

CONTENTS / TABLE DES MATIÈRES

**Gender, Sex, and Health/
*Le genre, le sexe et la santé***

- 3 Guest Editorial / *Collaboration spéciale*
**Gender, Sex, and Health Research:
Developments and Challenges**
Jan Angus
- 7 Discourse / *Discours*
The Gendered Ovary: Whole Body Effects of Oophorectomy
Gillian Einstein, April S. Au, Jason Klemensberg, Elizabeth M. Shin,
Nicole Pun
- 18 **An Integrative Review of Nurse Attitudes Towards
Lesbian, Gay, Bisexual, and Transgender Patients**
*Une recherche de synthèse sur les attitudes du personnel infirmier
à l'égard des lesbiennes, gais, bisexuels et transgenres*
Caroline Dorsen
- 44 **Nurses' Work With LGBTQ Patients: "They're Just
Like Everybody Else, So What's the Difference?"**
*Le travail du personnel infirmier avec des patientes LGBTQ :
« Elles sont comme les autres, alors quelle est la différence? »*
Brenda L. Beagan, Erin Fredericks, Lisa Goldberg
- 64 **Supporting Fathers' Efforts to Be Smoke-Free:
Program Principles**
*Soutenir l'effort des pères qui souhaitent cesser de fumer :
principes pour un programme*
John L. Oliffe, Joan L. Bottorff, Gayl Sarbit
- 84 **Reaching Adolescent Girls Through Social Networking:
A New Avenue for Smoking Prevention Messages**
*Toucher les adolescentes au moyen du réseautage social :
une nouvelle avenue pour les messages de prévention du tabagisme*
Laura Louise Struik, Joan L. Bottorff, Mary Jung, Claire Budgen



- 104 **Understanding Gendered Expectations and Exemptions Experienced by Male Double-Duty Caregivers: A Qualitative Secondary Analysis**
Comprendre les attentes et les exemptions selon le sexe dont font l'objet les aidants masculins à double emploi : une analyse secondaire qualitative
Ana Paula Anjos, Catherine Ward-Griffin, Beverly Leipert
- 125 Book Review / *Critique de livre*
Gender and the Language of Illness
Reviewed by Craig Dale
-
- 128 **Medication Management for Nurses Working in Long-Term Care**
Gestion des médicaments par les infirmières et infirmiers œuvrant dans les centres de soins de longue durée
Wendy Ellis, Sharon Kaasalainen, Pamela Baxter, Jenny Ploeg
- 150 **Metaphors and Medication: Understanding Medication Use by Seniors in Everyday Life**
Métaphores et médicaments : pour comprendre la question de la prise de médicaments quotidienne chez les aînés
Rosanne E. Beuthin, Ann Holroyd, Peter H. Stephenson, Britt Vegsund



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Guest Editorial

Gender, Sex, and Health Research: Developments and Challenges

Jan Angus

It is clear that gender and sex are deeply intertwined with multiple sociopolitical, environmental, and physiological influences that condition health (Hankivsky & Christoffersen, 2008; Lorber, 2006; Lorber & Moore, 2002). Consequently there are differences in how men and women experience and express illness, as well as disparities within groups of women and groups of men (Hankivsky et al., 2010). Research methodologies have tended to lag behind theoretical developments in this field, although recently there have been important corrective efforts (Oliffe & Greaves, 2012; Spitzer, 2006).

Interchangeable use of the terms “gender” and “sex” by laypersons and health researchers alike indicates widespread blurring and misunderstanding of definitional boundaries (Johnson & Repta, 2012). Furthermore, commonly held conceptualizations of both sex and gender frequently rest on simplistic and conventional assumptions about the dichotomous biological categories “male” and “female” and the socially constructed distinctions between men and women. When imported into health research, these distorted and essentialist assumptions may foreclose a more nuanced analysis of the complexities of health disparities (Hankivsky et al., 2010; Johnson & Repta, 2012). For this issue of *CJNR* we invited dialogue about this range of concerns and were inundated with high-quality responses, reflecting widespread scholarly activity. The final selection of articles for publication was indeed difficult, and as guest editor I am deeply grateful to the many reviewers who so thoughtfully and constructively supported this process. Their anonymous contributions to the development of this issue of *CJNR* convinced me that we have a strong base of Canadian scholars with lively and diverse expertise in sex, gender, and health research.

In their Discourse contribution, Einstein, Au, Klemensberg, Shin, and Pun demonstrate that, in conventional medical treatment, discourses of risk and the institutionalized gendering of the biological body may detrimentally influence health. These authors argue that the ovaries have been

socially constructed and gendered as reproductive organs that are vestigial after childbearing, hence their prophylactic removal is unproblematically accepted as a means to reduce the risk of breast and ovarian cancers in women with BRCA1/2 mutations. However, they review evidence of estrogen's regulatory influence on a number of bodily functions, including sleep, cognition, and immunocompetence, as well as on the skeletal and cardiovascular systems.

Two articles in this issue explore the institutionalized context of heteronormativity and gender normativity in health care. Dorsen's integrative review of nurse attitudes towards lesbian, gay, bisexual, and transgender (LGBT) patients indicates that many nurses may hold negative attitudes towards sexual minorities. However, Dorsen also found multiple limitations across studies, including lack of theoretical drive, inconsistent definitions of key constructs, and persistent problems with instruments used to measure nurses' attitudes. Beagan, Fredericks, and Goldberg used qualitative methods to explore nurses' perceptions of practice with patients who identify as LGBT. They report that nurses wanted to avoid harming their patients with discriminatory assumptions and thoughtless comments; however, this frequently resulted in a silencing of dialogue, which served to limit nurses' awareness of health care as a potential site of marginalization and social exclusion.

Two other contributions provide intriguing examples of how gender and life stage can inform the design and delivery of health promotion interventions. In response to a knowledge gap on the development of gender-sensitive health promotion programs for men, Oliffe, Bottorff, and Sarbit explain in detail how findings from their qualitative study of smoking in new fathers were used to generate principles for a smoking cessation intervention. Struik, Bottorff, Jung, and Budgen saw that social networking sites used by tobacco companies to target adolescent girls are also a new frontier for reaching youth with health promotion messaging. They held focus group discussions with girls to elicit their views on the placement of tobacco control messages on social networking sites, using existing examples to understand participants' concerns and preferences. Both of these articles advance gender-sensitive and inductive approaches to design of the products that result from gender-based research.

Finally, Anjos, Ward-Griffin, and Leipert explicitly drew on a constructivist, relational theory of gender in their analysis of qualitative interviews with men who were double-duty caregivers (DDC) — professional nurses as well as family caregivers. They found that professional affiliation complicated men's family caregiving work; for example, as DDCs, men were at times expected to provide personal care traditionally viewed as "women's work." While the DDCs could appeal to gender norms to exempt themselves from some tasks or adopt a more manage-

rial role based on professional knowledge, it was difficult for some to resist pressures to carry the major responsibility for family care.

The articles you are about to read offer insights into how a pervasively gendered social world influences human health and health care. They suggest ways that an astute awareness of this relationship can explicitly inform scholarship, research, program development, and practice. As guest editor for this issue of the Journal, I am very grateful to the contributors, the Editor, Dr. Laurie Gottlieb, and the editorial staff (Joanna Toti, Amélie Desrochers, and Jane Broderick) for their efforts in bringing this special issue on sex, gender, and health research to publication. I sincerely hope that this collection of articles will provoke thought and inspire future researchers.

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Discourse

The Gendered Ovary: Whole Body Effects of Oophorectomy

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Elizabeth M. Shin, Nicole Pun

Since oophorectomy in healthy women predates the commercialization of BRCA mutations screens, genomics cannot explain entirely why physicians and cancer specialists recommend this procedure for women at risk. Rather, one must situate the development of reproductive cancer genomics within a broader sociocultural context in which researchers bring to bear habits of mind about women, reproduction and motherhood. (Happe, 2006, p. 173)

Gendering Organs

The social world writes on all parts of the body, including, and perhaps most especially, the reproductive organs. Organs are not immune from the effects of gender. The depiction and attributes of organs, especially reproductive organs, reflect society's views on sexualities and the relative merits of being female or male (Laqueur, 1990; Martin, 1987). On the basis of this gendering, they can be assigned a positive or negative merit for a given body. For example, in some cultures the external portion of the clitoris is viewed as “male” and the foreskin of the penis as “female” — each must be removed in order to make a successful female or male body; the repercussions of that single act reverberate across the entire body (Einstein, 2008).

The ovaries, too, are gendered. Most of the medical discourse on the ovaries suggests that their only purpose is female reproduction. Internal and not easily accessed, they have become a site of fear and anxiety for the medical profession. In the United States alone, over 600,000 hysterectomies are done yearly, over half of which include bilateral salpingo-oophorectomy (BSO) to prevent *possible* future cancers, neoplasms, endometriosis, and pelvic pain (American College of Obstetricians and Gynecologists [ACOG], 2008). For women who have an increased risk

of ovarian cancer, the literature is replete with the instruction that “hysterectomy with bilateral salpingo-oophorectomy effectively reduces endometrial and ovarian cancer risk in women . . . and should be offered after completion of childbearing” (ACOG, 2008, p. 6).

While the biomedical literature includes acknowledgement of the well-known correlation between the loss of the ovaries and both cardiovascular disease and osteoporosis, these repercussions apparently do not outweigh the benefit of cancer risk reduction (ACOG, 2008). “Motherhood is, in fact, the only exception to the norm . . . I have yet to find a scientific report that acknowledges the acceptability of postponing, or avoiding altogether, oophorectomy because of health concerns” (Happe, 2006, p. 185). Furthermore, in one study a quarter of the women who were interviewed after BSO were not aware of the estrogen-production function of the ovaries at the time of the interview or before their operation (Gore, Hallowell, Jacobs, Mackay, & Richards, 2001). Those who were aware of this function understood it in terms of “femininity” and “being a woman” and not in terms of overall bodily health:

You have your ovaries, and they are for producing eggs to make babies, and if they're wasted every month that's part of nature's cycle. And because they're there they give you all the hormones that you need and you are a woman. But some women, when they have hysterectomies have terrible sadness because they think, “oh well I'm not a full woman any more because I haven't got a uterus or a cervix or ovaries . . .” (Hallowell, 1998, p. 270)

This gendering of the ovaries has serious health ramifications in a reductionist biomedical view of the body. In such a view, the individual parts can be removed and/or altered without ramifications for the rest of the body. While there are cases for which the benefits of this perspective outweigh the risks, the risks must still be acknowledged and weighed. In the case of the ovaries, the gendering that has circumscribed their “use” has served to dampen what we also know well: The ovaries produce and secrete biochemicals (hormones) that affect every body system. Thus, their removal can lead to unintended health risks for any body system.

Considering the ovaries as only “female” reproductive organs is highly consequential for women who are counselled to have them removed for conditions such as chronic pain or cancer, or for prophylaxis in the case of the breast cancer gene mutations BRCA1/2m.

Women with BRCA1/2m are an especially important example of the problematic ramifications of gendering and reductionism, since most are healthy women who are *counselled* to have their ovaries and fallopian tubes removed (BSO) as prophylaxis for both breast and ovarian cancers (Narod, 2006). This reduces significantly their risk of breast cancer (Eisen

et al., 2005) and ovarian, fallopian, and peritoneal cancers (Finch et al., 2006) and is recommended prior to the age of natural menopause but *after childbearing*. Quality-of-life studies post-BSO reveal that women who elect it are relatively satisfied with their decision (Finch et al., 2011b). They report some difficulty with sexual functioning and vasomotor symptoms (Finch & Narod, 2011), but overall quality of life is reported to be similar before and after surgery (Finch et al., 2011a).

Such outcome studies that focus on patient satisfaction with the surgery overlook the fact that the human body is not made of organs that act independently of one another but, rather, is a cohesive, cooperative unit composed of interacting systems. Nowhere is this more important than in glands that secrete hormones, which are carried by the blood to every body system. With respect to the ovary, removing this source of 17- β -estradiol (one of three naturally occurring estrogens, E2) prior to age 50 has the potential to alter every body system. Unfortunately, this has been lost on us because we think of the ovaries as *reproductive organs*. This gendering of the ovaries, viewing them as necessary only for female reproduction, may have extremely negative effects on the rest of the body and have the unintended outcome of making women with BSO sicker.

Here, we use the occasion of BSO to briefly explore what is known about the effects of estrogen deprivation on five major areas of non-reproductive health and consider how all of these changes might act together to make a woman sick — despite allowing her to be free of breast and ovarian cancer.

Memory and Cognition

Recent epidemiological evidence suggests that women with oophorectomy prior to natural menopause have a significantly higher incidence of Alzheimer's dementia and Parkinson's dementia. The younger the woman is at the time of surgery, the greater the risk (Rocca et al., 2007). Additionally, women who lose both ovaries to surgery have a higher risk of developing dementia than those who lose only one ovary. Thus, BSO prior to the age of natural menopause is associated with a greater risk of developing neuropathologies. To date, studies comparing cognitive functions of women pre- and post-BSO all indicate a post-surgical deterioration of memory without estrogen replacement (Farrag, Khedr, Abdel-Aleem, & Rageh, 2002; Sherwin, 1988).

Osteoporosis/Osteopenia

A sampling of the literature suggests the importance of estrogens in bone development and maintenance. Estrogens and androgens inhibit osteoclasts (cells that break down bone) and promote the formation of

osteoblasts (bone precursors). Consequently, low levels of E2 are associated with lower bone density (Notelovitz, 2002). Not surprisingly, bone density in women who have had oophorectomy is lower than that of women in natural menopause (Pansini et al., 1995). Fractures in the wrist, vertebrae, and hips are increased moderately in women with BSO (Cummings & Melton, 2002). The younger a woman is at the time of BSO, the higher her risk of fracture (Melton, Crowson, Malkasian, & O'Fallon, 1996). Of women with BRCA1/2m and BSO, 26% had abnormal bone density, 57% had osteopenia, and 14% had osteoporosis (Chapman et al., 2011). However, a chart review of 226 patients revealed that none of the women on hormone replacement therapy (HRT) developed osteoporosis, suggesting that the negative bone outcomes are a result of estrogen deprivation (Cohen et al., 2012).

Cardiovascular Disease

BSO prior to natural menopause is a risk factor for cardiovascular disease (CVD), particularly coronary heart disease (CHD) (Lobo, 2007). Women who have BSO prior to natural menopause are 2.62 times more likely to develop CVD (Shuster, Gostout, Grossardt, & Rocca, 2008). BSO prior to 40 years of age is associated with elevated risk of ischemic heart disease compared to after age 45 (Lokkegaard et al., 2006). Women with BRCA1/2m and BSO had a serum total and LDL cholesterol concentrations significantly higher post-BSO than pre-, as well as significantly higher levels of lipids and homocysteine — all associated with increased risk of CHD (Verhoeven et al., 2009). Risk factors for CVD, such as metabolic syndrome (odds ratio = 2.46; Michelsen, Pripp, Tonstad, Trope, & Dorum, 2009) and salt sensitivity (Schulman et al., 2006), are all higher in women with BSO.

Immunocompetence

BSO has been associated with significant changes in immune-system cell activity. When healthy premenopausal women with total hysterectomy are compared with those who also had BSO, women with BSO have more serum cytokines interleukin (IL)1 and IL6 (Cantatore et al., 1995). Within 1 month post-surgery, women with BSO have some aspects of their immune systems activated, increasing into the second month of follow-up (Pacifi et al., 1991), while at the same time demonstrating immunodeficiencies (Kumru, Godekmerdan, & Yilmaz, 2004). Other immune-system cells, such as T lymphocytes, change their ability to cause invader cells to die; this change is correlated with a decrease in their estrogen receptors. Estrogen replacement increases the expression of these estrogen receptors (Zhang et al., 2009). E2 deprivation in general has

been associated with lowered immune reactivity (Gameiro, Romao, & Castelo-Branco, 2010). With ERT, levels of many components of the immune system have shown reversal (Kumru et al., 2004; Xia et al., 2009).

The risk of immune-system diseases and non-reproductive cancers may also increase. After BSO, risk of the autoimmune disease lupus rises (Costenbader, Feskanich, Stampfer, & Karlson, 2007), and women with BSO prior to age 50 have an increased risk of lung cancer (Parker et al., 2009). A chart review of women who received BSO due to BRCA1/2m revealed that most of those who had BSO prior to 55 developed a different type of cancer within a decade (excepting lung cancer, which developed at a later average age) (Cohen et al., 2012). BRCA1/2m itself is linked with lower immune-competence even without BSO. Immune-system markers in women with BRCA1/2m are elevated, with significantly higher levels of serum cancer antigen mucin 1 (MUC1), whose overexpression and aberrant glycosylation is associated with adenocarcinomas (Hermsen et al., 2007). Similarly, healthy women with BRCA1m compared to age-matched controls have significantly decreased production of immune-system markers, with anti-tumour effects (Zielinski et al., 2003). Given that BSO may already impair the immune system, there may be a legitimate concern that those with BRCA1/2m undergoing prophylactic BSO are at greater risk of immunodeficiency.

Sleep

Sleep disturbances have long been associated with the physiological and psychological changes that accompany natural menopause. Thus, it is no surprise that sleep disturbances have also been associated with oophorectomy. In a study examining age and ethnic differences in self-reported sleeping problems of women at various stages of menopause, the prevalence of sleeping difficulties was highest in women who had undergone oophorectomy without HRT (Kravitz et al., 2003). Women who had undergone BSO before natural menopause had difficulty sleeping compared to the naturally menopausal controls (Benshushan et al., 2009). Compared to women who underwent hysterectomy alone, women with BSO for benign gynecological disease reported less improvement in sleep at 6 months post-surgery (Teplin et al., 2007). That it is estrogen deprivation that affects sleep quality is supported by studies in which estrogen is replaced. Healthy menopausal women with hysterectomies given HRT reported improved sleep quality (Polo-Kantola, Erkkola, Helenius, Irjala, & Polo, 1998). Estrogen replacement is also associated with an increase in both slow-wave and REM sleep (Antonijevic, Stalla, & Steiger, 2000), both of which are indicative of improved sleep quality. ERT was found

to improve sleep quality in naturally menopausal women compared to those not taking ERT (Moe, Larsen, Vitiello, & Prinz, 2001). The results of all of the studies cited above suggest that estrogen deprivation may affect sleep quality in women with BSO.

System Interactions

It is worth briefly considering the fact that changes in one of the above functions affect others. The immune and skeletal systems are interlinked in that the same factors (GM-CSF) that stimulate osteoclast recruitment and differentiation also increase activity of IL1 and IL6, cytokines that play a role in cartilage destruction in autoimmune diseases like rheumatoid arthritis (Cantatore et al., 1995). Also, after only 7 days post-surgery, premenopausal women who received hysterectomy with bilateral oophorectomy for benign reasons exhibited high levels of C-reactive protein (CRP), which were negatively correlated with levels of serum albumin, an inflammation marker (Kalyan, Hitchcock, Pudek, & Prior, 2011). Sustained elevated levels of CRP are associated with cardiovascular disease and metabolic syndrome (Kalyan et al., 2011), so this finding links heart health and the immune system in BSO. Estrogens may confer protection against various forms of vascular disease and their loss results in vulnerability to diseases such as atherosclerosis by inhibiting the production of inflammatory mediators (Ferreri, 2007). Further, changes in the immune system may affect the likelihood of women with BSO developing other cancers. Finally, long-term depression and anxiety post-BSO (Rocca et al., 2008) may be associated with troubled sleep and insomnia (Motivala, Sarfatti, Olmos, & Irwin, 2005).

Conclusion

Here, we have raised the possibility that the reductionism inherent in biomedicine and the gendering of the ovaries for female reproduction affects the types of treatment that are acceptable for prophylaxis or cure. We have used the example of removal of the ovaries prior to natural menopause, and in order to broaden the discussion beyond women's childbearing capabilities we have addressed bodily functions not linked directly with reproduction. Due to the ubiquitous effects of estrogens, the ramifications of early estrogen deprivation potentially affect the whole body. Sadly, gender has focused us narrowly on women's reproductive capacities, leaving us short-sighted with respect to all the other effects. Once we acknowledged that there are widespread effects of ovary removal, we would need to carry out clinical trials of estrogen replacement in all of these health domains, bearing in mind the differences in the type of estrogen being administered and the regimen of administra-

tion. Perhaps we would also need to encourage the development of estrogen analogues (SERMS) that will not act on the breast or the ovaries but will act on the rest of the body. As well, technologies that allow for successful imaging of the ovaries would need to be developed so there could be successful “watchful waiting” for women.

Methods for reducing the risk of breast and ovarian cancer are important; while removal of the ovaries does reduce this risk, it is detrimental from the perspective of every other body system. There are wide-ranging physiological changes in women with BSO, and health practitioners and patients need to be aware of these when considering the costs and benefits of BSO — especially women with BRCA1/2 mutations. The ovaries are not just for reproduction. Let us de-gender them for the health of the entire body.

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The Gendered Ovary: Whole Body Effects of Oophorectomy

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Une recherche de synthèse sur les attitudes du personnel infirmier à l'égard des lesbiennes, gais, bisexuels et transgenres

Caroline Dorsen

Un nombre croissant d'études suggèrent que les lesbiennes, gais, bisexuels et transgenres (LGBT) vivent des disparités importantes en matière de santé par rapport aux hétérosexuels. Les raisons de cette situation sont complexes et multifactorielles. Un domaine de la recherche sur ce sujet examine en particulier les attitudes négatives réelles ou perçues des fournisseurs de soins de santé. La présente recherche de synthèse a comporté l'évaluation critique et la synthétisation des données tirées de 17 articles traitant des attitudes des infirmières et des infirmiers envers les patients LGBT. Toutes les études analysées faisaient état de certaines attitudes négatives. La littérature révèle toutefois des limites importantes, notamment le manque d'études bien conçues et d'études qualitatives; l'utilisation inégale d'instruments validés et fiables; et le manque de mesures examinant les attitudes envers les lesbiennes, bisexuels et transgenres. Plus de connaissances dans ce domaine pourraient permettre la mise en œuvre d'interventions pour améliorer la compétence culturelle du personnel infirmier; l'allocation de ressources à la recherche en sciences infirmières, à l'éducation et aux services liés à la santé des personnes LGBT; et l'inclusion de plus de contenu LGBT dans les programmes d'études en sciences infirmières.

Mots clés : attitudes du personnel infirmier, LGBT, disparités en matière de santé, recherche de synthèse

An Integrative Review of Nurse Attitudes Towards Lesbian, Gay, Bisexual, and Transgender Patients

Caroline Dorsen

A growing body of literature suggests that lesbian, gay, bisexual, and transgender (LGBT) persons have significant health disparities as compared to heterosexuals. Although the reasons for this are complex and multifactorial, one area of research has examined the real or perceived negative attitudes of health-care providers. This integrative review critically appraises and synthesizes data from 17 articles regarding nurses' attitudes towards LGBT patients. Every study analyzed showed some evidence of negative attitudes. However, the literature revealed major limitations, including a paucity of well-designed studies; a dearth of qualitative studies; inconsistent use of validated, reliable instruments; and a lack of measures examining attitudes towards lesbian, bisexual, and transgender persons. Increased knowledge in this area could lead to interventions to improve nurses' cultural competency; resource allocation to nursing research, education, and services related to LGBT health; and inclusion of more LGBT content in nursing curricula.

Keywords: nurse attitudes, LGBT, homosexuality, health disparities, integrative review

Introduction

In the past three decades, a growing body of literature has shown that lesbians, gay men, bisexuals, and transgender individuals (LGBT) experience significant health-care disparities as compared to heterosexuals (Dilley, Simmons, Boysun, Pizacani, & Stark, 2009; Institute of Medicine [IOM], 2011; Solarz, 1999). The reasons for these disparities are complex and multifactorial, ranging from socio-economic discrepancies to individual risk-taking behaviours (Solarz, 1999). One area of interest has been health-care systems, including the possible role of negative attitudes on the part of health-care providers (Hutchinson, Thompson, & Cederbaum, 2006; IOM, 2011). Real or perceived homophobia among health-care providers may contribute to LGBT persons avoiding health-care providers; not revealing their sexual orientation to providers and thus not receiving individualized, evidence-based care; and/or not following the recommendations of providers, fearing that these may be fuelled in part by homophobia (Diamont, Wold, Spritzer, & Gelberg, 2000; Heck, Sell,

& Gorin, 2006; IOM, 2011). These factors may, in turn, contribute to poor individual health outcomes among LGBT persons as well as population-level health-care disparities.

Background and Significance

LGBT Health-Care Needs

The health of sexual minorities is a relatively new area of study. Although some research was done as early as the 1940s, most of the early literature is focused on the etiology of homosexuality and/or on homosexuality as a mental health pathology (Tully, 1995). The AIDS epidemic of the 1980s brought some of the unique health-care needs of the gay community into the spotlight but also led to increased homophobia and discrimination (Douglas, Kalman, & Kalman, 1985). Concurrent with the robust body of literature growing around the unfolding and evolving global HIV/AIDS crisis, a body of literature was being developed in the 1980s regarding a possible increased breast cancer risk in lesbian women (Gay and Lesbian Medical Association [GLMA], 2001). This continues to be an area of interest and study (Cochran et al., 2001).

In many other areas, however, there is still a dearth of literature (Gee, 2006; IOM, 2011; Solarz, 1999). The research that does exist suggests that LGBT persons experience health disparities on many of the leading US health indicators (GLMA, 2001; IOM, 2011; Mayer, Bradford, Makadon, Goldhammer, & Landers, 2008; Solarz, 1999), including substance abuse; overweight and obesity; tobacco use; mental health issues, including depression, anxiety, and suicidality; domestic and community violence; and certain cancers (Dean et al., 2000; Mayer et al., 2008).

Nurse Attitudes

The International Congress of Nurses (2006) code of ethics states explicitly that nurses must not discriminate: “. . . inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.” However, nurse attitudes are a reflection of societal attitudes, including sexism, racism, classism, and homophobia (Giddings & Smith, 2001). Thus some nurses may struggle to reconcile their personal attitudes and beliefs about LGBT persons with their professional responsibility to provide care. A small but growing international body of literature is examining nurse attitudes towards sexual minority patients in an effort to objectively gauge this phenomenon and its potential impact on LGBT health.

Aim of the Literature Review

An integrative review is a rigorous research methodology for examining, critiquing, and synthesizing literature on a specific topic in order to advance science and knowledge (Whittemore & Knafl, 2005). The purpose of the present integrative review was to summarize the current state of knowledge regarding nurse attitudes towards LGBT patients. Although the review was not grounded in a theoretical framework per se, the conceptualization of the study and interpretation of the data were filtered through a social ecological lens that considers the multiple layers of influence on attitudes and behaviours (Bronfenbrenner, 1979).

Design: Data Evaluation and Analysis

The goal of an integrative review is to present a “thorough and unbiased interpretation of primary sources, along with an innovative interpretation of the evidence” (Whittemore & Knafl, 2005, p. 550). The studies included in this review were critically appraised using the methodology of Polit and Beck (2009) and the Critical Skills Appraisal Programme (Milton Keynes Primary Care Trust, 2004). Data were extracted using a systematic method (Polit & Beck, 2009) and placed in an organizational matrix to facilitate “visualization of patterns and relationships” (Whittemore & Knafl, 2005, p. 551).

