runner, rugby player, and basketball player), risk-taking/adventure (evidenced by an emphasis on military service), and emotional detachment (figures with unsmiling, expressionless faces, directly facing the camera, several with arms crossed and leaning back). The text of one poster references “intelligence,” “courage,” “skill,” and “unlimited opportunities,” embodying themes of rational/technical skill and autonomy.

Among videos used for recruiting men to nursing, 39 percent (7 of 18 videos) began with a “hegemonic opener”—images of men engaging in sports or using technical equipment, or images of ambulances/helicopters in transit emphasized in the first ten seconds of the video. In one brochure, a nurse acknowledges the wide use of hegemonic openers: “Ads showing men jumping out of helicopters is exciting, but it only touches on the choices available to men in nursing. Nursing is a career that lets you chart your own course” (unidentified race, University of North Carolina brochure, 2007). The risk-taking/adventure aspect of the career is emphasized in hegemonic openers, while the
brochure comment adds another element of hegemonic masculinity—autonomy and
independence. Materials frequently cite unlimited opportunities and freedom to do
whatever you want as a means of enticing men, catering to autonomy and independence
as masculine ideals (or the “frontiersmanship” ideal [Trujillo 1991]). The
autonomy/independence theme is also illustrated by Bill’s comment, “I can work anytime
I want, anywhere I want” (white, California Institute for Nursing and Health Care
[CINHC], 2009).

An emphasis on the technical and rational skills of the job was also common.
Will, an emergency nurse classified as “racially other,” highlights this distinctly
masculine feature of nursing: “If you love math, if you love sciences, I mean, this is a
great career to get into” (other, ConnectEd, 2010). Science and math references allude to
the rational and technical skills needed in nursing: “[Emory] gives me access to science
so that I can do the best job that I can” (white, Emory, 2009).

Also emphasized in the hegemonic openers, and a frequent theme throughout, are
references to sports and athleticism. For example, a Johnson & Johnson video opens with
Romel introducing himself: “I'm a full-time nurse and a part-time beach volleyball
player” (Asian, 2010). Videos also included footage of cyclists, runners, four-wheelers,
football, martial arts, surfing, and weightlifting. Athleticism occasionally co-occurred
with risk-taking and adventure (8 instances of co-occurrence), as shown in the case of Ed,
a white hospice nurse whose past career as a firefighter is highlighted in a Johnson &
Johnson video (2010).

Autonomy/independence and risk-taking/adventure were also referenced by
visuals of motorcycles and nurses as bikers. The “Men in Nursing” video highlights a
white man who embodies the tough, risk-taking ideal: While interviewed, he leans against his motorcycle (away from the audience) while the camera pans across his neck and arms, focusing on his many tattoos. Before riding off, he tells the camera, “I’m a nurse. I’m doing it and I love it” (white, CINHC, 2009). A recruitment video about travel nursing also references the hegemonic notion of risk-taking/adventure multiple times: “The exciting thing about being a travel nurse is just the adventure that it takes you on” (white, American Mobile Healthcare, 2011).

Another frequently cited hegemonic ideal was the provider/breadwinner role. While good pay and benefits are necessary for attracting skilled workers to any profession, nursing has historically faced lower wages that may have turned men away from a nursing career (Evans 2004). In emphasizing high wages, good benefits, and job security, recruitment materials dispel the myth that nurses are poorly paid. In doing so, they allude to the traditional role that men have had in providing financially for a family:

You can make great money—great money. (Troy, white, Clover Park Technical College, 2005)

You will always have a job. (white, CINHC, 2009)

Benefits are great. (Doug, white, Whatcom Community College [WCC], 2011)

Tapping into the traditional provider role that men have historically fulfilled (Bernard 1981), these assertions signal to the audience that being a nurse does not require sacrificing a high-paying and dependable career.
Constructing Alternative/Non-Hegemonic Masculinities

While less frequent overall, alternative masculinities were highlighted in the recruitment materials, with men in the videos citing caring for others and making a difference as significant reasons for choosing nursing as a career. Purposeful, meaningful work was categorized together with the theme of making a difference, as they often co-occurred. Twenty-four of the 248 excerpts reflected this theme. References to caring/helping others were common, as well as an emphasis on teamwork and co-worker interdependence. Frequencies of non-hegemonic codes are also displayed in Table 2.2.

The most common of the non-hegemonic themes was caring for/helping others. Many men noted that being able to help others and provide care is what drew them to the profession. Doug articulates the unique element of carework: “The ability to be able to help others in a special way—it’s being allowed into the life of someone’s most intimate and maybe most difficult time of their life and maybe somehow having a part in improving their lives” (white, WCC, 2011). The human element of nursing is clearly valued by these nurses.

Helping and caring for others often dovetailed with the second most frequent non-hegemonic theme: making a difference/having purpose. The two co-occurred nine times. HillcAh illustrates the link between caring for others and feelings of purpose and making a difference: “Last week when I was taking care of a little premature infant that needed intensive care, and to watch that baby get better and it’s because of what you do to the point where that baby could go home with his mom made a huge difference” (Black, CINHC, 2009). Thomas, a hospice nurse, also reiterates how helping others relates to feeling like he has made a difference: “If I can help my patients, their families, the
community be more comfortable with this natural and inevitable experience [death], I’ve made a difference” (white, St. Francis Health, 2010).

Hegemonic codes rarely co-occurred with making a difference or having purpose. Technical competence or job security did not explain the feelings of meaning and purpose often elicited from caring for others. When financial reward co-occurred with helping others and making a difference the tension between the two was explicit: “You really do make a difference every day you work as a nurse helping people, but it’s also financially rewarding as well” (Black, CINHC, 2009, italics added). While financial matters are referenced in the same sentence as feeling as though one has made a difference, the “but” makes this connection appear polarized, highlighting the distinction between hegemonic and non-hegemonic concerns rather than constructing alternative masculinities that transcend hegemony. This stands in contrast to feeling like one has made a difference because one has helped others, a sentiment captured in Thomas’ if-then statement in the previous quote.

Feelings of making a difference often stood independently. For example, in a video a nurse states that “you can go home each day and look yourself in the mirror and say, ‘Hey, what I did today really, really makes a difference’” (Black, CINHC, 2009). Thomas, the hospice nurse mentioned earlier, also reiterates the importance of feeling purpose in one’s work: “I love being a hospice nurse. It allows me to go home at the end of every day knowing that I have made a difference in the world” (white, St. Francis Health, 2010). Helping others and desiring emotionally and existentially satisfying work may appear at odds with hegemonic notions of independence and emotional detachment.
Mobilization Strategies

The frequency of hegemonic and non-hegemonic themes throughout the recruitment items provides a general impression of organizational efforts to recruit men. However, looking at the percentage of hegemonic and non-hegemonic codes per each individual recruitment item, we gain a better understanding of the type of mobilization strategy employed in the case of each particular poster, video, and brochure. Each recruitment item is a distinct unit, with a specific type of mobilization strategy. Calculating the percentage of hegemonic and non-hegemonic themes found in each item revealed three strategies of recruitment: full hegemonic co-option, partial hegemonic co-option, and alternative construction of masculinities.

Seven of the 32 recruitment items (22 percent) used hegemonic qualities of men in nursing, emphasizing hegemonic traits of rational/technical skills, physicality/athleticism, autonomy/independence, and the breadwinner/provider role. Five of the seven full co-option items were posters – suggesting that the poster’s format may be somewhat constrained compared to longer videos that can show a variety of men and masculinities. A video exemplifying this strategy is “Men in Travel Nursing.” Beginning with a hegemonic opener of rock climbing and surfing, men in this film reiterate adventure, opportunity, good pay, and excitement as the reasons they went into nursing. Helping patients or making a difference are not mentioned, nor do any of the visuals
show a nurse interacting with a patient. Using only hegemonic themes, these materials illustrate a strategy of full hegemonic co-option.

Seventeen of the 32 items (53 percent) included a mix of hegemonic and non-hegemonic codes. This was the most common mobilization strategy, often illustrating continuing tensions within masculinity. Hegemonic and alternative codes co-occurred in only six excerpts from the materials. Hegemonic and non-hegemonic themes were often polarized, as in the case of the breadwinner/provider ideal contrasted against caring for others: “You really do make a difference every day you work as a nurse helping people, but it’s also financially rewarding as well” (Black, CINHC, 2009, italics added). In a second example, a variety of men in a 40-second montage each mention perks of the job: “120,000 new nurses are needed every year,” “The opportunities are endless,” and “I’ve had steady income and pay increases all along the way.” Within this montage, a single man (Hillcah, Black) emphasizes care in a distinct frame: “For me, I wanted to make a difference in someone’s life.” Rather than constructing transformed masculinities that simultaneously allow for motives of helping others and monetary compensation, income and benefits are polarized as ideals that contrast with making a difference. With hegemonic themes predominant, the co-existence of alternative and hegemonic themes appears conflicted rather than transformative of dichotomous views of ideal masculinity and caring for others.

Eight of the 32 items (25 percent) used a mobilization strategy that centered on the construction of alternative masculinities—conceptions of manhood that focused on caring for others, making a difference, or working with a team. These items did not reference any of the ideals of hegemonic masculinity. An example of this strategy is the
short, 30-second commercial by Johnson & Johnson titled “Name Game.” In this commercial, a white pediatric nurse closely interacts with a young patient named Emma. Seated next to her, he says, “I know it’s not your favorite, but it’s time for your medicine.” Leaning in, he inserts the medicine into her IV and the two smile and sing in unison: “Emma, Emma, bo-bemma, banana-fanna-fo-femma, fee-fi-fo-femma, Emma.” No reference is made to pay, technical skills, or autonomy. Constructing a portrait of men in nursing without reference to hegemonic themes, the video’s mobilization strategy is one of alternative construction rather than full or partial hegemonic co-option.

Discussion

Results of the analysis of nursing recruitment materials aimed at men show how organizations mobilize hegemonic and non-hegemonic constructions of masculinity in order to diversify nursing and reduce the stigma of men in nursing. In doing so, they suggest a paradox: Some recruitment content appears to reproduce aspects of hegemonic ideals while other items exclusively emphasize caring, helping others, and making a difference. Materials varied in the extent to which they embraced hegemonic conceptions of masculinity, as well as which aspects of hegemonic masculinity were referenced. The data revealed three distinct mobilization strategies: full hegemonic co-option, partial co-option, and alternative constructions of masculinity.

In an effort to reconcile conventional qualities of masculinity with a caring profession, some recruitment videos and posters rely exclusively on the image of a tough, emotionally detached, and rational man. Where recruitment items employ a strategy of full hegemonic co-option, aspects of care are eclipsed by hegemonic themes in a manner
similar to other historic campaigns (see Evans 2004, 325-26). Aspects of hegemonic masculinity could be constructed in a manner compatible with caring for others (O’Lynn 2007a), but compatibility cannot be highlighted when references to care are omitted altogether. In order to meaningfully represent men as caring, the historic conflation of femininity with care must be confronted along with increased understanding of how men may care differently than women (O’Lynn 2007a).

While the number of hegemonic codes outnumbered non-hegemonic codes, the majority of recruitment items include themes from both categories. Nursing scholars acknowledge the difficulties in reconciling conventional masculinity with care, arguing that hegemonic notions of masculinity must be transformed (Evans 1997; Meadus 2000). From the current analysis we see that this transformation is still in process, as aspects of hegemonic masculinity rarely reinforce an ethic of care. One of the organizational leaders in recruiting and retaining men in the profession, the AAMN continues to mobilize aspects of hegemonic masculinity despite claims to move away from overtly gendered tactics. Empirically, there is continued need to assess how hegemonic and non-hegemonic themes in recruitment material influence viewers and potential recruits, because their success in recruiting men is likely to influence their use and re-use. Further work is needed on the role that nursing and other organizations may play in critiquing, co-opting, or re-constructing hegemony.

Nurturing and providing care are not exclusively female skills, despite dominant cultural beliefs (Meadus 2000; O’Lynn 2007a). Some recruitment materials constructed alternative masculinities that emphasize caring for others and making a difference (e.g., Johnson & Johnson’s “Name Game” and St. Francis Health’s “Hospice” video). This
shift in masculine representations and the value of work centered on care illustrates how alternative masculinities are constructed. While future research is needed to assess the effectiveness of each mobilization strategy, adding alternative masculinities to the discourse counterbalances the hegemonic ideals of autonomy, stoic manliness, and the devaluation of work traditionally done by women – a necessary step toward transformative masculine constructions that might disrupt the dichotomous view of hegemonic and alternative masculinities.

One implication of the current study for gender theorists concerns the role of organizations in perpetuating gendering practices (Martin 2003). Gendering practices operate within organizations as the set of gendered knowledge from which individuals draw in order to enact masculinity and femininity in workplace situations. The analysis reveals how gendering practices, specifically configurations of hegemonic and non-hegemonic masculinities, are mobilized by organizations. Although organizations are not people, the analysis further suggests that, like people, organizations “mobilize” particular aspects of culturally idealized and alternative masculinity in order to recruit men to nursing. Reflecting one further theoretical implication, the analysis shows how these gendering practices are enacted at the organizational level – that is, through the ideological mechanism of mediated representations of men. Suggesting continued tension between ideal and alternative masculinities, the analysis reveals a dialectic within, rather than a transformation of, hegemony.

Martin’s (2001; 2003) fieldwork on gendering practices showed that mobilizing masculinity is not without consequence, as men and women often suffer professionally if they fail to mobilize masculinity appropriately at work. While the implications are
unknown, the use of gendered practices, such as mobilizing hegemonic masculinities at the organizational level, may also be harmful. Tough questions remain. Is the use of hegemonic masculinity – ideals that often constrict men and reproduce gender inequality – justified by the overall goal of desegregating a traditionally female profession? How might recruitment efforts that target men transform hegemonic ideals in such a way that makes them compatible with notions of helping others and making a difference?

Tackling the larger problem of diversity needs, organizations are likely to turn to commonly held, culturally valued characteristics that define ideal masculinity in hegemonic ways. This is well-intentioned and pragmatic. Organizations utilize hegemonic and non-hegemonic masculine themes simultaneously. Like individuals facing constrained choice within systems of oppression, the mobilization of masculinities in recruitment materials involves both complicity and resistance (Pyke 2010). In her analysis of women’s inclusion in the Israeli army, Sasson-Levy (2007:502) finds that the state’s “double-edged strategies” include women while simultaneously marginalizing them. The recruitment strategies of health care organizations can be seen as similarly double-edged, suggesting a simultaneous dialectic of hegemonic and alternative masculinities. While including alternative masculinities, recruitment materials often framed these in dialectic tension with hegemonic ideals, failing to fully transform hegemony. Echoing previous work on the inclusion of subordinated masculinities in television shows, “inclusion” of alternative masculinities may provide a false sense of balance that masks the “lead role” that hegemonic masculinity holds in relation to the subordinate roles of alternative masculinities (Hanke 1992:194-95). Hence, ideological “inclusion” may serve to reinforce the “norm” of hegemony. Efforts to construct
alternative forms of masculinity appear to subvert and resist strictly hegemonic ideals, while at the same time strategies of hegemonic co-option rely on entrenched ideals about what it means to be a man, often privileging these ideals over and above the value of helping others. A strategy of hegemonic transformation – one in which manliness and care are not constructed as antithetical categories – has yet to be realized (O’Lynn 2007a).

Critiques of a gendering practices approach note the need to specify the role of power and inequality in such practices (Ferree 2003) and theorize beyond the level of the individual (Connell 2003). By positing organizations within the health care industry as agents in the construction and reproduction of masculinities, the current study extends Martin’s (2001) original conception of “mobilizing masculinity” from a primarily one-dimensional, individual act to a multi-dimensional organizational and ideological practice. In using hegemonic and alternative masculinities, organizational gendering practices are linked to the vast literature on gendered power (Connell 1987; 2005). Furthermore, concepts of full and partial co-option, as well as alternative constructions, provide useful language for discussing how organizations and groups use masculinities at the ideological level. For example, advertisers’ efforts to capture the male demographic through “manvertising” may also utilize mobilization strategies that transform or co-opt hegemony.

One limitation of the current study is the limited number of men of color represented in the materials. While the sample was predominantly white (69 percent), the representations of racial minorities, particularly Black men, suggest ways in which race may shape masculinities. Hillcath is in illustrative case. One of two Black nurses in a ten-
minute promotional video, Hillcah provides a singular emphasis on helping others in contrast to the hegemonic themes of autonomy, provider/breadwinner, and risk-taking ideals promoted by white and Hispanic/Latino men in the same video. Hillcah’s presentation suggests that as Black men negotiate hegemonic masculinity in a context framed by gendered racism, they may rely more heavily on alternative, care based constructions of masculinity. This echoes prior work on African-American men in nursing (Harvey Wingfield 2010) and highlights the need for more research on the representations and experiences of men of color in caring professions.

The recruitment of men to a traditionally female profession such as nursing merits continuing scholarly concern. Results of the analysis highlight a tension between hegemonic masculinities and the caring demands of the profession, with nursing related organizations using three strategies that mobilize masculinities in an effort to recruit men. Recruiting men to nursing as a goal cannot stand apart from the goal of recruiting highly qualified and compassionate workers, hence the need to transform, rather than co-opt, hegemony. Believing that hegemonic constructions of masculinity often hurt individual men and society, Kimmel calls for a new masculinity in the United States “that is more about the character of men’s hearts and souls than about the size of their biceps or their wallets” (Kimmel 1997:333). Through a confluence of economic necessity and organizational practice, the alternative constructions of the contradictory male nurse may hold particular promise for a redefinition of masculinity based on heart and soul rather than biceps and wallets.
CHAPTER III
THEORIZING EMOTIONAL CAPITAL: A CASE STUDY OF MEN IN NURSING

Abstract

Theorizing a sociology of emotion that links micro-level resources to macro-level forces, the present study develops the construct of emotional capital by integrating the concept with gender and emotion management theories. Emotional capital refers to the emotion-specific, trans-situational resources that individuals situationally activate and embody. To develop the concept as distinctly gendered, I draw on case study data on men in nursing. The narratives gained through interviews with male nurses and their audio diaries suggest that, contrary to prior research, men do hold forms of emotional capital, with distinct practices of mobilizing and embodying that capital through emotional experiences and management. The data further suggest that the concept be refined to include primary and secondary sources of emotional capital. Men’s bring relatively rigid primary capital to the profession, while also developing secondary capital through occupational socialization centered on practices of empathy, compassion, and care. Theoretical implications of emotional capital for masculinity and emotion management theory, as well as implications for future research on men in caring professions are discussed.

Keywords: Emotional Capital, Gender, Emotion Practice, Primary and Secondary Socialization
Introduction

Under-theorized and under-utilized in the sociology of emotions, the concept of emotional capital holds promise for furthering emotion scholarship by linking individual resources and processes to macro-structural forces, including “social order, social inequality, and social cohesion” (Thoits 2004:372). Prior research has applied emotion-based resources to innate “caring selves” (Stacey 2011), self-processes of “emotional mining” (Schweingruber and Berns 2005), and reproduced class inequality (Reay 2004). A tripartite concept composed of knowledge, management skills, and capacities to feel, emotional capital links self-processes and resources to group membership and social location within the broader framework of Bourdieu’s social theory (1992).

Compared with other conceptions of emotion-based resources such as “emotional intelligence” (Goleman 1995; Salovey and Mayer 1990) and “emotional competencies” (Gendron 2004), emotional capital as a concept seeks to capture a direct relationship between macro-structures and micro-resources, constrained agency in practice, and the relationships among habitus and other forms of capital. Framed within Bourdieu’s (1992) conceptualization of social practice, emotional capital is an unequally distributed resource to which individuals and groups lay differential claim and embody/mobilize in everyday conscious/nonconscious practice. The transformation of emotional capital into other capitals takes place through emotion practice—the situated activation and embodiment of emotional capital that includes emotional experience, expression, and management. An emotion practice approach views emotion as influential and reflective of “the interests of individuals within everyday interaction while, at the same time,
(re)producing the broader structural and cultural conditions in which such interactions occur” (Erickson and Stacey 2013:179). Emotion management (Hochschild 1983) can be seen as one aspect of situated emotion practice—the interactional site of contested and/or reproduced structural inequalities surrounding class, race, and gender. As a trans-situational, personal resource, emotional capital is inextricably linked to variations in power and privilege in contemporary society, making it a key concept for addressing classic sociological issues of social order, inequality, and change.