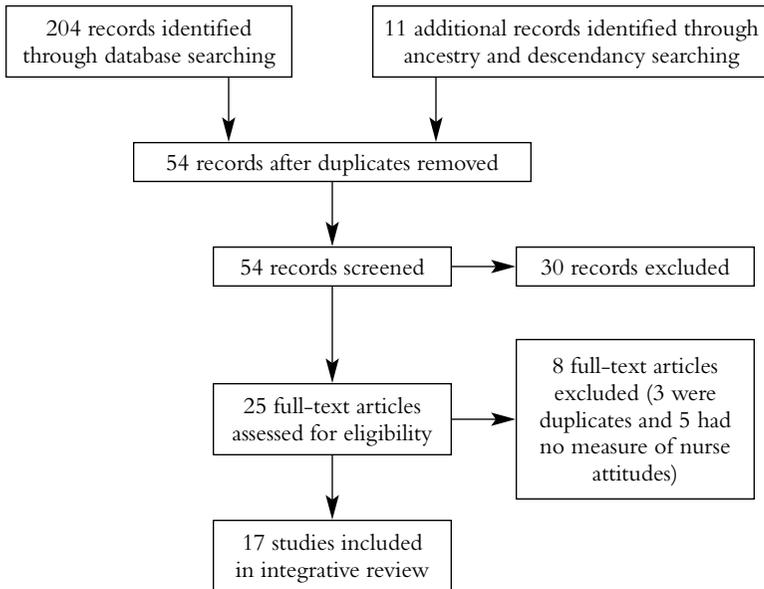
Literature Search

The objectivity and accuracy of an integrative review depends on the rigour of the methods used, including the transparency and reproducibility of the literature search (Ganong, 1987; Polit & Beck, 2000; Whittemore & Knafl, 2005). The method used for this review followed the guidelines of Whittemore and Knafl (2005) and is presented in Figure 1.

Following consultation with a health librarian, a search was conducted of the electronic databases PubMed, Web of Science, PsycInfo, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL) using literature-identified search terms and medical subject headings (MESH) terminology. Various combinations of the following terms were used: homophobia, homosexuality, homosexuality (attitudes toward), gay, lesbian, bisexual, transgender, transsexual, sexual minority, nurse (truncated to include nurse, nurses, nursing, and nurse practitioner), health professional, health professional (attitudes of), discrimination, prejudice.

The inclusion criteria for this integrative review were as follows: quantitative, mixed-method, and qualitative primary research studies, English only, published between 1990 and 2010 on the topic of nurse attitudes towards LGBT patients, correlates of attitudes towards LGBT

Figure 1 *Literature Search Method*



Source: Moher, Liberati, Tetzlaff, Altman, and the PRISMA Group (2009).

patients, and sequelae of nurse attitudes towards LGBT patients. As per Whittemore and Knaf (2005), unpublished manuscripts and abstracts were excluded from the review. Also excluded were articles pertaining to undergraduate nursing students, articles exploring patient perceptions of nurse attitudes towards LGBT patients, and articles describing the attitudes of health professionals other than nurses towards LGBT patients.

Search Results

The initial search identified 204 studies (see Figure 1). An additional 11 studies were identified for inclusion via ancestry and descendant searching, as recommended by Polit and Beck (2009) and Whittemore and Knaf (2005). When duplicates were removed, the total number of relevant articles was reduced to 54. Titles and abstracts were then read and evaluated for relevancy to the topic and for fit with the inclusion and exclusion criteria. This resulted in 25 possible studies for inclusion. Following a reading of the full text of each study, seven quantitative articles were excluded either because they were duplicate publications of other studies in the review and offered no new data for consideration

(three) or because they did not include measures of attitudes towards LGBT patients (four). As well, the only qualitative study identified was excluded because it was primarily a study of nurse attitudes towards patients with AIDS and contained only two sentences on attitudes towards homosexuality. It is important to note that there is a robust body of literature exploring nurse attitudes towards people living with HIV/AIDS. Studies in this area of inquiry were included only if attitudes towards homosexuality was a major focus of the study. The final sample comprised 17 articles on nurse attitudes towards LGBT patients, representing 15 quantitative studies and two mixed-methods studies.

Results

Nurse Attitudes Towards LGBT Patients

Overall attitudes. Results from studies in this review suggested that nurse attitudes towards sexual minority patients range from majority negative or very negative to generally positive (see Table 1). However, some studies equated individual or population instrument mean scores to overall levels of homophobia, whereas others simply reported descriptive frequencies, with little guidance on their interpretation and meaning. Therefore, descriptive statistics are presented as being “positively leaning” (i.e., attitudes towards LGBT patients are more positive than negative) or “negatively leaning” (i.e., attitudes are more negative than positive) based on mean scores on attitudinal instruments and researcher conclusions, in an effort to examine patterns and themes found in the literature.

As part of a larger cross-sectional, comparative study of attitudes towards AIDS among rural nurses, Koch, Preston, Young, and Wang (1991) surveyed 731 rural US nurses using the Nurses' Attitudes About AIDS Scale. This instrument has three subscales, including one on attitudes towards male homosexuality (Cronbach's alpha 0.95; no other validity or reliability information reported). The mean score for the homophobia subscale showed a general attitude that appears more positive than negative. However, examination of the responses to the individual questions on the survey reveals that only 27% of the sample agreed that “homosexual men are a viable part of our society,” 32% were “disgusted when I consider the state of sinfulness of male homosexuality,” and 40% thought that “male homosexuality is obscene and vulgar.” The researchers concluded that the majority of their sample held negative views about homosexuals.

Smith (1993) concluded that the majority of respondents in a sample of 250 randomly selected US psychiatric nurses showed evidence of moderate or severe homophobia as measured using the Index of Attitudes Toward Homosexuals (Ricketts & Hudson, 1980). This instru-

Table 1 Summary of the Literature

Author/ Year	Purpose	Design	Setting/ Sample	Major Findings (Related to Sexual Orientation)
Alexander & Fitzpatrick (1991)	Explore nurse attitudes towards AIDS and patients with AIDS	Descriptive	United States 136 inpatient RNs	Mixed attitudinal scores ranging from majority positive (68% gay lifestyle should not be “condemned”) to negative (70% uncomfortable establishing a relationship with gay man with AIDS) Significant differences between age groups ($p = 0.04$) and marital status ($p = 0.003$) on whether homosexuality should be illegal Positively leaning cognitive response to homosexuality but negatively leaning emotional response
Blackwell (2007)	Explore nurse attitudes towards LGBT patients and towards non-discrimination policy in the workplace	Descriptive, correlational	United States 165 inpatient and outpatient nurses	Of sample, 22% scored in “high grade” homophobic range Significant correlation between belief in free model of homosexuality and increased homophobia ($p < 0.05$) and between support for non-discrimination policy in workplace and decreased homophobia ($p < 0.05$)
Dinkel et al. (2007)	Explore homophobia among nursing students and faculty in a nursing baccalaureate program	Descriptive, correlational	United States 15 faculty members (student data not examined per exclusion criteria)	Low levels of homophobia among nursing faculty Positive correlation between homophobia and non-accepting religious beliefs ($p < 0.05$) Negative correlation between homophobia and accepting religious beliefs ($p < 0.05$) and LGBT acquaintance ($p < 0.05$)

Nurse Attitudes Towards LGBT Patients

Forrester & Murphy (1992)	Investigate nurse attitudes towards patients with AIDS and AIDS-related risk factors, including sexual orientation	R.randomized partial hierarchical experimental	United States 360 nurses (worksite unknown)	Generally positive attitudes and willingness to interact with patients with HIV/AIDS More negative attitudes towards ($p < 0.0001$) and less willingness to interact with ($p < 0.0001$) patients with AIDS/IVDU history than patients with leukemia No greater prejudice or less willingness to interact with gay male patients than heterosexual patients ($p > 0.05$)
Glad et al. (1995)	Investigate the relationship among nurses' homophobia, fear of AIDS, and occupational risk for contracting HIV	Descriptive, coorelational	United States 24 inpatient RNs	Of sample, 33% showed moderate to extreme homophobia Opinions ranging from majority positive (79.2% homosexuals should have equal rights) to majority negative (50% homosexuality is disgusting and a sin) Positive correlation between marital status (married) and homophobia ($p = 0.037$)
Hou et al. (2006)	Examine association between attitudes towards homophobia and intention to provide care, demographics, occupational factors, sexual orientation, knowledge, and experience with LGBT people	Descriptive, coorelational	Taiwan 133 inpatient RNs	Neither positively nor negatively leaning attitudinal scores Significant correlates of positive attitude include increased education ($p < 0.001$), increased knowledge about homosexuality ($p < 0.005$), LGBT family, friend, or colleague ($p < 0.009$) Intention to care for lesbian and gay patients correlated with positive attitude ($p = 0.005$)

<p>Jemmott et al. (1992)</p>	<p>Examine relationship of perceived occupational risk of AIDS and attitudes towards AIDS risk groups to behavioural intentions regarding care</p>	<p>Descriptive, correlational</p>	<p>United States 496 inpatient and outpatient nurses</p>	<p>Positively leaning attitudinal scores Correlates of negative attitudes include increased perception of HIV risk ($p < 0.0001$) and increased negative attitude towards IVDU ($p < 0.0001$) Negative attitude towards lesbian and gay patients correlated with decreased intention to provide care ($p < 0.0001$)</p>
<p>Koch et al. (1991)</p>	<p>Determine the personal and professional factors that are associated with AIDS attitudes in rural nurses</p>	<p>Descriptive</p>	<p>United States 731 rural inpatient and outpatient RNs</p>	<p>Majority of sample have negative or very negative attitudes (83% think homosexuals not viable part of society) Correlates of negative attitudes include decreased education ($p < 0.01$), Protestant ($p < 0.01$), religion rated as very important in their lives ($p < 0.01$), less knowledge about HIV/AIDS ($p < 0.01$), no experience of HIV/AIDS ($p < 0.01$), unwilling to care for patients with HIV/AIDS ($p < 0.01$)</p>
<p>Meisenholder (1994)</p>	<p>Examine contributing factors to fear of HIV contagion, including homophobia</p>	<p>Descriptive, correlational</p>	<p>United States 114 inpatient and outpatient nurses</p>	<p>Positively leaning attitudinal scores Homophobia correlated with fear of AIDS contagion ($p < 0.000$)</p>

Nurse Attitudes Towards LGBT Patients

O'Sullivan et al. (2000)	Examine relationship between rural critical-care nurses' attitudes towards AIDS/people with AIDS and willingness to care for AIDS patients	Descriptive, correlational	United States 61 rural inpatient and outpatient RNs	Positively leaning attitudinal scores Equivocal correlation between homophobia and intent to provide care to gay men with AIDS
Röndahl et al. (2004)	Explore attitudes among nurses and nursing students towards LGBT patients and whether these attitudes affect their willingness to care for homosexual patients	Mixed-method	Sweden 57 nurses in outpatient ID clinic	Negatively leaning attitudinal scores Of sample, 36% would refuse to care for gay men if given the option Increased homophobia among some immigrant groups
Siminoff et al. (1998)	Explore whether nurses avoid AIDS patients more frequently than non-HIV-infected patients and what attitudes are associated with avoidance behaviours	Mixed-method	United States 100 nurses in patient-nurse dyads, inpatient	Positively leaning attitudinal scores Increased homophobia correlated with increased avoidance behaviours (avoiding eye contact) but not with other behaviours (time spent with patient, non-verbal body language) Homophobia not correlated with decreased quality of care

<p>Smith (1993)</p>	<p>Describe attitudes of psychiatric nurses towards gay and lesbian patients and assess demographic correlates of these attitudes</p>	<p>Descriptive, comparative</p>	<p>United States 67 inpatient and outpatient psychiatric nurses</p>	<p>Negative emotional reaction to homosexuality but positive cognitive reaction</p>
<p>Strasser & Damrosch (1992)</p>	<p>Assess graduate nursing students' attitudes towards gay and hemophilic men with AIDS</p>	<p>Descriptive, comparative</p>	<p>United States 188 RNs in a master's program</p>	<p>“Weak anti-gay bias” Negative emotional reaction to homosexuality but positive cognitive reaction</p>
<p>Suominen et al. (2010)</p>	<p>Describe nurses' knowledge about HIV/AIDS and its relationship to their attitudes towards people with HIV/AIDS</p>	<p>Descriptive, correlational</p>	<p>Estonia, Lithuania, Finland 833 inpatient RNs</p>	<p>Range of attitudinal scores among countries but positively leaning overall Correlates of decreased homophobia include being single ($p = 0.003$), childless ($p < 0.001$), working in OB/GYN ($p < 0.001$), having a friend or family member with HIV ($p < 0.001$), increased education ($p < 0.001$), willingness to provide care to persons with AIDS ($p < 0.001$), decreased work experience ($p < 0.001$)</p>

<p>Vermette & Godin (1996)</p>	<p>Identify factors influencing nurses' intention to provide home care to gay male patients or patients with AIDS</p>	<p>R.randomized partial hierarchical experimental</p>	<p>Canada 102 home care nurses</p>	<p>Positively leaning (low-grade non-homophobic) Homophobia significantly correlated with intent to care ($p < 0.001$), perceived social norms ($p < 0.05$), general attitudes ($p < 0.01$), personal behaviour control ($p = 0.01$)</p>
<p>Yen et al. (2007)</p>	<p>Explore nurse attitudes towards gay men and lesbians and the association between attitudes and intent to provide care</p>	<p>Descriptive, correlational</p>	<p>Taiwan 1,540 inpatient and outpatient RNs</p>	<p>Neither positively nor negatively leaning Correlates of decreased homophobia include having an LGBT friend or relative ($p < 0.001$), increased education ($p < 0.001$), previously provided care to LGBT person ($p < 0.01$) Increased homophobia correlated with increased number of work years ($p < 0.001$), self-identified as "100% heterosexual" ($p < 0.01$), religious ($p < 0.05$) Homophobia negatively correlated with intent to care</p>

ment was designed to measure the “negative affective response to homosexuality” (p. 380). Smith found that 57% of respondents scored in the low-grade homophobic range, with another 22.8% scoring in the high-grade homophobic range. Differences existed, however, when the researcher examined scores for heterosexual participants and lesbian and gay respondents ($p < 0.0001$). Blackwell (2007) found that a remarkably similar 22% of his randomly selected Florida-based sample fell into the high-grade homophobic range.

Conversely, Jemmott, Freleicher, and Jemmott (1992) found a positively leaning mean in their study on nurse attitudes towards homosexual patients in the context of HIV/AIDS, using the Heterosexual Attitudes Toward Homosexuality Scale (Larsen, 1988). Similar results were found in studies by Siminoff, Erlen, and Sereika (1998) and Meisenhelder (1994), both of which used Bouton’s Index of Homophobia Scale (1987). This seven-item, five-point Likert-type instrument was designed to measure cultural bias against (primarily male) homosexuality, and reported good internal reliability in every study that employed it (Cronbach’s $\alpha > 0.80$). Glad, Tan, and Erlen (1995) used the same instrument and found that 33% of their convenience sample of 100 RNs in a large, urban hospital in the US Midwest had scores that suggested some homophobia among study participants (descriptive frequencies not given). It is important to note that there is significant concern about the generalizability of Glad et al.’s sample, as less than 8% held a baccalaureate degree or higher and all but one of the participants were white. Further concern about this sample is raised by the low response rate (24%). High refusal rates are associated with response bias and non-generalizability of the study findings to a broader population (Burns & Grove, 2009).

Further evidence of the existence of negative attitudes towards sexual minority patients is found in Vermette and Godin (1996). This study used a randomized, partial hierarchical design to assess attitudes, including homophobia, using Ricketts and Hudson’s (1980) Index of Attitudes Toward Homosexuals, among nurses providing home care in Quebec City, Canada. Of the 102 participants, 23.5% showed some evidence of homophobia. Although the mean scores on the instrument fell into the low-grade non-homophobic category, high scores on the Balanced Inventory of Desirable Reporting suggested that a significant number of participants may have under-represented bias in ways that they felt would be favourable to the researchers.

In contrast, Strasser and Damrosch (1992) and Dinkel, Patzel, McGuire, Rolfs, and Purcell (2007) found little evidence of anti-gay bias in their respective samples of licensed RNs enrolled in a graduate nursing program ($n = 188$) and faculty of an undergraduate nursing school ($n = 15$). As these were the only two studies conducted in an academic envi-

ronment, one needs to question whether their positive findings reflect the more tolerant atmosphere of academia or the social desirability of responding positively when participating in a research project at one's school or place of employment.

In summary, every study in this integrative review found some evidence of negative attitudes towards homosexuality. The majority of studies (8 out of 17) were positively leaning. Two studies had means at the mean between positive and negative attitudes. Four studies had scores showing a division between cognitive (positively leaning) and emotional responses (negatively leaning) to homosexuality. Three studies had negatively leaning means.

Complexities of attitudes. Some studies in this review provided overall means and frequencies of instrument scores as a measure of overall attitudes towards LGBT persons, whereas other studies used more complex measures to try and capture the complexities of attitudes. This reflects the findings of the concept analysis literature on homophobia, which has been critical of commonly used definitions of homophobia for not reflecting the multidimensionality of the construct (Christensen, 2005; Richmond & McKenna, 1998).

Three studies in this review reported results on both emotional and cognitive reactions to homosexuality (Alexander & Fitzpatrick, 1991; Glad et al., 1995; Smith, 1993). In their early study, "Variables Influencing Nurses' Attitudes Toward AIDS and AIDS Patients," Alexander and Fitzpatrick (1991) found that 96% of their convenience sample of RNs felt that "AIDS was not a punishment for sins" and 84% were "sympathetic to gay AIDS patients" (p. 318). However, 70% stated they were "uncomfortable establishing a therapeutic relationship with a homosexual AIDS patient" (p. 318). Although this could be reflective of fear of HIV contagion — a common finding in early studies — it could also be reflective of a discrepancy between cognitive acceptance of and negative emotional response to homosexuality. Similar results were found by Glad et al. (1995). In their sample, 79.2% of participants believed that homosexuals should have equal rights, yet 50% felt that "homosexuality is a sin" and "disgusting."

Smith (1993) conducted a formal exploration of this possible contradiction by using two measures in his study with 250 psychiatric RNs: the Attitudes Towards Lesbians and Gays Scale (Smith, 1993) to measure cognitive attitudes towards homosexuals, and the Index of Attitudes Toward Homosexuals (Ricketts & Hudson, 1980) to measure emotional reactions. His findings were similar to those of Glad et al. (1995) and Alexander and Fitzpatrick (1991). The Attitudes Towards Lesbians and Gays Scale showed mixed-range but positively leaning scores for cogni-

tive acceptance of homosexuality. However, 77% of the scores on the Index of Attitudes Toward Homosexuals fell into the homophobic range.

Other researchers used more complex measures to capture the multidimensionality of the concept. For example, two studies (Hou et al., 2006; Yen et al., 2007) used the Attitudes Toward Homosexuality Questionnaire (Beere, 1990) in their studies of nurse attitudes towards sexual minority patients in Taiwan. This instrument conceptualizes attitudes as having four dimensions: condemnation/tolerance, morality, contact, and stereotypes. Interestingly, in both studies, scores on all four dimensions were closely correlated ($p < 0.001$). In contrast, Røndahl, Innala, and Carlsson (2004), in their study with nurses, assistant nurses, and student nurses at an infectious disease clinic in Sweden, measured three concepts: homophobic anger, homophobic guilt, and delight. These researchers found differences between groups ($p < .01$) as well as within groups (p value not reported). Among the nursing staff, 36% stated that they wished to refrain from nursing homosexual patients. Lastly, Vermette and Godin (1996) used the variables of Ajzen's (1985) Theory of Planned Behavior and Triandis's (1975) Theory of Personal Normative Belief to guide their research.

Correlates of Nurse Attitudes Towards LGBT Patients

Of the 17 studies included in this integrative review, 13 looked at correlates of nurse attitudes towards LGBT patients in an effort to describe or predict the variables that influence those attitudes. The most commonly examined variables were age, marital status, degree of religiosity, education level, personal or professional contact with LGBT persons, and fear of AIDS. Great variability was seen across studies, with five important exceptions. Firstly, personal or professional contact with LGBT persons correlated with positive attitudes towards sexual minorities in the six studies that explored this relationship (Dinkel et al., 2007; Hou et al., 2006; Koch et al., 1991; Smith, 1993; Suominen et al., 2010; Yen et al., 2007). All reported p values below the standard significance level of 0.05. Secondly, increased levels of education were correlated with a significant increase in attitudinal scores towards sexual minorities in five out of the six studies that examined this association. One study (Forrester & Murphy, 1992) found a non-significant correlation between level of education and attitudes but reported no p value. This was one of only two randomized, partial hierarchical experimental studies in the analysis. Although this is a strong research design, and the study's moderate-to-large sample size ($n = 360$) showed no evidence of sampling or response bias, the researchers failed to report information on response rate, thereby limiting the ability to draw conclusions regarding bias (Polit & Beck, 2009).

Five studies examined the relationship between religiosity and attitudes towards sexual minorities. Three studies found an increase in negative attitudes towards LGBT persons among participants who self-identified as very religious (Dinkel et al., 2007; Koch et al., 1991; Yen et al., 2007). In contrast, Smith (1993) differentiated between religious faiths and found a significant difference in attitudes between those identifying as Catholic or Protestant and those identifying as Jewish or not religious. Increased religiosity among Catholics and Protestants correlated with increased negativity towards LGBT patients ($p < .01$). Hou et al. (2006) was the only study to find a non-significant correlation between religion and attitudes (p value not reported). It is important to note that the sample for this study differed from the other samples in three ways: It consisted only of nurses working in mental health, it consisted of nurses practising in Taiwan, and the participants were more educated (48% master's or doctorate) than those who made up the other samples.

Three studies examined the relationship between fear of AIDS and attitudes towards homosexuals. One study (Glad et al., 1995) reported a non-significant correlation ($p > 0.05$), while two (Jemmott et al., 1992; Meisenhelder, 1994) reported a significant, positive correlation between fear of AIDS and negative attitudes towards homosexuals. Lastly, two studies (Hou et al., 2006; Koch et al., 1991) found a positive correlation between increased knowledge of AIDS or increased training and positive attitudes. Marital status, age, parental status, and work site had inconsistent findings.

In summary, the literature suggests that the best predictors of positive nurse attitudes towards sexual minority patients are increased education, increased personal or professional contact with LGBT persons, decreased religiosity or belonging to a more "accepting" denomination, and decreased fear of HIV contagion. These findings have important implications for educational interventions to improve attitudes among nurses.

Sequelae of Nurse Attitudes Towards LGBT Patients

Of the 17 studies, 10 attempted to assess if, and how, attitudes affect behaviour. Nine studies conceptualized and measured this relationship as reduced willingness or intent to provide care or to interact with patients (Forrester & Murphy, 1992; Hou et al., 2006; Jemmott et al., 1992; O'Sullivan, Preston, & Forti, 2000; Røndahl et al., 2004; Siminoff et al., 1998; Suominen et al., 2010; Vermette & Godin, 1996; Yen et al., 2007). Eight of those nine studies found a positive correlation between negative attitudes and reduced willingness to care for LGBT patients (p value ranging from < 0.01 to < 0.001). Only one study, Forrester and Murphy (1992), did not find a significant difference in willingness to interact with heterosexual versus homosexual patients ($p > 0.05$). The researchers

hypothesized that this finding represented a temporal change in nurse attitudes. However, a review of more recent literature in the analysis failed to support this hypothesis.

One other study obtained contradictory results. In their study with 136 nurses working in a Midwestern US hospital, Alexander and Fitzpatrick (1991) asked the nurses if they would “not be comfortable establishing a therapeutic relationship with a homosexual patient” (p. 318); 70% of the nurses agreed. The researchers compared this result to the 78% who believed that it was “not distasteful to care for homosexual AIDS patients,” concluding that this is an area that needs further examination. However, this study used a non-validated instrument with no reported reliability. As well, some of the survey questions used double negatives. Improper question construction, such as double negatives, has been shown to be confusing for responders, leading to a potential increase in inaccurate responses (Dillman, 2007).

In summary, the findings of this integrative review lend support to the hypothesis that negative provider attitudes towards sexual minority patients may negatively affect care for LGBT persons (Solarz, 1999). However, as there has been no outcomes research in this area, it is unknown if this finding in the literature can be translated to “real life” provider behaviour.

Discussion

A growing body of literature suggests that LGBT persons experience significant health disparities. The attitudes of health-care providers have been postulated to be a major contributing factor in these disparities, by restricting access to health care for LGBT persons and/or by providing them with substandard or culturally incompetent care. The literature on nurse attitudes supports this hypothesis, suggesting that many nurses harbour negative attitudes towards LGBT patients and that these attitudes may adversely affect treatment. However, care must be taken in interpreting and generalizing the findings of the existing research, as the published studies have significant methodological, conceptual, and theoretical limitations.

Limitations of the Literature

Sample size. A representative sample is an essential element in the ability to draw conclusions on the generalizability of study findings (Burns & Grove, 2009). Of the 17 studies included in this review, 11 used convenience samples of varying sizes, from 57 to 1,540. Convenience sampling is a weak form of sampling that does not allow for control of sampling error, thus increasing the risk of bias. However, because it is inexpensive

and convenient, it is an acceptable form of sampling as long as its limitations are taken into account (Burns & Grove, 2009). Only one study in the analysis reported a power analysis (Siminoff et al., 1998). This essential but often missing element in nursing research helps to determine whether the sample size is adequate to “detect differences or relationships that actually exist in the population” (Burns & Grove, 2009, p. 357), thereby preventing false negative results.

Sampling strategy. When conducting a study, researchers choose from among a variety of sampling strategies and recruit participants from a variety of settings. Six studies in this review used convenience sampling from one site, such as a hospital, clinic, or school of nursing. Use of a convenience sample from one site often leads to bias (Burns & Grove, 2009). Three studies in this review used convenience samples from multiple sites (Hou et al., 2006; Siminoff et al., 1998; Yen et al., 2007). Three studies used population sampling, potentially increasing the heterogeneity of the sample and reducing sampling bias (Burns & Grove, 2009; Jemmott et al., 1992; Koch et al., 1991; Vermette & Godin, 1996). Lastly, five studies chose random sampling (simple or stratified) as their strategy (Blackwell, 2007; Forrester & Murphy, 1992; Meisenhelder, 1994; O’Sullivan et al., 2000; Smith, 1993). This method reduces the risk of systematic bias even further, by ensuring that everyone in the sampling frame has an equal chance of being selected for the study (Burns & Grove, 2009).

Sociodemographic variables. An examination of the basic sociodemographic variables of a sample is an essential element in analyzing a study’s external validity (Burns & Grove, 2009). In this review, four studies did not report basic sample demographics (Alexander & Fitzpatrick, 1991; Blackwell, 2007; Røndahl et al., 2004; Vermette & Godin, 1996). Another five studies left out descriptive frequencies of participants’ ethnicity (Dinkel et al., 2007; Forrester & Murphy, 1992; Meisenhelder, 1994; O’Sullivan et al., 2000; Strasser & Damrosch, 1992).

Given the sociodemographic data provided, multiple studies showed evidence of sampling/response bias. Three studies used samples in which the majority had only a diploma or an “associate degree” (Glad et al., 1995; Meisenhelder, 1994; O’Sullivan et al., 2000). In contrast, two studies used samples in which the majority of nurses had graduate training (Hou et al., 2006; Smith, 1993). As educational achievement has been the variable most closely associated with positive attitudes towards LGBT patients, one would expect to find disparities in the results of these two groups of studies. However, not all of the studies explored the correlation between education level and attitudes.

Instrumentation issues. This review found a lack of consistency among instruments used to explore attitudes towards LGBT patients. In

the 17 studies in the review, 14 different instruments were used to examine attitudes and beliefs. Lack of measurement consistency leads to difficulties with cross-study comparison and generalizability (Burns & Grove, 2009), as well as difficulty interpreting and comparing scores of the measures; not all studies in the sample adequately discussed measurement and interpretation issues with the chosen instrument. As well, the majority of the studies lacked explicit and complete reliability and validity information, precluding the drawing of conclusions about the accuracy of the data (Polit & Beck, 2007). Due to both the research goals and questions and the instruments chosen, different studies measured different constructs, or different aspects of the same construct.