The current chapter examines the concept of emotional capital, including its development in the literature, to highlight conceptual gaps and more clearly theorize the concept’s relationship to gender, emotion practice, and socialization (Cahill 1999; Nowotny 1981). Upon reviewing the concept’s use in the literature, I highlight gaps that remain in our understanding and offer theoretical suggestions grounded in qualitative, empirical data. Using data from a study of men in nursing, I extend the theory in order to address current critiques. Specifically, the current chapter examines the following three issues unattended to in the current literature: (1) men’s possession and practical use of emotional capital; (2) distinctions between emotional capital and practice; and (3) the structured but dynamic nature of emotional resources in relation to primary and secondary socialization.

Bourdieu’s Theory of Social Practice

Poststructuralist at its core, the social theory of Pierre Bourdieu (1986; 1992) seeks to transcend (1) the dualism between structural determinism and humanistic voluntarism, (2) the modern view of the consciously-calculating individual, and (3) the
objective/subjective divide. Bourdieu “roots human consciousness in practical social life” (Swartz 1997:39) by attending to the non-conscious practice of everyday living. Critical to his theory is the concept of habitus: “systems of durable, transposable dispositions” that include “structured structures predisposed to function as structuring structures” shaped by social conditions (Bourdieu 1992:53). Straddling mind/body and conscious/non-conscious dualisms, habitus operates at the visceral level of everyday being and doing rather than as a reflected upon, cohesive set of known beliefs and values held by Enlightenment’s idealized rational actor. Operating within the habitus, capital consists of “attributes, possessions, or qualities of a person or a position exchangeable for goods, services, or esteem” (DiMaggio 1979:1463). In bringing one’s worldview—one’s habitus—to bear on situated practical needs, individuals draw upon specific personal qualities that serve as transferable resources. Social conditions shape forms of capital, with dominant forms operating as those with greatest social value (Bourdieu 1986).

Bourdieu’s theory of practice (1992) has been criticized as circular and deterministic (Jenkins 1982; Swartz 1997) as well as inattentive to inequalities beyond class, such as gender (Adkins 2004; Skeggs 2005) and race (Emirbayer and Desmond 2012). While Bourdieu’s grand theory is beyond the scope of the current chapter, critiques of the Bourdieuan actor as overly-determined highlight the utility of clearly delineating between capital’s dynamic and fixed nature—clarity, I argue, offered in distinguishing between capital gained in primary versus secondary socialization. It is through socialization that individuals develop habitus—“a generative schema in which social structures come, through the process of socialization, to be embodied as schemes of perception that enable a practical mastery of the world” (Nash 2003:47). Socialization
sources include family and early education as well as sources that span the length of the life course to shape attitudes, behavior, and emotion (Ryder 1965; Singh-Manoux and Marmot 2005). Yet little work using Bourdieu distinguishes between different sources of socialization and how this may influence capital and its use in situated social practice.

Framed within feminist critiques, the current chapter also focuses on the relationship between gender and emotional capital. Unlike most feminist conceptions of emotional capital, however, I argue that the concept does not take a monolithic form across genders and, as such, comparing men’s and women’s emotional capital in terms of quantity alone—with men having less emotional capital—fails to meaningfully address the forms of emotional capital that men hold. Prior characterizations of emotional capital have been overly-feminized (Reay 2004; Gillies 2006; see Manion 2007 for this critique) or gender neutral (Cahill 1999; Schweingruber and Berns 2005). Counter to this prior work, I argue that emotional capital is gendered in form, shaped by primary and secondary socialization, and a critical concept for deepening our understanding of emotion and its relationship to the interactional embodiment/enactment of emotion in everyday life (Erickson and Stacey 2013).

As the embodiment/activation of emotional capital, emotion practice includes experiences of felt emotion as well as the management of emotion. Framed within emotion management theory (Hochschild 1979; 1983), emotion management refers to the active effort put forth by individuals in order to align felt and expressed emotions with interactional emotion norms (or feeling rules) – the constructed and situationally-specific expectations for what and how to feel. These rules vary by gender (Brown 2005; Chaplin, Cole, and Zahn-Waxler 2005; Garside and Klimes-Dougan 2002) as well as occupational
setting (Harvey Wingfield 2010; Pierce 1995). While emotion management theory has
successfully redefined emotion as an inherently social phenomenon (Shott 1979;
McCarthy 1989), its fixed attention to the interactional level has limited our
understanding of its scope and the potency with which emotion reciprocally shapes and is
shaped by social life. A focus on emotional capital and emotion practice contextualizes
the embodied nonconscious/conscious aspects of emotion and its management within
social hierarchies of power and distinction (Erickson and Stacey 2013).

Emotional Capital: Definitions and Development

Nowotny (1981) is commonly cited for developing the concept of emotional
capital (Gillies 2006; Reay 2004). However, its usage goes back even further to Jackson’s
(1959) contribution to an edited volume on “The Meaning of Death” (also referenced in
Lucas 1968). Jackson integrates psychology and theology in approaching the issue of
grief, defining the function of religion as enabling an individual to “meet the fact of death
at the physical level with a firm sense of reality, a healthful expression of feelings, and a
capacity to reinvest emotional capital where it will produce the best fruits in life”
(1959:219, italics added). He goes on to describe various rituals of grief and the
psychological benefit they provide for mourners. While outside the sociology of emotion,
Jackson’s phrasing hints at the tension between structure and agency that underlies social
theory more generally (Archer 1990; Fuchs 2001). Although he defines the “capacity to
reinvest emotional capital” as a function of religion, this “capacity” can be linked to
socialization and framed by the structural forces implicated in gendered, racialized, and
classed social locations. “Reinvestment,” by contrast, conveys an individual’s active role
in shaping emotional capital and its fruits. While capacities are constrained by social forces, it is only through structured capacities that individuals exercise reflexive agency by investing in their emotional capital, ideally leading to the “best fruits in life.”

Imposing a more sociological lens than Jackson (1969), Nowotny’s (1981) work on Austrian women in public life was the first to theorize emotional capital using Bourdieu. She defines emotional capital as “knowledge, contacts, and relations as well as access to emotionally valued skills and assets” (148). Froyum (2010) extends this definition, with emotional capital acting as an interpersonal resource that “treats emotions and their management as skills or habits that translate into social advantages” (39).

*Knowledge* of situationally appropriate emotional experiences and expressions compliments the skills needed to manage emotions. Adding to this definition further, Thoits (2004) argues that emotional capital encompasses not only emotion-based knowledge and emotion management skills, but also the capacity to experience “social emotions” predicated on role-taking (Mead 1934; Shott 1979). Combining these definitions, I use emotional capital to refer to *one’s trans-situational, emotion-based knowledge, emotion management skills, and feeling capacities.*

Providing an original definition of emotional capital as well as a critique of women’s relegation to private life, Nowotny analyzed Bourdieu’s social theory with a distinctly feminist angle. Unfortunately, Nowotny’s work does not engage the sociology of emotion literature and overlooks the role of emotion in the public sphere, connections Hochschild (1979; 1983) was developing contemporaneously. Similar to Bourdieu’s (2004) claim of a “sharp separation between masculine society and feminine society” in France, Nowotny contextualizes emotional capital within contemporary divisions
between public and private. For her, women’s role in the private sphere of family supplies them with more emotional capital than men. This feminization of the concept is carried forward in the education literature by Reay (2000; 2004) and Gillies (2006), largely closing off potential theorizing on the reciprocal relationship between masculinity, emotional capital, and men’s everyday emotion practice.

Emotional capital has been developed and applied primarily within the areas of education and family (Colley 2006; Gillies 2006; Nixon 2011; O’Brien 2008; Reay 2000; 2004; Reid 2009; Zembylas 2007). However, there has been a growing tendency to use the term within the context of occupations (Cahill 1999; Schweingruber and Berns 2005), particularly in regard to the role of emotional capital in work centered on care (Erickson and Stacey 2013; Husso and Hirvonen 2012; Stacey 2011; Virkki 2007). In some respects, the concept has followed women from the home to the workforce, from unpaid work in the home to paid labor in the public sphere. When focused on emotional capital within occupations, prior research has largely ignored gender as a significant factor. When focused on primary educational and familial settings, research has neglected the dynamic nature of capital as an evolving resource beyond sources of primary socialization. In both approaches, the relationships between emotional capital, experience, and management remain unclear. The following section provides an overview of the literature-to-date on emotional capital, attending specifically to these three limitations. Following this review, I turn to data on men in nursing to illustrate new ways of conceptualizing emotional capital.
Emotional Capital as Feminine or Gender-Neutral

A notable theme in prior research is the emphasis placed on emotional capital as a distinctly feminine resource. Education scholars and feminists have made the important contribution of theorizing the concept in relation to gender and inequality, however their treatment overly feminizes emotional capital and does not examine the full scope of gender’s influence on emotion-based resources. Following Nowotny (1981), Reay (2000; 2004) traces emotional capital across relationships between mothers and children as each navigate class constraints and opportunities within the educational system. She finds that just as wealthier middle-class families are able to pass along economic resources to their children, middle-class mothers are better positioned to equip their children with emotional resources (i.e., emotional capital). Reay theorizes emotional capital as nearly equivalent with mothers’ overall emotional support of their children, as well as qualitatively constant across groups (class, race, gender), rather than taking on varying forms depending on group membership. This approach poses several difficulties for clarifying the relationship between gender, capital, and practice (see the following for a similar critique: Manion 2007; Zemblyas 2007).

Also in the areas of family and education, Gillies’ (2006) work on mothers’ support for their school-aged children details the ways in which class shapes the links among emotional capital, self-esteem, protection, and economic success. Explaining her choice to focus on mothers rather than fathers, Gillies argues that fathers took an emotionally detached approach to their child’s schooling because they were unable to manage (control) their feelings of anger. This, she argues, suggests that it is primarily the mother’s emotional capital in service of educational goals that is transferred to the child.
Unfortunately, this presumes that men, fathers specifically, have less emotional capital to transfer to children rather than seeing this emotional capital as taking on different forms based on a father’s gendered location and the different emotion norms to which men and women are held. Gillies does not take this approach in her treatment of class, finding that working-class mothers’ “distant position” (2006: 287) in terms of their children’s education represents a different form of emotional capital rather than less emotional capital as compared to middle-class women. While Gillies successfully avoids imposing “middle class values on working-class lives” (285), she overly feminizes emotional capital in a manner that precludes theoretical and empirical attention to how it may be shaped by masculinity and mobilized/embodied in men’s everyday lives. Furthermore, the focus on mothers’ transfer of emotional capital to their children overlooks the more foundational transmission of emotional capital into emotion practice, as well as its transformation into other forms of capital – a critically important feature of Bourdieu’s original conceptualization. Men in nursing provide an illustrative case in which the relationship between masculinity and emotional capital might be better theorized, as well as the influence of gender on men’s activation/embodiment of capital through emotion practice.

Virkki (2007) uses the concept of emotional capital in her study of female social workers and nurses in Finland. Participants characterize patients as child-like and emotionally “illiterate” in order to establish themselves as emotionally competent and in possession of greater emotional capital. Virkki also suggests emotional capital as a resource exclusive to women: “emotional capital may be a dead letter in the masculine, working-class sphere, where physical superiority is more valued than emotional skills and
caring” (2007:278). While this may be the case, the implication that men do not possess any emotional resources is overly essentialist and dilutes the theoretical significance of emotional capital for other arenas of social life (Manion 2007; Zemblyas 2007). Virkki rightly notes that the conception of emotional skills as natural to women has disadvantaged them, but to counter this with a claim that only women possess emotional skills and competencies overextends the critique.

Nowotny’s (1981), Reay’s (2000; 2004) and Gillies’ (2006) treatments of emotional capital as gendered are, however, laudable in comparison with the relatively gender-neutral approach taken by occupational scholars. Within occupational settings, the role of gender in shaping capital, including its development and use, has been relatively ignored. Looking at both men and women, Cahill (1999) and Schweingruber and Berns (2005) attend to the role of occupational socialization in shaping emotional capital and its use. Cahill’s study of mortuary students emphasizes student’s prior experiences with death and mortuary work, but does not examine the role that gender as well as other factors such as race or class might play in shaping the emotional capital students need to be successful. Schweingruber and Berns’ research on how a sales company trains workers to develop emotional capital for the job makes important links between constructions of self and emotion management. Absent from this analysis is the role of gender in development of capital and self-constructions. With gender an integral aspect of self (Connell 2005), social structure (Risman 1998; 2004) and a primary social frame (Ridgeway 2011), linking emotion to the gendered selves of men in nursing extends our understanding of how gender shapes emotion-based resources and practices.
Emotional Capital as Investment or Support

Parallel to an overly feminine or gender-neutral conception of emotional capital, prior research on the concept often conflates emotional capital with support and well-being—failing to clearly relate emotional capital with emotion management or emotional experiences. Education scholars see emotional capital as the act of parental investment women make in the education of their children in the hopes of converting their emotional capital into the economic and cultural capital their children might gain from an improved education (Gillies 2006; Reay 2000; 2004). Using interview and observational data, researchers largely equate the intense emotions women reflect in interviews surrounding their child’s education with emotional capital, rather than defining capital as experiential capacities, management skills, and knowledge of emotion norms. For example, Gillies (2006) defines emotional capital itself as “emotional investments made by parents as part of their desire to promote their children’s wellbeing and prospects” (285). Such a conceptualization reduces capital to markers of a mother’s concern for her child. Certainly a mother’s concern is an important aspect of socialization, but equating concern with emotional capital is inconsistent with prior definitions (Froyum 2010; Thoits 2004) and tends to diminish its theoretical potency. Without clarity about how parents interactionally develop their child’s knowledge of emotion norms, skills, and/or experiential capacities, the links between a parent’s emotional capital, the mobilization of that capital through emotion practice, and children’s accumulation of capital remain obscure. Such distinctions are critical to understanding the relationships between capital and practice.
In applying the concept, Reay (2004) conflates mothers’ emotional capital with their emotional experiences: “it was primarily working-class women, with negative personal experiences of schooling, who found it extremely hard to generate resources of emotional capital for their child to draw on if they [were] experiencing difficulties in school” (63). From this quote, Reay uses the negative emotions of humiliation, embarrassment, and anger that mothers feel as result of their own educational success to indicate limited emotional capital. By using negative emotions as a proxy for capital, Reay does not distinguish between capital and practice but rather conflates the two. Disagreeing with Reay’s characterization, Manion (2007) argues that “conditions of poverty may catalyze the development and transfer of specific emotional capital resources” (94). Rather than diminish capital as a result of negative felt emotions, the experiences of the working-class and the poor may foster greater emotional capital needed to confront economic adversities.

Reay’s discussion of emotional capital is problematic in that it conflates capital with the experience of emotions, failing to distinguish capital from its mobilization/embodiment in everyday emotion practice. While Manion (2007) critiques the implications of this conflation for understanding the relationship between class and emotional capital, empirically-grounded work has not illustrated the relationship between emotional capital and practice. Addressing this issue in the present study, I use narratives of men in nursing to clarify distinctions between the emotional capital men gain from primary socialization experiences, capital developed on the in their work in a caring profession, and how they embody and activate that capital as a part of their emotion practice on the job.
Emotional Capital as Rigid and Evolving Resource

A third theme in the literature on emotional capital is the tension between how rigidly capital as well as habitus are “anchored” by social forces during primary socialization (Manion 2007:91) and their sensitivity to development and modification (Schweingruber and Berns 2005; Stacey 2011). The promise of Bourdieu’s (1992) social framework is that it seeks to transcend the dualism of structure/agency which commonly fails to account for agentive change. In the case of emotional capital, scholars have had difficulty theorizing aspects of capital that remain rigid and fixed and aspects that are amenable to modification. Cahill’s (1999) study of mortuary students provides insight into the emotional capital that students bring with them to their occupational training and he links this capital directly to family experiences. Students who remained in the program noted that they grew up around death and that it did not appear to bother them—did not lead to the same emotional experiences and management strategies—as compared to colleagues who lacked this upbringing and ultimately dropped out of the program.

Emotional capital gained in primary socialization appears impervious to program efforts, as those without the primary capital gained by growing up around death were unable to develop the emotional capital necessary to do mortuary work. Cahill’s study suggests a distinction between primary and secondary emotional capital, emotion capital gained in primary socialization and that which is gained in secondary socialization. Developing the concepts of primary and secondary emotional capital using data from men in nursing allows for a more complete understanding of which aspects of capital remain rigidly consistent despite secondary socialization efforts.
Schweingruber and Berns (2005) also discuss how emotional capital may be developed on the job in their examination of the training that book salespersons receive. Notably, they find that occupational training emphasizes “emotional mining” and “emotional bridging,” processes through which trainees produce and use their emotional capital for the purpose of selling books. These processes allow salespersons to develop the emotional capital needed to be successful in the occupational sphere. The question remains, how is it that Cahill’s (1999) mortuary dropouts were unable to produce, and in his view would never be able to develop, the emotional capital that second-generation mortuary students had while Schweingruber and Berns emphasize trainee’s dynamic construction of emotional capital through emotional mining and bridging? Delineating between primary and secondary capital, I argue, is key for clarifying capital’s simultaneous rigid fluidity and an individual’s constrained agency in the cultivation of emotional capital.

In prior research in the areas of family, education, and work, scholars of emotion have faced methodological and practical constraints in their effort to examine how emotional capital influences educational and occupational success as well as individual well-being. Theoretical distinctions between emotional capital and emotion practice remain unclear in the literature to date. This has had methodological implications as well, with emotional experience and investment in others used as a proxy for an individual’s emotional capital (Gillies 2006; Reay 2004). Furthermore, much of the research on emotional capital reproduces essentialist ideology, presuming that women have capital while men do not, or a modified view that women have more capital than men. Finally, comparing Cahill (1999) with Schweingruber and Berns (2005) opens up questions
concerning the tenacity of emotional capital and its sensitivity to modification as a result of secondary socialization. Prior work on emotional capital has insufficiently theorized how emotion-based resources may vary in form across gender, the relationship between capital and emotion practice (i.e., experiences and management), and the rigid but malleable nature of capital as a result of multiple sources of socialization. Drawing on data from male nurses, the current study examines emotional capital as a gendered resource men possess and use as they engage in job-specific emotion practice, as well as capital’s rigid fluidity as a result of primary and occupational socialization.

The Case of Male Nurses—Data and Methods

Using the experiences and perceptions of men in nursing as a theoretically illustrative case, the present study examines formations of emotion-based knowledge, management skills, and capacities to feel as the emotional capital that men bring to and develop within the profession of nursing. Drawing on interview and diary data, I address each of the three theoretical themes noted in the above literature review. These themes included an overly feminized or non-gendered conception of emotional capital, unclear distinctions between capital and practice, and inconsistency in the rigid yet dynamic nature of emotional capital. The unique experiences of men in nursing provide new insights into how emotion scholars might conceptualize emotional capital in relation to gender and occupation. Data come from interviews with 31 males nurses and 10 audio diaries completed by male nurses.
Audio Diaries

Audio diaries of male nurses were collected as part of a larger project on identity and emotion among nurses at a large Midwestern hospital system from spring 2011 through the fall of 2012. A complete listing of full-time, direct care RNs was obtained from the health system’s human resources department and written questionnaires in sealed envelopes were distributed to eligible RNs employed within each hospital (N = 1702). Completed surveys were returned by mail from 762 participants, or 44.8 percent of the original eligible sample. Among those who returned questionnaires, we contacted men who indicated interest in participating in future phases of the study. Those who responded were asked to participate in a one-time training session on operating a voice recorder which they would use to make recordings after 6 consecutive shifts. As instructed, the content of the diaries could include their reflections on the shift, memorable events, and how they felt during and after the shift. Participants were compensated with a $75 check for completing the audio diaries and $25 for participating in a follow-up interview with a team member. Ten men completed audio diaries, for a total of approximately 8 and ½ hours of recording.

In-Depth Interviews

Interviews with male nurses were conducted from the spring of 2012 through the fall of 2012. Participants were geographically dispersed. I relied on connections with the American Assembly for Men in Nursing (AAMN) to contact chapter leaders across the U.S. and solicit their participation and help in recruiting male nurses. Of the 29
interviews I conducted, 6 were conducted in person and the remaining 23 were conducted over the phone. Following the receipt of a monetary grant, subsequent participants were compensated with a $20 check mailed to their address. Participants were given an informed consent form approved by the university’s IRB prior to each interview (see Appendix B). Two interviews were conducted in person by a male member of the research team.