This review also found that social desirability measures were used in only two of the studies (Röndahl et al., 2004; Vermette & Godin, 1996). Measuring socially desirable responses is an essential element in assessing study validity, especially when the topic is personally or culturally sensitive, and may be done using a social desirability scale or via structuring of questions and surveys (Nederholf, 2006). Röndahl et al.'s (2004) mixed-method study included a short measure of social desirability imbedded into the small qualitative portion of the study; three out of the seven nursing staff who wrote a comment showed evidence of socially desirable reporting. Similarly, Vermette and Godin (1996) found evidence of social desirability in their study of the impact of homosexuality and AIDS on home care nurses. These findings support the need for systematic use of a method for gauging social desirability bias when discussing attitudes towards sexual orientation.

Theoretical framework and conceptual definitions. The use of a theoretical framework in health research is an important way to standardize and guide the development and testing of related concepts and/or variables in an identified area of research (Burns & Grove, 2009). This review found a dearth of studies looking at attitudes towards LGBT that reflected the complexity of the concept. The majority of studies measured “homophobia” (often undefined) or attitudes towards homosexuality as an add-on to an investigation primarily interested in attitudes towards persons with HIV/AIDS. This is limiting both conceptually and methodologically. First of all, it is difficult to separate the concepts of fear of contagion of HIV and attitude towards homosexuality when they are measured in tandem. Second, studies looking at attitudes towards homosexuality as part of a study of attitudes towards HIV/AIDS omit measurement and discussion of attitudes towards lesbians, bisexuals, and transgender persons. No studies in this review discussed bisexual or transgender persons, and studies mentioned lesbians only when the instrument used had a separate subscale for attitudes towards gay women (Blackwell, 2007; Smith, 1993). Lastly, including attitudes towards homo-

sexuality as a small part of a study precludes in-depth examination of the concept, as well as development and testing of conceptual models that explore evidence-based concepts of attitudes (Azjen, 1985) and homophobia (Christensen, 2005; Richmond & McKenna, 1998).

Of the 17 studies in this integrative review, five used a theoretical framework to guide their research (Glad et al., 1995; Hou et al., 2006; Meisenhelder, 1994; Smith, 1993; Vermette & Godin, 1996). However, they all used different frameworks, leading to selection of different variables of interest and non-comparable conclusions. Seven studies defined important concepts to a greater or lesser degree (Blackwell, 2007; Dinkel et al., 2007; Glad et al., 1995; Meisenhelder, 1994; Røndahl et al., 2004; Smith, 1993; Vermette & Godin, 1996).

In its 2011 landmark report on LGBT health disparities, the Institute of Medicine identifies four theoretical frameworks for LGBT health and research: (1) the minority stress model posits that the experience of stigma and discrimination in a society that devalues non-heterosexuals and those living outside of the traditional, biologically based gender binary leads to stress and poor health outcomes, especially those related to mental health; (2) intersectionality theory examines the experience of non-heterosexual sexual orientation in the context of its interaction with an individual's race/ethnicity, class, and sex, and examines the cumulative effect of marginalization on health; (3) the life course perspective understands sexual orientation/gender identity in terms of human development, highlighting the varying needs and experiences of LGBT persons across the lifespan; and (4) social ecology examines the multiple influences of individual experience, family and relationships, and community and society, and their complex interplay on behaviour, attitude, and experience (IOM, 2011).

Social, cultural, and historic context. One must be cognizant of the institutional, social, cultural, and historical contexts in which research is done. A strength of the existing literature is variation in the current practice setting of the RN samples. The research contains samples of RNs currently working in a variety of inpatient units (Alexander & Fitzpatrick, 1991; Glad et al., 1995; Hou et al., 2006; Siminoff et al., 1998; Suominen et al., 2010; Yen et al., 2007) and in outpatient/community practices (Røndahl et al., 2004; Vermette & Godin, 1996), recruited via educational activities and state boards of nursing without regard to practice site (Blackwell, 2007; Dinkel et al., 2007; Forrester & Murphy, 1992; Jemmott et al., 1992; Koch et al., 1991; Meisenhelder, 1994; O'Sullivan et al., 2000; Smith, 1993; Strasser & Damrosch, 1992).

Likewise, there is some geographic variation in the literature. The majority of studies were conducted in the United States (Alexander & Fitzpatrick, 1991; Blackwell, 2007; Dinkel et al., 2007; Forrester &

Murphy, 1992; Glad et al., 1995; Jemmott et al., 1992; Koch et al., 1991; Meisenhelder, 1994; O'Sullivan et al., 2000; Siminoff et al., 1998; Smith, 1993; Strasser & Damrosch, 1992). One study was conducted in Canada (Vermette & Godin, 1996); two used samples in Taiwan (Hou et al., 2006; Yen et al., 2007); one was conducted in Sweden (Röndahl et al., 2004); and one compared samples of nurses in Estonia, Lithuania, and Finland (Suominen et al., 2010). The attitudes of nurses towards LGBT patients remain unexamined in much of Europe; in most of Asia; and in Africa, Latin America, and the Middle East. Polls have consistently shown that societal attitudes towards homosexuality vary greatly by region (Pew Research Center for People and the Press, 2011); thus there is a wide gap in the literature regarding nurse attitudes towards LGBT patients in many areas of the world.

Lastly, it is essential to recognize the historical context in which research is done. Polls suggest that there has been a significant change in attitudes towards LGBT persons over the past decade, especially in the Americas, New Zealand, Australia, parts of the Middle East, and parts of Europe (Pew Research Center, 2011). Specifically, polls show greater acceptance of homosexuality after the passage of same-sex marriage laws (Naurath, 2007). In addition, public opinion polls suggest that younger people are more tolerant of LGBT persons than older people (Pew Research Center, 2011) and that the stigma of HIV/AIDS has decreased with improved treatment, although results indicate that many people still harbour concerns about contact with HIV-infected persons (Herek, 2010). As the majority of the research on nurses' attitudes towards LGBT patients was conducted in the 1990s, it is possible that their attitudes have changed significantly. Thus there is an urgent need to replicate studies in the current social and political climate.

Gaps in knowledge. Much of the literature is dated and is the result of research conducted as part of studies on attitudes towards persons with HIV/AIDS. Although the findings of these studies laid the foundation for further research in this area, caution is advised when interpreting the results, as they can quickly become out of date in the fast-evolving world of HIV/AIDS. As well, studies intertwined with studies on attitudes towards patients with HIV/AIDS generally have measured only attitudes towards gay men. The LGBT population consists of at least four distinct populations, each with its own health needs and differing levels of stigma and marginalization (IOM, 2011; Solarz, 1999). More research is needed on attitudes towards subpopulations of sexual and gender minority persons, especially transgender persons, who are often considered among the most marginalized of all US populations (Dean et al., 2000).

We need more quantitative research that uses national samples of providers; looks at correlates of negative attitudes; examines the relation-

ship between attitudes towards LGBT patients, nursing care, and patient outcomes; and examines attitudes of advanced practice nurses (nurse practitioners), who provide a significant amount of primary health care to diverse populations, including people of all ethnic backgrounds, ages, genders, and sexual orientations.

As well, there is a wide gap in the literature regarding qualitative research. Qualitative research is an essential method in developing an understanding of a new area of inquiry, when the goals of the study are to explore the complexities and nuances of a phenomenon, or to gain an understanding of the emic perspective of a phenomenon (Cresswell, 2007). We need studies that discern and explore the subtleties of nurse attitudes towards sexual minority patients, differentiating between the cognitive and emotional aspects of the phenomenon and between homophobia and the related phenomenon of heterosexism.

Conclusion

The purpose of this analysis was to critically appraise and synthesize the literature on nurse attitudes towards LGBT patients. The review found that there is a paucity of literature on this important topic. A synthesis of the literature found that the majority of studies are more than a decade old, use small, convenience, samples, and often show evidence of sampling or response bias, thus limiting the generalizability of the findings to larger populations. As well, the literature is limited by inconsistent definitions of key constructs (including homophobia, homosexual, and LGBT); lack of theoretical frameworks; inconsistent use of instruments and use of instruments with poor or unknown validity and reliability; inconsistent examination of possible predicting or consequential variables; and exclusion of measures of bisexual and transgender persons and, often, lesbians.

The implications of a more robust body of literature in this area are numerous. Increased knowledge in this area could lead to interventions to increase nurses' cultural competency regarding sexual minorities. As well, increased discussion of health disparities among LGBT persons, including discussion of provider factors, could lead to increased resource allocation to research, education, and direct services. Lastly, discussion of these findings could encourage nursing faculty to include more LGBT content in their curricula, thereby improving knowledge and attitudes towards LGBT persons among the nurses of tomorrow.

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Résumé

Le travail du personnel infirmier avec des patientes LGBTQ : « Elles sont comme les autres, alors quelle est la différence? »

Brenda L. Beagan, Erin Fredericks, Lisa Goldberg

Se fondant sur les méthodes d'études critiques féministes et *queer*, cet article explore les perceptions qu'ont les infirmières et les infirmiers de leur pratique avec des patientes lesbiennes, gaies, bisexuelles, transgenres ou *queer* (LGBTQ). L'étude a comporté la réalisation d'entrevues en profondeur semi-structurées avec 12 membres de la profession infirmière à Halifax, en Nouvelle-Écosse. Ces entrevues ont permis de faire la lumière sur diverses approches en matière de pratique infirmière. Les participants ont le plus souvent soutenu que les différences comme l'orientation sexuelle et l'identité de genre ne font pas de différence : tout le monde devrait être traité comme une personne distincte. Les participants semblaient tenir beaucoup à éviter la discrimination ou la stéréotypisation en tentant d'éviter les suppositions. Ils étaient soucieux de ne pas offenser les patientes par leur langage ou leurs gestes. Lorsqu'il était tenu compte des différences sociales, l'accent se limitait souvent à la santé sexuelle, bien que certains participants aient montré une compréhension nuancée de l'oppression et de la marginalisation. Faire la distinction entre les généralisations et les stéréotypes peut aider le personnel infirmier dans ses efforts pour reconnaître les différences sociales sans faire de tort aux patientes LGBTQ.

Mots clés : lesbiennes, bisexuelles, transgenres, pratique infirmière, LGBTQ

Nurses' Work With LGBTQ Patients: “They're Just Like Everybody Else, So What's the Difference?”

Brenda L. Beagan, Erin Fredericks, Lisa Goldberg

Informed by critical feminist and queer studies approaches, this article explores nurses' perceptions of practice with patients who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ). Qualitative in-depth, semi-structured interviews with 12 nurses in Halifax, Nova Scotia, illuminate a range of approaches to practice. Most commonly, participants argued that differences such as sexual orientation and gender identity do not matter: Everyone should be treated as a unique individual. Participants seemed anxious to avoid discriminating or stereotyping by avoiding making any assumptions. They were concerned not to offend patients through their language or actions. When social difference was taken into account, the focus was often restricted to sexual health, though some participants showed complex understandings of oppression and marginalization. Distinguishing between generalizations and stereotypes may assist nurses in their efforts to recognize social differences without harming LGBTQ patients.

Keywords: lesbian, bisexual, transgender, nursing practice, qualitative research, LGBTQ issues

Introduction

Women who identify as lesbian, gay, bisexual, transgender, or “queer” (LGBTQ) face social exclusion that can translate into significant health inequities (Fish, 2010). They are less likely than members of the general population to get regular Pap tests and mammograms, and more likely to use alcohol, tobacco, and other substances (Steele, Tinmouth, & Lu, 2006). Lesbian and bisexual teens are more likely than other teens to become pregnant, to abuse alcohol and drugs, and to consider suicide (Saewyc, Poon, Wang, Homma, & Smith, 2007). Transgender women, those whose bodies and socially assigned gender do not match their internal sense of gender, face considerable marginalization and mistreatment in health care, as well as unique health challenges (Bauer et al., 2009). Trans people have elevated rates of depression, substance abuse, other mental health conditions, suicidal ideation and attempts, HIV infection, and experiences of violence (Clements-Nolle, Marx, Guzman, & Katz, 2001; Kenagy, 2005; Shaffer, 2005). Stigma, homophobia, and transphobia (discriminatory prejudice that may manifest as avoidance, intol-

erance, fear, hatred, and violence) have been identified as major contributors to such health inequities (Banks, 2003; Weisz, 2009).

At the same time, LGBTQ women are less likely to seek out health services, in part because many experience health care as heterosexist, grounded in institutional and interpersonal assumptions that heterosexuality is the norm for relationships and any variation is considered deviant and subordinate (Sinding, Barnoff, & Grassau, 2004). For trans people, their very existence, as well as their health-care needs, is erased from attention and action at individual, organizational, and systemic levels (Bauer et al., 2009). In this study we explore how a small sample of nurses in one east coast Canadian city approached and understood their work with LGBTQ patients. We ask how everyday practices and ways of relating, as well as ways of thinking about sexual orientation and gender identity in nursing care, may unwittingly contribute to health inequities for LGBTQ women. At the same time, we ask how nurses may challenge those patterns to optimize care.

Literature Review

In 1993 Michelle Eliason (1993) wrote that “homophobia and heterosexism are not the fault of individual nurses, as they are the legacy of their socialization” (p. 18). Nonetheless, she argued, “failing to address prejudices and biases in adulthood is a breach of the nursing code of ethics” (p. 18). She argued that education and culturally congruent health care were key to bringing about change. In a systematic review of the nursing literature published 17 years later, Eliason, Dibble, and DeJoseph (2010) conclude that nursing scholarship has largely maintained an overwhelming silence with respect to LGBTQ health and health care. They call for emancipatory efforts in nursing education, research, and professional advocacy concerning LGBTQ health, to address the harms done by that silence.

LGBTQ Experiences of Health Care

LGBTQ persons are twice as likely as other Canadians to not have a family doctor, and are significantly less likely to seek out health care, often delaying until a condition is acute (Kenagy, 2005; Newfield, Hart, Dibble, & Kohler, 2006). Part of the reason for delaying may be fear of ill treatment. A study with 98 lesbian and bisexual women in Nova Scotia (Mathieson, 1998) found that many avoided routine and preventive care due to care providers’ assumptions. In the face of heterosexism in forms and documentation, as well as in discussions such as those surrounding sexual history and birth control, participants often felt forced to disclose

their sexual orientation. This left many providers feeling uncomfortable, not knowing what to do with the information. More recently, in a survey of 2,269 lesbian, gay, and bisexual persons in New Zealand, 83% of the women reported that their health-care providers usually or always presumed they were heterosexual (Neville & Hendrickson, 2006). Most also reported, however, that providers were comfortable with their disclosures and that their health care was not negatively affected by provider attitudes.

Many trans people experience their treatment by health-care providers as ignorant, insensitive, humiliating, and discriminatory (Newfield et al., 2006). Health professionals tend to lack knowledge and may express moral judgements about patients, sometimes even withholding treatment (JSI Research and Training Institute, 2000; Shaffer, 2005). In a transgender needs assessment carried out in Philadelphia ($N = 182$), 26% of respondents had been denied medical care at least once (Kenagy, 2005). A transgender participant in a Boston study reported that her physician withheld treatment, saying she "should 'see a veterinarian' as a medical doctor was 'a doctor for people'" (JSI Research and Training Institute, 2000, p. 22).

Heteronormative and Gender Normative Care

In recent studies, nurses have generally been described as having positive or neutral attitudes towards LGB patients (Goldberg, Harbin, & Campbell, 2011; Røndahl, Innala, & Carlsson, 2004; Sinding, Barnoff, & Grassau, 2004). For example, a Swedish study of perinatal care for lesbian mothers found that most had had positive experiences with nursing staff (Røndahl, Bruhner, & Lindhe, 2009). A broader study of nursing experiences with 27 lesbian and gay adults in Sweden found that most participants had found nurses to be caring and friendly, although some had experienced negative treatment (Røndahl, 2009). In a recent Canadian study, in contrast, trans persons reported constant struggles with uninformed health-care providers, with providers wanting to "pass" them off to other staff and belittling them (Bauer et al., 2009). This study found that forms, institutional procedures and policies, and health insurance requirements consistently erased the existence of transgender people.

Though minority sexual orientation and/or gender identity can evoke poor (homophobic and transphobic) treatment, a far more pervasive problem seems to be heteronormativity and normative assumptions about gender. A literature review carried out recently concludes, "Within the clinic, heterosexuality appears to be the expected 'default' norm" (Dysart-Gale, 2010, p. 24). Heteronormativity refers to the powerful interlocking set of assumptions and institutional practices that construct everyone as heterosexual unless shown to be otherwise and that view

heterosexuality as the preferred, normal — indeed only thinkable — sexual orientation. In heteronormative contexts, heterosexuality is descriptively normative (statistically “normal”) as well as prescriptively normative — unless heterosexual, one is cast as deviant, abnormal, lesser. At the very least, aberrations of the norm of heterosexuality require explanation. Heteronormativity, the pervasive assumption of heterosexuality, renders other sexual orientations (and people) invisible or marginal in health-care settings (Dysart-Gale, 2010; McDonald, 2009).

A similar set of normative assumptions contributes to the erasure of transgender existence and visibility. The normative assumptions that erase trans people are about gender binaries — that there are two distinct genders and everyone fits neatly and uncontestedly into one or the other, with no “spillage” over the edges of the categories. Normative assumptions about gender binaries erase not only trans people, but also those who experience themselves not as masculine or feminine but rather as something else, or something in the middle. Some of these individuals may identify as gender-queer. The pervasive assumptions that none of these gender-identity alternatives exist (or should exist) we refer to as gender normativity.

Recent research suggests that heteronormativity and gender normativity are pervasive in health-care settings, negatively affecting care for LGBTQ patients. In Canada, McDonald (2009) concludes, lesbians are rendered invisible in health care, as “the norm of heterosexuality is reflected in sexual and reproductive health-care practices, in demographic forms and interviews, and in the posters and pamphlets found on the walls and on the desks of health services” (p. 264). In two studies of lesbian prenatal and birthing experiences, heteronormativity was found to be ubiquitous, from the forms and language used to continual references to the father (Goldberg et al., 2011; Røndahl et al., 2009). Similarly, in a study of lesbian cancer care, Sinding and colleagues (2004) found that even the cancer support groups for lesbians or their partners were experienced as marginalizing, as they assumed that participants were heterosexual.

In Røndahl’s (2009) study with Swedish gay and lesbian adults, nearly all participants reported that nursing staff routinely assumed heterosexuality. Heteronormativity was conveyed through pamphlets and other information in waiting rooms, intake forms and documentation, routine questions about family relationships, and even routine practices such as insisting on a pregnancy test even when a patient said she was lesbian and could not be pregnant. Heteronormativity in written, verbal, and non-verbal communications marginalized and rendered invisible the lesbian and gay patients.

Fears, Discomfort, and Individualizing Difference

In the context of pervasive heteronormativity and gender normativity, LGBTQ patients clearly believe they may be subjected to ill treatment if they disclose their sexual orientation or gender identity. In a recent Canadian study of lesbian birthing experiences (Goldberg et al., 2011), the fear of and vulnerability to negative treatment in health-care settings were illuminated by the gratitude lesbians expressed when they received quality care. Participants were surprised and exceedingly grateful when they were treated well by nursing staff — when partners were acknowledged as partners, when nurses seemed comfortable with them as lesbians. The same finding is reported by Sinding and colleagues in their study of lesbian cancer care — simply being treated like other patients occasioned grateful praise:

What is normal treatment for heterosexual women was something that the lesbians remarked on and even praised. The narratives reveal that legacies of homophobia and heterosexism leave lesbians in the position of being grateful for things that heterosexual people take for granted. And if gratitude for equal treatment is a consequence of marginalization, so too are anticipation of problems and readiness to fight for care. (Sinding et al., 2004, p. 182)

Similarly, in Bauer and colleagues' more recent study of trans care in Ontario (Bauer et al., 2009), many trans participants felt grateful if they happened to encounter a care provider who was tolerant of their gender identity — let alone knowledgeable about their health needs.

In heteronormative and gender normative contexts, LGBTQ realities disrupt everyday assumptions, which may leave nurses and other staff uncomfortable. LGBTQ patients reporting on their health-care experiences have stated that their sexual orientation or gender identity seemed to make nurses and other staff feel insecure, embarrassed, and anxious about the possibility of saying or doing something “incorrect” and being seen as prejudiced (Goldberg et al., 2011; Røndahl, 2009; Røndahl et al., 2009). This fear of saying something wrong is sensed by patients, who then may bear the burden of facilitating communication. When nursing staff are afraid to discuss issues or are unsure about how to address LGBTQ patients (Røndahl et al., 2004), patients may fear that the nurses' discomfort will be accompanied by ill treatment. Communication then breaks down: “Insecurity, on the part of either personnel or relatives, could bring further interaction to a halt. . . . Nursing staff experience a great sense of insecurity concerning how they should behave in interactions with gay families” (Røndahl, 2009, p. 150). Røndahl (2009) notes that this is in spite of nurses generally holding positive or neutral attitudes towards LGBTQ people and being well-intentioned. He likens it to

cross-cultural communication struggles, when lack of knowledge coupled with good intentions can paralyze interactions.

One way that nurses can address fear of saying or doing something “wrong” is to focus on the individual. Goldberg and colleagues (2011) found that nurses often engaged in “care practices blind to difference” (p. 184), arguing that sexual orientation was irrelevant. They identify a “pervasive, problematic tendency to understand the requirements of acknowledging diversity as best met by sustained focus on the individual” (pp. 184–185). The desire to see all patients as individuals, and thereby perhaps avoid stereotyping LGBTQ patients, arises from a desire to cause no harm. However, it simultaneously precludes the opportunity to recognize and take into account how social factors — such as heteronormativity and gender normativity — shape patients’ (and nurses’) life experiences, health, and health-care interactions (Beagan & Kuma-Tan, 2009). The participants in Mathieson’s (1998) study of LGB women’s health care in Nova Scotia stated that a care provider must above all be gay-positive — able to grasp what it means to patients to be LGB and how societal responses to sexual orientation can affect health. A narrow focus on individualized differences precludes awareness of such social processes.

Summary

LGBTQ communities face particular health concerns, in part because health care typically does not take them into account. In the contexts of heteronormativity and gender normativity, LGBTQ patients challenge assumptions that may render their lives invisible and/or result in discomfort for practitioners. In this article we explore how nurses approach and understand their work with LGBTQ patients. We ask how everyday practices and ways of thinking about sexual orientation and gender identity in nursing may perpetuate or challenge inequitable health care for LGBTQ women.

Methods

This article is based on a subsample from a qualitative study of health care for LGBTQ women in which we sought to examine how taken-for-granted practices perpetuate or transform the marginalization of LGBTQ women within the health-care system. The study included in-depth face-to-face interviews with women, physicians, and nurses in two Canadian cities. The research team included LGBTQ researchers and members of several disciplines and professions, including nursing. In this article we draw on the data from registered nurses in Halifax, Nova Scotia. This sample comprised 11 nurses who identified as women and one who identified as a man; they had bachelor’s or master’s training, had practised

in various settings for between 10 and 20 years, and self-identified as working to some extent with LGBTQ patients. All of those who reported their sexual orientation self-identified as heterosexual; none identified as transgender. The sample was self-selected; thus participants might be expected to have an unusually high level of experience and familiarity in working with LGBTQ patients.

Following research ethics approval, recruitment was conducted through advertisements in local clinics, letters sent by the College of Registered Nurses, word of mouth, and snowball sampling.

After informed consent had been obtained, a qualitative in-depth, semi-structured interview was conducted with each participant. The participants were asked to describe how they experienced and understood primary health-care practice with LGBTQ women. The interviews were recorded, transcribed verbatim, and analyzed inductively, generating themes and subthemes, which were coded using ATLAS.ti software. Coding was conducted by a team of researchers in constant communication to reach consensus on codes and the use of codes. Analysis was informed by critical feminist and queer studies, which meant that we were sensitive to indications of power dynamics and to normative assumptions about gender and sexuality, and we read these as instantiations of social relations rather than as individual limitations. Transcripts were read and reread, and coded segments were interpreted both in the context of the entire interview and in comparison with the other transcripts. Drawing on the coded data, and again returning to transcripts repeatedly, the analyses described in this article explore the range of ways that nurses understood and approached difference.

Results

In the interviews, nurses described a range of approaches to working with diverse sexual orientations and gender identities. A common approach was to take the view that difference does not matter — in other words, to deny difference. An overwhelming message was the desirability of treating patients as individuals. In part this seemed to be an attempt to avoid discriminating or stereotyping by not making any assumptions. When difference was taken into account, the focus was often restricted to sexuality and sexual health. Yet some participants showed complex understandings of societal oppression and marginalization and the potential impact on health and health care. None of the nurses could be categorized into just one of the themes below; they all expressed various stances throughout their interview. Participants tended to have less experience working with transgender patients and thus had less to say about those patients than about other LGBTQ patients.

Denying Difference by Treating Everyone as an Individual

Almost every nurse interviewed expressed the idea that a patient's sexual orientation and gender identity do not matter, that the care the nurse gives to women is the same regardless of their sexual orientation and gender identity. Some participants simply did not see any differences that mattered relative to care. Others displayed a complex tension in their reasoning, clearly not wanting to reduce LGBTQ patients to their sexual orientation or gender identity by focusing on difference, yet wanting to acknowledge this difference as meaningful. For many this tension was resolved by acknowledging individual difference through treating each patient as a unique person.

When asked whether they treated or worked with patients any differently if they knew they identified as LGBTQ, most participants said they treated everyone the same. Kira asserted, "I think that I treat everybody the same, so I don't know that I would do anything different in regards to whether they've already identified that, you know, they're queer." Simon made it very explicit that sexual orientation and gender identity did not really matter because, inside, people are all the same: "It's not a great big deal, not only in terms of sexual orientation, but whatever, skin colour, whatever. I mean, in the end, we're all pink and squishy inside."

Some participants acknowledged that difference in terms of sexual orientation and gender identity did matter yet seemed to struggle with the idea of ascribing it any significance in their practice. For example, Abigail acknowledged that LGBTQ patients might face "things that could stem from the fact that they're part of that community," yet she went on to diminish the significance of that difference:

Even though I say "different," there's really so much of them that is still the same. . . . It really is only a small part of their life. There's so much more to the person than their gender identity or their sexual preference. . . . There's so much more to them that you just treat them like a regular — they are a regular person.

One of the nurses' most common rationales for not practising differently with LGBTQ patients was that they treated everyone as a unique individual. This approach was seen as avoiding discrimination or stereotyping and ensuring equitable treatment. Phyllis explained that she attempted to treat all patients the same but according to the unique needs of each: "Same and unique, same and individually as opposed to different. Yeah, because everyone has their own individual needs." Others said they focused on the individual health needs, "the medical issue," since sexual orientation or gender identity was not usually why a patient sought care.

Shelley was most explicit about treating LGBTQ patients as individuals. She and a colleague had been talking with other nurses about practice with LGBTQ patients:

One of the nurses was, like, "Oh, my gosh, how do you cope with that?" And we were saying, "Cope with them the same as you cope with anybody else." You know? They're individuals. They're patients the same as everybody else. . . . They're no different than anybody else. . . . They're individual and you treat individuals as individuals.

This focus on individualized difference served to diminish the role of social differences. Later in her interview Shelley suggested it was important to "look at both sides of it," treating people as individuals while also recognizing social diversity:

. . . making sure that each patient is an individual and that care regardless of what journey they're walking on, whether or not it's mental health, whether or not it's gay/lesbian, wherever, you're still dealing with the individual. But there's also that importance of always being mindful that you need to meet needs, and look at the diversity of those needs.

Shelley went on to compare LGBTQ to ethnicity, suggesting that a patient's ethnicity affects their needs in important ways but that a patient is always more than their ethnicity.

Acknowledging Difference as Discrimination

The idea that a patient is more than their ethnicity, or in this case more than their sexual orientation or gender identity, was a strong theme in the interviews. There was an overwhelming sense that the nurses interviewed did not want to harm any patient by stereotyping, making assumptions, or being discriminatory. Lia said explicitly, "I want them [LGBTQ patients] to know that I'm not homophobic or, you know, I'm accepting of everybody." She went on to say, "I'm always so worried about offending people and sort of making that assumption that everybody is heterosexual." Though this is to some extent about conveying a particular impression, we also interpret it as a genuine statement about not wanting to stereotype or harm.

The desire not to discriminate or to be seen as discriminatory may have been underpinning the pervasive denial of difference, the notion that sexual orientation and gender identity do not matter. In this context, the suggestion that LGBTQ patients might receive different care was taken to mean that the care would be poorer than that received by other patients. For example, when asked how she might work differently with LGBTQ patients, Clara said, "I don't think I would. I want to believe that. I think I would give the same care, you know, as [to] people who

are straight. I think I can honestly say that I would.” Phyllis similarly dismissed the suggestion that she might treat LGBTQ patients differently: “No. I’d never even consider that that would be, that they would get less of anything.”

In one of the few discussions of how care might be different for LGBTQ patients, some participants said that it was important to know patients’ sexual orientation or gender identity in order not to offend them by saying the wrong thing. This suggests that normative language and assumptions were prevalent. Some nurses did acknowledge the inevitability of making assumptions and struggled to contain or overcome them. Shelley explained that, especially in her work with trans patients, “You always are trying to be aware of what you say and what you’re doing, but you’re not always, a hundred percent.” Abigail noted, “You kind of get in a habit of . . . assuming that everybody’s the same . . . even though I know it’s not true, you do kind of fall into that trap.” Yet she clearly struggled to not discriminate against any patients, even in the everyday interactions that go beyond medical care: “You joke with all of them, when it’s appropriate . . . you try not to single out or exclude anyone from the type of care that you like to give to your patients.” Abigail’s efforts to connect helped her to avoid discriminating.

Similarly, while Shelley stressed the importance of attending to diversity, she was very concerned about stereotyping by reducing a person to their sexual orientation or gender identity:

What I guess I’m trying to say is that the diversity part, by my being able to look at the diverse person I’m better able to look at that person as an individual and a bigger individual than it’s just this. I’m not categorizing just as a gay person, but I’m looking at her as a gay person with this number of needs, this need that she brings to us as her being individual.

The tendency to associate assumptions with stereotyping undermines efforts to acknowledge social diversity and indeed encourages an individualized perspective on difference. When group differences were acknowledged, there was a tendency to reduce these to differences in sexual practices.

Focusing on Sexuality/Focusing on Oppression and Marginalization

The idea that people are individuals was sometimes accompanied by the notion that the only difference that mattered was that of sexuality and sexual practices. For example, when asked what difference it might make if a patient were LGBTQ, Anna said:

I don’t really care. If it’s a sore throat we’re talking about, [pause] it has really nothing to do with that, because, I mean, it’s still a person, it’s just

who they want to have sex with, you know what I mean? That's the only thing that's different, but they're just like everybody else, so what's the difference?

Clara said she did not care if patients were LGBTQ as long as affection was not evident: "I don't really care. As long as it's not publicly displayed, I don't, I'm just looking at the patient . . . I want to make them feel better." Later she affirmed that "it" referred to physical affection. It is not clear whether Clara was suggesting that LGBTQ people are more highly sexualized than others, or more inappropriately sexual, but she did seem to equate LGBTQ people with sex.

Similarly, when asked how she might work differently with LGBTQ patients, Shelley implicitly linked LGBTQ identity to sexuality when she connected it to having multiple sex partners: "There's a couple of our patients, there's one in particular, that I'm always aware of his health status, because of multiple partners." When the interviewer commented that this is not necessarily unique to gay men, Shelley agreed: "No. It would be the same if he was heterosexual." She went on to say that any difference would be due not to "their sexuality, but because of their, maybe lifestyle, maybe, um, of who they are." It was unclear if she meant an LGBTQ lifestyle or any lifestyle that included having multiple sex partners.

Several of the nurses said they invited disclosure of sexual orientation by inquiring broadly about sexual practices. Regardless of the patient's sexual orientation, they would ask all patients some version of "Do you have sex with men, women, or both?" Knowledge about practices could lead to another line of questioning, as indicated by Lia:

Practices might drive the discussion and the information a little bit differently. Okay, so you have sex with women. Do you use toys, do you share toys, what are you cleaning them with, do you know you can actually catch something off of those? Are you really good with safe sex practices?

In contrast to the tendency to reduce sexual orientation and gender identity to sex and sexual practices, about half of the nurses showed some insight into the complex ways that LGBTQ individuals face societal oppression and marginalization, which can affect their health, their health-care needs, and their health-care experiences. Abigail spoke about transgender youth growing up feeling different: "It's important that everybody become more aware of the fact that there are people in our greater community who may feel vulnerable, and they have different issues than the norm because they're part of the queer community." When asked if she thought being LGBTQ might affect a person's health-care needs, Shelley answered in the affirmative; she spoke of a gay family

friend who was raised in a conservative, religious family and had to “struggle for his identity all the time.” Jeanette worried about aging LGBTQ people who face placement in nursing homes and not have their long-term same-sex relationships acknowledged or respected by their families or the institution. These are all examples of nurses taking into account the ways in which sexual orientation and gender identity can affect the everyday lives of LGBTQ persons, shaping their health and their relationships to health care.

Some participants addressed the complexity of recognizing someone’s sexual orientation or gender identity and its possible effects on their health and health-care needs without reducing the person to that category and failing to see them as a whole person. This centred on recognition of oppression and marginalization, rather than on identities, practices, or “lifestyles.” For example, Jeanette said she gave women the same information about sexual health regardless of their sexual orientation, adding that she took into account barriers faced in previous health-care experiences:

I’d give the same information to a lesbian woman and a straight woman about Pap smears. But, you know, you might approach how you give information differently, especially when I think about some of the clients I’ve seen. Some of them have been not very well treated by their health-care practitioners, you know: nurses, doctors, dentists, social . . . it doesn’t matter who. I’ve had a lot of people that just didn’t have a good experience. So I’m probably going to tread a little bit more lightly . . . at least at first, until they get to know me and know that I’m not going to mistreat them or bad-mouth them because they’ve got a same-sex partner or whatever.

Similarly, Kira said that with an LGBTQ patient she drew on an understanding of possible barriers and harms experienced: “I’m cognizant of what she’s been through and that there’s more barriers and challenges. . . . I’d still go through the same assessment of what works with her, but I do see that there are a lot of barriers.”

Some participants learned about these barriers and harms by interacting with their patients. Jeanette, for example, had learned from conversations with lesbian mothers what it might be like for a non-biological mother to be misunderstood about her relationship with her child. Kate had learned a great deal from trans patients about the everyday aspects of seeking health care and day-to-day living as transgender:

I hear a lot . . . from them about fears . . . fear of identification in going to the lab and they call out their name and when they walk up to the desk they go, “No, I called out a woman’s name, you’re not —” because their

transition isn't complete . . . so they're still presenting as the opposite sex. And they fear that someone in that room has just heard that, and they also shouted out their address and they know now where they live . . . And suicide, like talk about how hard the transition has been and the really bad points they've been at in their lives before having the courage to make that move . . . So a lot of listening, I think.

Learning about the context of LGBTQ patients' lives is hindered when sexual orientation and gender identity are equated with sexual practices, because nurses may not want to invade the person's privacy. Clara had worked with a teenage girl who was very troubled, and, she believed, might have been lesbian. In order to provide good care, Clara said, "maybe we need to know a little more about their background, so we can help them better — not to stick our noses in their business, but to give them better care."

Phyllis used a broad understanding of LGBTQ lives and marginalization to let partners of LGBTQ patients know that their sexual orientation or gender identity was accepted. She did this by deliberately showing respect for the relationship:

Inviting the person to help with the bath or help with giving the medication, or we'll say, "You know them best. What do you think they would like?" And that sort of lets them know, it's like, "Okay, I know that you're the significant other here." That's probably the simplest way. I mean, that's the easiest way. . . it's sort of upfront and right there.

Here, Phyllis displays awareness of how everyday interactions in health care can unintentionally marginalize LGBTQ relationships.

Finally, a few nurses used their understanding of oppression to directly advocate for LGBTQ patients in health-care settings. Viewing homophobia as prevalent in hospital settings, Jeanette tried to make things easier for LGBTQ patients:

If I knew, I was more likely, then, to try to pave the way — like, say, if the partner wanted to come in to the ICU to visit them . . . I'd maybe go out of my way to be nearby to make sure nobody said anything to them or was mean to them. . . . I can remember a few times that nurses would be saying things about the patients behind their back. So I just knew that I would have to be on the lookout for them.

This kind of direct advocacy — challenging one's colleagues to improve care — was unusual in our sample, but clearly it was a very immediate way to affect understandings about oppression and marginalization in order to enhance the quality of care provided.

Discussion

The nurses in our sample displayed a range of ways of thinking about, understanding, and approaching their work with LGBTQ patients. To be clear, no nurse displayed only one approach — they all moved among differing understandings. This is a positive finding, since it suggests that individual nurses may hold multiple, even contradictory, understandings of LGBTQ care. That provides scope for drawing on and strengthening the understandings with optimal implications for equitable health care.

Different approaches have different implications. Most commonly, participants suggested that differences such as sexual orientation or gender identity do not matter: Everybody should be treated the same. Simon expressed this dismissal of diversity with the classic insistence that “we’re all pink and squishy inside.” There was pervasive concern that noticing social — as opposed to individual — differences is tantamount to discriminating. Most of the nurses were very concerned about reducing patients to their sexual orientation or gender identity, to a set of stereotypes or assumptions. This concern was coupled with fear of offending or stereotyping by saying or assuming the “wrong thing.” This could leave nurses paralyzed by the insecurity noted in previous studies (Goldberg et al., 2011; Røndahl, 2009; Røndahl et al., 2004, 2009; communication then becomes problematic.

One of the ways that LGBTQ identity mattered, the participants found, was that it led them to be careful with their language and to avoid making incorrect assumptions about patients. To be clear, these nurses were well-intentioned. They tried in multiple ways to avoid inadvertently causing harm to the LGBTQ patients in their care. Yet the focus on individualized difference, while undeniably important, was not accompanied by equivalent attention to social differences. The fear of making unwarranted assumptions is valid; it is challenging to recognize, let alone avoid, the normative assumptions attached to categories and labels such as lesbian, bisexual, or transgender (McDonald, 2009). If knowing a patient is lesbian leads a nurse to think they know how that patient lives her life, who she shares it with, what her health concerns are, and what risk activities she is engaging in, that nurse is definitely relying on stereotypes, which, coupled with the power of the health-care context, contributes to stigma (Weber, 2010). In her study of lesbian experiences of disclosure, McDonald (2009) urges nurses to avoid complicity in the maintenance of restrictive categories such as “lesbian” and to instead focus on individual practices: “Health-care practices directed towards women should move beyond unexamined categories of identity to consider the particular behaviours that influence the health of each woman” (p. 265).

This approach was apparent in our sample, with nurses arguing that what matters is not *who* someone is (their social identity) but their sexual practices: “Do you have sex with men, women, or both?” However, in attempting not to reduce patients to categories, nurses restrict their ability to see the potential impact of social differences. This approach fails to acknowledge that there *are* generalized social patterns in experiences, life chances, and influences on health (care) (Beagan & Kuma-Tan, 2009). “Colour-blindness,” for example, is unhelpful when skin colour causes people to experience racism on a regular basis and when racism can have stress-related health consequences (Quintero, Lilliot, & Willging, 2007).

Similarly, “care practices blind to difference” (Goldberg et al., 2011, p. 184) render sexual orientation and gender identity irrelevant, when in fact they shape people’s lives. In the context of heteronormativity and gender normativity, social power relations privilege some people (as “normal”) while marginalizing and harming others. Generalizations about the potential impacts of such contexts are not the same as stereotyping and discrimination. Generalizations allow nurses to take into account the possible effects of shared experiences that arise from historical and contemporary power relations. In other words, instead of assuming that all LGBTQ individuals share common practices or lifestyles (stereotyping), nurses could attend to potential experiences of marginalization and oppression.

To be clear, not every LGBTQ person experiences homophobia, transphobia, heteronormativity, or gender normativity in the same way. Class, race, ethnicity, citizenship, age, and other forms of social privilege can lessen the impact of LGBTQ marginalization. This does not mean that marginalization does not exist, or that it does not affect LGBTQ people as a social group. The fact that other social privilege may ameliorate the impact of oppression does not erase it. Similarly, class, gender, sexual orientation, skin colour, disability, religion, and age may all affect the ways that members of a specific ethnic group experience and relate to their cultural heritage and potential cultural identity. This does not change the fact that ethnocentrism privileges some cultural groups and systematically disadvantages others. Individual access to alternative sources of social privilege in no way nullifies the social marginalization of a group; it simply mediates the individual experience.

Generalizations look at the shared values, beliefs, tendencies, and typical experiences of the majority in a particular sociocultural group. They bring together group-specific observations and experiences. They imply difference, not deficit. Stereotypes are an end point for understanding a person, limiting rather than broadening understanding. They apply

group tendencies as if they were always true for all members of the group. In contrast, generalizations are a starting point for understanding a person. Practitioners cannot understand an individual from generalizations, but generalities can sensitize nurses to probable patterns, issues of social difference, leading them towards particular kinds of questions.

For example, Jeanette used her understanding of patterns of homophobia to advocate for and protect LGBTQ patients on hospital wards. More simply, Kira said of an LGBTQ patient, “I’m cognizant of what she’s been through and that there’s more barriers and challenges.” While not every LGBTQ individual faces more challenges than every non-LGBTQ individual, Kira is acknowledging that distinct social barriers accrue to LGBTQ status. Phyllis, without ever needing to ask about a patient’s sexual orientation (with the attendant fear of prying or “getting it wrong”), found ways to honour same-sex relationships by simply saying, “You know them best. What do you think they would like?” She used her understanding of heteronormativity to challenge the business-as-usual marginalization of LGBTQ realities.

Generalizations can only provide what might be considered “sensitizing awareness.” They cannot be a stand-in for knowledge of an individual patient. As McDonald (2009) argues, health care must “consider the particular ways that a range of oppressions and privileges influence the health and health care of each woman” (p. 265). Each patient’s story and experiences will be individual. Yet, by alerting nurses to the ways that marginalization and social exclusion can shape LGBTQ experiences of health and health care, generalizations may cause them to bring up particular issues or ask particular questions, rather than leaving it entirely to LGBTQ patients to raise concerns.

If taking difference into account means acknowledging the context of heteronormativity and gender normativity, then we must acknowledge that many LGBTQ patients fear (justifiably) that they will be treated poorly in a vulnerable situation. Yet nurses, for fear of offending, take a “don’t ask, don’t tell” approach, trusting that quality care can be provided without acknowledging LGBTQ identities and the ways in which marginalization and oppression may shape LGBTQ patients’ health and health care. While the nurses in our study said they were comfortable with disclosure of LGBTQ identities and experiences of marginalization, few apparently saw it as their responsibility to facilitate such discussions. The assumptions of heteronormativity and gender normativity remain unquestioned. Nurses enact a certain privilege when they decide that the risks of discomfort of having got it wrong or having offended are too great to address relevant social differences.

Conclusion

One of the most significant findings from this study is that the nurses were very concerned to not harm their LGBTQ patients in any way — through stereotyping, discriminating, making assumptions, using offensive language, or saying the “wrong thing.” This regard is extremely important and can be used productively. Education and training could help nurses to grasp the differences between generalizing and stereotyping, enhancing awareness of the patterned ways that heteronormativity and gender normativity shape health and health care, and potentially improving care for LGBTQ patients and their families.

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Résumé

Soutenir l'effort des pères qui souhaitent cesser de fumer : principes pour un programme

John L. Oliffe, Joan L. Bottorff, Gayl Sarbit

Il existe peu de données empiriques sur les moyens efficaces d'élaborer, de diffuser et d'évaluer des programmes de promotion de la santé tenant compte de la spécificité des sexes et ciblant les hommes. L'objectif de la présente recherche était de transformer des constatations qualitatives sur les hommes fumeurs en principes d'intervention visant l'abandon du tabagisme chez les pères. Des points de vue d'hommes ont été recueillis lors de quatre séances de discussion de groupe menées avec 24 nouveaux pères fumeurs. Ces données ont permis de dégager trois principes à adopter dans l'élaboration d'un programme de promotion de la santé ciblant les hommes : utiliser des messages positifs qui favorisent le changement sans mettre l'accent sur les idées de stigmatisation, de culpabilité, de honte et de responsabilité; renforcer les liens entre les valeurs correspondant à l'idéal de la masculinité (p. ex., la force, la détermination, la résilience et l'indépendance) et le fait de ne pas fumer; privilégier les témoignages de bénéficiaires éventuels du programme (p. ex., les pères qui fument et souhaitent arrêter). L'étude présente une description des expériences tirées de la conception et de l'essai pilote d'une brochure et d'un programme de groupe reposant sur ces principes. Les conclusions pourront servir à orienter le personnel infirmier dans la conception ou la prestation de programmes de promotion de la santé chez les hommes.

Mots clés : abandon du tabagisme, masculinité, promotion de la santé chez les hommes, spécificité des sexes

Supporting Fathers' Efforts to Be Smoke-Free: Program Principles

John L. Oliffe, Joan L. Bottorff, Gayl Sarbit

There is limited empirical evidence on effective ways to develop, distribute, and evaluate men-centred, gender-sensitive health promotion programs. The purpose of this research was to transition qualitative findings on men's smoking into father-centred cessation interventions. Men's perspectives were gathered in 4 group sessions with 24 new fathers who smoked. The data led to the identification of 3 principles for men's health promotion programs: use positive messaging to promote change without amplifying stigma, guilt, shame, and blame; foster connections between masculine ideals (e.g., strength, decisiveness, resilience, autonomy) and being smoke-free; and privilege the testimonials of potential end-users (e.g., fathers who smoke and want to quit). Experiences drawn from the design and pilot-testing of a booklet and a group program based on these principles are described. The findings can be used to guide nurses in the design and/or delivery of men's health promotion programs.

Keywords: smoking cessation, masculinities, men's health promotion, gender

Introduction

Although research in men's health promotion has gained momentum in recent years, there is limited empirical evidence on effective ways to develop, distribute, and evaluate men-centred, gender-sensitive programs. This is due in part to challenges around engaging men in sustainable programs as well as difficulties in building a foundation of evidence to guide men's health promotion work. The purpose of this article is to describe the principles that underpin the design and delivery of father-centred smoking cessation interventions drawn from the perspectives of new fathers who smoke but want to quit. The principles were inductively derived from consultation sessions with fathers who smoked and were detailed within a print-based and group-based tobacco reduction and smoking cessation intervention for fathers. The principles offer insights that can guide the efforts of nurses in designing and delivering men's health promotion programs.

Masculinities and Men's Health Promotion

By definition, masculine ideals are understood as socially constructed practices, performativities, and power relations to which many men align.

In the context of men's health, studies have revealed how diverse masculine ideals can restrict or support men's engagement with health promotion (Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012; Sloan, Gough, & Conner, 2010). In terms of restricted choices, researchers have described how men's resistance to health help-seeking and/or engagement in risk-taking behaviours are embodied by many men to signal their alignment to masculine ideals, including self-reliance, competitiveness, and aggression (Courtenay, 2000, 2011; Kimmel, 2008; Sabo, 2005). Within this body of knowledge, epidemiological data reveal that men die more often than women from preventable causes, including motor-vehicle accidents and suicide (Bilsker, Goldenberg, & Davison, 2010). Linking men's preventable mortality to masculinity, however, can essentialize and pathologize masculine ideals while downplaying contextual factors and the diversity that exists within and between men. Recently, the focus of masculinities and men's health promotion research has swung towards commentaries that balance benefits and challenges associated with men's masculine ideals and health practices. Lohan (2007), for example, argues for nuanced accounts and life-course research. Robertson (2007) and Oliffe (2009), among others, have responded by studying the potential for working with, rather than attempting to change, men to promote their health. In addition, masculinities and their diverse connections to other, related, social determinants of health, including culture, social class, and age (Evans, Frank, Oliffe, & Gregory, 2011), and the need to locate men's health practices within diverse communities of practice (Creighton & Oliffe, 2010), have reasserted the need to thoughtfully consider an array of issues when moving descriptive findings towards targeted men's health promotion programs (Oliffe, 2012). Recognizing that diverse health-related practices can emerge in response to masculine ideals of self-reliance, competitiveness, and autonomy, Robertson and Williamson (2005) argue that attending to the heterogeneity of subgroups of men is key to meeting the health promotion needs of "target" audiences. Acknowledging diverse masculinities, many authors have highlighted the naivety of taking a "one size fits all" approach to men's health promotion (Oliffe et al., 2011; Pease, 2009).

Accepting that effective health promotion programs are designed for and targeted to specific audiences, there is recognition that understanding connections between masculinities and men's health practices within particular subgroups is central to capturing the appropriate program look, feel, and insertion point(s). For example, the US-based Denver Men's Health Initiative ran the It's Not Your Time campaign to communicate the frequency of men dying from preventable diseases while offering affordable and accessible preventive health care (Whitley, Jarrett, Young, Adeyemi, & Perez, 2007). The Men's Health Center campaign in

Baltimore used slogans, including “Be More Man . . . Be More Healthy,” to appeal to masculine breadwinner and protector ideals in suggesting their program was dedicated to Building Healthy Families One Man at a Time (Whitley et al., 2007). These examples illustrate how aspects of idealized heterosexual masculinities can be used to catalyze strength-based men’s programs that connect manly virtues and self-health to affirm men’s actions towards health promotion (Robertson & Williamson, 2005; Smith & Robertson, 2008). Of course, such approaches are not straightforward. Greaves, Oliffe, Ponc, Kelly, and Bottorff (2010) argue that doing health for someone else, a message that is implicit in the aforementioned programs, is unlikely to sustain behavioural change. Moreover, Gough and Robertson (2010) claim that trading on masculine ideals in health promotion can negatively impact health by reifying patriarchal power and privilege as the most legitimate performativity for men.

Some men are interested in discussing their health but are reluctant to do so for fear of ridicule and stigma (Dolan, Staples, Summer, & Hundt, 2005; Whitley et al., 2007). Varying counterpoints and strategies have been proposed. Gibson and Denner (2000), for example, argue that the permission of other men is the elixir for promoting men’s talk about self-health, a point of view that others confirm as a key factor in the effectiveness of North American-based prostate cancer support groups (Arrington, Grant, & Vanderford, 2005; Oliffe et al., 2011). Various strategies have also been detailed regarding how online environments might allay men’s concerns about confidentiality to garner their “virtual” talk about health and illness (Robinson & Robertson, 2010). Social marketing, a strategy for reaching men in places where they ordinarily gather (e.g., pubs, sporting venues), has been endorsed by Courtenay (2004) as affording opportunities to engage men with health promotion programs in familiar environments and on their own terms.

Men’s Smoking Cessation Programs

In the specific context of smoking, a systematic review of studies evaluating cessation programs for men concluded that, although smoking is associated with adverse health effects and significant disease burden among men, few studies examined men-specific cessation programs (Okoli, Torchalla, Oliffe, & Bottorff, 2011). That said, of the seven randomized control trials that were included in the review, six showed significant treatment effects in favour of the men-centred cessation interventions. In addition, the results of descriptive studies suggest that targeting cessation programs to men may be beneficial. Dutta and Boyd (2007) analyzed smoking images in men’s magazines. They report that images used to sell cigarettes play to men’s ideals about sensuality, inde-

pendence, and mystery, and that these images could also be used to authentically depict non-smoking men as clean, carnal, and enigmatic. A systematic review of men's health promotion interventions found that self-help manuals, details about nicotine replacement therapy (NRT), and a video featuring a testimonial by a well-known sportsman illustrating the health effects of smoking on infants could increase quit rates among men (Robertson, Douglas, Ludbrook, Reid, & van Teijlingen, 2008).

In the specific context of fathers who smoke, effective approaches to supporting cessation are poorly understood (Okoli et al., 2011). In a clinical trial to evaluate an intervention that consisted of counselling and NRT by request, a significant decrease in men's smoking during pregnancy was demonstrated, but this was not sustained at 2, 6, or 12 months postpartum (McBride et al., 2004). A study in which information to support cessation and free NRT were provided to male partners resulted in significant quit rates, but these were measured at pre-birth only (Stanton, Lowe, Moffatt, & Del Mar, 2004). Having pregnant women provide cessation interventions to their male partners was found to be ineffective in two trials (de Vries, Bakker, Mullen, & van Breukelen, 2006; Loke & Lam, 2005). In summary, emergent work suggests that understanding connections between masculinities, fathering, and smoking holds potential for advancing the design and efficiency of targeted smoking cessation programs.

Situating the Current Study

The Families Controlling and Eliminating Tobacco (FACET) (www.facet.ubc.ca) research program, while investigating how best to support pregnant women in their efforts to reduce and quit smoking, gained insights into the smoking patterns of new fathers, who often continued to smoke even after their partner had reduced or quit. Men's smoking was linked to masculine ideals and identities (e.g., independence, self-reliance, and stoicism) in rationales for continued smoking (Bottorff et al., 2006; Oliffe, Bottorff, Johnson, Kelly, & LeBeau, 2010; Oliffe, Bottorff, Kelly, & Halpin, 2008). For example, many men used smoking to manage work-related stress in ways that delinked their smoking from direct fathering amid highlighting fathers' breadwinner and provider ideals through their paid work (Oliffe et al., 2010). Female partners confirmed the linkages between men's smoking and work but acknowledged that they were largely unsuccessful in influencing men's cessation (Bottorff et al., 2010).

However, as men became fathers and engaged in direct care of their baby, alignments with masculine norms appeared to shift and they started to rethink their attitudes towards smoking (Bottorff, Radsma, Kelly, & Oliffe, 2009; Greaves et al., 2010). Aspirations to be good role models and

fathers were at odds with smoking, and a renewed interest in quitting followed for many men. Despite this increasing interest, few men were successful in becoming smoke-free and they pointed to the lack of tailored cessation resources and supports for new fathers (Bottorff et al., 2009). Based on our understandings of how masculinities and gender relations can connect with men's smoking, we reasoned that a father-centred approach was needed. We also were aware that smoking cessation at this time in men's lives could significantly improve their current and future health, support women's quit efforts during pregnancy and the postpartum period, provide smoke-free environments for children, and strengthen the overall well-being of their families.

Methods

As Lomas (2009) eloquently suggests, descriptive research and findings are the feedstock for health promotion interventions. While the FACET team systematically explored men's smoking in pregnancy and the postpartum period to understand smoking from the perspective of expectant and new fathers, we also had an interest in transitioning these findings towards men-centred, gender-sensitive cessation supports. A total of 12 urban- and rural-based consultation sessions were conducted in the province of British Columbia with community health professionals ($n = 4$), new fathers who smoked or quit during their partner's pregnancy or postpartum ($n = 4$), and new mothers whose male partner smoked ($n = 4$). The sessions were designed by a knowledge broker (third author) with a view to sharing the FACET research findings on fathers and smoking and to seek counsel from the participants about how best to use this knowledge to support new fathers in their cessation efforts. Following university ethics approval, the sessions were conducted over a period of 2 months in 2009.

While all of the consultation sessions were used to inform the transition of the FACET findings towards father-centred cessation interventions, the results shared in this article are drawn entirely from the data collected in the men's sessions. A total of 24 fathers, ranging in age from 20 to 59 years, participated in four 2-hour sessions. A variety of smoking patterns and socio-economic backgrounds were represented (see Table 1). Disaggregated group demographic data are provided (see Table 2) to ensure that the quotes used to illustrate thematic findings can be contextualized by linking excerpts to specific consultation sessions.