In conducting in-depth interviews, I relied on a script of open-ended questions that probed participants on the emotional demands of nursing, their experiences as men in the profession, general reflections on providing care to others, as well as specific examples of providing care (see Appendix C). The primary questions that guided the issues dealt with in the current chapter included the following: “How do you see men in terms of their experience of emotions and capacity to nurture others? How do you see yourself in terms of anticipating others’ emotion and the capacity to nurture in your role as a nurse? To what extent does being a man hinder you as a nurse? To what extent does being a man help you as a nurse? Do you see your time in nursing as influential to who you are as a man?” I also used follow-up probes asking men if they had always been empathic and compassionate or if this developed while they were in nursing; as well as if they thought others could be taught capacities and skills that they discussed as relevant to meeting the emotional demands of the profession. Interviews were recorded and transcribed by myself, members of a research team, and through the professional services of a research company. All quotations used in the text were checked multiple times for complete accuracy against the original recording.
Interviews were conducted in person and via telephone using open-ended questions that centered on men’s experience in the profession, if and how they confronted emotional demands, and how they reconciled cultural masculine ideals of stoicism and emotional detachment (Connell 2005) with nursing’s emphasis on emotional nurturance, empathy, and care. My status as a female researcher likely shaped interviewees’ responses and presentation. This is especially likely in qualitative research with men (Lupton 2006; Schwalbe and Wolkomir 2001; Williams and Heikes 1993) and when researching emotion (Smart 2009). Men in the study may have emphasized their emotionality and empathic, caring nature more as a result of my gender, however, as Hearn and Kimmel (2006:61) note, “studying men cannot be left only to men.” I worked to establish rapport with interviewees by using a conversational tone, leaving demographic and sensitive questions until the end, and emphasizing the practical goals of improving the recruitment and training of male nurses.

Ten men completed audio diaries and 31 men participated in interviews. Two men supplied both diary and interview data, with 39 men participating in total. Participants were, on average, 45 years old, with 13 years of nursing experience (ranging from less than one to 39 years), and worked within a variety of units (pediatrics, emergency, intensive care, community health, primary care, etc.). The vast majority of participants identified as white/Caucasian, with three identifying as Latino/Hispanic, one African-American, and one who identified as other. See table 3 for participant demographics. Participants were from all regions within the continental U.S. Compared to national data on the racial composition of nurses (Institute of Medicine 2010), Black/African-
American and Asian nurses are underrepresented and Hispanic/Latino nurses are overrepresented in the sample.
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Race</th>
<th>Year Born</th>
<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Jerry*</td>
<td>white</td>
<td>1969</td>
<td>1</td>
</tr>
<tr>
<td>2. Andrew*</td>
<td>white</td>
<td>1981</td>
<td>1</td>
</tr>
<tr>
<td>3. Thomas*</td>
<td>white</td>
<td>1978</td>
<td>3</td>
</tr>
<tr>
<td>4. Walter*</td>
<td>white</td>
<td>1963</td>
<td>17</td>
</tr>
<tr>
<td>5. Manny*</td>
<td>white</td>
<td>1962</td>
<td>24</td>
</tr>
<tr>
<td>6. Justin*</td>
<td>white</td>
<td>1973</td>
<td>7</td>
</tr>
<tr>
<td>7. John*</td>
<td>white</td>
<td>1966</td>
<td>25</td>
</tr>
<tr>
<td>8. Richard*</td>
<td>Black</td>
<td>1961</td>
<td>30</td>
</tr>
<tr>
<td>9. Carson*</td>
<td>Hispanic</td>
<td>1984</td>
<td>3</td>
</tr>
<tr>
<td>10. Derrick*</td>
<td>white</td>
<td>1963</td>
<td>8</td>
</tr>
<tr>
<td>11. Milton*</td>
<td>white</td>
<td>1984</td>
<td>1</td>
</tr>
<tr>
<td>12. Sam*</td>
<td>white</td>
<td>1973</td>
<td>14</td>
</tr>
<tr>
<td>13. Carl*</td>
<td>white</td>
<td>1960</td>
<td>16</td>
</tr>
<tr>
<td>14. Ron*</td>
<td>white</td>
<td>1974</td>
<td>3</td>
</tr>
<tr>
<td>15. Doug*</td>
<td>Latino</td>
<td>1945</td>
<td>39</td>
</tr>
<tr>
<td>16. Jason*</td>
<td>white</td>
<td>1983</td>
<td>8</td>
</tr>
<tr>
<td>17. Ben*</td>
<td>white</td>
<td>1979</td>
<td>3</td>
</tr>
<tr>
<td>18. Alex*</td>
<td>white</td>
<td>1959</td>
<td>10</td>
</tr>
<tr>
<td>19. Ethan*</td>
<td>white</td>
<td>1968</td>
<td>3</td>
</tr>
<tr>
<td>20. Max*</td>
<td>other</td>
<td>1980</td>
<td>2</td>
</tr>
<tr>
<td>21. Art*</td>
<td>Hispanic</td>
<td>1977</td>
<td>11</td>
</tr>
<tr>
<td>22. Dylan*</td>
<td>white</td>
<td>1964</td>
<td>25</td>
</tr>
<tr>
<td>23. Mason*</td>
<td>white</td>
<td>1953</td>
<td>22</td>
</tr>
<tr>
<td>24. Victor*</td>
<td>white</td>
<td>1954</td>
<td>36</td>
</tr>
<tr>
<td>25. Hank*</td>
<td>white</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>26. Vince*</td>
<td>white</td>
<td>1960</td>
<td>28</td>
</tr>
<tr>
<td>27. Jared*</td>
<td>white</td>
<td>1962</td>
<td>1</td>
</tr>
<tr>
<td>28. Donnie*</td>
<td>white</td>
<td>1950</td>
<td>35</td>
</tr>
<tr>
<td>29. Ed*</td>
<td>white</td>
<td>1954</td>
<td>35</td>
</tr>
<tr>
<td>30. Connor**</td>
<td>white</td>
<td>1982</td>
<td>5</td>
</tr>
<tr>
<td>31. Leonard**</td>
<td>white</td>
<td>1984</td>
<td>5</td>
</tr>
<tr>
<td>32. Russell***</td>
<td>white</td>
<td>1966</td>
<td>6</td>
</tr>
<tr>
<td>33. Jack***</td>
<td>white</td>
<td>1961</td>
<td>16</td>
</tr>
<tr>
<td>34. Travis***</td>
<td>white</td>
<td>1961</td>
<td>8</td>
</tr>
<tr>
<td>35. Pat***</td>
<td>white</td>
<td>1964</td>
<td>13</td>
</tr>
<tr>
<td>36. Emmanuel***</td>
<td>white</td>
<td>1974</td>
<td>12</td>
</tr>
<tr>
<td>37. Collin***</td>
<td>white</td>
<td>1964</td>
<td>4</td>
</tr>
<tr>
<td>38. Frank***</td>
<td>white</td>
<td>1972</td>
<td>6</td>
</tr>
<tr>
<td>39. August***</td>
<td>white</td>
<td>1973</td>
<td>14</td>
</tr>
</tbody>
</table>

Mean | 1968 | 13

*Interview Data Only (n = 29)
**Diary and Interview Data (n = 2)
***Diary Data Only (n = 8)
Analysis

In analyzing data from audio diaries and in-depth interviews, I attempt to construct a “metanarrative of the many stories heard” while also capturing the “complexity of lived experience” (Miller and Crabtree 2004:200-201). I coded for descriptions of empathy, compassion, and caring; comparisons between men and women in terms of emotion; and aspects of emotional capital, including capacity for feelings, management skills, and knowledge of emotion norms/expectations. Once these were coded, the data were analyzed for emergent themes on more specific aspects of emotional capital and their relation to their status as men and the occupation (Glaser and Strauss 1967). In reporting the data, participants are identified with pseudonyms, along with their reported race and years in the profession (see table 3 for reference). Italics are added for emphasis by the researcher, underlined words denote emphasis by the participant. Quotations are edited for readability.

Results

Results of the analysis are organized along the three limitations of the prior literature outlined above. These three limitations include: an overly-feminized or non-gendered conception of emotional capital, unclear distinctions between emotional capital and practice, and contradictory views concerning capital as a rigid or malleable resource. The first set of results, then, deal with the issue of gender and how it shapes the form and application of emotional capital in the field of nursing. This section details the gendered and emotion-specific beliefs of participants and how they view the dominant cultural
belief that men are less nurturing and compassionate as compared to women. The second section focuses on the aspects of men’s narratives that highlight distinction between emotional capital and practice. Emotional capital is clarified as a trans-situational resource that makes up the conscious and nonconsciously constituted habitus, in contrast to the embodiment and enactment of capital within particular fields and situations through emotion practice. The third section introduces the concepts of primary and secondary emotional capital in order to delineate capital’s rigid yet malleable nature.

**Emotional Capital as Gendered**

Currently debated within the education and feminist literatures is the influence of gender on emotional capital. Reay (2000; 2004) and to some extent (Gillies 2006), follow Nowotny’s original framing of emotional capital as a resource to which women are particularly privileged despite its presumed limitation to the private sphere. This claim has been contested for its perpetuation of essentialist ideology (Manion 2007). A gendered approach to emotional capital in the occupational literature has been more limited. Cahill’s (1999) study of mortuary student’s offers little empirical or theoretical insight into gender’s influence on the emotion-based resources students brought to their occupational training. Men in nursing confront dominant gender discourse centered on the cultural beliefs that presume women’s greater competency in nurturing and caring for others (Ridgeway 2011). Rather than confirm such beliefs, the majority of men in the study contest it as inaccurate.

Male nurses in the sample overwhelmingly affirmed that they are just as compassionate and caring as their female colleagues, denoting their belief that they have
similar capacities to feel compassion and care for others. When asked for their view on the stereotypic gender beliefs that men were not as nurturing or compassionate compared to women, participants claimed that this stereotype was patently false:

I think I can be as compassionate as any woman, I think I can be compassionate to patients, to my family, to my own kids, to my wife […] I think men can absolutely care as much as women. (John, white, 26 years)

I know a lot of men who are extremely nurturing, and loving, and open and it’s just not supported in our culture. (Ben, white, 3 years)

Of course they [men] are compassionate and caring. (Walter, white, 17 years)

I don’t agree with that [the cultural belief that men are not as compassionate/caring as women]. I believe that men can [be] as caring as women. (Art, Hispanic, 11 years)

As one of the three aspects of emotional capital, men’s capacity to feel compassion, empathy, love, and care for others is affirmed in the above quotes. Male nurses contest the hegemonic and essentialist belief that men lack the capacity to experience these emotions on the same level as women. By stating “of course,” Walter hints at the “commonsensical” nature of his belief that men are compassionate. Following Epstein’s (2007) characterization of habitus as the internalized “patterns and behaviors that we view as commonsensical,” Walter’s phrasing suggests that this attitude is deeply held, to the point of being an unimpeachable aspect of his habitus (11). It is unsurprising then that Walter boasts 17 years in the profession.

Some men suggested that there was some truth in the cultural belief that men do not have the capacity for compassion and care to the same extent as women. In doing so, they suggest a type of gender essentialism. While Jerry notes that it could be an issue of

---

2 Years listed are the number of years in the nursing profession.
“demonstrating” emotions, he believes that men and women are fundamentally different from each other in terms of emotional capital:

I recognize that in some ways I might not be as empathetic or compassionate, or at least demonstrate that, show that, play that role, as a woman. And I’m ok with that. A woman can’t lift 150 pounds over her head and I can, so there are things I can do that she can’t. We’re built differently, not only physically but emotionally. I think that when you accept that, then you embrace it. I don’t want to be like a woman, and I don’t want a woman to be like me. (Jerry, white, 1 year)

Jerry, on the one hand, views the emotional difference between men and women as an essential difference—we are just built differently—though his caveat, “or at least demonstrate that,” suggests some ambivalence about this view. With gender essentialism a key issue in the stalled gender revolution (England 2010), attention to how men in the female-dominated profession of nursing view gender differences informs our understanding of how essentialism persists even among men who work in a caring profession. While a small minority, here we see Jerry emphasizing his physical superiority to women (“A woman can’t lift 150 pounds over her head and I can”) in order to justify women’s greater emotional capital, or at least demonstration of emotional capital\(^3\). This disconfirming evidence contradicts the majority view expressed by participants and does not threaten the validity of the study findings.

Similar to Jerry, Ethan describes the difference between men and women, but sees this as an issue of emotional expression, noting the role of culture in shaping men’s expression:

I think men have this full range of emotion [as] everybody else, but they’ve been acculturated not to express that to the degree that women are allowed to. (Ethan, white, 3 years)

\(^3\) Notably, Jerry was one of the few nurses who cried during the interview as he relayed the story of tragic a car accident.
Ethan sees an emotional difference between men and women in terms of expression, not one of capacity. In doing so, he suggests that men have similar levels of emotional capital—capacity for a “full range of emotion”—but that they use this capital in different ways as a result of cultural norms that constrict men’s expression of emotions. Linked to dominant gender discourse and cultural beliefs (Ridgeway 2011), men and women may hold similar amounts of emotional capital, particularly in terms of capacity for feeling, but draw on and use this emotional capital in different ways in order to meet differing cultural expectations.

While affirming their capacity for feelings of care and compassion, male nurses confronted others in the profession who did not always agree with them. Jason, for example, was told explicitly that men did not have the same emotional capacity as women when it comes to caring for others:

My second year as a nurse, I had one of my managers told me that ‘for a guy you’re doing very well because guys are not capable of caring at the same level as a woman in a pediatric ICU.’ (Jason, white, 8 years)

Stating that Jason does well “for a guy,” Jason’s manager confirms stereotypic beliefs that men’s emotional capital is not equivalent to women’s in terms of caring for others. This theme overlaps with Snyder’s (2010) study of male and female nurses in which many female nurses felt that men lack the capacity to care and nurture others (32). Men must confront not only generic gender beliefs espoused in our culture but also managers, teachers, and co-workers who believe them to be less emotionally equipped for the profession. They are seen as having diminished capacity for feelings, an aspect of emotional capital. Finding claims that men lack emotional capital in comparison to
women from lay sources also suggests that scholarly claims of this sort may be linked to
gender ideologies rather than empirical reality (see Manion 2007).

Recognizing cultural stereotypes about men and emotion, Ben also notes that he is
aware of the belief that men are not as capable of being nurturing and caring. Taking this
to heart, such a belief fuels his motivation to prove colleagues wrong:

I think the very same prejudices about men being not nurturing, not emotionally
available works against me as well. And I think that, I don’t know if this is
coming from me or my colleagues, probably both, but I feel like I need to prove
that I’m capable and worthy of the profession that I can go into a room and sense
if someone is uncomfortable and make them comfortable. (Ben, white, 3 years)

Firmly believing that stereotypes about men being less nurturing are false, Ben tries to
prove his emotional capital by enacting/embodying that capital in line with professional
norms. Proving that he “can”—that he has the capacity, skills, and knowledge—Ben
applies knowledge of others’ emotional states (“sense if someone is uncomfortable”) and
skillfully manages their feelings of discomfort. Criticisms of his capacity to feel,
criticisms of his emotional capital, drive Ben’s emotion management. Men not only
believe that they have the same degree of emotional capacity as women, but that they also
hold emotion-specific knowledge and skills needed to care for others.

Echoing Ethan above, Alex believes that differences between male and female
nurses lie in behavior, the activation/embodiment of capital rather than the capacity to
care as an aspect of emotional capital itself:

we [men and women] express our care and work with patients in different ways
and there are times where I think there are some gender specific ways that we
may behave but in general I don’t think that that gets in the way of being a caring
nurse. (Alex, white, 10 years)

Alex highlights the fact that, while men can be just as caring as women, the way that this
care is expressed through behavior may be distinct. Men’s emotional capital, including
their capacity for compassion/empathy, and emotion-specific knowledge, and skills, is similar to women’s. Gender distinctions lie in the expression of emotion and therefore the manner in which emotional capital is embodied/activated and hence converted into emotional management within the nursing context. Turning to this difference in care, the next section analyzes the particular ways that men express their care to patients and how the situational use of emotional capital in the form of emotion practice is distinct from emotional capital as a trans-situational resource.

*Emotional Capital and Practice: Capacity vs. Expression Among Male Nurses*

As the quotes above begin to show, a critical component of theorizing emotional capital is distinguishing the resource itself from the activation and embodiment of that capital through emotional experiences and management (i.e., emotion practice). The narratives of male nurses clarify this conceptual distinction. Rather than focus on the range of emotions they experience or examples of enacted/embodied capital—that is, emotion practice—their responses lend particular insight into the underdeveloped issue of capacities for feeling. While situational enactment/embodiment of emotional capital is captured in the term emotion practice, emotional capital is trans-situationally available regardless of its conversion to practice. Reay’s (2004) analysis confuses this issue by seeing mothers’ emotional support for their child’s education as emotional capital rather than enacted/embodied capital. Data from male nurses allows us to clearly distinguish between capital as a resource and the embodiment/enactment of capital into practice through emotional management and experience. Just as cultural capital is mobilized/activated within situations, but remains trans-situationally available alongside
the lasting dispositions of habitus (Bourdieu 1986), so too emotional capital is mobilized/embodied in the experience and management of emotion. Men in nursing manage emotion in two respects, management of their own emotions and the interpersonal management of patients’ emotions (Francis 1997; Thoits 1996). This particular aspect of emotion practice is highlighted in chapter 4.

While male nurses generally see themselves and other men as fully capable of feeling compassion and care for others—as holding similar emotional capacities and skills—as compared to women, they note that they express their care differently as a result of their gendered social location. This, they believe, explains the misconception that men do not care as much as women. Despite recognizing this difference, men in the sample were not always able to describe how men and women express care differently in nursing:

[I]t's definitely a different type of nurturing type thing. [...] it's hard to put my finger on it but I have been in the room, like a mothering type, female nurses become like the patient’s mother. Where I know I’m definitely not doing that. I think it’s just like a type of care that is given. As far as like I don't think we have a word for it, like how males do that. [...] I have a hard time putting my finger on it but I haven't had anybody directly say, ‘you don’t care.’ (Ron, white, 3 years)

Ron contrasts his own style of care with a female nurse’s matronly style, but notes that he has difficulty describing what it is that distinguishes how he goes about providing care as a man from his female colleagues. This lack of clarity likely stems from the naturalization (and hence misrecognition) of the rules of the habitus that shape Ron’s emotion practice as a man. John also had difficulty clarifying how men “do it differently”:

I guess men do it differently, but men - men can raise children, men can contribute, men can do all of that and I don’t - I have never been able to put my finger on it but men care and I just go back to my own, my caring aspect, I
completely deliver that to my patients [...] you just care for them, you help somebody and take care of them and whether you’re a man or a woman it doesn’t really matter. (John, white, 25 years)

Despite not being able to fully describe how men differ in their delivery of care, John and Ron suggest that men’s expression of care—situational embodiment/mobilization of emotional capital in tandem with the habitus of masculinity and nursing—does not imply differences in their capacity to care and the skills necessary to provide quality care to patients. I highlight their ineffable state as an indicator of the nonconscious and non-deliberate nature of aspects of men’s emotionality as nurses. Emotional capital exists alongside “long-lasting dispositions of both mind and body—in other words, in the form of habitus, and it is as much unconscious as conscious” (Virkki 2007:278).

Explaining why their care differs from female nurses, participants highlight the cultural taboo that limits men’s affection and touch. Mason articulates this distinction for men and women in nursing:

A man in the situation can provide as much nurturing or just as much nurturing. The one reason I think a lot of people don’t see that is that we have to work within very strict parameters. That a - a patient who is having a hard time having difficulties - female nurse can go in and give the person a hug and say, ‘It’s going to be alright, I’m with you, things are going - we’re going to get through all this.’

A male nurse cannot do that because then that is looked upon as sexual contact versus nurturing contact so we have to provide the nurturing and the care but we have a invisible line that is drawn between patients and nursing we cannot cross because of those perceptions. (Mason, white, 22 years)

Mason’s word choice here is key as he says men “can provide” as much nurturing as women. Men do not necessarily mobilize nurturing skills, but they do have access to those skills as trans-situational emotional resources. With their touch and contact with patients potentially viewed as sexual, men must express their care within the “strict parameters” of how others will interpret their actions. This limitation in comforting
patients suggests that male nurses develop alternative ways of demonstrating care—alternative ways of mobilizing emotional capital that are distinctly masculine. Men’s perceived sexual agency impact their physical contact with others. Notably, it is because of their concern for the patient’s well-being and comfort that male nurses will often avoid physical contact. In other words, their feelings of care and concern for others motivate their development of alternative ways of expressing care. Not wanting others to misunderstand their touch, they draw on other emotional resources.