The consultation sessions, driven by the objective to promote reciprocal learning and collaborative, participatory co-production of knowledge, were purposive in their design, content, and delivery. For example, jigsaw puzzles depicting key findings from the FACET research were

Table 1 Demographic Data and Smoking History	
Participants	(N = 24)
Urban	13
Rural	11
Age	
20–29	9
30–39	9
40–49	3
50–59	3
Ethnicity	
Euro-Canadian	22
First Nation	2
Education	
Incomplete high school	6
High school	9
Postsecondary	9
Employment	
Working	13
Not working	11
Marital status	
Married	3
Common-law	16
Single	5
Parental status	
Have children	16
Average age of youngest child (years)	2.15 (SD 1.89)
Expecting first child	8
Smoking history	
Average age started smoking (years)	13 (SD 3.29)
Average cigarettes/day when smoking	13 (SD 6.78)
Changes in smoking during most recent pregnancy/postpartum period	(n = 23)
Successful quit	6
Successful reduction	2
Unsuccessful quit/reduction	5
Maintained pre-pregnancy level of smoking	10

Participants	Vancouver Group 1 (n = 7)	Vancouver Group 2 (n = 6)	Kelowna Group 1 (n = 9)	Kelowna Group 2 (n = 2)
Age				
20–29	2	1	6	
30–39	3	2	3	1
40–49	0	2		1
50–59	2	1		
Ethnicity				
Euro-Canadian	6	5	9	2
First Nation	1	1		
Education				
Incomplete high school	1		5	
High school	5		3	1
Postsecondary	1	6	1	1
Employment				
Working	5	1	5	2
Not working	2	5	4	
Marital status				
Married	2		1	
Common-law	4	6	4	2
Single	1		4	
Parental status				
Have children	4	2	8	2
Expecting first child	3	4	1	
Changes in smoking during most recent pregnancy/postpartum period				
Successful quit	1	4		1
Successful reduction	1		1	
Unsuccessful quit/reduction	3		4	
Maintained pre-pregnancy level of smoking	2	2	4	1

used at the beginning of each session, whereby subgroups (3–4 men) worked together in a bid to complete their jigsaw puzzle first. This strategy generated a faux sense of competitiveness between the small groups while eliciting intragroup collaborations that fostered camaraderie and a climate of openness to new ideas. The puzzles also provided a basis for explanation and discussion of FACET findings describing the experiences of dads who smoke. Participants' identification with the findings provided us with assurances about the representativeness of our results and the need to transition what we had found towards cessation interventions. Groups were invited to collaboratively reflect on and discuss the FACET findings, and problem-solving was encouraged as a means of identifying strategies to motivate and support cessation efforts among dads who smoked. The men were positioned as "experts" and "insiders" in relation to smoking and the challenges around cessation for dads. Participants' experiences were privileged in the attempt to distil effective supports, and the men were encouraged to be creative in scoping their recommendations for potential solutions.

The sessions were audiorecorded and the recordings were transcribed verbatim. Field notes were taken by three facilitators at each session. These notes focused on describing the group members' interactions amid the distilling of key insights drawn from the discussions. The field notes were integrated into the transcribed data to contextualize the conversations. Based on a close reading of the data, important ideas were highlighted and used to create codes. NVivo software was used to facilitate coding and retrieval of data. Data were compared within and across coding categories to identify themes. The codes were used by the research team to highlight the principles invoked to guide the development of two smoking cessation interventions for men.

Results

Despite the men's diverse backgrounds and ages, fatherhood was consistently highlighted as a life-changing event that continued to influence their lives, and participants regularly spoke openly about their infants and the fathering role they aspired to play. The men shared cessation-related testimonials that focused on balancing challenges and strategies and offered tips to one another. As well, they commended the members of the group who had initiated and/or sustained a quit. Participants also indicated that they would benefit from peer support and many expressed disappointment about the lack of programs and specific resources to help fathers reduce or quit smoking. In terms of program content and modes of delivery, participants suggested that a suite of text, face-to-face peer support, and Web-based resources would best meet men's diverse needs.

Based on the men's discussions and the suggestions put forward, we identified three program principles for the design and delivery of father-centred cessation interventions: use positive messaging to promote change without amplifying stigma, guilt, shame, and blame; foster connections between masculine ideals (e.g., strength, decisiveness, resilience, autonomy) and being smoke-free; and privilege the testimonials of potential end-users (e.g., fathers who smoke and want to quit). Based on these principles, we developed a booklet titled *The Right Time . . . the Right Reasons* and an 8-week face-to-face program, Dads in Gear (DIG), which focused on helping fathers to be smoke-free. What follows is a detailed discussion of the principles. Participants' comments are shared, as are details about how the principles were used in the development of our booklet and program.

***Use Positive Messaging to Promote Change
Without Amplifying Stigma, Guilt, Shame, and Blame***

A key direction to the participants was to focus on positive messaging to promote smoking cessation. Central were men's assertions about being viewed as dissatisfied with their smoking and genuine in their desire to quit. In this respect, participants wanted to be known as striving to smoke less instead of being labelled and judged as fathers who chose to continue smoking. Victim blaming, a feature of commentaries linking men's risk-taking behaviours to their poor health outcomes (Lee & Owens, 2002), may have contributed to their sensitivities in this regard. Also at play was the risk to others, including family, due to their second-hand and third-hand smoke. This was especially evident because British Columbia is a province known for its low smoking rates and legislation prohibiting smoking in public places. These factors may have fuelled the men's intolerance for any additional surveillance and judgements about their smoking, no matter how well intended these might be.

It was clear that the messaging had to be proactively directed towards cessation instead of amplifying the smoking-related stigma that they already endured. Participants were keen to focus on the benefits of reduction and cessation rather than on the familiar risks of smoking:

The positive association . . . I think, with the things you're trying to put over, not the negative association of the other [smoking] but the positive associations of the change. We should be focusing on the better life type of thing and the future and all that stuff. (Vancouver group 1)

Embedded in this comment, and evident throughout the sessions, is the need to support and acknowledge men's genuine interest in cessation as a means of affirming their quit efforts, regardless of the outcome of their attempts. Images that appeal to dads and language that addresses a broad

range of ability levels were carefully selected for our booklet, to reinforce positive messaging. Positive messaging approaches to men's health promotion programs were prerequisite for catalyzing men's actions towards smoking cessation (Robertson, 2007).

In terms of strategies for positive messaging, many participants said that humour might engage men. In line with findings by Oliffe, Ogrodniczuk, Bottorff, Hislop, and Gerbrandt (2009) connecting masculinities, humour, and prostate cancer, a participant suggested that men's humour could counter stigma while prompting them to continue their smoking cessation efforts:

I think it's better, instead of beating people over the head . . . to prod them in the side a bit, you know, with humour. It's just a subtle thing that appeals more to men. And guys . . . when they communicate with each other, a lot of it is humour, and it is said as banter and as jest. I think that's a way that men communicate that isn't used effectively when marketing health things. (Vancouver group 1)

Of course, there is a danger that humour, if used excessively, will dilute and even counter men's health promotion messages. While remaining cognizant of this when designing our booklet and program, we purposely kept the content light and positive as a means to engage men in thinking about smoking less or quitting entirely. This was especially evident in the DIG program, which was piloted in conjunction with community partners at a fitness centre. The 8-week program included a 2.5-hour interactive group session each week. The sessions focused on fathering, exercise, and smoking cessation and were organized around masculine themes, including hockey (this session was called Puck in the Net), card-playing (Full House), and fishing (Fishing for Answers). Interactivity was central in soliciting participants' opinions, views, and questions as a means to maximize the synthesis and uptake of the information presented. It was most often within these interactions that the men's humour emerged to foster a sense of camaraderie. It is important to note that we did not explicitly write humour or jokes into our smoking cessation resources but instead provided opportunities and a positive environment that might encourage the men to connect with each other and with the program content.

Foster Connections Between Masculine Ideals (e.g., Strength, Decisiveness, Resilience, Autonomy) and Being Smoke-Free

There is evidence that "Big Tobacco" has for many years understood and marketed masculine ideals to sell cigarettes to men. White, Oliffe, and Bottorff (2012) chronicle a long history of cigarette consumption being both shaped by and influential in determining masculine ideals. Less

often discussed are the manly virtues associated with being smoke-free. Participants were adamant that men's strength, decisiveness, and resilience are lynchpins in convincing them that they can quit and perhaps sustain a quit. In turn, becoming smoke-free by mobilizing these masculine ideals could affirm non-smoker identities as manly once that end-goal is achieved. "If you can associate non-smoking with your hometown hero," one participant suggested, being a lifelong non-smoker and quitting smoking might be seen as masculine.

Aside from achieving the end-goal of being smoke-free, the fortitude to maintain a smoke-free identity affords opportunities for men to embody a set of highly valued masculine ideals. Extending this idea, many men suggested that seeking help and/or using strategies other than will power could be reconfigured as the actions of resourceful men committed to smoking cessation. The strength to protect and provide for family was idealized, and attempts by others to restrict the use of cessation aids, including NRT, was defended. One man who used NRT patches to bolster his chances of sustaining a quit refuted the authority of other men to police his strategies for becoming smoke-free:

Most people are all for it . . . You've got to be a bit of a knucklehead to be teasing someone that wants to do something good for himself. (Kelowna group 2)

Also on the subject of NRT patches, another participant suggested that not trying the patches could be viewed as representing weakness:

If there's a way you can stroke a guy's ego by marketing to a guy — I don't quite know how to word this, but "you're a manly man if you use the patch," as opposed to wimping out by not trying it. (Vancouver group 1)

Our booklet incorporated men's responsiveness to reformulating masculine ideals around smoke-free identities and to overcoming the challenges to sustaining a quit. A key strategy for doing so was to play on the dissonance that men expressed about their smoking by challenging the reader to consider his identity as a father by contrasting what it means to be "a guy who smokes" with being "a dad who smokes and wants to quit." Quotes by fathers were used to highlight the strength that men need in order to address such internal conflict.

While participants stated that some cessation strategies are more likely to succeed than others, and that these vary across men, there was consensus that health promotion resources that provide an abundance of information and cessation strategies are likely to engage men. Most men had tried various quit options and had abandoned hope of ever finding a sure-fire cure. They acknowledged that, ultimately, they had to choose

their own path to being smoke-free. One participant explained that, although it was sometimes difficult to predict when men might quit, ultimately it occurred on their own terms:

It's kind of hard to convince anybody to quit anything. You have to want to do it yourself. (Vancouver group 2)

Another man said, "If you want someone to quit, it has to be of their own free will." Another suggested that a decisive commitment is key to quitting: "... the desire — if you're serious, you're there."

Unlike many prescriptive, step-wise approaches to smoking cessation, our booklet and program were designed to encourage autonomous decision-making. The content was intended to appeal not only to men's desire to know the facts about smoking and cessation but also to their interest in everyday, practical solutions designed by other men to fit into their lives. In addition, the DIG program engaged men in physical exercise in support of the masculine desire to be strong and fit, to perform at work, and to take a male approach to stress management. It was also thought that conducting the DIG program in a gymnasium would signal, and indeed facilitate, opportunities for the men to be physically active.

***Privilege the Testimonials of Potential End-Users
(i.e., Fathers Who Smoke But Want to Quit)***

Central to the men's narratives were aspirations to be great fathers amid acknowledgements that they had underestimated the extent to which fatherhood would change their lives. A number of participants had recently become dads:

The best time [to reduce or quit] is when they find out they're going to be a father. Then they're going to try everything to try and do the right thing. (Vancouver group 2)

This and many other comments signalled fatherhood as a time of uncertainty but great potential for transforming the way men thought about their lives, and how smoking was discordant with the kind of fathers they wanted to be. The authenticity and candour with which participants talked about being a dad permeated and often book-ended their narratives about smoking. Yet it was predominately through the shared experience of fathering — rather than smoking — that the men connected with one another in the sessions.

Smoking practices and fatherhood were but two of many changes that men experienced:

Supporting Fathers' Efforts to Be Smoke-Free

When I actually saw the baby, that's when it clicked to me that I'm a father and I got to think about making some changes. (Vancouver group 2)

In this regard, rather than being a compartmentalized change, smoking cessation emerged as one among many transformations, and participants positioned this as benefiting their quit attempts:

. . . once you got that newborn in your hand — I mean, it's like the world stops. That's the moment that you're thinking about the future, and how much your life has changed — changed so much now, why not go that extra step? (Vancouver group 1)

Another participant said, “Change is coming, change is here, change is now.” Some men understood the changes as including the pregnancy, but for most men the birth of their child was the epiphany, signalling the need to re-evaluate their smoking:

That wakes you up a lot, makes you think, man, do I really want this [smoking] around my kids? I tried, but I'd find myself sneaking off outside the house or whatever having a cigarette. It becomes like a little secret. (Kelowna group 2)

Alignment with dominant discourses about contemporary fatherhood that position men as “present” in the direct care of the child (as distinctly different from being an absent provider) was also evident. Men's smoking cessation was also used to renew masculine ideals around being physically fit and active as a means of fostering family connection. One man described an urgent need to be sufficiently fit to engage fully with his child in the long term:

I want to quit because I wheeze, I can't breathe properly, and I can't run, probably, to the end of the block any more . . . and I'm only 28. (Kelowna group 1)

The men listened attentively to each other's stories about being a father, and they encouraged each other, provided suggestions, and applauded each other's successes. Many men were adamant that the best way to support dads was to hold group sessions where men could help each other quit smoking by sharing their experiences:

If you were serious about quitting you could go to the group . . . And you'd have to show your dedication to it . . . you'd have to prove to you that you want to quit, then they're going to quit. (Kelowna group 2)

The DIG program included activities that were structured to reinforce and support men's desire to be “good dads” and to work on their

fitness and on their confidence and skills with respect to fathering. Positioning DIG participants as men who were committed to being good dads also supported a camaraderie that allowed men to share stories and advice about being a father, talk about their children, and reinforce their active engagement with fathering. It was in this context that men engaged with smoking cessation resources and shared experiences of past and current quits.

Conclusion

Men-centred health promotion programs are in the nascent stage of development and, while responding to many of the recommendations made by the participants, the resources that we have developed require formal evaluation to fully assess their acceptability to end-users. That said, the way in which principles derived from men's perspectives and suggestions for cessation support that were taken up in the print and face-to-face father-centred interventions provide direction for the design and delivery of men's health promotion programs. Our research shows clearly that when men are given an opportunity to share their views, much can be learned from them about their health. The use of positive messaging, connections with masculine ideals, and privileging men's testimonials, reflected in the program principles described in our findings, provide a foundation for redesigning approaches used to influence men's health.

While these principles can support men's efforts to reduce their smoking or to quit, we acknowledge that the masculine ideals that inform them are prevalent in Western culture, which routinely marginalizes the sociopolitical circumstances of many low-income and ethnic-minority fathers. There is clearly a need for refinement and adaptation of the principles for specific subgroups of fathers. Understanding masculinities as plural within and across men, for example, suggests that nurses can work with men to highlight the array of healthy practices that legitimately qualify as manly. Given that masculinities are relational and co-constructed, nurses can be highly influential in granting men "permission" to abandon entrenched masculine ideals that describe "real" men as risking rather than promoting their health. In the specific context of men seeking cessation advice, nurses can affirm men's help-seeking as strength-based, so that men's strategic mustering of all available resources to overcome a "problem" is understood as rational and wise, a manly choice. In addition, nursing, as a largely female profession, can engage in traditional health-based gender relations in which women (including mothers, wives, and female nurses) are the primary health advisors to men in clinical settings and/or the men in their lives (Lee & Owens, 2002). In line with Miers (2000), we propose that nurses focus on

encouraging men to control their personal risk-taking while simultaneously addressing the patriarchal and socio-economic processes that are destructive to men's health. For example, our program principle that benefits can be drawn from working with masculine ideals to be smoke-free should be understood as distinct from being complicit in sustaining men's behaviours that risk their own health and that of others.

In addition to the empirical findings, the methods used in our research offer important insights. As Poole (2012) suggests, including end-users early on, and where possible throughout the research, is a key component of effective knowledge translation. Involving dads who smoke helps to distil the challenges and potential remedies with regard to fathers who smoke. Nurses have many informal opportunities to query potential end-users about their perspectives. If such queries are explicitly posed in clinical practice, before programs are designed, much can be learned to bolster men's uptake of health services.

In considering additional options for delivering our father-centred cessation interventions, the Web seemed a logical next step. The Web has been touted as changing the way men's health promotion is done (Robinson & Robertson, 2010). While emergent, the literature reveals that men turn to the Web for health promotion (Bock, Graham, Whiteley, & Stoddard, 2008). This trend is attributable to the private nature of the Web and the wish to avoid the threats to masculine ideals that can be invoked by health-care providers. Our decision to develop the DIG program online was also influenced by the participants' need for flexibility in terms of when and for how long they accessed its resources, especially since those in the face-to-face DIG would likely have to juggle other commitments, including work, in order to attend all of the sessions. While the patterns of men's Web usage for health are not well understood (Evans, 2007), by expanding the reach of our DIG program and evaluating its uptake on the Web, much needed empirical insights into the ways in which fathers interact with online health promotion programs will be collected. Moreover, opportunities to gain insights into end-users' literacy levels during the testing phases will provide direction for the development and content of the Web program. Such data are key to enhancing our knowledge about the viability of online health promotion programs for men.

In conclusion, nurses play an integral role in promoting men's health, and, while detailed here in the specific context of fathers' smoking cessation programs, the insights shared can be used in an array of men's health programs. By recognizing how we can work with men's specific health and illness practices, rather than assuming that their alignment to masculine ideals leads to poor health outcomes, nurses can make available and legitimize many healthy options for men.

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Résumé

**Toucher les adolescentes au moyen
du réseautage social : une nouvelle avenue
pour les messages de prévention du tabagisme**

**Laura Louise Struik, Joan L. Bottorff,
Mary Jung, Claire Budgen**

L'industrie du tabac utilise à présent les sites de réseautage social pour cibler les adolescentes. Pour combattre cette publicité, il faut créer de nouvelles initiatives de lutte contre le tabagisme (LT) en ligne. La présente étude descriptive interprétative visait à explorer la vision qu'ont les adolescentes de l'utilisation des sites de réseautage social pour diffuser des messages de LT ciblant les jeunes femmes. Des groupes de discussion ont été formés avec 17 filles âgées de 16 à 19 ans. Sept messages de LT ont été utilisés à des fins d'évaluation et ont servi de contexte pour la discussion sur la diffusion de messages de LT dans les sites de réseautage social. L'analyse des données a permis de dégager certains thèmes, y compris les préoccupations relatives à l'efficacité des messages actuels de LT et les représentations stéréotypées du genre, les facteurs perçus comme influençant l'efficacité des messages de LT sur les sites de réseautage social, et les suggestions pour améliorer l'efficacité des messages de LT placés dans les sites de réseautage social. L'appui aux messages de LT dans les sites de réseautage social laisse entendre que ce moyen de communication est une ressource inexploitée pour la prévention du tabagisme.

Mots clés : tabagisme, genre, lutte contre le tabagisme, adolescentes, sites de réseautage social

Reaching Adolescent Girls Through Social Networking: A New Avenue for Smoking Prevention Messages

**Laura Louise Struik, Joan L. Bottorff,
Mary Jung, Claire Budgen**

Because adolescent girls are being targeted on social networking sites by the tobacco industry, new online tobacco control (TC) initiatives are needed. The purpose of this interpretive descriptive study was to explore adolescent girls' perspectives on the use of social networking sites to deliver TC messages targeting young women. Focus groups were conducted with 17 girls aged 16 to 19. Seven TC messages were provided for evaluation and as context for discussion about the delivery of TC messages on social networking sites. Data were analyzed for themes, which included concerns about the effectiveness of current TC messages and the stereotypical representations of gender, factors perceived to influence the effectiveness of TC messages on social networking sites, and suggestions for enhancing the effectiveness of TC messages placed on social networking sites. Endorsement of TC messaging on social networking sites suggests that this medium is an untapped resource for smoking prevention.

Keywords: tobacco use, technology, health promotion, women's health, youth health, gender

Introduction

Despite trends showing that rates of cigarette smoking among Canadian youth are decreasing (Health Canada, 2012), smoking among adolescents remains a critical public health concern. Advances in technology and the rapidly increasing use of social media have created new challenges and opportunities for tobacco control (TC). TC policies have forced the tobacco industry to be more creative in its marketing approach. As a result, tobacco companies are using the Internet and its social networking sites as unregulated media for advertising to adolescents, especially girls (Freeman & Chapman, 2007; Jenssen, Klein, Salazar, Daluga, & DiClemente, 2009). These advertising tactics take advantage of trends indicating that adolescent girls are common users of social networking sites (e.g., Lenhart, Madden, Macgill, & Smith, 2007) and are more frequent communicators on social networking sites, such as Facebook, than

boys (Hargittai, 2007; Lenhart et al., 2007). It is critical, then, that social networking sites be explored for their potential to deliver TC messages directed towards adolescent girls in an effort to counter the effects of pro-tobacco advertising and prevent smoking uptake by girls.

Research involving the use of social networking sites, such as Facebook, for TC initiatives has only just begun. A few studies have reported that social networking sites are a favourable medium for reaching youth with health information (Moreno et al., 2009; Team Shan, 2011). Based on a survey of 167 young women aged 17 to 29, Team Shan found that social networking sites were a preferred medium for receiving information about breast cancer risks, including smoking. However, researchers have yet to investigate what types of images, content, and delivery strategies are preferred among adolescent girls for receiving tobacco-related health information in this medium.

The purpose of this study was to explore adolescent girls' perspectives on the use of social networking sites to deliver TC messages directed towards young women. Special attention was paid to girls' evaluations of and suggestions for modifying current TC messages that specifically target girls for use on social networking sites. An understanding of how young women perceive TC messages and their thoughts about delivering these on social networking sites will provide an important foundation for efforts to improve smoking-prevention strategies targeting adolescent girls.

Methods

Study Design

Interpretive descriptive methodology (Thorne, 2008) was used for this focus group study. The purpose of interpretive description is to identify patterns and themes relating to the phenomenon of interest so that new understandings of it from the viewpoints of particular individuals are brought forward (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). Interpretive description is used to develop knowledge that will inform practice (Thorne et al., 1997) and thus is aligned with the aim of this study, which was to inform the development of social networking-based TC strategies directed towards young women. The focus group method was used because it is a flexible approach to learning about the ideas and opinions of groups and is considered an excellent way to gather information from adolescents (Creswell, 2007). Focus groups have also proved valuable in assessing the needs of target groups in order to develop meaningful and effective health promotion programs (Heary & Hennessy, 2002).

Ethical approval for the study was obtained from the Behavioural Research Ethics Board at the University of British Columbia Okanagan.

Recruitment

To recruit adolescent girls for the study, we contacted staff at community and education centres serving youth and requested their permission to hold a focus group at their site and their assistance with reaching young women through a recruitment poster. The recruitment poster was also posted as an advertisement on Facebook. To be eligible, girls had to be between the ages of 15 and 18. Because 13 and 14 are the required ages to open an account on Facebook and MySpace, respectively, girls can be expected to have some experience with social networking by age 15. Additional eligibility criteria were previous or current use of Facebook or MySpace and ability to converse in English. Both smokers and non-smokers were eligible. All participants provided informed consent. Because all participants were of the legal age (16 years) to provide informed consent in the jurisdiction where the study was conducted, parental consent was not required. An honorarium of \$40 was provided at the end of the session to compensate participants for their time and travel costs.

Sample

The sample comprised 17 girls aged 16 to 19 (4 high-school students, 12 university students, 1 member of the workforce). The majority of the participants ($n = 15$) described themselves as Caucasian; one described herself as Filipino and one as Korean. While 11 participants self-identified as non-smokers and 6 as smokers, only 4 indicated being addicted to tobacco and to have smoked in the past month.

Most of the participants went online regularly and felt comfortable navigating the Internet. Almost all sought health information on the Internet and six reported that they sought information specifically on the topic of smoking. All participants had a Facebook profile and four had a MySpace profile. Most participants signed onto their Facebook site regularly (2–10 times/day). Participants with a MySpace profile reported that they did not visit this site as often as they visited Facebook. All of the participants had a large number of Facebook “Friends”; none had fewer than 100 and a few specified having 700 or more.

Data Collection

The primary form of data collection was three semi-structured focus groups consisting of eight, five, and four girls. In keeping with guidelines for focus group methodology (Krueger & Casey, 2009) and the age of the target group, a topic guide that incorporated open-ended questions, activities, and stimulus materials (TC messages) was developed to encourage active involvement and discussion on key issues without restricting

openness of response. Similar approaches to the design of focus group discussions have been used successfully with adolescents and young women (Bottorff et al., 2010; Heary & Hennessy, 2002).

Two of the focus groups were conducted in a meeting room at the University of British Columbia Okanagan and one in a meeting room at the YMCA. In keeping with gender-sensitive research, the study used a female moderator and two female research assistants to assist with data collection. After signed consent was obtained from each participant, the focus group sessions commenced and were audiorecorded for transcription. Field notes were used to enhance the recorded information with observations about the interview process and the content. The sessions lasted approximately 2 hours.

Selection and description of TC messages for focus group sessions. We included a selection of existing TC messages as stimulus materials in the focus group discussions because they provided a useful starting point for developing TC messages for use on social networking sites. In addition, we reasoned that the messages were an effective tool for engaging young women in a discussion about TC messages and ways these could be integrated into social networking sites. We selected seven TC messages targeting young women. Because the Internet sources various types of TC message intended for many different media, the messages were selected from several different Web sites. This allowed for evaluation of various messages presented by different health organizations and agencies. The selection of messages was based on our desire to present a variety of images and different depictions of smoking. Because it is well documented that messages used for health promotion are often embedded with specific representations of gender (Greaves, 2007; Haines et al., 2010), we also included messages that expressed a variety of representations of gender. The names of the selected TC messages are as follows: The Truth, Poster Child, America's Next Top Model, Chic?, Above the Influence, Cigarettes Smoke People, and Live to See It. Table 1 provides an overview of the messages, which were presented to the participants in poster format.

In relation to representations of smoking, Poster Child was the only message that included detailed information to educate young women on the health risks of smoking. Most of the other messages included only a brief caption and a picture to raise awareness. America's Next Top Model featured no wording or caption. The TC messages typically depicted body image as a reason for young women to avoid tobacco, limiting the negative outcomes of smoking to physical appearance (e.g., Chic?). The messages were also determined to have an individualistic focus because most featured a single female image. Fear-appeal is frequently used in

messages targeting youth, as it was in the selected TC messages (e.g., depiction of a woman with a tracheotomy).

In the selected TC messages, gender was often reflected in representations of femininity and female sexuality through the image of an attractive, slender body. The underlying assumption was that the gendered role of females entails maintaining sexual attractiveness by keeping slim. Many of the young women in the TC messages were depicted in stereotypically sexual ways, such as caressing a cigarette (e.g., *Cigarettes Smoke People*) or with their mouths slightly open (e.g., *The Truth*). Also, most of the messages depicted a lone female in a passive position disconnected from the world and somewhat docile and dependent, her feminine identity hidden and insignificant. Two of the fear-based messages featured headless female bodies, reinforcing the notion of physical attractiveness as an important feminine attribute.

Focus group sessions. The focus groups began with a survey to collect data on demographics, smoking status, and Internet use. Following an “ice-breaker” activity, participants were asked to provide reactions to and evaluations of the seven selected TC messages by answering three questions on a board located beside each message displayed as a poster: (1) What do you like about this message and why? (2) What do you not like about this message and why? (3) What would you change about this message and why? The participants were then asked to identify their two favourite messages and the two they liked the least, marking them with “thumbs up” and “thumbs down” stickers. The purpose of this exercise was to encourage further individual reflection on the different ways in which TC messages are directed towards young women. The participants were then invited to discuss their evaluations of the messages as a group. Open-ended questions were posed to facilitate discussion about features of the TC messages that would influence their effectiveness if delivered on social networking sites and about changes that might improve TC messages targeting girls on social networking sites — for example, “If we posted this message on Facebook and MySpace, do you think it would be effective at reaching girls your age? Why or why not?” Because Facebook and MySpace are known to be the most popular social networking sites, they were the focus of discussion. Finally, we consolidated participants’ suggestions for developing and delivering TC messages on social networking sites by giving them a printout of a Facebook page and asking them to suggest ways to make the messages more receptive to young women in this medium.