One alternative set of skills which male nurses emphasize is listening and communication. Describing how he provides care, Thomas emphasizes his empathy and listening skills rather than providing physical touch to patients:

I’ve found that when somebody’s upset, it’s kind of a tip of the iceberg type thing - what they’re upset about and what they’re saying to you isn’t always what’s really going on. So I try to always be very empathetic with all my patients, […] a lot of times it’s just them having somebody to talk to, just being a warm body there that says “I care” and that’s what nurses are supposed to do. Sometimes that’s all they really need is somebody to say “Hey, you’re really sick, you’ve got cancer, I care, I’m here, I’ll help you” and you just sit there and listen to them and sometimes they just want to chat and that can be all the difference and sometimes it can be as simple as being there literally and that’s all you have to do. (Thomas, white, 3 years)

He makes a concerted effort to mobilize his capacity for empathy. And, by his presence and openness to talk, he notices that patients’ needs are satisfied.

Similar to Thomas, Ron emphasizes listening over physical touch as a means of reaching a particularly “negative” patient:

My last shift at work I had a patient who was uh, I actually went into the room first thing in the morning. I got report that the patient was very negative to the night shift nurse. And so I went in there and he didn’t want to be woken, he didn’t want to be touched, he didn’t want anything to do with me at all. He was real sick, he wasn’t doing too well. But he would still wake up, talk, communicate. But after 3 days, I was able to discharge him off the floor. He was doing much better just physically. And over those three days we definitely developed a positive
relationship and he said I was one of the best nurses he had. So it was pretty awesome to hear he was doing better, so he went home. When I went in to do to my assessment [originally], he didn’t want anything to do with me, like “why are you even here?” And [I was] able to talk to him casually about family and those types of things. (Ron, white, 3 years)

Dealing with a patient that “didn’t want to be touched,” Ron was able to connect with him through casual conversation to the point that the patient felt better, went home, and said that Ron was one of the best nurses he had had. Men’s everyday emotion practice takes different forms as a result of situational and cultural constraints on touch. Substituting for this touch is an available, embodied empathy that signals to patients a willingness to listen and communicate.

While men emphasize listening and communication in how they care for patients, this does not suggest that women lack emotional capital in this area nor that they do not mobilize these skills. Rather, male nurses emphasize these skills as a significant aspect of their care as a demonstration of their caring and empathetic capacities. Women, we would expect, may emphasize these skills, but they do not need to use these skills to signify their capacities to care because their capacities are seen as an innate part of being a women. Highlighting the communication skills of a nurse that he looks up to, Ben, emphasizes the aspects of her care that he himself would like to perfect:

[She] knows how to connect with people and she’s really sharp. She’s intelligent, she’s incredibly observant, she knows all the right questions to ask to illicit what’s really going on with the patient. Somebody could come and go ‘I’ve had a really bad headache for the last 3 weeks and I don’t know why.’ And I’ll go in and say you’ve had a headache and ask the standard questions, but she knows how to connect with that person as a skillful enough clinician to ask the right questions, to find out in fact that she is malnourished, and in an abusive relationship and is super stressed out. I don’t know, just that kind of knowledge, the ability to go in and navigate an office visit and in 20 minutes be able to extract really personal and really critically valuable information from someone. (Ben, white, 3 years)
Ben describes this female nurse’s emotional capital in terms of knowledge and ability—she “knows how to connect with people” and “knows all the right questions to ask.” These skills and knowledge serve to establish rapport with the patient—a sense of connection and sympathetic relation—that allows the nurse to gain sensitive information. While described in knowledge/reason language, Ben downplays the emotional significance of her resources. Similar to the descriptions above, the capital Ben describes is centered on listening and communication skills that elicit feelings of social cohesion (“connection”) in others and, as a result patients divulge vital information.

Male nurses emphasize listening and communication as the means by which they express their care, that is, the ways in which they embody/mobilize emotional capital on the job. While this use of their emotional capital is emphasized in their training as nurses, it is worth noting that their training does not focus exclusively on listening and communication. Dylan, a long-time nurse who currently works as a dean in a nursing program, describes the training that nurses receive:

I would say communication is one of the keys that we really teach them [nursing students], you know. And then also role modeling that it’s ok to touch the patient. […] I’ve had some of my faculty tell me that the student would say ‘oh I was almost gonna cry.’ Well, it’s like, ‘cry, you know, that’s ok.’ (Dylan, white, 25 years)

Modeling physical touch and crying is something that male nurses would have likely encountered as students, suggesting that it is not because of professional taboos that men avoid these behaviors. This makes their emphasis on listening as an expression of care all the more notable as it suggests men do this on their own, outside of the formal occupational socialization received in nursing school.
Echoing the other men quoted above who emphasize attentive listening and the importance of creating an environment where patients can openly express themselves, Russell also articulates this distinction as connected to the issue of physical touch:

I tend not to be a very touchy feely nurse and I think as a male nurse that's one of the things that I bring different to the table than a lot of the female nurses and a lot of my patients I think appreciate that and if they need a hug or whatever I'm open to sharing that. I think I am not nearly as touchy feely as a lot of the female nurses and I think a lot of the male patients kind of appreciate that and sometimes they don't need that, they just need an ear to listen to. I'm not one that generally sits down and cries with them but I notice a lot of female nurses will and sometimes I think it makes it harder on the patient when they see somebody cry but it's also just partly the way that I was brought up, I don't show a lot of emotion because of the way I was brought up but I think they [patients] feel comfortable sharing their feelings with me in a lot of cases mainly because I am open with them and I am open to listen and when they ask for my opinion in those scenarios I do share it. (Russell, white, 6 years)

Russell brings something “different to the table,” suggesting trans-situational knowledge of what patients, particularly male patients, need and appreciate. This further suggests that one gendered distinction in emotional capital is the knowledge of emotion norms concerning how to express care to male patients. Rather than mobilize capital through physical touch or embody feelings by crying, he focuses on being open with patients and creating a space where patients “feel comfortable sharing their feelings.” He further notes that he sees this approach as beneficial in cases when he is caring for a male patient, one who might need a listening ear more than a physical gesture.

Stating that he is not as “touchy-feely” as some of the female nurses, Russell suggests an individual explanation for not using physical touch in patient care rather than a social or cultural explanation like the one given above by Mason. Russell discusses this as complementary (“one of the things that I bring different to the table than a lot of female nurses”) to female nurses’ physical touch rather than conflicting. Russell also
explains this approach as rooted in his primary socialization: “because of the way I was brought up.” This suggests a primary form of emotional capital linked to early family/parenting socialization rather than occupational or secondary socialization sources. Expanding on this distinction in the following section, I use the concepts primary and secondary emotional capital to examine the sources of men’s emotional resources.

**Primary and Secondary Emotional Capital**

Beyond distinguishing emotional capital across gender and in relation to emotion practice, a third gap in the literature on emotional capital has been a limitation in seeing it as a rather ingrained resource gained in early socialization—a process constrained by social location—while also susceptible to modification in educational (Froyum 2010) and occupational (Cahill 1999) settings. Socialization refers to the processes by which individuals form identities, values, beliefs, and habitual ways of being and doing. Primary sources, including the family and early education, are thought to exert the most influence on the habitus. However, secondary sources encountered later in life, including occupational training and secondary education may also shape men’s emotional capital.

When asked if they had developed empathy, compassion, and care for others as a result of their work in a caring profession, men in nursing responded in ways that suggest a view of emotional capital as both a set of innate qualities brought to the profession and skills, capacities, and knowledge developed over time. While they argued that they had the capacity for empathy and compassion before entering the profession, their experiences in nursing and taking care of others helped them develop this emotional
capital further. In order to distinguish between what participants see as innate characteristics and developed emotional resources, I use the terms primary and secondary capital. These terms conceptualize emotional capital as a resource linked to social location—and hence primary socialization in the family and school—as well as susceptible to expansion and modification through secondary sources such as occupational training. These terms also help to distinguish emotional capital from trait-based, personality theories of the individual.

Seeing empathic capacity as a part of their emotional capital developed in primary socialization, several male nurses emphasize empathy as part of who they are rather than a capacity developed on the job:

I think some people are naturally predisposed to being more empathetic and I think I’m one of those people. (Carl, white, 16 years)

I think that some people were just born to have compassion and [be] caring. (Walter, white, 17 years)

Adding to the description, Max sees the capacity for compassion as both innate and developed:

I think that I’ve always had it [capacity for compassion] and I do think that because of nursing it has developed and gotten stronger. (Max, other, 2 years)

Max describes his capacity for compassion as something he’s “always had” but also “developed” and strengthened as a result of his experiences in nursing. This highlights the tension between primary and secondary sources of socialization – sources that shape emotional capital. Critiques of Bourdieu’s conception of habitus, capital, and practice have argued that, in an effort to explain the reproduction of inequalities, he paints an overly deterministic portrait of social life, and class inequality in particular (Jenkins 1982). Using the term “primary” emotional capital connotes the more rigid, socially
constrained aspects of habitus developed during formative years that individuals bring to bear within various situations. “Secondary capital” compliments this concept by making room for agentive efforts to shape and modify emotional resources and, in theory, the habitus. While socialization is often characterized as an outside force that acts upon individuals, secondary emotional capital might be seen as the situationally needed, actively accumulated resources that individuals gain within distinct social spheres in order to meet practical goals.

Similar to Max, Ben discusses the primary “emotional framework” that he received from important members of his family (notable men), as well as how his primary emotional capital was modified over the course of taking care of his chronically ill mother:

So when I was a kid, there were a couple - my dad, a couple other uncles, […] are also sensitive and communicative, at least they were when I was younger. We talked about love and we talked about life and I really loved the guys that helped me become emotionally aware of myself, emotionally intelligent as much as possible, there’s always room for growth. So that I think laid the emotional framework for me, then there’s also just who you are as a person I think that plays some part, an explicable part. My mom became chronically ill about 7 years ago, she got diagnosed with multiple sclerosis and I’ve been a caretaker for her. I started to before I considered going into nursing. And that wasn’t why I got into nursing but I knew, I realized that I learned more about caring for someone. My relationship for her got better and I guess I kind of go back and forth between being a son and a caretaker for her and it’s helped me be a lot more patient being a caretaker for her. (Ben, white, 3 years)

Ben notes the specific men in his life that helped him become “emotionally aware” during his childhood socialization. With this primary capital as a “framework” for him, he later notes that his time as a caretaker further shaped aspects of his emotional capital, namely his skill in managing his feelings of annoyance and/or frustration—i.e. patience. This secondary emotional capital was directly linked to his adult experience as a
caretaker for his mother, suggesting that individuals’ emotional capital is malleable to different situational experiences. This narrative is similar to Stacey’s (2011) findings concerning mostly female home care aides. Caring for others informally in an unpaid setting helped aides in her study develop the emotional capital that they would later transfer to paid work.

Carl describes empathy as stemming from primary socialization as well as concerted introspection and experience:

*Empathy is really something you can develop,* not everyone really thinks about it. If you’re someone who reflects a lot and you’re put in those situations, you try to understand what that person feels and that’s something I’ve done my whole life. I think that’s one of the reasons I was drawn towards the theater and I think that’s one of the things that’s helped me through nursing. The whole idea of empathy. I understand what it’s like for kids who are sick and who are in the hospital. (Carl, white, 16 years)

Carl suggests that empathy—that is, the capacity to feel what another person feels as a trans-situational resource—can be cultivated. The capacity for empathy forms part of his primary emotional capital—“something I’ve done my whole life”—while also being susceptible to modification through reflection and experience. Carl later notes that you have to become “a chameleon to a certain extent and adapt to situations” in order to care for others. But his capacity to empathize has its limits. Cases of potential child abuse, for example, make it difficult for him to empathize with the parents:

It’s always hard to be empathetic with parents when there’s suspected cases of abuse. […] It is hard to be empathetic to that parent. Certainly more, I can understand, for instance with shaken babies. I can understand the frustration of having a colicky baby and to how it just might make you crazy. I can empathize with that. But when you get to the point to where you shake a child and you cause brain damage. Or shake a child and don’t cause brain damage, you’ve lost me. A baby’s not going to die from crying. If you have to, go in the room and shut the door. But it’s hard; those are the times where it’s really hard to empathize. (Carl, white, 16 years)
Despite the difficulty of being empathetic in cases of abuse, Carl still makes a concerted effort to put himself in the position of a parent with a colicky baby and imagine how that might frustrate a parent. It is apparent from his account that he goes to great lengths to try to understand the perspectives of his patients and their family. Where others might demonize abusive parents as abhorrent, Carl taps the limits of his empathic resources.

Other men see the capacity for compassion and empathy as effortful (has to be “reached for”) and potentially developed over time through teaching and situations encountered later in life:

It’s hard to find compassion for that - when they calmly tell you my pain is 14 out of 10 and then go back to laughing and joking on the phone. I mean, I’ve had that experience. It’s not a terrible experience, but it’s one where you have to really reach for the compassion, you know? (Max, other, 2 years)

Yeah, I think you can teach them [nurses] that [empathy]. I think most people, you can help them develop what they have and how to use it better. I do think there are some people, and they’re usually called sociopaths, that don’t have that ability. [...] Some people it comes innately to, and they can put those pieces together real quick and naturally, some people have to think it out a little. But, if you think certain things out enough, you’re able to do it easier in the future. (Carl, white, 16 years)

I think it’s really powerful when you take a human being and you show them another human being suffering and then you give them a skill or a task and if they were to execute that task it would reduce that suffering in an immediate measurable way. Right in front of their eye. Something as simple as changing somebody’s position in bed or propping their head up so that they can breathe easier. Or after somebody has a bowel movement, and you clean them, using a nice one of those wet wipes to just make it nice and clean and put a little powder, simple basic stuff like that. Seeing how that can totally change somebody’s mood. I think that’s really powerful and somebody who does not become more empathetic after a few of those experiences is a sociopath. (Ben, white, 3 years)

Max, confronting situations that test the limits of his capacity for compassion, must “reach for the compassion,” suggesting that through difficult occupational experiences he extends his capacity for feeling, and with it his emotional capital. Carl believes that
empathy is teachable and distinguishes between helping others “develop what they have” (capital) and “how to use it better” (practice). Ben frames nursing as a set of skills that alleviate suffering. By exercising those skills and seeing the effect on others’ emotional state, nurses necessarily “become more empathetic.” Experiencing the effective application of emotional capital through emotion practice reciprocally reinforces the capacity for empathy.

Notably, both Carl and Ben pathologize individuals who do not have or do not develop the ability to empathize with others as sociopaths. In doing so, they mark boundaries between themselves and “uncaring others” in a manner similar to the home care aides in Stacey’s ethnography of identity and care work (2011:117). Virkki (2007) notes the link between this demarcation and Bourdieu: “For Bourdieu, the formation of one’s capital is based on social exclusion: one’s possession of capital requires that some others lack it” (275). Unlike the social workers and nurses in Virkki’s study who distinguished themselves from emotionally “illiterate” and childlike clients, men in the current study construct social distinction using an extreme group of stigmatized others. Their selection of such an extreme group may be linked to an underlying concern that their capacity for and situational embodiment of empathy might negate their claim to masculinity, with the ideals of stoic, emotional detachment linked to cultural prescriptions for men (Connell 2005; Lewis 2005; Lively 2000).

Discussion

A review of the literature on emotional capital revealed three gaps that limit scholars’ theorizing the concept in relation to a Bourdieuan theory of social practice.
These include: little work on men’s emotional capital; unclear distinctions between emotional capital and practice; and little research distinguishing primary from secondary emotional capital. In attending to each of these gaps I drew on interview and diary data from men in nursing to suggest that emotional capital is distinctly gendered, occupationally developed, and a vital concept to understanding emotion’s role in social practice. While the experiences of men in nursing suggest a tension between primary emotional capital (perceived as innate) and secondary emotional capital developed on the job, it is critical that future work attempt to tease out which aspects of emotional capital are more rigidly fixed within the habitus during primary socialization versus those susceptible to change through secondary sources. Cahill’s (1999) study of mortuary students, for example, suggests that occupational training was insufficient for developing the emotional reactions that students with a mortuary background took for granted.

Male nurses embody and mobilize emotional resources through emotional experience and management as an everyday feeling/doing practice at the conscious and nonconscious level. As part of the trans-situational, but field-specific habitus, emotional capital operates in tandem with other capitals (social, cultural, and economic) as a “feel for the game.” Not seen as naturally caring, men argue that caring, compassion, and empathy are things they “can” do, in opposition to women who are inherently engaged in such practice. In other words, their status as men in a caring profession renders aspects of their “feel for the game” effortful rather than natural. While men and women’s use of capital likely differs, findings challenge prior literature that frames emotional capital as a resource that only women hold.
A clearer distinction between emotional capital and practice allows for a better conception of how emotional capital is converted into other forms of capital. Nowotny’s (1981) early considerations suggested that “different rules of conversion of capital” (148) might exist between men and women. While I question Nowotny’s claim that emotional capital is only accumulated in the private sphere where women are concentrated, her suggestion of gendered rules of capital conversion might well explain how men’s enactment/embodiment of emotional capital in the profession of nursing is associated with improved occupational outcomes as compared to women (Cottingham, Erickson, and Diefendorff, unpublished manuscript). Ben’s narrative suggests that “proving” his colleagues wrong concerning men’s lack of capacity for care and compassion fueled his emotion practice on the job. By engaging/activating capital, men may prove their resource to others, meet professional norms, and challenge the constraints of masculinity—this agentive approach might then lead to higher job satisfaction and lower turnover intention among men as compared to women.

By distinguishing between primary and secondary emotional capital, the narratives of male nurses concerning their capacity for empathy, compassion, and caring feelings suggest a tension between primary and secondary socialization. Furthermore, men’s narratives on this topic have implications for nursing and dominant cultural beliefs that nurses (and women) have an innate, unchanging capacity for empathic emotions. Male nurses, by their very position as men in a caring profession, call into question assumptions about the “innate” and deterministic nature of feeling capacities implicit in essentialist gender beliefs. The notion of primary and secondary emotional capital has two critical implications for emotion and gender theory. Dominant discourses on emotion
dichotomize reason and emotion as well as conflate women with the emotional (Ridgeway 2011). Prior work on emotional capital has, unfortunately, reaffirmed this discourse by presuming women to have greater emotional capital. Results of the study of male nurses’ primary and secondary emotional capital implicate a more nuanced relationship between reason, gender, and emotion. Through experiences, self-reflection, and conscientious teaching/learning, participants argue that empathic capacities may develop. Rather than see emotional capacities, skills, and knowledge as overly determined by one’s gender (or other social characteristics, including class and race) during primary socialization, men may actively acquire knowledge and skills in order to meet the practical demands of their work. This, in turn, modifies the trans-situational emotional resources that inform the habitus and are situationally embodied and enacted. In the case of men in nursing, men were able to actively modify their emotional capital as a result of the occupational requirement that they be compassionate and empathic. These capacities were not solely linked to their gender nor to their primary socialization, but were shaped through the reciprocal relationship between an individual’s active “reaching” and the situational, practical demands of nursing.

Overall, prior theoretical and empirical work on emotional capital has overly feminized the concept, conflated emotion practice (management and experience) with capital, and failed to articulate capital’s simultaneously dynamic and rigid nature. In theorizing emotional capital, the current chapter draws on qualitative data from a study of men in nursing. Results illustrate how gender shapes the form and practice of emotional capital; the relationship between emotional capital as a trans-situational resource and emotion practice as situationally embodied and mobilized capital; and the utility of
distinguishing capital based on primary and secondary socialization. Findings push sociology of emotion scholars to account for these distinctions and processes in future work. Using emotional capital as part of a larger emotion-as-practice perspective is critical to the development of emotion theory that links social psychological processes to systemic factors and, in doing so, promises to revitalize the relevance of emotion for sociological inquiry.
CHAPTER IV
LEARNING TO “DEAL” AND “DE-ESCALATE”: HOW MEN IN NURSING
MANAGE THEIR OWN AND PATIENT EMOTIONS

Abstract
While prior research has explored how gender frames emotion management processes, little work has specifically considered how men meet the emotional demands of a caring profession. Stereotyped as less sensitive to their own and others’ emotions, male nurses confront unique challenges in navigating the profession’s emotional demands. Drawing on diaries and interviews, I examine emergent social psychological processes that shape men’s emotional labor—the strategies men use to manage their own and patient emotions on the job. In managing their own emotion, men’s narratives reveal three distinct strategies: reframing the nurse role, distancing, and relinquishing control. In managing patient emotions, they frame control over their own emotions as a means for managing others and emphasize knowledge/education as a strategy for managing patient stress and anxiety. Men’s emotion management strategies simultaneously reproduce and disrupt hegemony and the reason/emotion dualisms that undergird the current gender system. Implications for theory, as well as recruiting, training, and retaining male nurses are explored.

Keywords: Emotion Management, Masculinities, Nursing
Introduction

A minority in the profession of nursing (Institute of Medicine [IOM] 2010), male nurses confront essentialist cultural beliefs that women are better suited to emotion-specific tasks (O’Lynn 2007a; Ridgeway 2011). Despite this, they must meet the demands of an emotionally intense occupation. With nurses reporting frustration, grief, and powerlessness coupled with the interpersonal demands of patient’s emotions (Erickson 2008), “managing” these emotions is a critical component of their job. Prior research has examined men’s promotion and financial gains in nursing (Snyder and Green 2008; Williams 1992; 1995) and their construction of masculinity (Heikes 1991; Simpson 2007), but little work has dealt specifically with men’s emotion management strategies as they perform the crucial health care role of nursing.

Emotion management theory (Hochschild 1979; 1983) contends that social forces shape the intimate arena of personal emotions, framing emotional aspects of work as acts of labor. This view contradicts the cultural belief that emotional care emanates from women’s innately nurturing dispositions (Rasmussen 2004). Hochschild’s view of emotional labor as inherently alienating has been increasingly critiqued (Bolton and Boyd 2003), but the concept remains useful for illuminating women’s (and men’s) previously invisible labor. Through deep and surface acting—cultivating felt emotions and modifying emotional expression—men must perform the feminine-typed task of managing their own and others emotions on the job. Operating within the current gender system (or “gender regime,” see Connell 1987), this labor is likely shaped by the gendered structure of health care (Zimmerman and Hill 1999), and gender’s influence on interactions (West and Zimmerman 1987) and constructed selves (Connell 2005).
Integrating emotion management and masculinities theories, the current study explores the emotion management strategies of male nurses and how these relate to hegemonic and alternative conceptions of masculinity. In doing so, men’s strategies of care extend our understanding of how aspects of men’s lived practice simultaneously contradicts and reproduces ideals of masculinity. In their emotion management, men’s strategies mimic aspects of hegemonic masculinity—rationality, emotional detachment, control over others—but in service to the feminine-typed task of caring for others. The results extend prior work on “managing emotional manhood” (Vaccaro, Schrock, and McCabe 2011), and suggest that aspects of men’s emotional labor disrupt the reason/emotion dualism which underlies the current hegemonic gender system (Fausto-Sterling 1993; Sprague 1997). Understanding how men successfully perform “women’s work” is critical to the training and retention of men in nursing as well as unraveling the many ways that gender influences emotion management processes.

Emotion Management Theory

Emotion is not a timeless phenomenon, but is always emerging and changing within distinct social climates (Lutz 1988, Stearns 2006). Economic, political, and cultural forces shape not only the experience and management of emotion, but its definition and conceptualization. Contextualizing emotion is a necessary step in contesting essential, universalistic definitions and the power structures that maintain dominance through essentialist ideology. Only when emotion is seen as a social phenomenon can its links to ideology be understood, for “it exists in a system of power relations and plays a role in maintaining it” (Lutz 1988:54). Just as the ruling ideas of any
epoch are the ideas of the ruling class (to paraphrase Marx 1978), so too are the experiences and expressions of emotion significantly shaped by systems of power.

Within this critical tradition, Hochschild’s (1979; 1983) path breaking work on the social origins of emotion has proved immensely useful for understanding how emotion-based processes are framed within resilient but shifting social structures. Emotion management, or emotion work, takes place in a variety of settings. When performed in the workplace for a wage, it takes the form of “emotional labor.” While the emotional experiences discussed by male nurses have their origin in the workplace, I use the broader term of emotion management to denote the aspects of their emotion work that may not be directly linked to receiving a paycheck. This includes philanthropic emotion management (Bolton and Boyd 2003), in which workers may go above and beyond job requirements, as well as management of job-related personal emotions outside of work.

Hochschild (1983) further differentiates between two types of emotion management: surface acting and deep acting. Surface acting refers to the modification of expression in order to convey a certain emotion to others (Lovell, Lee, and Brotheridge 2009). Putting on a smile or masking feelings of anger are two examples of this strategy (Grandey 2003). Deep acting involves the emotionally effortful act of cultivating a particular feeling so as to match the emotion norms within a given situation. Emotion management can focus on personal emotions or other’s emotions through interpersonal emotion management (Thoits 1996; Francis 1997).

In looking at emotion processes in occupations, previous research has framed the subject matter in terms of emotional capital—the emotion-based knowledge, management skills, and capacity for emotional experiences. As an often unacknowledged resource,
emotional capital plays a significant role in vocational choices and occupational success (Cahill 1999; Schweingruber and Berns 2005; Thoits 2004). Schweingruber and Berns (2005) find, for example, that young salespeople were directed by their organization to engage in “emotional mining” (i.e., using aspects of their biography to motivate successful sales) and “emotional bridging” (i.e., how emotional capital can be used to link a worker’s past self to the self being developed on the job in order to maintain motivation). Extending Mead’s conception of significant others (1934), they argue that emotional mining and bridging can involve reference to emotional others—individuals in one’s life who incite strong emotions—to motivate workers. Emotional capital, they argue, “is not just something that people own but something they produce and use” (2005:701). Similarly, Cahill’s study of mortuary students focuses on the emotion-specific capital that students hold prior to their experiences in class. Those with more appropriate “capital” are better able to meet the demands of the occupation.

Emotional capital is differentially available to individuals depending upon their social structural position (Froyum 2010; Thoits 2004; Reay 2004). For example, the experience and management of emotion, as well as the emotion norms to which individuals are held, varies across gender, class, and race (Froyum 2010; Harvey Wingfield 2010; Pierce 1995; Reay 2004). Boys are socialized to develop different forms of emotional capital than girls as a consequence of the differing emotion norms to which they are accountable (Brown 2005; Chaplin, Cole, and Zahn-Waxler 2005; Garside and Klimes-Dougan 2002). A detached, cool demeanor that conveys emotional control reflects the dominant masculine ideal (Connell 2005; Lewis 2005; Lively 2000), while being supportive, congenial, and showing empathy is considered feminine (Lewis 2005).
Held to different emotion standards and having different emotional capital, we would expect men’s discussion of emotion management strategies to also be distinct from women’s. Previous work has noted the role that gender plays in shaping emotional expression (Erickson and Ritter 2001; Simon and Nath 2004) and the amount of emotional labor performed (Lovell, Lee, and Brotheridge 2009), but little attention has been given to how men’s styles of care (O’Lynn 2007a) and the strategies men use to manage emotions in a caring profession. To understand the potential influence of gender on male nurses’ emotion management, I turn to the literature on men and masculinities.

Hegemonic and Alternative Masculinities

Framing gender as a system of structural and discursive forces, scholars conceptualize masculinity in terms of hegemonic and alternative forms. Hegemonic masculinity consists of the culturally dominant form of masculinity to which men either attempt to conform or deconstruct (Connell 2005; Connell and Messerschmidt 2005). It entails hyper-heterosexuality, control over others, technical or physical competence, and rationality (Connell 2005; Lutz 1988; Pascoe 2005; Schwalbe 2009; Williams 1995). Men’s conformity to hegemonic masculinity influences a variety of outcomes, including men’s health, criminal activity, and education (Connell and Messerschmidt 2005; Courtenay 2000; Green and Halkatis 2006; Messerschmidt 1993; Messner 1992; Peralta 2007).

As both an historical and individual project, masculine self-construction involves negotiations between the hegemonic prescriptions for the detached, emotionally-reserved ideal and varying situational demands and individual needs (Connell 2005). In doing so,
men may construct alternative masculinities that contradict some or most masculine ideals. Connell (2005), in his examination of the masculine “projects” of six men, sees a central theme of their alternative reconstruction as the cultivation of “the capacity to be expressive, to tell the truth, especially about feelings” (2005:132, emphasis added). While “hegemonic” suggests a one-dimensional construct, recent work on masculinities argues that different aspects of hegemony may be emphasized across class, race, ethnicity, and sexuality (Carlson and Corcoran 2001; Kohn 1977; Lareau 2003; Nixon 2009; Pyke 1996; Thoits 2004). Nixon (2009), for example, suggests that working class men decline low-skill service work because they are constrained by a working class habitus—which emphasizes manual labor (309) and “sticking up for yourself” (310)—and are unable to conceal emotions in the manner prescribed by entry-level service work.

Integrating masculinities and emotion management theories is necessary for understanding the emotional lives of all men. Males nurses, though, whose claim to hegemonic masculinity is challenged by their work in a caring profession (Heikes 1991; Simpson 2007), are particularly well-positioned to illuminate strategies of emotion management. While men in general are severely sanctioned when they defy important elements of hegemonic masculinity such as sexuality (Pascoe 2005; Wolkomir 2001; 2006; Schrock, Holden, and Leid 2004), male nurses’ token status can be devastating to a positive gender identity (Hesselbart 1977). Heikes (1991) argues that “male nurses must continually struggle to maintain a positive masculine identity” (1991:399, italics added). Performing a traditionally feminine occupational role may require male nurses to emphasize other facets of hegemonic masculinity (e.g., hyper-heterosexuality, physical strength, technical expertise, or family providership) to legitimate their claim to ideal
masculinity (Chen 1999). Examining how men talk about their emotion management strategies on the job, the present study links recent work on masculinities to men’s emotional labor in a caring profession.

Attention to male nurses is also merited by the changing job market in the U.S. The shift from a manufacturing-based economic system to one focused on service has occurred in combination with an increase in the number of women in the labor force (Bell 1973/1999; Bulan, Erickson, and Wharton 1997). Both of these trends have particular relevance for conceptions of masculinity. Being the “breadwinner”—the primary or sole provider of economic resources—forms part of a normative conception of masculinity (Bernard 1981). The manual labor typical of manufacturing work has also informed hegemonic constructions of a masculine self, particularly for working class men (Nixon 2009). With the current economic conditions radically altered (Bernard 1981; Bradley 1989; 1999; Cotter, Hermsen, and Vanneman 2001; Green and Owen 1998), men face new demands in a service-based economy.

Parallel to these changes, desegregation of sex-based occupations remains stagnant (England 2010) despite shifts in the economy (Bell 1973/1999; Bulan, Erickson, and Wharton 1997) and gender norms (Graf and Schwartz 2011). In light of this trend, scholars and feminists have called for increased attention to the barriers that keep men from moving into predominately female occupations (Bradley 1989; England 2010; O’Lynn 2007b). As men fail to move into traditionally female occupations at a pace similar to women’s movement into traditionally male professions, the potential benefits of an integrated job market remain unrealized (Cohen and Huffman 2003; Cotter et al. 1997) and projected shortages in areas such as nursing continue (Bureau of Labor
Statistics 2012). In order to address the recruitment and retention of men to female-dominated professions, greater examination of men’s work in such professions is needed. One obstacle to change is our limited understanding of how men confront the emotional demands of a caring profession. Given nursing’s focus on care and the critical role it plays in health care, it is a practical and theoretically-meaningful research site to explore the issues at hand. Projected shortages in nursing (Bureau of Labor Statistics 2012) and recent calls to diversify the workforce (IOM 2010) make research on men in nursing all the more urgent. The experiences of men in nursing are likely to be shaped by the historical development and structural conditions of the profession.

Nursing: A Gendered Profession

Gender distinctions underlie the structure of the medical profession (Zimmerman and Hill 1999). Florence Nightingale’s efforts to professionalize nursing as a white, middle class occupation exaggerated the disconnect between “caring” and “curing” in order to mirror traditional sex role segregation (see Bradley 1989:193-195; Evans 2004). Women were and continue to be seen as naturally adept at caring, while men, with their technical skill and knowledge, are assumed to be better suited for curing. Within this gendered environment and despite projected staffing shortages (Bureau of Labor Statistics 2012), male nurses remain a small minority. Buerhaus and his colleagues (2005) found that males make up 6-7% of nurses who provide direct patient care in both a 2002 and 2004 nationally representative survey. A more recent study by the Institute of Medicine (2010) finds a similar figure of 7%.
Although previous research investigates the reasons that men enter traditionally female jobs along with their financial and promotion outcomes (the “glass escalator,” Williams 1995), few studies examine the contours of men’s emotional labor in a caring profession (Heikes 1991; O’Lynn 2007a; c.f. Simpson 2007). One exception is Simpson’s (2007) interviews with male nurses and male primary school teachers. She explores how “men who care” negotiate masculinity and perform emotional labor (2007:72), finding that men in her study emphasize technical competence, rationality, and seeing their emotional labor is a “gift” more than an occupational requirement. While notable, Simpson’s findings are based on a small sample (15) of nurses in the UK and do not capture the strategies that men use to manage their own and patient emotions. O’Lynn (2007a), noting the dearth of empirical work on men’s approach to caring, states that “it is not clear how emotive nurturance from men may differ from emotive nurturance from women in a caregiver context” with particular need to “delineate gendered differences in the delivery of care” (2007a:133, 139). One step toward delineating gender differences in care is to examine male nurses’ efforts to manage emotion on the job as a component of their overall emotive nurturance and patient care. With little prior work on the topic, empirical research grounded in the masculinities and emotion management literatures is needed.

Research Questions

Framed within emotion management and masculinities theory, the current study explores the strategies that men use to manage emotions as nurses. In doing so, I ask the following research questions:
1. How do male nurses manage their own emotions on the job?
2. How do men manage the emotions of patients in order to fulfill the demands of their job and provide high quality care?
3. How do strategies of emotion management among male nurses reflect hegemonic and/or alternative constructions of masculinity and what are the implications of these strategies for theory and practice?

Methods

In order to answer these questions, I draw on two forms of in-depth data: solicited audio diaries and interviews. With a focus on the everyday emotion management of men in nursing, diaries are particularly suitable for answering the above research questions because they capture the “practices and experiences of everyday life” (Kenten 2010). Interviews further allow for rich examination of intrapersonal processes such as emotion management strategies that would be difficult to capture with alternative methods (Ragin, Nagel, and White 2004:10).

Audio Diaries

Audio diaries of male nurses were collected as part of a larger project on identity and emotion among nurses at a large Midwestern hospital system from spring 2011 through the fall of 2012. A complete listing of full-time, direct care RNs was obtained from the health system’s human resources department and written questionnaires in sealed envelopes were distributed to eligible RNs employed within each hospital (N = 1702). Completed surveys were returned by mail from 762 participants, or 44.8% of the
original eligible sample. Among those who returned questionnaires, we contacted men who indicated interest in participating in future phases of the study. Those who responded were asked to participate in a one-time training session on operating a voice recorder which they would use to make diary recordings after 6 consecutive shifts. As instructed, the content of the diaries could include their reflections on the shift, memorable events, and how they felt during and after the shift. Participants were compensated with a $75 check for completing the audio diaries and $25 for participating in a follow-up interview with a team member. Ten men completed audio diaries, for a total of approximately 8 hours of recording.

In-Depth Interviews

Interviews with male nurses were conducted from the spring of 2012 through the fall of 2012. Participants were geographically dispersed. I relied on connections with the American Assembly for Men in Nursing (AAMN) to contact chapter leaders across the U.S. and solicit their participation and help in recruiting male nurses. Of the 29 interviews I conducted, 5 were conducted in person and the remaining 24 were conducted over the phone. Following the receipt of a monetary grant in April 2012, subsequent participants were compensated with a $20 check mailed to their address. Participants were given an informed consent form approved by the university’s IRB prior to each interview. Two interviews were conducted in-person by a male member of the larger research team and were sampled from the same Midwestern research project that collected audio diaries.
In conducting in-depth interviews, I relied on a script of open-ended questions that probed participants on the emotional demands of nursing, general reflections on providing care to others, as well as specific examples of providing care and responding to emergent feelings discussed by the participants. Interviews were recorded and transcribed by myself, members of the research team, and through the professional services of a research agency. All quotations used in the text were checked multiple times for complete accuracy against the original recording.

Ten men completed audio diaries and 31 men participated in interviews. Participants were, on average, 44 years old, with 14 years of nursing experience (ranging from less than 1 year to 39 years), and worked within a variety of units (pediatrics, emergency, intensive care, community health, primary care, etc.). The vast majority of participants identified as white/Caucasian, with 3 identifying as Latino/Hispanic, 1 African-American, and 1 who identified as other. Participants were from all regions within the continental U.S. Compared to national data on the racial composition of nurses (IOM 2010), Black/African-American and Asian nurses are underrepresented and Hispanic/Latino nurses are overrepresented in the sample.

**Analysis**

In analyzing data from audio diaries and in-depth interviews, I attempt to construct a “metanarrative of the many stories heard” while also capturing the “complexity of lived experience” (Miller and Crabtree 2004:200-201). In doing so, I looked for strategies of emotion management that focus on the emotions of the nurse (frustration, fear, grief, sadness, etc.) as well as the management of patient emotions.
Some of the patients’ emotions were similar to the nurse (anger, fear, and anxiety), but others were unique to the patient (loneliness). The “stories heard” include the relaying of specific interactions with patients as well as reflections on the general emotional demands of the profession. Upon an initial reading of the transcribed data, I coded for themes from the literature on emotion management, including surface acting, deep acting, managing personal emotions, and managing patient emotions. Once these were coded, the data was analyzed for emergent themes on more specific strategies (Glaser and Strauss 1967).

While the interviews provide rich reflections on how men view the emotional aspects of their work, the structure of the interview can shape the responses of participants around terms and phrases predetermined by the interviewer (Miller and Crabtree 2004). In contrast, diaries provide more spontaneous responses, unstructured by an interview script. Using these two forms of data together, emergent themes present in both the interview and diary data have increased validity (for more on the merits of triangulating data, see Yin 2003). To show this clearly, I label data excerpts by source (either diary or interview) in the results section. All themes discussed have support from both interview and diary data sources. All names used in the text are pseudonyms.

Results

Results of the analysis revealed five distinct emotion management strategies. Categorized in terms of personal management or interpersonal, patient management, these include: (1) reframing the nursing role, (2) distancing, (3) relinquishing control, (4) self-management as patient management, and (5) education as patient management. While these distinctions provide clarity in understanding the emotion management
strategies of men in nursing, it is apparent that they interconnect in many ways. Men may engage in all or a few of these strategies in fulfilling their nurse role. After detailing each of these strategies with illustrative data, I discuss the implications for gender and emotion management theory, as well as for the nursing profession.

Strategies for Managing Personal Emotions

Reframing the Nurse Role. One strategy that men use to manage their emotions (feelings of guilt, remorse, sadness, failure, and grief) is a reframing of their role as nurse. Coping with grief and sadness, as well as feelings of failure, male nurses construct alternative narratives of the nursing role in order to minimize or stave off negative feelings. Alex (white, interview) notes that “you’re there to help them [patients] get better, but you also understand that sometimes people don’t get better.” In doing so, he reframes the nursing role in such a way that his success as a nurse is not bound to the tangible outcome of patient improvement. Held to a standard of care in which patients must always improve, Alex might frequently confront feelings of failure. By reframing his role as a nurse in a way that acknowledges the reality that “sometimes people don’t get better,” Alex manages his emotions at the level of deep acting—modifying genuine felt emotions.

Similarly, Russell talks about reframing how he sees the nursing role. Instead of seeing nursing as “saving lives,” he now focuses on “providing comfort.” He links this strategy directly to the management of grief and coping with loss:

I've found better ways to deal with it [losing a patient] I guess, but it's still hard every time you lose a patient but I don't take it home so much as when I first started. I could be very down for several days when I first started as a nurse, trying to deal with that, but I think now that I've adapted the attitude of making
their final days more comfortable and um don't go to the funerals or wakes as much, I think I am dealing with it better but it's still very hard um but it's the reality of what we do. (Russell, white, diary)

This reframing highlights the problematic nature of using “hero” rhetoric which emphasizes that nurses “change lives” in recruitment materials aimed at men. Such a strategy may leave nurses, particularly male nurses, with few alternative narratives for making sense of their work when patients are not or cannot be saved.