Data Analysis

Transcripts of the focus groups were analyzed through constant comparison (Corbin & Strauss, 1990), an analytical approach recommended by

Message	Message Overview	Source
The Truth	The Truth.com is run by the American Legacy Foundation, which was founded under the terms of the Masters Settlement Agreement to prevent teen smoking uptake. This message displays a teenage girl (from her mid-section to her cheeks) holding a cigarette. A white dotted line encircles her larynx and the cigarette, and the message challenges the reader to “remove one.”	http://theinspirationroom.com/daily/2008/truth-remove-one/
Poster Child	The British Columbia Ministry of Health and NOW Communications of Vancouver collaborated to depict the damage that a young girl could sustain. This message shows a girl holding a cigarette, with areas of her body highlighting visuals of tobacco-related damage. A description is provided for each visual.	http://tobaccocontrol.bmj.com/content/8/2/128/F2.large.jpg
America’s Next Top Model	America’s Next Top Model Anti-smoking Campaign focused on the side effects of smoking for young women. There were several messages portraying a different side effect. This particular message depicts a beautiful model with long hair holding a cigarette, but in the mirror she sees a sad woman who is bald due to chemotherapy.	http://www.myinterestingfiles.com/images/2008/03/anti_smoking_campaign_from_america_top_model_7.jpg
Chic?	This message was developed by the World Health Organization for 2010 World No Tobacco Day. It depicts a beautiful young woman who has a tracheotomy because of her smoking habit.	http://www.who.int/tobacco/wntd/2010/en_wntd_2010_chic_no_throat_cancer.pdf
Above the Influence	This message was produced by the Vigilante advertising agency for Above the Influence (for Partnership for Drug Free America) as part of a substance-abuse campaign. Above the Influence’s main approach to preventing substance abuse is to encourage teens to resist peer pressure and societal influences. This message depicts a teenage girl and text expressing her decision not to be drawn into drugs or alcohol.	http://adsoftheworld.com/media/print/above_the_influence_partnership_for_a_drugfree_america_i_do_me

Smoking Prevention: Reaching Adolescent Girls Through Social Networking

Message Title	Year Developed	Year Accessed	Country of Origin	Format	Tone	Aim
Remove One	2008	2010	United States	Campaign poster	Negative	Education/ awareness
Tobacco Industry's Poster Child	1998	2010	Canada	Campaign poster	Shocking	Education/ awareness
Bald From Chemo	2008	2010	United States	Campaign poster/ picture	Negative	Education/ awareness
Chic? No, Throat Cancer	2010	2010	Switzerland	Campaign poster	Shocking	Education/ awareness
I Do Me	2010	2010	United States	Web site/ poster	Positive	Empowerment

(continued on next page)

Message	Message Overview	Source
Cigarettes Smoke People	The Cancer Patients Aid Association ran a print campaign by the Canadian company Bleubancrouge. This message is set in a bistro where there are only two female disembodied arms burning down like a cigarette. It is meant to illustrate how addiction controls and devours its hosts.	http://spaceinvaders.com.br/2009/02/09/ccpa-cigarettes-smoke-people/
Live to See It	This message was developed by Neogama/BBH for ADESF to show that smoking will prevent people from living to see interesting future developments, such as rising temperatures, as demonstrated in this message. This message displays naked Barbie-like females walking city streets.	http://adland.tv/ooh/adesf-institutional-stop-smoking-now-future-live-see-it-print-brazil

Thorne (2000) for studies using interpretive description to develop understandings of the participants' experiences of the phenomenon. Analysis began with the coding of data segments by comparing the data and making notations in the margins. Broad categories developed from this analysis were then further reviewed and critically analyzed, resulting in more refined categories and subcategories. This process was facilitated by asking iterative, analytic questions (e.g., what is happening here?) and engaging in reflective, critical examination of the data to identify underlying meanings and explanations (Thorne et al., 1997). Transcripts and field notes were also reviewed in an iterative manner, to ensure that all emergent themes and subthemes were captured. Representative quotes were selected from the transcripts, poster comments, and Facebook pages to illustrate key themes and subthemes.

Results

The young women who participated in the study were receptive to the use of social networking sites for the delivery of TC messages directed towards them and believed that this medium holds distinct advantages in reaching young women. However, their evaluations of the selected TC messages targeting young women suggested that there are important considerations in developing effective TC messages for this medium. Their perspectives were captured in three broad categories: (1) participant eval-

Message Title	Year Developed	Year Accessed	Country of Origin	Format	Tone	Aim
Cigarettes Smoke People	2009	2010	Canada	Campaign poster	Shocking	Education/awareness
Live to See It. Quit Smoking Now	2008	2010	Brazil	Campaign poster	Positive	Provocation

uations of TC messages, (2) factors perceived to likely influence TC message effectiveness on social networking sites, and (3) suggested changes to TC messages for use on social networking sites.

Participant Evaluations of TC Messages

Participants thoughtfully considered the seven selected TC messages targeting young women and were forthright in offering their perspectives on the effectiveness of the approaches used. Their evaluations were grouped in relation to overall evaluations, images/messages associated with smoking, and female/gendered issues and representations.

Overall evaluations. In general, the participants were critical of the approaches used to reach young women. They thought that many of the TC messages lacked clarity, were unrealistic, or contained too much written information. The lack of clarity was related to confusing or insufficient information. For example, the statement “remove one” in The Truth, referring to the choice between a cigarette and an intact throat, was viewed as confusing because it was not presented as a question. Several messages were considered too unrealistic to make a relevant connection between the girls and the message foci. For example, there was consensus that Live to See It was “too fake” because it contained Barbie-like females, a cartoon image, and a hypothetical situation. The participants also said that some of the messages contained too much information. For example, they thought that the picture in the Poster Child

message made a “strong point” about the dangers of smoking but found the amount of written information “overwhelming to the viewer.”

Images/messages associated with smoking. Not surprisingly, many of the comments concerned the images/messages associated with smoking. These related to the lack of meaningful contexts represented in the messages, the use of fear-appeal messaging strategies, and fostering a personal connection.

The concern about the lack of meaningful contexts in the messages reflected a wish to see contexts that resembled one’s own everyday experiences. For example, when discussing the Poster Child message, the participants spoke of their preference for images of girls doing things that they could identify with: “Put her in situations that we’d be in, as opposed to just standing there.” Some also criticized the individualistic focus of the messages and said they preferred messages that demonstrated the effect of smoking and second-hand smoke on significant people in their lives:

I just realized that all of these posters are about you, like, an individual smoking, but not about how it affects other people, like, second-hand smoke. I think it’s important to bring that out and let smokers know that you are killing your friend, your family member, just people around you, so it’s not just about you.

The use of fear-appeal messaging strategies was a subtheme threaded throughout the young women’s conversations about the smoking image/message, although there were differences of opinion on this topic, particularly between the smokers and non-smokers. Those who smoked were adamant about their dislike for “sugar-coated” messages, their comments reflecting an appreciation for messages that arouse fear. One participant who smoked said that “scarier images” were more effective:

I think that the scarier images are the more effective ones because they are, ultimately, more truthful. It’s not sugar-coated, it’s just, like, this is what’s going to happen. So having the truthful images like the poster [Poster Child] over there [is] more effective because it [shows] what’s actually going to happen.

The participants who smoked also said that fear-based messages prompted them to “contemplate” changing their behaviour. Those who did not smoke, however, perceived fear-appeal messages to be ineffective because they elicited a negative affective reaction. They did not like being “scared” or “grossed out.”

The focus group discussions also included noteworthy dialogue about messages that were perceived to foster a personal connection with the viewer, such as prompting the viewer to consider making a decision

about smoking or challenging socially accepted ideas about smoking. For example, all of the participants liked the fact that The Truth invited the viewer to think about the decision in relation to whether or not to smoke and the consequences of that decision.

Female/gendered issues and representations. The participants' comments on gendered issues and representations in the TC messages were focused on how young women were portrayed in the messages. The discussions centred on female sexuality, self-assurance, emotional expression, and the balance between beauty and health within the messages.

The messages prompted discussion about the use of female nudity and sexuality in TC messages and concerns about exploiting women and portraying them as sex objects. Some of the participants appeared to be frustrated and offended by some of the TC messages:

It's just like every TV commercial, or something that has to do about women. It usually involves sex or looks, and that shouldn't matter at all. Like, we women should just be loved for who we are. It doesn't matter if they are fat, skinny, muscular. [It] doesn't matter — they are just the same. I don't know. I just I hate it when they make women look like sluts.

The participants wanted to see expressions of self-assurance, such as confidence or sophistication, in the representations of women. They thought that this would make the message more impactful for girls their age, for whom these attributes are important. For example, one participant spoke about the sophisticated disposition of the young woman in America's Next Top Model: "I would look at this message, because, besides the cigarette, this girl is sophisticated and I would possibly strive to be more like her."

There was also discussion about the emotional expressions reflected in the messages and how these demonstrated the negative effects of smoking. Participants believed that the expression of negative emotions such as sadness, loneliness, and regret would have enhanced the effectiveness of the messages because these are emotions that most people want to avoid. Concerns were expressed about the perceived inappropriate emotional expression of the woman in the Chic? message. The participants thought that her expression should have reflected how upsetting it would be to have a tracheotomy. They saw her as "flaunting her throat cancer and didn't seem upset by it." It was also noted that the effectiveness of messages depicting headless/faceless female bodies or bodiless limbs might be limited by the absence of emotional expression. For example, in her poster comment on The Truth, one participant said, "I wish her whole face was shown to be able to see what her emotions are."

Discussion was also generated by perceptions of how the TC messages focused on beauty rather than health. This subtheme was carried through

the discussions on several of the messages, with many of the young women stating that there was too much emphasis on physical attractiveness and not enough on health and well-being: “Make it more about your life, not just vanity.”

Factors Perceived as Likely to Influence TC Message Effectiveness on Social Networking Sites

The young women were invited to discuss factors that could be expected to influence the effectiveness of TC messages on social networking sites. The discussion centred on four topics: instant impact, message novelty, portrayal of women as self-assured, and gender stereotyping.

Instant impact was described as essential if TC messages delivered on social network sites were to be effective in attracting the attention of young women. For an anti-smoking message to have instant impact, according to the participants, it must be easily comprehensible and readily understood. They explained that, since they spent little time looking at advertisements on social networking sites like Facebook, instant impact was very important:

When you're on Facebook, everything's really quick [and] gets at you right away. You want to get to that information as quick as possible, because you're not going to put a lot of time into looking at these.

Some of the TC messages were described as having this kind of instant impact. Regarding the Chic? message, for example, participants thought that viewers would “get the message right away” because it was simple (consisting primarily of a picture and the caption “Chic? No, throat cancer”) and stood out due to its bright-yellow lettering.

Novelty also helped to create the kind of strong image considered suitable for TC messages on social networking sites. Participants found the novel image in Cigarettes Smoke People engaging and said it would motivate them to click on the message: “Since you don't know what it is . . . or . . . see stuff like that . . . you click on it.”

There was a noteworthy discussion about how the self-assured image of the teenage girl in Above the Influence would make the participants want to click on it. Since the girl in the message demonstrated confidence in and satisfaction with her decision not to be enticed into alcohol or drug use, they were drawn to the message. The participants explained that these self-assured attributes were what they aspired to.

The use of stereotypical gendered images of women was thought to hinder the receptivity of young women to the TC messages on social networking sites. All of the participants said that portraying girls as “sex objects” did not “appeal” to them and detracted from a message's effectiveness. A TC message featuring a stereotypical image of a woman was

even perceived to be something that would be “clicked on mostly by guys.”

Suggested Changes to TC Messages for Use on Social Networking Sites

The participants made suggestions for enhancing the effectiveness of TC messages on social networking sites. Their thoughts about delivering TC messages on these sites, as well as their ideas about how to design TC messages that appeal to girls in this medium, were captured in three themes: interaction, animation, and positive message framing.

Interaction. There was considerable discussion in the focus groups about the need for TC messages on social networking sites to have interactive elements. The participants discussed several different ways that interactivity could be incorporated into the messages, such as through social sharing/broadcasting, media games, and information links.

“Social sharing” is a term used to describe how social networkers broadcast their thoughts and activities through certain features built into social networking sites. For example, in their comments about Facebook, the young women identified several Facebook options into which a TC message could be integrated, such as News Feeds, Group Pages, Fan Pages, Walls, and Like/Dislike options. The participants thought that receptivity to TC messages would be enhanced more through the use of these features within the social networking medium than by displaying them as stand-alone messages in the sidebar of a Facebook page, which is where most advertisements and messages are displayed. They said they would be more inclined to look at TC messages if they were integrated into these social sharing features, because these are safe and reliable areas:

I just don't know where [messages in the sidebar are] taking me, so I don't go there, but if it was actually part of Facebook somehow, or just posted somewhere and a bunch of people were Liking it [and] it was being passed through the Walls, then I'd be more interested in it.

The young women also suggested that providing the option to “play” with the information in the messages would draw them in. For example, their comments about the Facebook page said that viewers could be asked to “draw with their mouse” or scroll onto areas that would expand with information once they clicked on it. Using Poster Child as an example, one participant suggested that written information about the effects of smoking could be made visible by “scrolling the mouse along the body.”

The participants pointed out that social networking sites could facilitate access to the detailed information needed to improve the effectiveness of TC messages without overwhelming the viewer. They believed that having one simple message was not enough to inform young

women about smoking and that messages need to lead users to further information so they can “learn from it and apply it to their lives.” Detailed information could be provided in interactive, user-centred ways:

Maybe something to grab your interest and then have a whole host of pages where you have information [and] you have some kind of interaction where you could post things or ask questions or something like that. Because if you just have one thing, then it doesn't give you anything so that you can do something with the information that you gather. And if you try to cram too much onto one picture, you kind of draw away from it.

Animation. The participants also recommended incorporating animation into TC messages on social networking sites, to attract the attention of young women and ensure instant impact. It was suggested in the Facebook page comments that TC messages “pop up” and incorporate “flashing” or other types of movement in key elements of the images and text:

I think including animation would make it stand out, because a lot of the side ads are still images and we ignore it — like, no one actually looks and reads it, but if the smoking ad is flashing or moving in some way, then people would be like, “Oh, what's that?”

Positive message framing. Also noteworthy was a preference expressed by both smokers and non-smokers for TC messages that have a positive orientation when delivered in a social networking context. Some of the young women who smoked, for example, expressed a preference for messages that portray the positives of quitting: “Push that you can get a fresh start.” Some of the non-smokers also said they would be inclined to click on TC messages that demonstrate the positives of not smoking: “I think it would be a really effective way to advertise if the focus is [to show] that you can really have fun, have an active social life, and connect with your peers over things that are not smoking.”

Discussion

This is one of the first studies to explore the perspectives of young women on the use of social networking sites for the delivery of TC messages. The participants were receptive to the use of this medium for TC messages directed towards them and believed that this medium has distinct advantages in reaching young women. This finding is supported by the results of a recent survey of 167 young women aged 17 to 29 in which participants suggested that social networking sites would be an effective means of messaging girls about smoking in relation to breast cancer (Team Shan, 2011); the authors state that this represents a signifi-

cant change from their 2008 survey, in which young women reported a preference for print materials.

The participants made some important suggestions for enhancing the effectiveness of TC messages on social networking sites. Their suggestions related to the way that TC messages are integrated into social networking sites through the use of interactive media, including social sharing/broadcasting features. Moreover, the participants indicated that the social networking medium presents unique opportunities to effectively meet their information needs. These suggestions are consistent with the Web 2.0 context, where online information is characterized by interactivity, user-generated content, and multi-directional communication flows (Schein, Wilson, & Keelan, 2010). It has been suggested that new media channels, such as social networking sites, allow users to access the information that is most appropriate for them — relevant and personally engaging (Fotheringham, Owies, Leslie, & Owen, 2000) — thus enhancing tailored health interventions. Traditional media, such as television, radio, and print, simply do not have this potential for individual tailoring and interactivity of health interventions (Bennett & Glasgow, 2009).

Participants' preferences for negatively or positively framed TC messages varied based on their smoking status when evaluating messages intended for traditional media. However, both smokers and non-smokers preferred messages that encouraged or reinforced positive health behaviours associated with being smoke-free and were intended for use on social networking sites. Since women join social networking sites for the purpose of enjoying themselves and having positive experiences (Lin & Lu, 2011), this may be an important consideration in designing TC messages for social networking sites. The focus group discussions highlighted the need to consider the smoking status of the target audience, as well as how different media might influence the effectiveness of particular TC strategies.

The young women's discussions pointed to the importance of adopting age-specific messaging strategies that acknowledge the different transitions that adolescents in particular age groups may go through. It has been suggested that TC advocates must become aware of the different developmental stages of adolescence when creating tobacco prevention messages, because this will have a significant impact on their effectiveness (Vardavas, Connolly, Karamanolis, & Kafatos, 2009). New research specifically indicates that directly involving young women in developing health promotion strategies and including their voices is a way to ensure targeted, age-specific messaging (Bottorff et al., 2010; Team Shan, 2011). The viewpoints of the participants in the present study hold potential for guiding the development and evaluation of tailored TC messages that resonate with young women on social networking sites.

One of the most striking findings is that many TC messages directed towards girls are underpinned by assumptions about gender. There appears to be a long history of discrepancy between what TC advocates think is effective and what young women and experts in women's health consider effective. The TC movement has a history of uncritically advancing TC messages that do not promote equity among women but, rather, exploit women by playing into dominant views of gendered roles and femininity (Greaves, 2007). Researchers who have analyzed breast cancer messages targeting young women have been critical of the sexualized images and messages used by experts to raise awareness about the risk of breast cancer; they note the potential value of alternative messages about breast cancer, produced by young women for young women (Haines et al., 2010). Based on these findings, Haines et al. (2010) conclude that promoting health and well-being would likely be a more effective health promotion messaging strategy for young women than focusing on physical appearance. In a similar vein, the participants in the present study expressed concern about the stereotypical presentations of women (i.e., sex objects) in TC messages and suggested that stereotypes be avoided in order to improve the effectiveness of messages targeting young women. These findings highlight the importance of ensuring that TC messages are gender-sensitive.

The use of interactive, Web-based technologies for smoking prevention is not well established. The findings of this study provide direction for the development and evaluation of such efforts targeting young women as well as other youth groups. The unique ethical and methodological issues and challenges (e.g., obtaining informed consent, data collection) in online health research are being identified and new approaches are being developed (Convery & Cox, 2012). Furthermore, evaluation studies of online health interventions, while still in their infancy (Shahab & McEwen, 2009), have made progress and indicate promising results for cancer-prevention initiatives targeting young women (e.g., Craciun, Schuz, Lippke, & Schwarzer, 2012). Social networking sites are an untapped resource with distinct advantages for effective smoking prevention among adolescent girls.

These findings need to be considered in light of several limitations. Since this study specifically examined Facebook and MySpace, these exploratory findings may not be applicable to other social networking contexts. Although smokers and non-smokers were not identified in the focus groups, the inclusion of both groups may have constrained some participants in what they shared. Finally, it is important to be mindful of the rapid changes in technology when applying the findings to message development and implementation as well as to future research.

Conclusion

Although TC policies have severely restricted pro-tobacco marketing, the Internet provides new and anonymous media for the promotion of tobacco products. Understanding young women's perspectives on this medium as a means to counter pro-tobacco advertising to girls is therefore important. Based on the findings of this study, TC advocates should be encouraged to consider the use of social networking sites for TC messages and should continue to solicit the views of young women to inform TC message development. The use of interactive technologies and user-centred designs hold potential for reaching a wide range of young women to effectively promote non-smoking lifestyles.

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**Comprendre les attentes et les exemptions
selon le sexe dont font l'objet
les aidants masculins à double emploi :
une analyse secondaire qualitative**

Ana Paula Anjos, Catherine Ward-Griffin, Beverly Leipert

De plus en plus de données montrent que les aidants naturels qui occupent aussi un emploi ont de la difficulté à équilibrer les multiples demandes associées à ce genre d'aide. On s'attend des professionnels de la santé qui sont des aidants naturels, ou aidants à double emploi (ADE) comme ils sont désignés dans cette étude, qu'ils utilisent leurs connaissances professionnelles dans la prestation de soins à leurs proches. La présente analyse secondaire qualitative avait pour objectif d'explorer comment les attentes et les exemptions selon le sexe ont un effet sur l'expérience en tant qu'aidant et la santé personnelle des infirmiers qui prodiguent des soins à des membres de leur famille. Être un ADE masculin créait un croisement des attentes et des exemptions selon le sexe. Ces attentes et ces exemptions qui coexistent et, parfois, se contredisent, forment le thème général des déterminants de soins et ont un effet direct sur la santé des ADE masculins, qui vivent des tensions en raison de leur double rôle. Les résultats de cette analyse ont des répercussions directes sur les politiques, les pratiques, la recherche et l'élaboration de théories en soins de santé.

Mots clés : aidant naturel, famille, aidant à double emploi masculin, infirmiers

Understanding Gendered Expectations and Exemptions Experienced by Male Double-Duty Caregivers: A Qualitative Secondary Analysis

Ana Paula Anjos, Catherine Ward-Griffin, Beverly Leipert

There is growing evidence that family caregivers who are also employed face challenges in balancing the multiple demands associated with family caregiving. Health professionals who are family caregivers, defined in this study as double-duty caregivers (DDCs), are expected to use their professional knowledge in the provision of family care. The purpose of this qualitative secondary analysis was to explore how gendered expectations and exemptions affect the caregiving experiences and personal health of male nurses caring for family members. Being a male DDC created intersecting gendered expectations and exemptions. These coexisting and at times conflicting expectations and exemptions, constituted by the overarching theme of the determinants of care, directly influenced the health of male DDCs as they experienced tension when negotiating their dual role. The findings have direct implications for health-care policy and practice, research, and theory development.

Keywords: caregiving, family, gender, home care, men's health, nursing roles

Introduction

It is expected that the number of individuals aged 85 or older in Canada will grow from approximately 430,000 to over 1.6 million by the year 2041. With the incidence of chronic illness rising among older adults (Health Canada, 2002), the increased need for family caregivers is unavoidable. In addition to these demographic trends, reforms in health care have led to increased cutbacks, shorter hospital stays, and increased community care, creating a greater reliance on and need for family caregivers (Armstrong, 2002). Ongoing health-care reforms and cutbacks, combined with other factors, have resulted in a large population of those who are required to provide familial care (Armstrong, 2002), a significant proportion of whom may be professional caregivers. Because of their professional knowledge and skills, those who are employed as nurses while also providing familial care are in the unique situation of being double-duty caregivers (DDCs) (Ward-Griffin, 2004). Female DDCs have reported that their familial and professional expectations are shaped

by gender norms (Ward-Griffin, Brown, Vandervoort, & McNair, 2005). However, little is known about male DDCs — whether they experience similar gendered expectations or whether gendered exemptions enter into their experience as DDCs. Although the literature on DDCs is informative, it does not address the possible coexistence of gendered expectations and exemptions experienced by male DDCs.

Literature Review

Familial Caregiving

In Canada, approximately three of every four family caregivers are women (Statistics Canada, 2006), as there is an underlying gendered expectation for women to assume traditional caregiving roles (Pavalko, Henderson, & Cott, 2007). Those who are family caregivers are likely to draw upon gender norms and use specific skills and strategies to affirm gendered expectations (Ussher & Sandoval, 2008). For example, male caregivers tend to focus on tasks that are consistent with traditional male roles, such as home maintenance and financial assistance, while being exempt from the tasks that are associated with the traditional female role, such as bathing and other physical hands-on care (Pinquart & Sorensen, 2006). When men occupy the role of primary caregiver, they tend to delegate tasks that are viewed as “feminine” to female family members (Campbell & Martin-Matthews, 2003). The differences in caregiving expectations and the predisposition to delegate or be delegated illuminates different gendered expectations of familial caregiving. Men may use gendered norms to exempt themselves from aspects of care, while the same gendered norms increase the expectations for women to provide care.

Multiple studies discuss the numerous circumstances that sons and daughters use to explain their involvement, or lack thereof, in filial care. The concept of “legitimate excuses” developed by Finch (1989) encompasses the reasons for or circumstances considered to be valid explanations for one’s limited involvement in familial care. According to this concept, such excuses absolve those who are seen as unable or unwilling to provide care. Lack of competence or skill is reported to be a major legitimate excuse for not providing care to ill family members. Women are regarded as “natural carers” and as somewhat more competent caregivers than men (Calasanti & King, 2007). However, the successful use of legitimate excuses does not apply in all situations and often diminishes with the degree of caregiving necessary when familial obligation begins to trump social expectations and exemptions (Campbell & Martin-Matthews, 2003; Matthews, 2002). Several researchers have suggested that sons’ caregiving involvement is dependent upon the parent’s condition

becoming unstable or reaching a higher level of need (Matthews, 2002). Still, in these circumstances female relatives continue to take on the majority of care (Campbell & Martin-Matthews, 2003). Family structure may also dictate the degree of male involvement in caregiving. In brother-only sibling networks, sons typically provide more care to parents, relative to mixed-sibling networks, and rely more on formal services for tasks perceived as “women’s work” (Matthews & Heidorn, 1998; St. Amant, 2008). Also, unmarried sons and daughters take on more parental care than married sons and daughters (Campbell, 2010). The difference may lie in perceived obligations; also, unmarried status may be associated with greater availability. In brief, it appears that men (and society) tend to assume and expect that women, when present, will be the main providers of care to family members.

Professional Caregiving

According to the 2006 Census, 94.2% of registered nurses in Canada are female and 5.8% are male (Statistics Canada, 2006). Still, women are increasingly employed in lower-paid nursing positions (Statistics Canada, 2006), while men are concentrated in positions of higher pay, prestige, and authority (Mullen & Harrison, 2008). The reasons behind this phenomenon may be gendered expectations and exemptions in a feminized profession. The feminization of paid caregiving can be linked historically to the identification of nursing as “women’s work” extending from women’s domestic and maternal roles (Huebner, 2007; Pavalko et al., 2007). Intimate physical care is one of the required and expected skills in the health professions; however, while female caregivers tend to provide this care while empathizing with and displaying friendliness and informality towards their patients, male caregivers tend to provide it in a somewhat sterile and emotionally detached way (Huebner, 2007). The results of multiple studies with men in nursing suggest a need to downplay feminine aspects of the profession in reaction to perceived social disapproval of their involvement in a feminized occupation (Cross & Baglihole, 2002), as well as to accommodate the gendered expectations of their colleagues (Calasanti & King, 2007). Men who do engage in “feminine” work are challenged to assert their “masculinity” in other ways, such as by downplaying the nurturing aspects of their job; highlighting the practical tasks, professional training, technical skills, and physical strength involved (Cross & Baglihole, 2002); and working in managerial positions (Mullen & Harrison, 2008). Such strategies enable men to redefine their work to conform to the gendered social expectations that shape their understanding of masculinity.

***Double-Duty Caregiving:
Combining Professional and Familial Caregiving***

Some researchers have begun to focus their investigations on nurses who are both professional caregivers and familial caregivers (Mills & Aubeeluck, 2006; Ross, Rideout, & Carson, 1994; Scott, Hwang, & Rogers, 2006; Ward-Griffin, 2004; Ward-Griffin et al., 2005, 2009; Ward-Griffin, Keefe, Martin-Matthews, Kerr, & Brown, 2010); these DDCs are in a unique position in that they experience the combined gendered expectations faced by both professional and family caregivers (Ward-Griffin, 2004). In general, little is known about DDCs. Most of the literature focuses on how DDCs navigate between the two caregiving domains (Barrett & Marshall, 1992; Ross et al., 1994; Ward-Griffin, 2004). Some researchers are of the opinion that professional caregiving is a separate domain, distinct from familial caregiving, and that one does not impact the other (Barrett & Marshall, 1992). Others believe that the uniqueness of nurses' familial caregiving experiences is embedded in the duality of the caregiving role (Ross et al., 1994; Ward-Griffin, 2004). Conceptualizing these two caregiving domains as separate may account for the dearth of research available on DDCs (Ward-Griffin, 2004).