Jason also discusses a shift in how he sees his role as a nurse. While initially drawn to nursing “because I enjoy helping people,” over time he as shifted his focus to his skill in executing the technical aspects of the job:

I think the thing that I most enjoy about nursing is doing a good job more than anything. I enjoy helping people but it’s not the thing that kind of gets me going every day. Because the odds are you’re not going to help someone everyday, honestly some days people are going to die and there’s nothing you can do to stop that. (Jason, white, interview)

He goes on to describe the pleasure of retaining his technical expertise despite weeks and possibly months of “easy” cases that are not as technically demanding. His account suggests that the emphasis he places on technical skill is not intended to make him appear more masculine per se, but rather as a means for dealing with the reality of loss that he must face as a nurse trying to save lives. While a focus on technical expertise has been reported in other studies of men in nursing (Simpson 2007), the emotional buffer that this may provide men has not been previously discussed. Rather than using technical competence to prove hegemonic masculinity, men in nursing may reframe their role in order to manage feelings of helplessness (“some days people are going to die and there’s nothing you can do to stop that”) rather than compensating for the feminine-typed nature of their work. An emphasis on “doing a good job” over saving lives represents a deep
acting strategy through which male nurses maintain a sense of accomplishment in the face of unfavorable odds.

Walter discusses the need to reframe the nursing role in order to meet the unique challenges of serving psych patients:

A lot of people don’t want to go into psych because a lot of psych patients come back. It’s a revolving door; it’s an ongoing process for life. Whereas you’re a med-surg nurse, or ICU, or whatever floor you’re on, you’re gonna pump medicine through them, get them back on their feet in a couple days and they’re back to their life the way they were before. But with psych, it doesn’t happen that way. [...] Patients are going to come back and a lot of times they can’t help that because they cycle, it’s their mental attitude. We’re not going to fix everything. You just have to accept it that you do your best. (Walter, white, interview)

Noting the particular characteristics of the psych population, Walter emphasizes a reframing of the nurse role that accepts the limitations of the job ("we’re not going to fix everything"). A new nurse (less than a year of experience, Andrew, white, interview) frames the main goal of nursing as “fixing people.” Based on the responses of the more experienced nurses above, we might expect this new nurse to, over time, reframe his role from “fixing people” to doing the best that he can to make them comfortable. Such a reframing may be a necessary strategy for dealing with the reality of loss, grief, and feelings of failure that all nurses confront. This reframing is similar to the situational re-defining described by Francis (1997) in her analysis of interpersonal emotion management in divorce and bereavement support groups. However, while Francis focused on the situation group members confront, men’s reframing of the nursing role focuses on the job that nurses set out to accomplish.

Distancing. A second emotion management strategy discussed by male nurses is distancing. Here men discuss distancing themselves from patients so that they are not as “close” and the nurse does not relate to them or empathize with them too much. This
represents a paradox, as some men discuss developing empathy for patients in order to provide better care, several also describe learning to distance themselves from patients in order to deal with negative emotions on the job. Russell alludes to this strategy in the quote above when he mentions avoiding funerals and wakes as a way of dealing with the emotions surrounding patients’ death. Jason talks about becoming “numb” over time: “not that you don’t care anymore - it still affects you, but you just don’t get affected by it [losing patients] in the same manner” (white, interview). Similarly, Carl notes that empathy is necessary for the job, but detachment is also needed at times: “You have to be very empathetic to be able to do this job. There are times when you detach yourself just for self-preservation” (white, interview).

Ron talks explicitly about becoming more callous the longer he’s been in nursing. In doing so, he relates his strategy of distancing to having increased control:

I’m a little more callous. Where when I first started, maybe everything was full blast. I think now I have a little bit more control, better control of knowing what I need to do. I can’t harp on something all the time. But yeah, I guess I just haven’t figured it out yet, it’s definitely a major part of the job and basically you have to somehow figure out how not to make it affect your life. (Ron, white, interview)

Callousness, numbness, and avoiding wakes and funerals all reflect a process of emotional distancing whereby male nurses preempt and manage feelings of grief and loss.

While distancing is effective in some situations, there can be limits to the effectiveness of this self-focused emotion management strategy, as one nurse discussed the ultimate distance he must create by leaving the unit. Collin notes that if certain changes are implemented, he will no longer be able to work with patients who are similar to a past loved one:
Once [management] take the orthopedics out [of the emergency room] and it’s just drug and psych, I will definitely be leaving. I can’t handle dealing with the issues of this due to having a drunk ex-wife that was a cutter [and] bipolar—which I don’t know if it causes me to go through burnout faster, given that I had had that for 20 years. (Collin, white, diary)

The above examples show how male nurses engage in distancing strategies in order to alter their genuine feelings of loss and grief that come from being too close to patients who die—a strategy that might be categorized as a form of deep acting, or modifying felt emotions.

Derrick’s account discusses distancing as a form of surface acting—avoiding situations where he knew that he could not openly argue with patients. Derrick discusses this in terms of “avoidance”:

I’ll come up and they’ll [other nurses] go like “Oh I had this person yesterday and I can’t deal with them or their family again.” So we’ll put them on a different shift or during the shift if there’s a demanding patient or family, which seems to be becoming more common, you actually back away from them, you’ll give them the chair they need, the medicine, and all the stuff you know but then you won’t go in and try to socialize you’ll just kind of avoid that room. […] You do what they ask or you call the doctor and they don’t answer the nurse’s call, they call you back on their time and I just avoid that room (Derrick, white, interview)

While not dealing with feelings of grief and loss, Derrick discusses distancing or avoidance as a tactic for coping with feelings of frustration that come from dealing with a demanding patient. Through avoidance, he distances himself from the situation and the patient in order to preempt feelings of emotional exhaustion.

Relinquishing Control. Another strategy for managing personal emotions involves relinquishing control of the situation. Jack repeats the phrase “what can you do?” throughout his diary. In doing so, he suggests a relinquishing of control over the situations that might cause negative emotions, almost like an incantation to ward off negative feelings:
So I knew that when I walked in there that we would have a new patient, but you always hope it’s not, but you know, what can you do? (Jack, white, diary)

Jack uses the phrase “what can you do?” (Andrew says, “you do what you can”) in order to relinquish control over the situation and stave off feelings of frustration that a new patient creates. In a similarly frustrating situation, Jack used the phrase “what can you really do” to manage both his own and his co-worker’s sense of frustration:

She [other nurse] is just fed up because she’s got two hard patients, she’s got this going on, and is not even able to go and take care of her other two patients that really need something, too. […] And she’s just like saying, “you know, I can hardly take this, I feel like walking out right now” and all this kind of stuff. But I’m saying, “hey, we just have to take it in stride. I mean, this kind of stuff happens and, you know, what, what can you really do?” (Jack, white, diary)

Dealing with an overwhelming situation with multiple patients, Jack suggests that his co-worker use the emotion management strategy of relinquishing control in order to manage feelings of frustration and the desire to “walk out right now” that this frustration leads to.

Also alluding to a strategy of relinquishing control, Andrew describes learning to accept the fact that “you’re not going to save them all” as something he learned while serving in the military and from seeing “people die, I’ve lost my own men.” But he notes that he still struggles to relinquish control over situations and has difficulty resolving feelings of regret:

I get hard on myself sometimes too, you know, even with that stroke patient I was just talking about, you know, I’m sitting there thinking, what could I have done? It’s very hard for me to leave work at the door. I do care enough for that, you can’t leave it at the door, you know. It’ll be like one of those days that you have a bad night and you don’t get any rest because you’re just going through your head, what could I do? What could I have done differently? What could I have done differently? And there’s not much you can, you’re not gonna save them all (Andrew, white, interview)

A newer nurse, Andrew shows signs of emotional exhaustion and difficulty separating from his work when off the clock. As noted above, we might expect his strategy of
relinquishing control to be more effective if he also reframed the nursing role away from “saving” and “fixing” people to more realistic goals such as providing comfort and taking pride in his technical expertise.

Confronting the situational factors that limit his ability to provide high quality care, Thomas too explains how he relinquishes control in order to manage potential anxiety and worry. He references other nurses similar to Andrew who have difficulty managing such emotions:

there are some days where you make a little mistake and some nurses, I’m the type where I clock out and I leave and “hey I did the best job I could and I’ll come back tomorrow and do it again” but some nurses really lose sleep and get real high anxiety levels worrying about the demand for their job and if they did the best and if they made a mistake and if they hurt someone (Thomas, white, interview)

Thomas makes the explicit link between relinquishing control and managing potential anxiety. Unlike nurses that lose sleep, he’s able manage his feelings by emphasizing that he did the best that he could.

Strategies for Managing Patient Emotions

Managing Self as a Means to Manage Patient Emotions. Complementary to strategies of managing personal emotions are strategies that focus more directly on the emotions and feelings of the patient. However, distinguishing between self and other may be primarily analytical, as several men discuss the management of personal emotions as instrumental to the management of patient emotions. Thomas describes remaining calm so as to not “stir up” more patient emotions:

I try to remain very calm for a multitude of reasons, one is sometimes there are so many emotions going on between the patients and their families, the last thing
they need is somebody else coming in and stirring things up. (Thomas, white, interview)

By remaining calm, Thomas avoids adding to the “many emotions” already present among patients and family members, and in so doing he sees his management of self as instrumental in keeping the patient from becoming “stirred up.”

Describing a patient who was “pink-slipped”—requiring psychiatric approval before release—and threatening to leave unapproved, Jerry notes the primacy of managing his emotions in order to “de-escalate the situation”:

And so it’s just talking to them and I think being clear with them and trying to de-escalate the situation. If I would have said to her “Well you know what, walk your ass out that door and see what happens to you.” And I know nurses who would say that, she would have been belligerent and she would have tried to walk out that door. I would have had to leather restrain her and give her Geodon [a sedative]. I would have had to do a bunch of paperwork. She would have been ticked off at me the rest of the night. By the end of the night she and I were best friends she was looking for me—it’s because I just didn’t let myself get involved in that vicious circle of emotions. (Jerry, white, interview)

In keeping control of his own emotions—resisting anger in light of a confrontation—Jerry sees his own emotion management as critical to developing rapport with the patient (“she and I were best friends”) and preempting the patient’s belligerence and possible aggression.

Ethan also discusses the process of de-escalation in which he manages his own emotional expression in order to manage his patient:

Something I learned in nursing, but they really emphasize it, is de-escalation. I work at a federal prison in [Southwest State] and as the patient or inmate […] starts ramping up, you need to start calming down and getting quieter so that they are forced to de-escalate to hear you or to interact with you. (Ethan, white, interview)
Citing the deep acting of modifying his actual feelings of calmness with surface acting by becoming “quieter,” Ethan describes managing himself as a means toward de-escalating and managing the patient’s “ramped up” emotions.

Discussing how he calms things down, Collin cites managing his emotional expression through surface acting as the necessary but difficult strategy:

I go in and I try to calm things down when things get out of control. Which sometimes is very, very difficult when you gotta keep a smile on your face, knowing that they don't really care about you. (Collin, white, diary)

Using surface acting, Collin manages his facial expression (keeping a smile on his face) and is able to control the situation and calm patients.

Looking at self management as a mechanism for managing patient emotions, men may view controlling emotions as instrumental to performing their duties as nurses. Framed as instrumental, men’s emotional labor may have more agentive qualities that minimize the potentially negative outcomes previously linked to the emotional labor of nurses (Erickson 2008). Given that culturally shared gender beliefs link emotion to women’s essence (Rasmussen 2004), men’s emotion management might be conversely seen as active, signifying an agentive self, rather than essential and signifying a passive self. Thus, even as they engage in a task stereotyped as feminine (Ridgeway 2011), men seem to maintain agency by seeing their emotion management strategies as instrumental to the tasks of nursing.

*Education/Knowledge as a Means to Manage Patient Emotions.* The second theme in managing patient emotion is the strategy of education/knowledge. Nurses describe providing information—education on disease processes, anatomy, and hospital protocol—as a common means for calming anxious, angered, or frustrated patients. Ethan
describes this in his work serving a prison population. When asked specifically how he helps a patient through feelings of anxiety, Ethan responds:

   tell him where he’s at in the process and what’s happening next and what we’re waiting on and just grounding him in what’s going on and what the process is, so he at least has knowledge. He doesn’t have any power in the situation, but he at least has knowledge of what is going on. (Ethan, white, interview)

While knowledge does not provide the patient with power, Ethan sees his role as educator as linked to his ability to manage patient’s feelings of anxiety.

   In talking about his interactions with chemo patients, Russell also emphasizes educating patients as a means for making them feel more comfortable:

   I just educated them a little bit, spent a little time with the people and it's just always nice to talk to them and see where they are and how realistic they are in their thought process of what's about to happen and just trying to make them comfortable with what they're going through (Russell, white, diary)

Russell suggests that educating patients on the next steps in treating cancer is one way to make them more realistic and comfortable.

   In collaborating with physicians, Frank discusses the importance of relaying information in order to manage patient emotions:

   That's always the thing I like to do—when the doctor comes and talks to them, see what direction we're going, what's the plan for the patient. Then I can relay the information to the patient because just like any unit whether it is mental health, ER, a med-surgical unit, ICU, always keep patients informed and let the families know if they need to get permission. That way they're not left out in the dark. That relieves a lot of anxiety. Patients know where they stand because a lot of times they're misinformed and get stressed out and that's a shame that we don't inform our patients more thoroughly and let them know what's going on, give them some direction. That helps relieve a lot of their anxiety while they are in the hospital. (Frank, white, diary)

Frank characterizes education and providing information as a strategy for relieving patient anxiety and stress. He goes so far as to suggest that it is a “shame” when patients are not thoroughly informed as this lack of information creates anxiety for them.
In his diary, Emmanuel suggests that he too sees conveying information and knowledge to patient families as a way of managing their anxiety:

“Eventually mom woke up and I invited her to round with the team […] So I tried to structure things to help mom's anxiety and to also help her have some faith in the team that was rounding on her daughter and after that I followed mom back into the room and asked her if there was anything I could help her with and if she wanted to possibly start morning care for her daughter and she seemed surprised by me asking and was actually very receptive and I helped her with trach [tracheotomy] care and just changing bed and bath and clothes and everything, which seemed to take mom's frustration level down (Emmanuel, white, diary)

Learning the assessment of the health care team through rounding Emmanuel felt would help a patient’s mother develop trust and help with her anxiety. Also, including her in her daughter’s care by teaching her how to care for the tracheotomy site and changing the bed is also a means for managing her feelings of frustration.

Discussion

Analyzing audio diaries and interviews collected from men in nursing revealed several strategies that men use to manage their own and patient emotions. In an effort to manage their own feelings of failure, grief, and helplessness, men engage in role reframing, distancing, and relinquishing situational control. Working to de-escalate angered patients or comfort the anxious, male nurses emphasized the role that their own managed emotions play as well as the importance of educating and providing knowledge to patients. These findings extend prior work on emotion management and gender theory, as well as provide preliminary insight into styles of care, that may, with future research, be specific to men.

Turning to the literature on men and masculinities, we can see that these strategies have theoretical links to aspects of hegemonic ideals. Rationality, technical expertise, and
control form part of the ideal masculinity valorized in contemporary U.S. culture (Connell 2005). Somewhat paradoxically, the men in this study appear to relinquish control over their situations while simultaneously affirming their control over their own emotions. They engage in deep acting as they cultivate feelings of calmness as well as surface acting—maintaining a smile and quieting their voice—in an effort to manage patient emotions of anger and anxiety. Jerry controls himself to that point that he doesn’t let himself “get involved in that vicious circle of emotions,” but also relinquishes control (“I just do the best I can”) so that he doesn’t dwell on negative aspects of the job. While paradoxical, this is an important finding that highlights the role that gender, particularly masculinity, may play in shaping emotion management processes. With the link between control and masculinity well-established, male nurses may reach burnout or leave the profession as a result of feeling out of control or unable to reframe failure as “doing the best that they could.” These strategies emerge from the narratives of nurse diaries and interviews and have yet to be linked to particular outcomes, however this exploratory study provides a basis for developing future work on male nurses’ emotion management strategies—key elements of their styles of care—and how these may influence outcomes of job turnover and overall well-being.

In emphasizing education and knowledge as a means for managing patient emotions, the men in the study reaffirm the cultural belief that rationality can conquer the unpredictable emotions of patients, alluding to the gender-linked dualisms of the rational man subduing the irrational woman (Lutz 1988). Men in the study saw education and providing information to patients as a means of managing patients’ anxiety, stress, and comfort levels. While its effectiveness is outside the scope of the present study, the links
between this strategy and masculine ideals are clear. Of course, how this knowledge is delivered to patients is likely a critical factor for how the information is received. Perhaps men in the sample are unaware of the more subtle ways that they manage patient emotions as they relay information, but regardless, their construction of education as a means of managing emotions is telling of the influence hegemonic ideals have on men in a caring profession.

Results also suggest that men’s emphasis on technical expertise may serve to help them confront heightened feelings of failure and loss of control when patients’ health does not progress as desired. Prior research has viewed men’s emphasis on technical expertise as a form of identity work intended to minimize role strain (Simpson 2007). Framed differently, an emphasis on technical competence may also be a strategy for managing feelings of failure and powerlessness. The present study gives us insight into how some male nurses confront those feelings, but more research is needed if we are to improve upon the training and context of nursing so that it better supports men in the field and keeps them in the profession.

Theoretically, men’s use of education and knowledge to manage patient emotion and their emphasis on rational/technical competence in role reframing disrupts of reason/emotion dualisms which underlie the current hegemonic gender system (Fausto-Sterling 1993; Sprague 1997). While male nurses draw on hegemonic aspects of masculinity in order to perform the feminine-typed task of providing care, they simultaneously disrupt dichotomous constructions of reason and emotion by seeing their use of reason/knowledge as a means for managing emotion. Patients are calmed and comforted by the knowledge they provide, rendering education an aspect of emotion
management processes rather than antithetical to such processes. The implications of this may not be fully understood from the current study, but this finding should inform future work on men in caring professions. Future research should consider the simultaneous reproduction and disruption of hegemonic masculinity and its impact on the self and emotion-based processes.

The strategy of reframing the nursing role has implications for both recruitment and training of male nurses. With “improving” lives and “helping others” a common theme of recruitment materials aimed at men (see chapter II), it is important to critically evaluate this tactic in light of the potential counteracting effects it may have on men’s strategies for managing grief and feelings of failure. While helping others and improving lives are common draws to the profession, recruiting nurses by emphasizing this facet alone may leave nurses particularly susceptible to burnout and vulnerable to feelings of failure and grief when they are unable to help others.

Similar to other qualitative studies of men and masculinity (Connell 2005; Simpson 2007; Vaccaro, Schrock, and McCabe 2011), the current study used in-depth data from men. Without a comparative group of women, it is an overreach to suggest that the strategies discussed are exclusive to men. Rather, men’s framing of their own strategies is approached as descriptive data with theoretical implications for men and masculinities scholarship. Quantified comparisons of male and female nurses’ emotion management suggest that men engage in less management than women and have better occupational outcomes when they do engage in management (Cottingham, Erickson, and Diefendorff, In progress). Findings from the present study suggest that men approach emotion management in an agentive way that may explain their positive occupational
outcomes in other studies. Future qualitative and quantitative work that includes both men and women is needed in order to determine uniquely gendered strategies of emotion management and distinctly masculine styles of care.

In sum, the present chapter examines men’s management of personal and patient emotions. Strategies include reframing the nursing role, distancing, and relinquishing control. The results suggest a paradox of relinquishing control over the situation coupled with retaining control over personal emotion. Furthermore, men’s narratives suggest that management of personal emotions and education/imparting knowledge both play an instrumental role in the management of patient emotions. With links to hegemonic ideals of rationality, technical expertise, control, and emotional detachment, some of the emotion-based strategies of men in nursing appear to be heavily influenced by the current gender system and the hegemonic ideals that support it. Some strategies, however, such as relinquishing control over situations and reframing the nursing role away from a rhetoric of heroism, suggest alternative masculinities more amenable to the emotional demands of the profession. Given the national nursing trends in terms of projected shortages (Bureau of Labor Statistics 2012) and calls for a more diverse workforce that matches the demographics of the population it serves (IOM 2010), it is critical that scholars examine the emotion management strategies of minorities in the profession and work to create a more diverse and robust nursing workforce.
CHAPTER V
SUMMARY AND CONCLUSION

In the preceding chapters, I drew on organizational and individual-level data on men in nursing to examine issues of masculinity, emotional capital, and emotion management. Spanning these two levels of analysis, I divided the dissertation into three article-length chapters. Chapter II focused on the efforts of health care organizations to recruit men to nursing. In that chapter, I was guided by the following research questions:

1. How do organizations recruiting men to nursing reconcile the qualities of dominant masculinity that seem at odds with the requirement that nurses provide physical and emotional care to others?

2. More specifically, what qualities of hegemonic masculinities and non-hegemonic masculinities are represented in the recruitment material?

3. Finally, using each recruitment item as a separate case, what type of mobilization strategy does each poster, video, and brochure utilize in an effort to attract men to the profession?

Answering these questions, I examined the efforts of health care organizations to recruit men to nursing. Organizations mobilize hegemonic and non-hegemonic forms of masculinity. Emphasizing hegemonic themes, 22 percent of recruitment materials eschew the caring aspects of the profession and instead emphasize autonomy, athleticism, technical/rational competence, and the breadwinner ideal in order to make nursing an
appealing career option to boys and young men. A majority of recruitment materials (53 percent), however, attempt to combine a caring/helping masculinity with hegemonic ideals, but they do so in ways that often polarize the two forms. A subset of materials center on alternative forms of masculinity—forms that focus on caring and helping others without recourse to hegemonic ideals.

Turning to the individual level of men’s experience in the profession of nursing, chapter III developed the concept of emotional capital in order to address limitations in prior research and theorize men’s emotional resources in relation to socialization sources and their emotion practice. In this chapter, I sought to answer the following research questions:

1. What are the limitations of prior studies of emotional capital and its link to gender, emotion practice, and occupational socialization?
2. How does case study data on men in nursing illustrate each facet of emotional capital (capacities, knowledge, and skills)?
3. What is the relationship between emotional capital, emotion practice, and the primary and secondary socialization processes by which men actively shape their emotional capital?

I addressed these questions by examining the concept of emotional capital as a trans-situational resource that men possess, embody/enact in emotion practice, and develop as a result of occupational socialization in nursing. Prior research on emotional capital was limited by an overly-feminized definition that did not clearly delineate between capital and practice, or between primary and secondary sources of emotional socialization. Contrary to cultural beliefs about men being emotionally detached and less
empathic than women, male nurses do not see their capacity for feelings of compassion and empathy as limited. Rather, they argue that it is their expression of these emotions— their emotion practice—which is distinct. Working within a profession that centers on the feminized tasks of caring for the emotional and physical well-being of others, men in nursing confront head-on the dominant cultural belief that men are not as nurturing as women. In doing so, their experiences and reflections suggest delineating between capacities, skills, and knowledge (i.e., emotional capital) and the activation/embodiment of that capital in their everyday nursing practice. I develop the concepts of primary and secondary emotional capital in order to account for the dynamic rigidity of emotional resources in the face of familial, educational, and occupational forces. In meeting the practical demands of their profession, men bring primary emotional capital to nursing, but also actively shape that capital by developing their capacity for empathy and compassion on the job.

Focusing on men’s emotion practice in nursing, chapter IV looked at men’s specific emotion management strategies. I asked the following questions in chapter IV:

1. How do male nurses manage their own emotions on the job?
2. How do men manage the emotions of patients in order to fulfill the demands of their job and provide high quality care?
3. How do strategies of emotion management among male nurses reflect hegemonic and/or alternative constructions of masculinity and what are the implications of these strategies for theory and practice?

One facet of men’s emotion practice in nursing is their personal and interpersonal emotion management strategies—how they manage their own and patient emotions.
Personal management strategies include reframing the nursing role, distancing, and relinquishing control. Men’s emotion management strategies suggest both hegemonic and alternative constructions of masculinity, with their emphasis on rational/technical competence and emotional detachment serving as a means to manage feelings of failure and grief rather than solely as a means to prove their masculinity to themselves and others. Male nurses describe control over their own emotions as well as an emphasis on education and providing knowledge as effective strategies for managing patient emotions. Using hegemonic ideals of rationality and control to calm and de-escalate patients and manage their own feelings of grief, the emotion management strategies of male nurses subtly subvert the emotion versus reason dualism that pervades Western thought. Their strategies of relinquishing control and reframing the nursing role also imply alternative constructions of masculinity that are used to ward off feelings of helplessness and failure that arise throughout the course of their work as nurses.

Common Themes Across the Empirical Chapters

Through all three empirical chapters, two common themes emerge. These center on the dynamic and embodied nature of gender and the notion of practice as a means for framing individual and organizational action. In terms of masculinity, Connell and Messerschmidt (2005) argue that the lasting utility of the concept of hegemonic masculinity depends on its conceptualization in relation to the physical body and its dynamic nature across contexts:

“masculinity is not a fixed entity embedded in the body or personality traits of individuals. Masculinities are configurations of practice that are accomplished in
social action and, therefore, can differ according to the gender relations in a particular social setting” (2005:836).

While not embedded in the body, and thus essentialist, the body itself contextualizes the various forms that masculinity takes. Masculinity as embodied and dynamic is evident in the three empirical chapters outlined above. Physical athleticism and risk-taking are valorized in recruitment materials. Men’s navigation of therapeutic touch and management of personal grief link masculinity to the body and its social expectations and limitations. By highlighting the embodied and relational nature of masculinity, therapeutic touch (O’Lynn 2007a) for example, is understood as a problematic practice for men in the profession. Both the body of the nurse and the patient come into play, as touching a male or female patient takes on different, but equally hypersexed meanings in the context of caring for others. Extending the “bodies as weapons” characterization made by Messner (1992), men’s attempts at care-focused, therapeutic touch are inherently suspect because of men’s presumed sexual agency. Men’s bodies are framed in dominant discourse as tools of physical and sexual subjugation, a framing that constrains men’s embodied practice as caregivers.

Along with their call to situate masculinities in relation to the physical body, Connell and Messerschmidt (2005) highlight masculinity’s dynamic and contradictory nature: “Although long acknowledged, the internal complexity of masculinities has only gradually come into focus as a research issue” (852). This dissertation builds on that emerging focus by showing how organizations and individual men dynamically synthesize ideal and alternative constructions of masculinity in order to meet certain practical demands in health care. Confronting projected nursing shortages and a call for a
more diverse workforce (Bureau of Labor Statistics 2012; IOM 2010), organizations mobilize different, seemingly contradictory configurations of masculinity in order to reach boys and young men who might consider the profession a viable vocation. These included an emphasis on helping others as well as athleticism and risk-taking. Notably, some materials polarized the alternative from the hegemonic and hegemonic themes were cast in a “lead role” over alternative themes.

Male nurses themselves also embodied and activated dynamic forms of masculinity (and emotional capital) in order to provide context-specific, high-quality care to their patients. For example, men emphasized the evolving nature of their emotional capital in relation to their experiences in giving care to others as nurses. Men both critiqued and affirmed aspects of gender hegemony (Connell 2005). They critiqued the cultural beliefs that men are not as compassionate or nurturing as women, while maintaining the belief that men and women are distinct in their emotion practice or expression of care. Extending the notion that gender serves as a primary frame on social life (Ridgeway 2011) and the significance of emotion for the construction of the self (Boyns 2006), men’s development of emotional capital through occupational socialization could be characterized as the dynamic construction of an emotive masculine self that straddles the demands of hegemonic masculinity on the one hand with the call of nursing for compassionate care for others.

A second theme of the current research on men in nursing is the notion of practice as a means for framing the conscious/nonconscious action of organizations and individuals. This dissertation highlights the active role that both health care organizations and individual men play in reproducing, contesting, and reconstructing masculine
emotionality in their social practice. Throughout each chapter, dominant discourse centered on idealized masculinities are synthesized with alternative masculinities centered on care. Part of this synthesis emerges from the influence that organizations exert over gender discourse and the influence men exert over their self-constructions. This shows the contradictions that arise when individuals and organizations confront practical needs within the current gender system and the need to account for social reality as a product of practical, habituated doing within the context of social structures and cultural ideologies (Bourdieu 1992). Health care organizations and male nurses are not purely determined by their social location, but actively negotiate their everyday ideological and emotion practice within the constraints of that system.

Countering overly feminine and deterministic conceptualization of emotional capital in prior literature (Reay 2004; Gillies 2006), the results of chapter III show how capital and practice interconnect and change as a result of the situational demands that men confront. The development of emotional capital and men’s construction of emotive masculine selves occurs within the context of specific situational needs that require men to be compassionate and nurturing to others. Emotion practice—how men activate and embody emotional capital—emerges from men’s constrained agency. By showing how men develop capital through occupational experience, the findings in chapter III show how Bourdieu’s theoretical concepts can be used to theorize situationally and structurally constrained agency rather than offer a wholly deterministic view of the individual as critiques have argued (Jenkins 1982). Both organizations and individuals exert influence over their social practice within the context of a broader gender system.
Theoretical Implications

The findings in this dissertation have theoretical implications specific to the study of masculinities and the sociology of emotion. From chapter IV, results suggest that men’s use of hegemonic masculinity can in fact counter the emotion/reason dualism that undergirds hegemonic ideals (Fausto-Sterling 1993; Sprague 1997). By using distancing and control as a means to manage personal and patient emotions, men in nursing use these strategies to deal with personal grief and patient fear and rage. But men may also relinquish control over situations and reframe their role as nurses away from the rhetoric of saving lives. These non-hegemonic strategies are necessary in order to stave off feelings of failure and helplessness. Both hegemonic and non-hegemonic aspects of masculinity may be used by men as strategies for meeting the emotional demands of their work. By better understanding the practical utility of aspects of hegemonic masculinity for men in nursing, masculinities scholars should carefully assess the ways in which masculinity constrains and enables men’s emotional lives within the context of a caring profession. Rather than demonize all aspects of hegemony, findings suggest that future work on men and masculinities should explore the outcomes of specific aspects of hegemonic masculinity for organizational and individual social practice.

In this dissertation, I drew on elements from both emotion management theory and Bourdieu’s social practice to develop a new approach to the sociology of emotion. Chapter III extends Erickson and Stacey’s (2013) work to reframe emotion management as part of the situated embodiment/enactment of emotional capital through emotion practice. Men draw on primary and secondary emotional capital by enacting/embodying empathy, compassion, and care in their everyday work as nurses. Emotion management is
one aspect of emotion practice. Chapters III and IV thus extends prior research on what might be termed an “emotion-as-practice” theoretical approach (Erickson and Stacey 2013). Within this approach, emotion management (and labor) is seen as the conscious/nonconscious activation and embodiment of emotional capital within the field of health care. Facing the emotional demands of nursing, men confront different “rules of the game” and must develop field-appropriate forms of capital—emotional capital that includes capacities for compassion, empathy, and care, as well as knowledge and skill in expressing and managing emotion. Enacting that capital through emotion practice, men convert field-appropriate capital into other forms of capital. Meeting the emotional labor demands of their profession, men earn a living by effectively converting emotional capital into economic capital.

While beyond the scope of the present study, it is possible that male nurses (as well as female nurses) convert emotional capital into other forms of Bourdieuan capital such as social capital. By successfully developing emotional bonds with patients, colleagues, physicians, and managers, nurses develop social connections and networks of potential social support. Furthermore, emotional capital specific to the field of health care may also be transferable to other fields such as the family. Men in the study noted that being a nurse had made them a better man and they see their current and future role as fathers more favorably as a result of their experiences in nursing. Finally, how male nurses use and develop emotional capital may lead to better occupational outcomes (Cottingham, Erickson, and Diefendorff, manuscript under review) and individual well-being as compared to female nurses. Future work should attend to the effectiveness of men’s emotion practice in nursing and the implications their practice has for a number of
parties, including patients, colleagues, and their own well-being. I discuss this in more
detail in the “Future Research” section below.

The Role of Class Background and Other Characteristics

One of the empirical questions that originally framed this research concerned the
role of class background in shaping how men discuss emotional capital and how they
meet the emotional demands of their work as nurses. Of initial concern was my ability to
recruit a reasonable number of men from varying class backgrounds that would allow for
comparative analysis. Fortunately, I was able to recruit nearly equivalent numbers of men
from working class and middle class backgrounds, making comparisons between the two
groups feasible. Notably though, differences based on class background were not evident
despite the equal proportion of each. One reason for this may be the primacy of
masculinity over and above class background when it comes to issues of emotion.
Ridgeway (2011) argues that gender is the primary social characteristic that frames men
and women’s lives. The pervasive and essentialist nature of cultural beliefs surrounding
gender may make it a more dominant frame than race or class. The lack of clear
distinctions between men based on class background may offer limited support to this
claim, albeit this is preliminary and suggests the need for further research on class and
emotion.

I also collected data on other facets of men’s social location besides class
background. As the demographic questionnaire shows (see Appendix D), I asked men to
report their years of experience in nursing, their current unit, race, sexual orientation, and
age. Given the inductive nature of qualitative research, it is unsurprising that the variation
I expected in terms of class background did not emerge in the analysis. Rather, men’s sexuality did emerge as one of the more salient and influential facets of men’s experiences in nurses. This comes out clearly in chapter III in relation to how men’s enactment/embodiment of emotional capital is constrained by their actual and/or perceived sexuality and how this influences perceptions of gender differences in emotional capacities. Men’s perceived hypersexuality, both gay and straight, impacts how they believe themselves to be perceived by others and the care they give as a result. Future work might tease out differences in men’s actual and perceived sexual orientation and how this impacts their emotion practice in nursing or other caring professions. I also used years of experience in chapter IV as a means for framing how men discuss developing strategies for managing their own emotions over time and experience in the profession. As they accrue years of experience, male nurses may engage more of the strategies of role reframing, distancing, and relinquishing control as a result of the negative emotions that losing patients and a frustrating work environment create. Future work should consider the role that years of experience may play in how men manage emotions on the job.

Implications for the Nursing Profession

Harding (1991) states that “Men must struggle to create for themselves a kind of experience of their own gender location which male supremacy has forbidden” (286). The constraints of the current gender system impact women as well as men, though men rarely see themselves as gendered beings. Given their work in a female dominated profession, men in nursing do see themselves as gendered, however I would extend
Harding’s call to key players in health care organizations. The AAMN’s efforts to move away from the “Are you man enough?” campaign slogan is laudable. However, their efforts to “de-gender” recruitment materials by removing this slogan were not entirely successful. Aspects of hegemonic masculinity, including risk-taking and adventure, were still given central focus over and above the non-hegemonic aspects of helping others and providing care. Nursing and health care organizations should be cognizant of the gender system in which they are embedded as well as the role they play in privileging some forms of masculinity over others and the potential outcomes of their recruitment strategies. Diversity of the nursing workforce is an important goal. However, diversity should not be defined in solely gendered or racialized ways, but should incorporate diversities of masculinity that are absent in hyper-macho images of tough, risk-taking men.

Other tactics have been used by nursing organizations to attract more men to the field. These include summer camps for elementary and middle-school boys that introduce them to nursing and to male nurses. This interactive approach is likely to provide a more nuanced understanding of what it means to be a nurse and can help to dispel stereotypes by introducing boys to actual men in nursing rather than mediated caricatures. While nursing does involve technical and critical-thinking skills, emphasizing these over empathy and caring for others does little to critique cultural devaluations of female-dominant work. Rather, it tries to reframe this type of work as masculine. Both the feminine and masculine aspects of nursing must be highlighted and valued in text, image, and encounters aimed at recruiting compassionate and competent men to nursing.
To nursing educators and policy makers, the issue of emotional capital and its use has practical significance. Despite efforts to train all nurses uniformly, men’s unique social location in a profession centered on physical and emotional care presents them with unique challenges. Addressing these challenges directly, through specialized workshops on men’s use of therapeutic touch (O’Lynn 2007a) for example, might help men as they work to give appropriate care within the constraints of the current, often invisible, gender system. To effectively do this, nursing organizations interested in men’s experience in the profession must address the elephant in the room: sexuality. The issue of touch and sexuality are inherently connected and men need strategies of interacting with patients that allow them to counteract all suspicions of their touch as potentially sexual. While hypersexuality is a part of hegemonic constructions of masculinity more generally, the stereotype of the male nurse as gay also increases the saliency of sexuality for patients, family members, and health care providers. Educating the patient population on therapeutic touch and its important role in recovery and health might also counter the perception of men’s physical interaction as inherently sexual. While broad cultural beliefs may characterize the male nurse as a contradiction in terms, this characterization should be critiqued and challenged within nursing circles, including educational and professional associations. Helping male and female students develop emotional capacities and skills, that is, helping them develop their emotional capital, should be the goal of any well-rounded nursing education.
Limitations

While this dissertation contributes to gender theory and the sociology of emotion as well as practical concerns within the nursing profession, there are several limitations to the methods used. Below I discuss methodological limitations, following this with some suggestions for future research.

“Even more than other forms of cultural capital—such as wine tasting or familiarity with high culture—emotional capital seems to mobilize the least reflexive aspects of habitus. It exists in the form of ‘long-lasting dispositions of the mind and body’ and is the most ‘embodied’ part of the embodied cultural capital (Bourdieu 1986:243)” (Illouz 1997:41).

The quote above from Illouz (1997) suggests that one of the defining features of emotional capital is its relationship to the least reflexive aspects of the habitus. Hence it is least likely to be of conscious awareness to individuals who possess its varying forms. Because of emotional capital’s deeply embodied nature, methodological questions emerge about the best way to observe and capture capital in sociological research.

One of the primary sources of data for the current project is interview data. In line with Illouz’s quote above, Bourdieu scholars have suggested that the interview is not an ideal form of data, as one implication of the practice of logic is that “much of social life is simply taken for granted and its logic is implicit” (Williams 1995:583; see also Young 1992). As such, relying on the discursive accounts of individuals is “literally asking too much of informants” (Williams 1995:583). This stems from the pervasiveness of what Bourdieu (1992) terms “misrecognition”—the obfuscation of power relations implicit in
structures of practice. Individual agents misrecognize the sources of inequality because the social has been artificially dissected from the self and the body.

Interviews, however, have been frequently used in exploring aspects of Bourdieu’s theory, including the work described in chapter III on emotional capital. Young (1999) relies on in-depth interviews with poor African-American men to understand how capital is and is not accumulated throughout the life course in the fields of family, education, religion, and peer associations. Defending his choice, Young argues that we need to know the explicit values held by those who share a similar habitus in order to understand how capital is gained. Furthermore, individual’s “imagine” the potential outcomes of their pursuits in terms of constrained agency (1999:202) and these imaginations and values may be suggestive of an underlying worldview that eschews reflection.

While I supplement interview data with other forms, including recruitment materials and audio diaries taken at a men-in-nursing conference, the analytical richness of the data used must speak for itself. Interview data may capture more of the conscious and reflexive aspects of habitus, but these aspects suggest when and how capital is embodied and activated in everyday social practice. Future research using more measures of biofeedback, timed questions asking participants to identify the emotional states of others, and other methods are needed in order to take into account features of habitus and capital not captured in the narratives of individuals.

A further limitation of the study was the demographics of the men who participated in diaries and interviews. Though the sample was fairly diverse in terms of age and years of experience, the vast majority of men in the study were white. While the
non-randomized, non-representative nature of the sample already limits statistical
generalizations to all men in nursing (but not theoretical generalizations, see Yin 2003),
the racial make-up of the sample means that particular caution is merited when it comes
to extrapolating the findings to male nurses of color. As I noted in chapter II, black
masculinity may be more amenable to the aspects of care found in nursing than white
masculinity (Harvey Wingfield 2010). The extent to which the findings represent nurses
of diverse backgrounds remains to be seen and requires further quantitative and
qualitative research with more racially diverse participants.

Future Research

While the current research provided new insights into the relationship between
masculinity and emotion, the above implications and limitations have significance for
future research in the area of masculinity and emotion scholarship. Methodologically,
future work should expand upon the recruitment materials, interviews, and diaries used in
the current study to include ethnographic and observational data that might further
capture the behavioral and nonconscious practices of organizations and individuals. The
findings of this dissertation can inform future researchers who use such methods by
alerting them to the issue of therapeutic touch and its complexity for male nurses, as well
as the dynamic nature of masculinity at both the organizational and individual level. For
example, Floge and Merrill’s (1989) combine observational and interview data to assess
how tokenism operates among male nurses and female doctors in a hospital setting. Their
original analysis was not attentive to the emotional demands that men in nursing face and
future work using similar methods might illuminate how, for instance, male nurses mange
emotions in real time on the job during their interactions with patients, colleagues, and physicians.