While DDCs acknowledge their advantage in having nursing knowledge, nursing skills, and connections with the formal health-care system, many feel that they have no choice but to provide care to their family members (Ward-Griffin, 2004; Ward-Griffin et al., 2005). As well, some health professionals and family members expect health workers such as nurses to take on care that they may feel inadequately prepared for (Ward-Griffin et al., 2005, 2009). Furthermore, nursing practice standards do not adequately guide nurses in their familial care responsibilities. Indeed, when engaging in double-duty care, nurses experience a blurring of the boundaries between work and family life and are constantly challenged to find balance (Ward-Griffin, 2004; Ward-Griffin et al., 2005, 2009). Inherent in these challenges is the issue of the combined gendered expectations and exemptions associated with both professional and familial caregiving. Although expectations and exemptions are acknowledged separately in the familial and professional caregiving literature, questions about how the dialectic of gendered expectations and exemptions affect the health of DDCs remain unanswered. Therefore, a qualitative secondary analysis examining the caregiving experiences of male DDCs was conducted.

Theoretical Perspective

This study applied a social constructivist lens informed by the scholarly work of West and Zimmerman (1987). Gender typically refers to socially

constructed roles, behaviours, activities, and attributes expected or not expected of men and women (West & Zimmerman, 1987). West and Zimmerman provide a useful summary of how gender is socially constructed and “done.” They believe that gender should be understood as a “routine, methodical, and recurring accomplishment” that is constructed and deconstructed in everyday social interactions (p. 126). Men and women do not achieve a gender solely through a set of traits and norms; rather, gender is both a product and a process of social interaction (West & Zimmerman, 1987). In other words, individuals behave in response to what they perceive to be socially acceptable for their gender. Therefore, gender norms and expectations regarding femininity and masculinity, as well as individuals’ conformity with and resistance to them, are not fixed (Deutsch, 2007). However, in Western cultures gender norms are largely based on the dichotomous understandings of men and women. In addition, according to West and Zimmerman, individuals are constantly accountable to gender norms and consequently perceive that other individuals are also gendered and accountable.

The view of gender as a social construction highlights the role of the individual in creating, maintaining, or challenging gender through interactions with other individuals and with society (Deutsch, 2007; West and Zimmerman, 1987). Health is viewed as a co-creation through relationships (Hartrick, 2002). The ways in which men and women relate to socially constructed gender norms and their associated expectations and exemptions ultimately affect their health. Furthermore, one’s sense of identity and health is interrelated with and influenced by one’s relation to everyone and everything (Hartrick, 2002), including social norms. By examining the relationship between male DDCs’ experience of gendered expectations and exemptions, this study was intended to offer insight into the health experiences of DDCs.

Method

The present research is a qualitative secondary analysis derived from the study *Health Professionals Caring for Elderly Relatives: Investigating the Health Effects of Double Duty Caregiving* (Ward-Griffin et al., 2010). This analysis provides a more in-depth exploration of an issue that was not fully addressed in the original study (Heaton, 2004). That study was a sequential mixed-method investigation incorporating both quantitative (phase one) and qualitative (phase two) data. Specifically, phase two used constructivist grounded theory and its main objectives were to refine the conceptual knowledge of double-duty caregiving and further explore the health experiences of DDCs and the broader contextual factors that shape these experiences.

The 2009 study involved telephone interviews with registered nurses practising in the provinces of British Columbia, Ontario, and Nova Scotia who were also family caregivers. The participants were asked non-directive questions designed to trigger dialogue about their experiences as DDCs. The questions focused on familial care expectations, resources, strategies, and personal health experiences.

Although gender was examined in that study, the purpose of this secondary analysis was to explore how gendered expectations and exemptions enter into the caregiving and health experience of male DDCs. The research questions for this study were as follows: *What are the gendered expectations experienced by male DDCs? What are the gendered exemptions experienced by male DDCs? How do gendered expectations and exemptions enter into the health experiences of male DDCs?*

This secondary analysis involved 28 transcripts and field notes from interviews with male DDCs. The DDCs included in this secondary analysis ranged in age from 40 to 63 years. Seventy percent were currently living with a partner and 30% were divorced, widowed, or never married. Most were employed full-time in hospital or community management positions (such as patient case manager or nursing unit administrator) or in high-acuity departments (such as emergency or intensive care), with 72% working 30 to 49 hours per week. Sixty-one percent cared for one family member, while 28% and 11% cared for two and three family members, respectively. Familial care ranged from 1 to 21 hours per week, with 24% providing 2 hours per week. Most of the DDCs were sons or sons-in-law. The nature of the care provided was either hands-on, supervisory, or emotional.

Immersion and crystallization were used to elicit interpretive data (Borkan, 1999; Lincoln & Guba, 1985). Immersion consisted of simultaneously listening to audiorecordings and reading transcripts in detail. Initial coding, whereby data were condensed and categorized, was followed by focused coding (Lofland, Snow, Anderson, & Lofland, 2006). Concepts were identified and categorized until themes and patterns emerged (Borkan, 1999). Crystallization also involved the keeping of a reflective journal to capture questions and memos on the coding categories and the research experience. Ongoing immersion and crystallization helped to synthesize the data findings and interpretation (Borkan, 1999; Lincoln & Guba, 1985). NVivo software was used to manage the themes and codes and to support the identification of relationships within the data.

Findings

Extensive analysis of the transcripts and field notes provided insight into the male DDC caregiving experience, which was revealed by an over-

arching theme, *the determinants of care*, and three subthemes, *familial responsibility and relationships*, *nursing knowledge and skills*, and *access to resources*. The gendered expectations and exemptions experienced by the DDCs occurred within the context of the theme and subthemes. The health experiences of these DDCs were most visible at the intersection of their double-duty caregiving experiences — that is, at the point of overlap between their role as male family member and their role as male nurse. Pseudonyms are used for the participants.

Determinants of Care

For the purpose of this study, the determinants of care were the socially constructed factors that constitute the gendered expectations and exemptions experienced by individuals to provide care. Specifically, these gendered expectations and exemptions entered into the negotiation and distribution of tasks and affected the familial care that DDCs did or did not provide. Three determinants of care were identified: familial responsibility and relationships, nursing knowledge and skills, and access to resources.

Familial responsibility and relationships. The concept of reciprocity invoked and reinforced the familial expectations experienced by these male DDCs, as might be the case with many caregivers. For Jacob, reciprocity was a family value that played a large part in determining who provided familial care:

I feel because of the way we were brought up it's something that we want to do, make sure we have them around for a long time — because they're your parents and they helped you, so you help them back.

Constant interplay between birth order and familial responsibility was also evident. Some participants referred to birth order as an important factor in their caregiving experience. Fred explained that, in addition to his health-care knowledge and proximity to the care recipient, his status as the eldest sibling affected his caregiving:

I think my role would be more stressful, because they live just across town from us, so I have the geographical familiarity. I'm the oldest and I'm the only health-care-trained person.

However, Sam found that his youngest brother had a greater sense of obligation towards his parents and took on a more prominent role as power of attorney (POA). Sam seemed to resent this and decided to stop providing health-care advice:

My youngest brother announced that he was designated POA. So that frustrated me and I thought my observations were not being respected. And I said, "From this point on, you make all the decisions. It's up to you. I'll

be available to chat with you whenever you want, but don't ask me for any decisions." . . . [He] has a sense of obligation to Mom and Dad because he's the youngest and stayed with them for a long time.

The loss of control Sam felt by not having POA greatly influenced his familial relationships and the type of care he was willing to provide. This suggests that responsibility for familial care is negotiable and is influenced by the degree of power and control held by the DDC.

Familial responsibility and interpersonal relationships may play a role in the expectations placed on all family caregivers. However, in the case of male DDCs these expectations were related to the intersection of the socially constructed roles of male son and male nurse. The relationships between the DDC and his family changed to reflect his DDC position. The DDCs were often expected to take on the role of nurse instead of the role of family member, which likely caused tension between their gendered expectations as a son, husband, or father and their expectations as a nurse. This tension could affect relationships negatively, as exemplified by the case of Fred. Fred's marriage suffered greatly, even ending in divorce, as a result of his constant struggle to be a nurse to his mother-in-law and a supportive husband to his wife:

I believe as a son-in-law I tried to be almost professional about it and it was a positive end. The price that I paid was personal in that my wife wasn't looking for a professional — she was looking for emotional support, and that's sort of the bat I swung and missed with. . . . Basically, my wife was frustrated that I took on that role. I was being the family advisor and not being my wife's support.

Nursing knowledge and skills. Nursing knowledge is possibly the main factor differentiating DDCs from other family caregivers. The participants were aware of the value of their nursing knowledge, and, although it appeared that the family expected male DDCs to provide answers and use their knowledge, DDCs also used their nursing knowledge as a means of being exempted from aspects of care. For example, John, who provided care to his mother-in-law, insisted on not providing hands-on care because he felt that this should not be expected of a male family member, especially a son-in-law.

I'd make sure she's looked after but I'm never doing hands-on care for this person. I'm not going to do it; she's my mother-in-law. She can get as sick as ever and I'm not, I'm not going to do it. You know, I'll just make sure the resources are there to look after her. . . . I'll help her find the people to do it, like CCAC [Community Care Access Centre] when she has a surgery, but I'm not going to do hands-on care, even though I probably could do it.

John's understanding of his socially constructed gendered expectations may have played a part in his refusal to provide hands-on care. The socially accepted boundaries between a man and his mother-in-law may have also determined the type of care John was willing to provide.

Due to their occupational status, the DDCs were expected to possess, use, and share health-care knowledge. For example, Ralph was expected to provide support for a full range of health-related concerns, regardless of the type or severity of health problems:

I'm the health go-to person in my family . . . when anyone has any problems they'll call me. I mean, they're all very intelligent, capable people, but when there's a specific health issue they phone the brother who's a registered nurse.

Consistent with their nursing role, the DDCs also took on the task of passing their knowledge and skills on to other family members. This was most notable when the care recipient's health was stable, which permitted the DDC to be excused and ultimately exempted from specific aspects of care. The tasks that were taught were often gendered in nature; physical and hands-on tasks, such as bathing, versus the more managerial tasks of advocating or organizing care, were taught and delegated to others. Specifically, the participants appeared to teach and delegate the tasks that were not "gender appropriate" for them. By doing so, they were exempted from some tasks while still maintaining expectations of others. In this sense, the occupational status of the male DDCs allowed them to keep their options open and decide which tasks could be delegated while maintaining control over other tasks. For example, Adam, an only child, had been expected to manage his father's care for more than 12 years; however, he taught his mother many hands-on "nursing" skills, which ultimately led to his exemption from hands-on tasks:

Personal care, like dressing changes, stuff like that, I guess normal folk would get home care to come in and do. I'm taking care of that. I'm teaching my mother how to do that as well. So my mother now is basically filling the role of the nurse.

Thus, due to their nursing status, the male DDCs tended to assume a managerial position within their familial care network; they had control over which tasks they were expected to perform and which ones they were exempted from.

Access to resources. Men in nursing typically occupy high-status positions within the profession (Mullen & Harrison, 2008), and many of the male DDCs demonstrated how their connections and positions within the health-care system had benefited the care they provided to their family member — and likely had positively impacted their own health.

However, they had the added burden of being *expected* to use their professional status to access resources for their familial care. Adam acknowledged his advantageous position in comparison to caregivers without a health-care background:

I'm an OR nurse so I've got contacts with all the different services . . . in my hospital. I was able to get him in to see the urologist. I jumped the line. So my professional work is helping with my private life. . . . I'm interacting with the surgeons on a daily basis. I know the urologists because I work in the rooms. If anything happens, I know the orthopedic guys, I know the general surgery guys. So if he needs to see a specialist, instead of waiting 6 months we might be able to get him in earlier.

In addition to accessing and navigating the health-care system with greater ease than other family caregivers, the DDCs had access to other health professionals and services. Furthermore, their awareness of available community resources meant that they were better able to obtain appropriate care for their family member. Due to his awareness of Community Care Access Centre (CCAC) services, John was able to arrange for the health care that his mother-in-law would need, thus decreasing the expectation that he would provide care:

She's always been independent, but suddenly she's had a knee replacement and she's expecting the daughter and the son-in-law and the kids to run home and look after her. The daughter is saying, "Okay, we got to go do this," and I'm saying, "No, we don't. When she has the surgery, we ask to speak to the CCAC coordinator at the hospital and we tell him, 'This is the situation. What does she need?' And 'This is what we think she needs'."

The participants also had the support of colleagues in the nursing profession. This support helped in the emotional and physical aspects of care. Ralph explained that his colleagues not only supported him at work, but were ready to provide nursing care to his mother if necessary:

With nurses, there's unofficial tact where, you know, "If you're in trouble we're here." They don't push — they're not pushy about stuff — but they're always there. My coworkers would deliver food to the house or other ways where they'd actually show up and send you home . . . The support things that really were helpful was coworkers offering to come and sit, do ADLs [activities of daily living], bathe her — all that kind of stuff.

However, sometimes nursing colleagues expected the DDC to be a nurse rather than a son when the family member's care happened to be in their work environment. For example, Ralph intervened in his father's

care in the emergency room, despite the possibility of being reprimanded for his actions:

All of a sudden all of the nurses disappeared. He was doing poorly and he just needed to be cared for now. . . . having said that, I recognize that I wasn't in the best position to determine that at the time, because of emotional attachment coupled with stress. But then what I did was hook up his oxygen, started an IV, drew his blood work, [and] at the same time did a blood gas. Now, that's what I would have done if I was assigned to him as his nurse, but that was completely inappropriate for me to do.

In addition to accessing the health-care system and health professionals, the DDCs often accessed and deployed family members as resources in the provision of care. Usually female family members took on the role of primary caregiver, while male DDCs maintained the roles of health-care advisor, educator, and liaison as a result of the combination of their gender and occupational statuses. These male DDCs tended to deploy family members in accordance with socially constructed gendered tasks: female relatives for “female” tasks such as bathing and male relatives for “male” tasks such as yard work. For example, Tom specifically stated that bathing his mother would be a female task and that as a male he was exempted from this aspect of care. He deployed female family members for this task:

We used my sister-in-law for a couple [of] months because I didn't think it was right to bathe my mother. I also used my daughters when they were home. Otherwise my mother [wouldn't] bathe herself— she'd go months without bathing— so we basically used nieces and nephews and daughters to make her bathe, because as a guy I'm not going to bathe my mom.

Tom may also have felt the need to have female relatives provide care for his mother as a way of helping her to “do” her own gender. By providing his mother with personal care such as bathing, Tom would perhaps have caused discomfort due to his mother's gendered expectations of herself and of him. The DDCs may have sensed a need to protect and reinforce the gendered expectations of the care recipient.

Gendered Expectations and Gendered Exemptions

The participants experienced gendered expectations and gendered exemptions from many sources, such as family members, the health-care system, and even themselves. Being a nurse as well as a son added another dimension to typical familial caregiving. The DDCs felt pressure to provide care beyond the traditional expectations of male family members. At times they felt obligated to fill the gaps left by other family members, which resulted in resentment and anger. John observed that the increased

family expectations he experienced were due to his being a nurse; thus familial expectations became intersected with expectations related to his status as a member of the nursing profession:

When Mom got really ill, my father couldn't handle it. My sister couldn't deal with it. Dad would ask, "Can you come and help me bathe her?" "Okay, Dad, I'll be right there." How do you think I felt about bathing my mother and resenting the fact that my sister wouldn't help me? I remember when my dad got sick — he had cancer — and my sister wouldn't help with that, nor my brothers, because "You're a nurse — deal with it." When he got sick I had to bring him into my house and I had to deal with it all.

The uniqueness of the male DDC experience was shaped by the interface between gendered expectations and exemptions. As explained by Darren, this entwining of expectations as a nurse and as a son led to confusion and frustration:

You provide care to family members and that's just the way it is, whether you're a nurse or you're not a nurse. I think it's the expectation in life, but because I'm a nurse, then I'm the one who's qualified and therefore should do it. I'm constantly having to tell people, "You know, it doesn't take . . . a nurse to be able to make somebody a sandwich or bring them food."

The participants had some control over the expectations and exemptions they encountered when delegating and teaching care tasks. They used their gender status to exempt themselves from certain tasks. Their gender status within their family network exempted them from "female" tasks. However, their status as a nurse meant that they were often expected to provide care that fell within "female" gender norms. As male DDCs they apparently had the advantage of being able to choose when to be a nurse and when to be a family member, and they often acted on the gendered expectations or exemptions associated with each role. The concept of choice is best illustrated with respect to the managerial role of male DDC, as the participants chose which aspects of care to become involved in and which to be exempted from. Although the concept of choice and control may have advantaged these male DDCs, tension frequently arose when they negotiated the intersection of being a male family member and being a male nurse, and this tension could lead to a lack of control and ultimately negative personal health experiences.

Personal Health Experiences

The personal health experiences of the participants were central to their overall caregiving experiences and were shaped by the determinants of care. They were able to use their professional knowledge and training to

manage any negative personal health effects and prepare themselves for familial caregiving:

I guess you just have to figure it out. Being in the psychiatric end of it — with stress — with all the training that we've gone through, we all know stress can cause a lot of problems, so it's best to try and minimize any types of stress. (Jacob)

However, even though their backgrounds may have prepared them for familial care, they still experienced stress when providing health-care support to family members:

As a nurse it's rewarding caring for people, so it sort of continues on from your job and it's a rewarding although a frustrating experience, as it can be at work. You feel the pressure, too, because you're the knowledgeable one and so family sort of looks at you as the one that has the right answers for things. (Mike)

Although the participants appreciated the sensitive nature of being a DDC, the expectations they experienced often greatly changed the dynamics of their social relationships. George used the metaphor of “stepping in a minefield,” with everyone watching and expecting him to deliver. He had to be cautious in navigating his way:

It feels a lot like first-year clinical when your preceptor is watching you, over your shoulder, except that there's a lot more emotional hooks. So you're kind of stepping in a minefield, especially in my role as the son-in-law. I guess that's kind of unique, but I would think it's the same thing as a daughter-in-law working on a relative. It's kind of like dancing through a thorn bush — you have to be really careful because the things you see coming, you have to negotiate how you're going to present them to the family.

The DDCs tended to focus on the health of their family member at the cost of their own health. For instance, Ralph described how he would ignore his own health when providing care to his mother. He felt pressured to be a family caregiver and a working nurse simultaneously. The multiple expectations made him feel that he was burning out and not fulfilling all of the roles expected of him:

You ignore your personal needs and, unfortunately, your immediate family needs . . . working all those shifts because you still have to pay the mortgage or this or that. So if you can fit everything in and still get it done in a day, I'll work and do that and I'll do everything else. . . . emotionally, for the health of myself and my family, I would have been better off [taking] a leave of absence, with or without pay. I think nurses have to be

careful, because if you're everything to everybody all the time you're burning a candle from both ends sometimes and it's a tough balancing act.

The participants believed that nurses are always expected to provide care. The expectations associated with nursing constantly shape the life experiences of all nurses, including familial care experiences. Ralph likened the caregiving experience to a rollercoaster ride, with crises and periods of calm. During the crises he would be aware of the effects on his health but not be able to address them. Only upon reflection was he able to see the stress he endured and the health consequences he suffered:

When you're in an acute thing, and my dad's illness ran for 3 years, it's like a rollercoaster, so you run for 6 months and then . . . you'd be really busy for a while and in your busy time you notice you're run down, weight loss, blood pressure would go up, things like that. When things would smooth out you relax a little bit more, back to normal. You fool yourself into thinking it's normal and wait for the next wave or the next high point down the rollercoaster or whatever. . . . But 3 years ago when my dad wasn't doing well it was very hard, it's very hard to cope. People are very generous, you take a lot on yourself, you feel this obligation and it's a lot of work at the time, but later it comes out . . . you don't realize the stress you were under until a year later, 3 years later.

As male DDCs, the participants appeared to be in an advantageous position with respect to familial care. However, they constantly felt pressured to attend to the needs of others while disregarding their own health. When they finally took note of the toll on their health, they tended to either cope with their concerns or simply deny their existence.

Discussion

Three main insights can be gleaned from the findings of this research. First, the caregiving experiences of male DDCs are shaped by the determinants of care: familial responsibility and relationships, nursing knowledge and skills, and access to resources. Consistent with other findings (Bedard, Koivuranla, & Stuckey, 2004; Marshall, 2006; Pavalko et al., 2007; Ussher & Sandoval, 2008), gender and social norms shaped both expectations and exemptions in the provision of care. In line with the findings of Matthews and Heidorn (1998) in their study with brother-only siblings, the participants, as male DDCs, tended to engage in tasks based on traditional male roles, such as yard work or home maintenance, while delegating tasks that are considered "women's work" to female family members or formal services. However, the care provided by these male DDCs was shaped by additional factors, such as the knowledge and resources afforded by their profession. Specifically, their nursing knowl-

edge and skills affected their typical filial responsibilities. As members of a feminized profession, these male familial caregivers were sometimes expected to perform tasks traditionally viewed as female. The addition of the nursing role to their filial role transformed the gendered expectations and exemptions associated with their familial care.

Similarly, the participants' access to health-care resources affected their familial relationships. As male nurse in the family, the participants typically adopted a managerial role and became responsible for all aspects of care. They were able to do this because, as male nurses, they could call upon a multitude of resources and strategies, including the delegation of care tasks to other family members. Consistent with findings reported in the literature (Ingersoll-Dayton, Neal, Ha, & Hammer, 2003), conflict within sibling relationships appeared to emerge and change as a result of inequities, specifically in relation to the power associated with task delegation. The participants, as male DDCs, tended to manage and control the activities of care. These coexisting determinants of care entered into their own health experiences. Caregiving is a complex process, with many factors playing a part and shaping the health of caregivers. All caregivers cannot be treated the same: The uniqueness of the care provided by male DDCs and other caregivers must be acknowledged and appropriate support offered by means of community and workplace initiatives. Specific workplace policies must be put in place to address the needs of employed caregivers such as DDCs.

The second insight gleaned from this study concerns the interface between expectations and exemptions associated with double-duty caregiving. Although caregiving expectations and exemptions are well documented, few studies have acknowledged their simultaneity and the coexistence of multiple caregiving expectations or exemptions. While Matthews (1995) uses the concept of legitimate excuses to highlight the exemptions experienced by caregiving sons, the present study reveals how expectations and exemptions associated with the nursing and filial roles of male DDCs are intertwined and experienced simultaneously. The male DDCs used the expectations that guided their actions to determine the consequent exemptions, and exemptions similarly guided expectations. For example, when they lived up to their caregiving expectations related to nursing, the male DDCs would exempt themselves from some of their filial care expectations. Thus, not only did expectations and exemptions occur simultaneously, but the DDCs appeared to at times control and determine movement between expectations and exemptions — to their advantage.

Future research could further examine the coexistence of gendered expectations and exemptions and its role in health experiences. Specifically, investigations that focus on the gendered power relations

associated with controlling and delegating familial care may help to identify and address potential health and care inequities.

The third insight gleaned from this study is that male DDCs experience both gendered advantages and disadvantages. The participants were able to use gender as a resource, which allowed them to choose which “gendered” care tasks to take on themselves and which to delegate. However, although their nursing background afforded advantages with regard to resources and skills, they were disadvantaged in terms of conflicting expectations, which ultimately caused them to lose their sense of control. For example, at times siblings would step back from making a filial contribution because the nurse in the family was seen as the ideal caregiver. Similarly, it became incumbent upon the male DDC to ensure that the gendered expectations of the care recipient were met. The DDCs’ nursing background intensified caregiving expectations and challenged the exemptions they typically experienced as sons. They consequently encountered coexisting gendered expectations and exemptions, which simultaneously advantaged and disadvantaged them. Thus the advantages and disadvantages encountered by the participants were often influenced and shaped by social gender norms constructed in their everyday social interactions.

Gender is not viewed as an individual attribute based on the dichotomous understandings of men and women, but, rather, is defined as one of the social determinants of health (Raphael, 2009), which creates inequities within multiple social contexts (Keheler, 2004) and cuts across all aspects of social life (Raphael, 2009). According to Deutsch (2007), since gender is “done” or constructed, it can also be “undone” or deconstructed. Theoretical development aimed at deconstructing gender norms could help to address some of the challenges and health compromises faced by caregivers. Additionally, it should be recognized that the social construction of gender is complex and is shaped by other social relations, such as culture and sexual orientation. For instance, the health experiences of homosexual male DDCs may be different from those of heterosexual male DDCs. Further research into the gendered expectations and exemptions of male DDCs representing various sexual orientations is warranted.

Conclusion

This qualitative secondary analysis explored the caregiving and personal health experiences of male double-duty caregivers. Determinants of care were found to play a role in the gendered expectations and exemptions experienced by male DDCs. Some participants reported negative health experiences at the intersection of the gendered expectations and exemp-

tions associated with their roles as nurse and as son. A number of implications for health-care policy and practice, research, and theory development have been identified. Health and social services as well as workplace policies need to be refined if they are to support the growing number of family caregivers. Research that links professional and familial caregiving would have the added value of increasing our understanding of employed caregivers, specifically how double-duty caregiving plays a role in health experiences and care provision. Finally, theory development should aim to deconstruct the gender ideologies associated with caregiving. Challenging gender ideologies within caregiving and their associated social norms would help to ensure that responsibility for the health of both family caregivers and care recipients is assumed by society as a whole rather than by family caregivers alone.

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Book Review

Gender and the Language of Illness

By Jonathan Charteris-Black and Clive Seale
Houndmills, UK: Palgrave Macmillan, 2010, 247 pp.
ISBN 978-0-230-22235-9

Reviewed by Craig Dale

In the introduction to *Gender and the Language of Illness*, Charteris-Black and Seale share an illuminating anecdote that may sound familiar to many. One of the authors overheard a woman asking a male acquaintance if he had been absent from work due to a case of “man flu.” In sharing this satirical exchange, the authors underscore the abiding presence of gender in how people talk about illness. Words and phrases hold distinct meaning and serve to reinforce identities, of which gender is one. Gender theorists suggest that men’s abilities to “do health” are constrained by an overriding focus on work and sport. Inevitably, this results in a sense of discursive and performative incompetence when injury and illness push men to the sidelines. Despite changes in the balance of power between the sexes, there remain significant tensions between traditional role expectations and the freedoms espoused in contemporary views of gender. In this line of thought, Charteris-Black (a linguist) and Seale (a medical sociologist) argue that broad generalizations about men and women obscure our understanding of health as a highly varied practice. They assert that our capacities as clinicians, carers, and information providers would benefit from a deeper understanding of the language of illness.

In the first chapter, Charteris-Black and Seale introduce the reader to the recent history of gender and sociolinguistic study in health. In bringing us up to speed with a postmodern approach, they allude to a significant shift in the field of gender research. Outmoded in this regard is the theme of *Men Are From Mars, Women Are From Venus*. The authors argue that this timeworn approach to sex–role comparison stalls in its analytic categories. Following the nod to gender tensions in their introductory anecdote, they briefly consider the popular belief that men’s stoicism and lack of expressiveness is equated with a low degree of help-seeking in illness. Men are thought to be reliant on the emotional and linguistic performance of women to negotiate the biographical disruptions of acute and chronic illness. While a large body of empirical

research supports this belief, Charteris-Black and Seale assert that it is an incomplete or oversimplified set of relations. In their minds, the intersection of age and socio-economic status influences the identities revealed through discourse. They argue that age and social status, as powerful entities in health inequalities, need to be brought forward.