Future research should also attend to how male nurses are educated and trained to meet the emotional demands of the job. This would provide greater context to the current and future studies on how men develop emotional capital as a result of educational forces, including formal and informal processes. Men who participated in the dissertation noted the continued use of “she” throughout nursing educational material and its reinforcement of the subtle message that, as men, they did not belong in the profession. Analyzing the content of nursing textbooks, orientation manuals, and seminars/workshops might contextualize the gendered nature of the nursing profession and the formal occupational socialization that men in nursing undergo in preparation for the job. The IOM’s (2010) call for increased diversity, including gender diversity, requires a more systematic assessment of diversity within the educational content that structures nurses’ in the classroom and in clinical training. In their study of the effect of a communication skill training workshop, Razavi, et al. (2002) found that a training workshop did impact nurses’ empathy and use of emotional words when interacting with cancer patients. Unfortunately, the sex of participants was not reported in their findings, and the extent to which men may respond to and implement training on empathy and emotional expression remains unknown. Razavi, et al.’s study does provide a model for future work that assesses the role of training workshops in men’s development of emotional capital. Furthermore, the AAMN has recently initiated a mentorship program that matches experienced with less experienced male nurses. As a cite of informal training, future work on mentorship programs, including their effectiveness at retaining
men, should be mindful of the emotional capital that is transferred through these channels.

Adding a longitudinal component to the research discussed in this dissertation, future work might also continue to examine the gendering practices of health care organizations and the degree to which they succeed in recruiting more men to nursing. The outcomes of recruitment strategies are conspicuously missing from the above analysis and would add needed context to understanding the choices that organizational leaders make in selecting and omitting some content over others. Prior focus groups have targeted the opinions of men already in the nursing profession (Bernard Hodes Group 2009) rather than the target audience of recruitment material - boys and young men not yet in nursing. Future research on the recruitment of men into nursing should include the how boys and men in the general population view the recruitment materials. Measures of outcomes for nurses and patients, including the quality of patient care that nurses provide and the mental and physical well-being of nurses, would also contextualize our understanding of the effects of emotional capital as it is activated and embodied by men in nursing, furthering our understanding of how and with what effect emotion-based processes operate in a caring profession.

Drawing on various methodological traditions, the findings in this dissertation might also be used to construct new measures of emotional capital and its activation/embodiment in social practice. Biofeedback measures, tests of explicit identification and implicit emotion recognition, and responses to vignette narratives might all provide quantifiable measures of the more nonconscious aspects of masculinity and emotional capital and practice (Hendriks, Croon, and Vingerhoets 2008; Williams, et
These include measures of men’s conformance to masculinity (Mahalik, et al. 2003), the “Emotion Recognition and Identification Test” (Williams, et al. 2009) and the development of new vignettes might capture the emotional capital and practice that men use in a caring profession. Supplementing these measures with self-reports of individual’s emotional capacities, emotion management skills, and knowledge, a composite of these items might then be linked to various occupational and well-being outcomes, including patient care, job satisfaction, and emotional burnout. Such measures could be applied to larger, more representative samples that allow for statistical generalization of findings to men in nursing or even more broadly to men in caring professions.

In sum, this dissertation offers an organizational and individual-level analysis of issues of masculinity and emotion among men in nursing. The dynamic and embodied nature of masculinity is apparent throughout the three empirical chapters presented, as ideal and alternative constructions of masculinity are synthesized and embodied in organizational and individual social practice. The ideological gendering practices of organizations mobilize aspects of both hegemonic and alternative masculinity in an effort to recruit more men to the nursing profession. Individual men reconcile the ideals of emotional detachment with the demands of a caring profession by constructing alternative ideals of masculinity that address the practical demands of their everyday work. Men care. They are and are becoming empathic, compassionate caregivers despite the cultural beliefs that set limits on their emotional capacities. And not all aspects of hegemonic masculinity inherently reproduce the hegemonic gender system, as men use control over self and rationality in order to serve the emotional needs of themselves and
others. Through increased representation in the profession as well as continually shifting
gender and emotion norms, the supposedly “contradictory” male nurse is well-positioned
to become a revolutionary figure in the transformation of masculinity and emotion in the
contemporary U.S.
REFERENCES


Theoretical Perspective on Cultural Schemas and Social Relations.” *Social Psychology Quarterly* 69:5-16.


of Facial Emotions: I. Age Effects in Males and Females Across 10 Decades.”

Wolkomir, Michelle. 2001. “Emotion Work, Commitment, and the Authentication of the
Self: The Case of Gay and Ex-Gay Christian Support Groups.” Journal of
Contemporary Ethnography 30(3):305-334.


Wolkomir, Michelle. 2006. Be Not Deceived: The Sacred and Sexual Struggles of Gay

Sage.

Young, Alford A. 1999. “The (Non)Accumulation of Capital: Explicating the
Relationship of Structure and Agency in the Lives of Poor Black Men.”
Sociological Theory 17(2):201-227.


Zemblyas, Michalinos. 2007. “Emotional Capital and Education: Theoretical Insights

Zhang, Yuanyuan, Travis L. Dixon, and Kate Conrad. 2010. “Female Body Image as a
Function of Themes in Rap Music Videos: A Content Analysis.” Sex Roles
APPENDICES
APPENDIX A

HUMAN SUBJECTS APPROVAL

NOTICE OF APPROVAL

September 20, 2011

Marc D. Gottingham
218 Beach Street
Pittsburgh, PA 15218

From: Sharon McWhorter, IRB Administrator

Re: IRB Number 20110911 “Classed Masculinities and Emotional Capital: Intersections of Class and Gender in the Emotional Lives of Male Nurses”

Thank you for submitting your IRB Application for Review of Research Involving Human Subjects for the referenced project. Your application was approved on September 20, 2011. Your protocol represents minimal risk to subjects and meets the following federal category for exemption:

☐ Exemption 1 – Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☐ Exemption 2 – Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior.

☐ Exemption 3 – Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.

☐ Exemption 4 – Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5 – Research and demonstration projects conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6 – Taste and food quality evaluation and consumer acceptance studies.

Annual continuation applications are not required for exempt projects. If you make changes to the study’s design or procedures that increase the risk to subjects or include activities that do not fall within the approved exemption category, please contact me to discuss whether or not a new application must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to implementation.

Please retain this letter for your files. This office will hold your exemption application for a period of three years from the approval date. If you wish to continue this protocol beyond this period, you will need to submit another Exemption Request. If the research is being conducted for a master's thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

☐ Approved consent form/s enclosed

Cc: Rebecca Erdosan - Advisor
Cc: Stephanie Woods - IRB Chair

Office of Research Services and Sponsored Programs
Akron, OH 44325-2102
330-872-7666 • 330-872-6281 Fax

The University of Akron is an Equal Education and Employment Institution

150
April 2012

Dear Nurse:

Thank you so much for being willing to contribute your insights and experiences by participating in an interview. These interviews focus specifically on the emotional demands that you face each and every day as you provide care to others and the conflicting emotions you likely face as a man in a traditionally female occupation. From these interviews I hope to develop recommendations for improving the nursing work environment as well as the training that male nurses receive.

The aim of the interview is to better understand how your conceptions of being a man have shaped how you view nursing. Previous research has shown that men in traditionally female occupations experience their profession differently than their female colleagues. Furthermore, I expect that your experiences require negotiations with what our culture defines as ideal manhood and how you see yourself as both a man and a nurse.

Please note that your participation in the interview is completely voluntary and you can refrain from any or all questions without penalty or explanation. Given the small number of nurses being asked to participate, your involvement is very much appreciated and will help to enhance the quality of the data collected. I am also asking for your consent to record the interview to ensure that I fully capture your current views on the situations we’ll discuss.

The recorded interview data will be kept in the strictest of confidence and will not be shared with anyone except the members of my dissertation committee. Once the
interview recording is transcribed and checked for accuracy, it will be erased from the device. Any mention of names or other identifying information that is recorded will be also deleted from the final transcript of the recording. The written information being collected will be kept confidential and will not be connected to your name or any other personally identifying information. All of these data will help to ensure that recommendations for change are as effective as possible.

It is estimated that your participation will take approximately 1 hour. This time may vary to the extent you have more or less to say about the topic of study. Once this interview is transcribed, I would be happy to mail you a printed copy if you desire one.

It is not expected that this project will cause you any serious discomfort. However, you may feel your job is at risk if you share any negative feelings about where you work. Your job is NOT at risk in any way because all of the transcribed document will use numbered codes as identifiers and no administrative personnel will have access to the recorded interviews. Please know that even by signing this consent form, you are free to terminate your participation at any time without penalty or explanation.

The Institutional Review Board for the Protection of Human Subjects at The University of Akron has reviewed the procedures and materials involved in this project. If you have any questions or comments about the study, you are welcome to contact me at (918) 289-5052 or mdc63@uakron.edu. You can also direct your questions to The University of Akron’s Institutional Review Board by contacting Ms. Sharon McWhorter, Associate Director, Office of Research Sciences and Sponsored Programs, The University of Akron, Akron, Ohio 44325-2102; (330) 972-8311.

Thank you again for your help. Please print your name and sign below (or acknowledge verbally at the beginning of the interview) if you are willing to participate. There is a second place for you to sign indicating your consent for the interview to be recorded.

Marci Cottingham
The University of Akron

_________________________ _____________________________________
Printed Name     Signature

______________________________
Date
“I acknowledge, understand, and agree to participate in a recorded interview.”

Participant’s Signature
Interviewer: Thank you for being willing to participate in this interview. I’m Marci Cottingham, a doctoral student in the Sociology department at the University of Akron.

In general, this interview aims to understand how you see yourself as a man working in a traditionally female occupation. Also, because nursing involves giving care to others, I am interested in the types of experiences you have had in trying to provide care. First, however, we need to have your consent in writing to participate. I have given you a letter of informed consent. Please take a few minutes to read the letter before signing. If you have any questions as you read the letter, I would be happy to answer them.

When you are finished reading the informed consent, please print your name, sign, and date the form. [Wait for participants to read and sign informed consent. Collect informed consent and make sure both parts have been signed – including the signature for recording the interview.]

You’ll also notice a short, 1-page questionnaire. Please fill this out and then we’ll begin the interview.

Since you have agreed to participate and have signed the informed consent, I want to be sure that you understand that our conversation will be digitally recorded and that you consent to such recording. (Wait for indication of assent to record and turn recorder on)

**Please remember that you are free to speak openly and that everything said here today will be kept completely private.

We will be transcribing the recording being made here today and quotes may be used in a brief report given to the hospital and in subsequent publication of results. Please be assured, however, as noted in the consent form that all personal identifiers – including your name – will be removed at the time the interview is transcribed and that no employee will see the complete interview transcriptions.

Our goal is to create a safe and open environment for this conversation; one in which you feel you can express your views freely and honestly.

Finally, please know that there is no penalty for not answering the question(s) or for changing your mind about participating.
So, do you have any questions before we begin?

As I’ve noted, this interview is aimed at getting an in-depth understanding of your experiences as a nurse, your feelings about yourself as a nurse, and your ability to provide quality patient care.

After filling out the questionnaire, I’d like to ask some general questions about your experiences as a nurse:
[Cue words: control, competitive, risk, independence, tough, adrenaline rush, power, success]

What does being a nurse mean to you?

What do you think the emotional demands of being a nurse are?

Why did you decide to become a nurse?

How did you describe nursing to friends and family and how did friends and family respond to your decision to become a nurse?

What do you most enjoy about nursing? Could you describe a positive experience you’ve had recently?

What do you dislike the most about nursing? Could you describe a negative experience you’ve had recently?
Have you ever thought about leaving nursing and if so, why?

How do you think your childhood, including family life and experiences in school prepared you for the work you do? Can you think of any specific events?

For example, did you have any experience at home taking care of others (such as a sibling or sick parent)? Were there others there to give care or were you the only one available? [Follow-up prompts will be used to learn about the context, involved parties, and potential resource constraints pertinent to the events described.]

[Cue words: control, competitive, risk, independence, tough, adrenaline rush, power, success]

Growing up, we often look up to certain people and want to be like them. These people help to shape the kind of person we want to be and even the kind of person we become. I’d like to ask you a few questions about who you wanted to be like growing up:

Who were some of the people you wanted to be like while growing up?

What qualities did you admire about these individuals?

Who are some of the current people you admire and why do you admire them?

Nursing can involve caring work that requires complex skills in anticipating the emotions of others. Our culture stereotypes men as being less sensitive to emotions and not well-suited to nurturing and caring for others.

How do you think society views male nurses?

Some might say that being an ideal man requires that you be competitive, domineering, and in control of your emotions. [3 of the 11 subscales of the Mahalik, et al. 2003 Conformance to Masculine Norms Inventory]
To what extent do each of these characteristics—competitive, domineering, in control of your emotions—describe you?

To what extent do you think they help or hinder your work as a nurse?

[Cue words: control, competitive, risk, independence, tough, adrenaline rush, power, success]

Turning specifically to the issue of emotion, do you think men experience emotions any differently than women? If so, how?

To what degree do you think men understand emotions differently than women?

To what extent do you think men are able to care for others as well as women?

To what degree do you think as a man you are less knowledgeable about the emotions of others and what is expected of you when interacting with others?

To what extent do you think being a man limits your ability to nurture and provide emotional support as a nurse?

Has this view changed at all over the course of your experience as a nurse?
What are some situations or experiences that may have shaped your views?

How do you see yourself in terms of anticipating others’ emotion? How do you see yourself in terms of nurturing others?

What are some situations in which you were able to provide emotional support?

How did you feel?

How did you respond?

How did others respond?

[Cue words: control, competitive, risk, independence, tough, adrenaline rush, power, success]

Any situations in which you felt unable to provide emotional support? How did you feel?

How did you feel?

How did you respond?

How did others respond?

One of the goals of this study is to understand the experiences of male nurses so as to improve the training male student nurses receive. Imagine that a male student approaches you and asks what it is like to be a nurse and what advice you have for him should he choose this profession.

How would you respond to such a student? What advice would you give?

What are some things that you wished you had learned in training but did not?

Do you think that male nurses have different experiences than female nurses?
How might male nurses be more effectively prepared for the unique situations they are likely to encounter?

Is there anything more you’d like to add or that you think I’ve overlooked?

Thank you for your time! Once the interview has been transcribed I can mail or email a copy of it to you. Which method would you prefer?

Best mail or email address?
APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

Participant ID:_______   Years Nursing:_______   Unit:_______

Educational history: __________________________________________________

Birth Date: _________ Race/Ethnicity:_____________ Sexual Orientation:___________

The following questions are about your parents while you were growing up. If a grandparent or guardian was your primary caretaker, please keep him or her in mind in answering the question instead.

What was your father’s highest level of education while you were growing up?

1. Less than high school
2. High school diploma/GED
3. Some college
4. Bachelor’s degree
5. Graduate degree or higher

What was his primary occupation while you were growing up?

______________________________________________________________________

Did he have any supervising duties (did he oversee others on the job)?

1. Yes
2. No

What was your mother’s highest level of education while you were growing up?

1. Less than high school
2. High school diploma/GED
3. Some college
4. Bachelor’s degree
5. Graduate degree or higher

What was her primary occupation while you were growing up?
Did she have any supervising duties (did she oversee others on the job)?

1. Yes
2. No

What would you say your family’s class was while you were growing up?

1. Lower/poor
2. Working
3. Middle
4. Upper
APPENDIX E

DAILY DIARY TRAINING GUIDE

Rebecca J. Erickson and James M. Diefendorff
“Identity and Emotional Management Control in Health Care Settings”

Audio Diary Training Script – Phase II Daily Diaries

BEFORE BEGINNING: Highlight team member’s name on contact list in the booklet and note the recorder and participant ID for each nurse (on the booklet and on the shared spreadsheet). Distribute consent form (sign and return), instruction booklet, and recorder. Also, make sure that recorders have new batteries and are set to the following specifications:

- Low-cut filter: ON
- Rec Mode: HQ
- VCVA: OFF
- Folders: Cleared

********************

Thank you for agreeing to participate in the daily diary phase of the CARMA project and for coming to this training session.

This is definitely the most critical phase of the project and the information you provide will be central to the recommendations we’ll be able to provide to [hospital] for changes to policy and practice.

My name is [research team member name]. I’m a member of the project’s research team and am a(n) [university role; e. g., professor, doctoral student] at The University of Akron.

Background:
- Funding from NSF
- Only hospital system in the country participating
- Began with surveys
- Analyzing that data but now we need your help. . .

The information you are going to provide over your next 6 shifts will allow us to learn in much greater detail about exactly what happens at work that triggers feelings like
frustration and pride and about those experiences that are most important to you as a nurse.

If at any point during this training you change your mind about participating fully, please do not hesitate to let me know. In fact, you should know again that this daily diary project is voluntary and you will not be penalized in any way by not participating.

So, what do you need to do?

There are 2 parts to the process that we need to go over: 1 = working the audio recorder and 2 = what to record.

We’re going to go over each part in detail to make sure you are comfortable with everything and that you get all your questions answered.

(1) Handling the Recorder

- Take a few minutes to look over the device and point out the power/hold button and the play, stop, and record buttons on the side as well as the USB input on the opposite side.

- Turn the device on. It may prompt you to enter the date and time. Do so using the arrow keys on the front. Please do this whenever the device prompts this (usually when the batteries have been replaced).

- In navigating through the device, you will see that it has 5 folders (A-E). Each of these should be used for each recording, with the last folder, E, holding the recordings for two days. This will make the transfer of the recordings easier to organize.

- Perform a sample recording in folder A, using the Record and Stop buttons on the side. Play the recording back. Note that recording settings have already been adjusted and participants should NOT make any changes to these.

- Using the USB cord supplied, email the sample recording using the team member’s computer. This process will need to be followed after the first diary recording.

  - Plug in each end of the cord (small end into recorder, large end into laptop)
  - Select the drive that appears on the laptop
  - Rename recording as “nurselastnamesample.wma”
  - Copy and paste (or drag and drop) recording to desktop
  - Disengage device on laptop before unplugging
  - Send .wma as attachment in email to team member’s address
Delete sample recording on device and locate the battery storage and extra batteries supplied. Turn the recorder OFF by sliding the power button to power position again and then push button to HOLD position.

Recorder may have trouble turning back on if it is not put in the hold position. Remove and reinsert batteries if this happens. Note that you will need to reset the date and time again whenever removing or replacing batteries.

Any questions?

(2) What to Record

After each of your next 6 work shifts:

Turn the recorder on and let us know what happened during your day. Please start each recording identifying the particular date you will be talking about.

There is no right or wrong way to record your experiences and reflections. One way you might think about approaching this is to think about what went on during each of the following routine activity times during your shift. For example: [with input from nursing researchers, provide list of daily activities in the order they are likely to occur – e.g., shift change, clinical rounds, distribution of medicine, mentoring students etc.]

Some of the specific issues we’d like you to be sure to talk about are:

*How are you feeling after the shift you just completed?
*What is leading you to feel this way?
*What events during the shift were meaningful to you?

We know it will sometimes be hard to do but PLEASE try to give yourself ample time to record your stories about the day and let us know how you are feeling about how the day went.

When you are done recording, turn off the recorder and put it in a place where you won’t forget it the next day – perhaps keeping it in your car, bag, or purse.

Feel free to add other thoughts about the day at any time – it’s great if you think of something you forgot to mention earlier or now have something new to add after thinking about an event for a few hours. No problem – just turn the recorder on, let us know what day you are talking about, and add to your story!

Remember, the more details the better. We’ll remove any identifying names or other information when we transcribe the recording so feel free to just let us know what went on from your perspective, how the events of the day made you feel, and how it feels to be a nurse at the end of each shift – and why.
REGRETS: Later on, you may realize that your reaction has changed since the time you made an earlier recording. That’s no big deal. As time passes, we often feel differently.

Your initial reaction is critical however in that our initial survey results are suggesting that the intense emotional reactions can have a very real impact on outcomes like burnout and job satisfaction.

Please, if this happens, do not attempt to rewind and record over what you said. Instead, feel free to record your new view of the situation into the tape recorder. It is OK to tell us that what you experienced originally is now perceived differently and how your feelings have changed.

**Please be assured that your stories WILL MATTER – not just for you, your unit, or hospital but, hopefully for nurses more generally.

ARE THERE ANY QUESTIONS?

** GO THROUGH HOW TO WORK THE RECORDER ONE MORE TIME AND HAVE THEM PRACTICE AGAIN**

Finally, please don’t worry about “what we want to hear.” Please do not try and guess at what we want, because what we want is just your everyday lived experiences on the job. And we know that you might say to yourself, “this is not a normal day” whether it is too sad or too good, don’t worry about trying to give us your “typical” day, just give us the day you are having today and you will have done a great job.

**Call us if you have a question that arises that you are unsure about – our phone number and email address are listed in the instruction booklet.

I realize I’ve given you lot of information today. The main thing is just to reflect on what happened during your shift – turn the recorder on and tell us about it.

More questions?

***Be sure they still want to participate now that they know what is involved***

****SET UP A TIME AND PLACE FOR THE FOLLOW-UP MEETING***