With a postmodern, performative, and intersectional view of gender established, in the second chapter the authors describe a contemporary approach called “corpus linguistics.” Using a computer program, they describe a method of scanning a corpus of established interview transcripts to identify the frequency of keywords, concepts, and clusters of related expressions. Because keyword analysis has not previously been applied to gender and illness, they argue that this combination of qualitative and quantitative processes can offer insights that might not be revealed by other approaches. The sample is drawn from Healthtalkonline, a collection of 1,035 interviews with British patients and carers addressing a wide range of health conditions, including heart disease, cancer, chronic pain, and depression. From this data set, they identified 99 male and 99 female respondents who shared the same age band, socio-economic classification (SEC), illness, and gender with the interviewer. With approximately two million words extracted, they proceed to compare significant differences and similarities across this paired sample.

In subsequent chapters Charteris-Black and Seale present their results in sections dedicated to men, women, emotional talk, and the desire for support in illness. As would be expected, there are many similarities between male and female narratives. However, there are also some surprises. Of great interest is their finding of men’s discursive strategies of avoidance and distancing through words like “difficult” and “problem” when describing illness. As a characteristic of traditional masculine discourse, men take a mechanistic and external view of their illness-related incapacities. The frustrations encountered with failing function are qualified as “serious” and “major” to denote a critical state. Within a problem-solving mental frame, the authors posit that men discursively distance themselves from illness as a way of maintaining control. For example, men will often speak in the third person whereas women will use “I” more frequently. Thus women are more adept at saying what they “need” and “want.” As a result, a typically feminine narrative employs a very direct communication style that is self-reflective, proactive, and transformational.

While many of Charteris-Black and Seale’s findings adhere to traditional norms of masculinity and femininity, their methods do reveal important variations. One discovery is that younger age and higher socio-economic status allow some men to incorporate a narrative style more characteristic of the feminine one described above. For example,

high-SEC men are similarly expressive to low-SEC women in using adjectives such as “happy” and “wonderful.” Further, younger men talk much more freely about being “upset” and “alone.” Those working in cardiovascular health will be particularly interested in men’s preoccupation with “sport” and “exercise” as a means of self-transformation. Men speak four times more frequently than women about “playing” sport, which suggests that elements of traditional masculinity positively interact with medical prescription for physical activity. In contrast, women with heart disease use the phrase “help yourself” four times more frequently than men, and this appears to collocate with diet and lifestyle efforts. Further, women mention family members 30% more frequently than men, which suggests an intensification of pre-existing social networks. While “talk” with professionals appears to be of equal value for men and women, preferred methods to do so are not equivalent. Women of lower SEC preferentially use the “phone” to remain in contact with clinicians and reduce the isolation associated with illness.

In their brief conclusion, Charteris-Black and Seale discuss how illness both reinforces and challenges longstanding norms for performing gender. They confirm that age and SEC groupings are important variables in identifying traditional and non-traditional ways of doing health and therefore warrant careful consideration in clinical encounters. They suggest that the discursive and social constraints of masculinity weigh heavily on middle-aged men, somewhat less so on youth and the elderly. This implies that health inequity exists between men and that women may have a particular advantage. Moreover, illness will remain a women’s domain unless men readily adopt a discursively feminine approach.

Although Charteris-Black and Seale’s conclusions would have benefited from expanded discussion of practice and policy implications, this book is a fascinating addition to the field of gender and health. Given its focus on discourse, the views expressed limit additional understanding of how the overt manifestations and material contexts of illness interact and influence acceptable ways of speaking. However, it does open a space for considering how our roles, work processes, settings, and standardized discourses as clinicians, health-information providers, and researchers may elicit different responses across age, SEC, gender, and disease states. Given that health care is an intensively social practice, this book presents an opportunity for clinical reflection and further research into gender and the language of illness.

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Gestion des médicaments par les infirmières et infirmiers œuvrant dans les centres de soins de longue durée

**Wendy Ellis, Sharon Kaasalainen,
Pamela Baxter, Jenny Ploeg**

Dans les centres de soins de longue durée (SLD), la complexité de l'état de santé des résidents et de leurs besoins en matière de traitement représente pour les infirmières et les infirmiers un défi de taille en ce qui a trait à la gestion des médicaments. L'objectif de la présente étude descriptive et qualitative était d'examiner la tâche de gestion des médicaments à partir de descriptions données par des infirmières et infirmiers autorisés travaillant dans des centres de SLD. Un total de 22 infirmières et infirmiers autorisés provenant de deux centres de SLD situés dans la province canadienne de l'Ontario ont participé à quatre groupes de discussion. Après une analyse de leur contenu thématique, les données recueillies lors des séances de discussion ont été classées par thèmes et un modèle théorique a été élaboré. Le thème dominant qui est ressorti des données est que les infirmières et infirmiers doivent se livrer à une « course contre la montre » dans la gestion des médicaments, et les trois sous-thèmes qui ont pu être cernés concernent les étapes de cette importante tâche dans la prestation des soins : *la préparation à la course, la course elle-même et la fin de la course*. Les obstacles à une gestion sécuritaire des médicaments comprennent les contraintes de temps, le manque de connaissances, les interruptions et distractions, ainsi que la mauvaise communication. Les conclusions de l'étude pourront servir à mieux informer les fournisseurs de soins de santé et à orienter la recherche future. Ils sont également susceptibles d'avoir un effet direct sur les résultats liés à la gestion sécuritaire des médicaments dans la prestation des SLD.

Mots clés : prestation de soins, gestion des médicaments, soins de longue durée

Medication Management for Nurses Working in Long-Term Care

**Wendy Ellis, Sharon Kaasalainen,
Pamela Baxter, Jenny Ploeg**

In long-term care (LTC), the complexity of residents' conditions and their treatment requirements present challenges for nurses managing medications. The purpose of this qualitative descriptive study was to explore medication management as described by licensed nurses working in LTC. A total of 22 licensed nurses from 2 LTC facilities located in the Canadian province of Ontario participated in 4 focus groups. Thematic content analysis was used to organize data into themes and a conceptual model was developed. The overarching theme was that nurses are "racing against time" to manage medications and 3 subthemes described how they coped with this important care process: preparing to race, running the race, and finishing the race. Barriers to safe medication management included time restraints, knowledge limitations, interruptions and distractions, and poor communication. The findings can be used to better inform health-care providers and to guide future research. They also have the potential to directly impact outcomes related to safe medication management in LTC.

Keywords: advanced nursing practice and education, care delivery, collaborative practice education, delivery systems, geriatric

The long-term-care (LTC) setting is unique and complex, requiring safe, ethical medication management. LTC residents are prescribed more medications than individuals in any other setting to treat multiple comorbid conditions, and are at risk of adverse events, including death, associated with poor management of medications. Nurse staffing and workload issues increase the potential for unsafe medication-management practices, resulting in poor outcomes for residents. There has been little research examining the experiences of nurses in managing medications in LTC settings. This qualitative descriptive study explored how nurses describe their experience of medication management in LTC settings.

Medication Management in LTC

The complexity of the conditions and treatment requirements of LTC residents presents a challenge for nurses managing medications (Bergman-Evans, 2004; Eisenhauer, Hurley, & Dolan, 2007). With the increasing number and acuity of older adults living in LTC, coupled with nurses' workload and care demands, LTC residents are at risk for serious

problems related to safety, and even death (Goodyer, 2002; Gurwitz, Field, & Avron, 2000).

The extensive use of medications in LTC settings is evident. In Canadian LTC facilities, 75% of current residents have severe age-related debilitating conditions (Statistics Canada, 2009) and more medications are prescribed to treat complex co-morbid conditions than in any other health-care setting (Guay, Artz, Hanlon, & Schmader, 2003). Treating multiple co-morbidities results in polypharmacy (Goodyer, 2002; Rancourt et al., 2004). Doshi, Shaffer, and Briesacher (2005) report that residents in American LTC facilities received an average of 8.8 routine prescribed medications per day (7.6 regular and 1.2 *pro re nata* [p.r.n.], or as needed) and 32% of residents received 9 or more medications per day.

Medication management involves the administration, monitoring, evaluation, and documentation of medications (Aitken, Manias, & Dunning, 2000; Galbraith, Bullock, & Manias, 2000). An adverse event is defined as injury resulting from the use of a drug (Gurwitz et al., 2000). This includes medication errors (i.e., errors in prescribing, dispensing, administering, or monitoring) and adverse reactions in which an error was present. Given the number of medications that residents consume daily, there is a high risk of adverse drug events, including death, related to medication error (Baker et al., 2004; Forster, 2006; Gurwitz et al., 2005; Lau, Kasper, Potter, & Lyles, 2005). Of all medication errors, 19% involve an incorrectly timed dose (43% of the time), an omitted drug (30% of the time), or the wrong dose (17% of the time) (Perri et al., 2005). As the number of medications ordered per resident rises, so too does the risk of a resident receiving an inappropriate medication (Perri et al., 2005).

Nurses, as part of their practice, must ensure that medications are managed in a safe, competent, ethical, and therapeutic manner (College of Nurses of Ontario [CNO], 2008). Thomson et al. (2009) estimate that approximately one third of a nurse's scheduled time per shift in LTC is used to administer medications. However, how nurses manage medications in LTC remains unclear. Although the literature is mostly focused on the acute-care setting, it indicates that both nursing practice and structure-system issues are barriers to safe medication management (Baker, Jeffs, Law, & Norton, 2007; Dilles, Elesviens, Rompaey, Bortel, & Vander Stickele, 2011; Forster, 2006).

Causes of medication errors by nurses include lack of attentiveness, poor judgement, and misreading of physicians' orders (Benner et al., 2002). A survey of 61 acute-care nurses was conducted to explore medication error and patient safety (Ulamino, O'Leary-Kelly, & Conelly, 2007). Many respondents (45.8%) perceived that nurse error was a primary issue (not checking dose and bypassing safety checks), while

other perceived factors contributing to error included nurse fatigue (33.3%), illegible physician writing (28%), and distraction (25%).

Lack of pharmaceutical knowledge also appears to be a persistent problem among nurses (Cheek, Gilbert, Ballantyne, & Penhall, 2004; Dilles et al., 2011; Leape, Bates, & Cullen, 1995; Schmidt & Svarstad, 2002; Winn & Dentino, 2004). Results of one study indicate that 29% of medication errors by nurses are due to lack of pharmaceutical knowledge (Leape et al., 1995). The increased complexity of LTC residents requires nurses to know and understand complex pharmaceutical trends and treatment regimens. LTC nurses report that they lack adequate information regarding medications and their side effects (Dilles et al., 2011). Evidence suggests that LTC nurses who continually update their knowledge base make fewer medication errors (Leape et al., 1995).

It is estimated that almost 50% of LTC residents have some form of cognitive impairment or dementia (Canadian Study of Health and Aging Working Group, 2000). Almost 25% of LTC residents exhibit difficulties with swallowing, which include frequently spitting out medications, consistently chewing medications, or hiding tablets/capsules (Wright, 2002). In a survey of 540 LTC nurses, 56.5% said they concealed medication in food without residents' knowledge, 26% omitted the dose, and over 60% crushed medications before administration. In this study, over 58% of nurses stated that it was a challenge to obtain an alternative route for administration and perceived that cost was a factor (Wright, 2002). Another administration strategy when low doses of medications are not available is pill-splitting (Fischbach & Gold, 2001). Pill-splitting involves nurses splitting medications apart prior to administration to decrease the dosage (thought to minimize the adverse reactions of inadequate dosing specific to older adults). Crushing, opening, or splitting pills is considered unlicensed administration and nurses are liable for such actions. All of these strategies are controversial, with ethical and legal implications, and are considered medication errors that can lead to adverse events (Fischbach & Gold, 2001).

Mayo and Duncan (2004) discuss the potential for not reporting an adverse event if no harm has been caused to the patient. They suggest that the rates of adverse events due to medication mismanagement may in fact be higher than reported. Nurses in their study believed that negative pressure from staff and managers was a barrier to reporting such events. Similarly, Scott-Cawiezell and Vogelsmeier (2006) conclude that the "culture" of LTC homes is not conducive to nurses reporting errors because of the "blaming" that occurs in these settings. They note that patient safety will continue to be compromised as long as nurses feel they cannot report errors.

Bowers, Lauring, and Jacobson (2001) interviewed and observed 18 nurses who worked at two LTC facilities in the Midwestern United States. They report that nurses' workload, nurses' attitude towards work, and patient outcomes were impacted by "time." The authors suggest that time constraints limit nurses' ability to provide adequate information and to implement current evidence-based practices. Due to time constraints and constant interruptions, the nurses in their study had to develop strategies to minimize the time required to complete tasks, which affected the quality of care provided, including the way in which they managed medications. A greater focus on improving the individual and systems issues linked to unsafe medication practices is needed (Baket et al., 2007; Biron, Loiselle, & Lavoie-Tremblay, 2009; Dilles et al., 2011; Forster, 2006; MacDonald, 2010; Thomson et al., 2009), starting with a thorough understanding of how nurses are managing medications in the LTC setting. There has been little qualitative research conducted in Canada addressing this important care process.

Purpose

The purpose of this qualitative descriptive study was to explore medication management from the perspective of registered nurses (RNs) and registered practical nurses (RPNs) working in LTC facilities. The study also explored the factors that influence nurses' experiences when they manage medications for LTC residents. The study was guided by two research questions: *How do nurses (RNs and RPNs) describe their experience of medication management for LTC residents? What barriers and facilitators influence how nurses manage medications when caring for LTC residents?*

Methods

A qualitative descriptive approach was used to describe nurses' experiences with medication management when working with LTC residents (Creswell, 2007; Patton, 2002; Sandelowski, 2000). This approach captures the richness and diversity of the human experience (nurses) and facilitates understanding of a behaviour (medication management) based on the participants' (nurses') own interpretation (Sandelowski, 2000).

Settings and Sample

Two LTC facilities located in southwestern Ontario, Canada, took part in the study. Both facilities were not-for profit and together they housed over 600 residents. The two facilities had similar medication-management practices, which included a blister-pack system for the distribution and administration of medications by both RNs and RPNs. Typical medication administration times were 8 a.m., noon, 5 p.m., and 8 p.m. Ethics

approval was obtained from a university-based Research Ethics Board and the two LTC facilities.

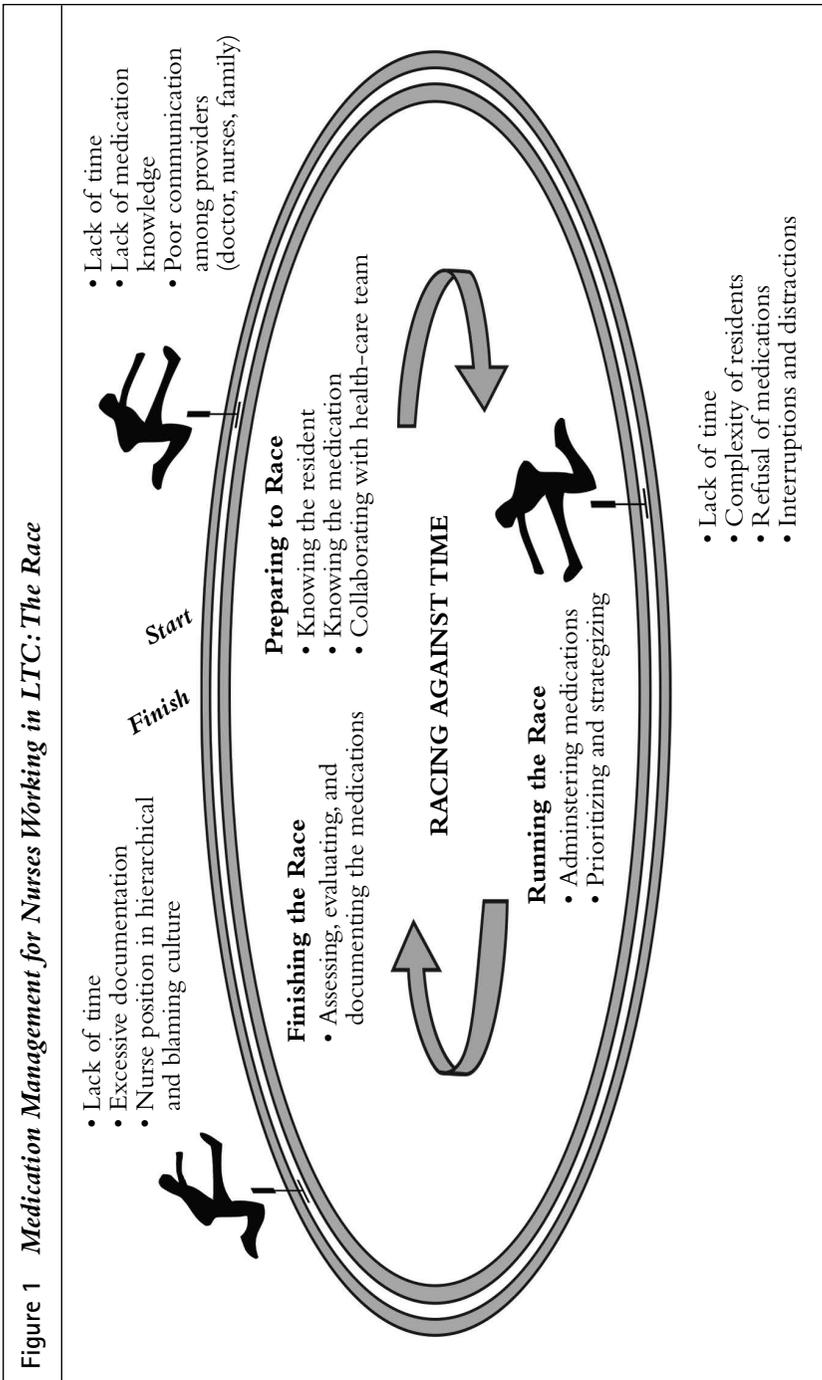
Purposive criterion sampling techniques were used to identify RNs and RPNs who would be able to provide rich information (Fain, 2004; Patton, 2002). The criteria for inclusion were as follows: (a) speak and read English well enough to participate in the study and to provide informed consent, (b) licensed nurse in good standing with the College of Nurses in Ontario, and (c) work in LTC and be involved in managing medications. At each facility, nurses were notified by administrative staff about the study and were given the principal investigator's contact information and details about the focus groups. Confidential informed consent was obtained (Tri-council Policy Statement: Ethical Conduct for Research Involving Humans, 1998) from nurses who volunteered to participate.

Data Collection

Four focus groups were conducted — one for RNs and one for RPNs at each of the two LTC facilities — using a semi-structured interview guide (available from the first author upon request). Separate focus groups for RNs and RPNs were conducted in order to obtain a full description of their unique experiences (Brown, 1999). The 1-hour sessions took place in a quiet, private meeting room at each facility at a time that coincided with scheduled shifts, to prevent travel and time burden on the participants. Each group comprised from four to seven participants, consistent with recommendations in the literature (Greenbaum, 1993; Krueger, 2000; Sandelowski, 1995). A trained facilitator took notes during the audiorecorded sessions.

Data Management and Analysis

All audiorecordings were transcribed verbatim and names and identifying markers were erased manually by the principal investigator. The transcripts were reviewed by the principal investigator for accuracy and data were organized using NVivo software. Each participant's non-verbal language (facial expressions, posture), mood, and tone of voice were noted and included in memos that were used during data analysis (Krueger, 2000). These observations helped the reviewers to understand the context in which statements were made as the transcripts were reviewed and analyzed (Duggleby, 2005). The use of thematic content analysis (Patton, 2002; Sandelowski, 2000) required that the transcripts be coded in order to identify themes and organize the data under these. Codes were generated and defined based on the research questions and systematically used to develop a coding scheme. The data were reviewed and collapsed or grouped in order to identify themes. Next, connections were made



between codes to allow for robust description of the medication-management process by identifying subthemes as they emerged from the data. Once the themes and subthemes were identified, a model was developed to illustrate the findings. The four members of the research team met regularly to analyze and validate the data and to discuss findings. A final conceptual model was developed (Figure 1).

The research team took a number of measures to ensure rigour (Guba & Lincoln, 1989). The credibility of data was addressed through member checking with participants during an informal meeting at their facility to review and discuss the preliminary findings (i.e., themes and categories). Twelve participants from the two sites provided feedback, which was used to make revisions. Peer debriefing within the research team was used to ensure credibility of the findings and trustworthiness of the process by acknowledging possible biases, assumptions, and past experience. By obtaining multiple viewpoints through the inclusion of RNs and RPNs at two LTC facilities, the researchers improved the transferability of the findings. An audit trail of the processes used and decisions made in data collection and analysis ensured dependability of the data.

Variable	Registered Nurses Female (n = 10)	Registered Practical Nurses Female (n = 12)
Mean age (years)	42.5 ± 2.5	39 ± 2.3
Work experience (years)	8.6 ± 2.1	6.9 ± 1.4
Employment position	8 full-time, 2 part-time	10 full-time, 2 part-time
Education	3-year diploma program	2-year certificate program ^a
^a 2 RPNS did not report their education level.		

Findings

Twenty-two nurses (10 RNs and 12 RPNs) participated in four focus groups. Demographic data are provided in Table 1.

Both RNs and RPNs described the process of medication management in LTC as “racing against time,” noting that they wanted to finish the race in a safe and timely manner despite facing many barriers, over and above those encountered in their other care duties:

[Medication management is] a race . . . you're just running back and forth doing pills . . . up and down and up and down in the elevator. . . You're trying to stay on top of everything with the patients . . . it's just expected you do it. (RN)

. . . race against the clock . . . all day long, all day long. So you have to go like hell to make sure you get those pills out before it [the day] ends . . . perform magic. (RPN)

Within this race to manage medications, nurses reported three distinct phases: *preparing to race*, *running the race*, and *finishing the race* (see Figure 1). These phases were sequential but could also be simultaneous and recurrent, depending on the individual nurse, the needs of the resident, or barriers that impeded the medication-management process. Within each of the phases, a number of barriers influenced optimal medication management. Each of the three phases and the associated facilitators and barriers are described below.

Preparing to Race

Preparing to race refers to the way nurses collected information about the residents and medications prior to administration. This included knowing the resident, knowing the medications, and collaborating with other members of the health-care team.

Knowing the resident. During this first phase of the medication-management process, nurses reviewed the residents' charts and systematically gathered information about their conditions, co-morbidities, and current health status. Nurses explained that by reviewing each individual chart and talking with the residents and their families, they got to know the residents better. Making decisions about the plan of care was facilitated by knowing the resident. One RN said, "Because the triage nurse knows all the residents really well, she might second check [the medications]."

Knowing the medications. Nurses stated they were responsible for knowing the medications in order to prepare for their safe administration. Knowing the medications included obtaining medication orders for residents and understanding the use and side effects of each drug. Knowing the medications was facilitated when nurses knew, recognized, and could distinguish between the name, brand, colour, and appearance of each medication:

You have to be able to recognize [drug name]: Oh, that's the little pink pill, okay, yeah, but does it say right on it? Because I have another little pink pill in here — you have to know your meds really well, what they look like. (RN)

Nurses noted that sometimes their knowledge was lacking in this area.

Collaborating with other members of the health-care team. Nurses stated that collaboration, including effective communication, within the health-care team was a vital component of the *preparing to race* phase. Collaboration was required to adequately collect information about the residents' medications and health status. Effective communication among all members was seen as essential in order to maintain safety standards when there were issues with prescribed medications and also facilitated collaboration within the team. Nurses explained that expertise within the health-care team was diverse and that when resource persons at the facility were not available they would attempt to collaborate with health-care providers located off-site, in order to gather necessary information so that safety standards were met:

I'll talk to other nurses in my office, but I find most of us are secluded. It's nothing to go and talk to three other nurses and try to get their opinions on medications. But I find even with management they're not always readily available. That's why I call the pharmacy [consultant] more often and deal with the doctors more often than anyone else. (RN)

Nurses collaborated with pharmacy staff to clarify issues around the ordering of medications or to confirm the appropriateness of a medication based on the resident's conditions. Nurses acknowledged that in this phase it was helpful to use communication books and leave interdisciplinary notes outlining issues or concerns. This sharing of vital information helped the nurses to be better prepared:

Sometimes the pharmacies, if they do note that a resident has an allergy to a certain medication and they may have the same allergy to a different medication, they'll send us a note saying that they may have this or that side effect and we can monitor for that. (RN)

Running the Race

The second phase of the medication-management process was *running the race*, and it included administering medications to residents while prioritizing and strategizing. After relevant information was collected (first phase), the nurse interpreted the information and determined what needed to be done.

Administering medications while prioritizing and strategizing. In this phase, nurses considered a number of factors when prioritizing care demands and administering the medications. Nurses strived to complete this phase as quickly as possible in order to fulfil their other care demands:

[In medication management] you really have to time-manage and prioritize . . . But most importantly, you have to get it done, especially when it comes to meds and treatments. You can't leave the person on the floor and not give out your meds and get to them later. You have to be quick . . . otherwise you're there all morning and it's time for the lunchtime meds. (RN)

Nurses stated that the number of medications and the number of residents played a role in the medication-management process. One nurse estimated that the 40 to 50 residents received an average of 7 to 10 medications per day and said that one nurse was assigned to administer these. If a resident could take only one pill at a time, it affected the amount of time spent with that resident. The nurses reported that being “flexible” and “quick” was important in the successful completion of this phase.

Nurses employed various creative techniques to quickly and efficiently administer medications. These included diverting the resident's attention, re-approaching, crushing and hiding medications in food, pre-pouring medication, and lying in order to ensure that the residents received their medications on time. Because they were under time constraints, being creative was the only way they could complete this phase:

It's quite a challenge . . . you get very manipulative and lie, [or you] hide it, and if they're adamant about not taking it, then you'll leave it. I'm not going to force them. We crush it, put it in applesauce and get them to take it, because they need it. (RN)

Although there was acknowledgement that some of the strategies ran against policy, the majority of participants said that the priority was to administer the medications. There were few alternatives, given the time pressures and the workload:

What's important is that they get the medication. (RPN)

For example, potassium — you can't crush it, but the liquid has a distinct taste and if you do have someone who has behaviours and thinks you're poisoning them, you have to find various ways to hide it, like in chocolate, or put it in juice. (RN)

In one focus group there were conflicting views among the nurses regarding the pre-pouring of medications. The discussion became confrontational:

RN 1: A lot of people pre-pour here. It cuts back on the time. (concerned tone)

RN 2: *It's not accurate if you've got your hands on the wrong container.*

We're not supposed to do it! (raised voice)

RN 3: *I know, but a lot do!* (sharp tone)

RN 4: *I know — I'm guilty of it the majority of the time too.*

However, strategies were rationalized and justified by nurses who stated that they had little choice with residents who spat out their pills, were cognitively impaired, and/or had difficulties swallowing. They felt that, because of their heavy workload, they had no time to re-approach and coax residents.

Finishing the Race

Finishing the race was the final phase of the process. Once the nurse had completed the administration of medications, there was a shift towards assessment and evaluation and then documentation.

Assessing and evaluating. Responsibility for adequately and safely evaluating the effectiveness of the medications being administered was delegated to nurses. Depending on the facility, it was the responsibility of either RNs or RPNs to evaluate and then advocate for the resident by reporting to the physician on the need for or the effectiveness of a medication. The nurses felt a sense of responsibility concerning the reliability of their recommendations and their assessment of possible adverse events:

You're the one that suggested it [medication], so you feel like . . . it's not that easy trying things. A lot of people are having side effects, so you have to watch. (RPN)

Nurses stated that it was imperative they try and decrease the amount of unnecessary medication to prevent adverse events, complications, and interference with medically necessary medications.

Documenting. Documenting and recording the medications administered and the needs of the residents were useful in the transmission of information to various team members. When team members recorded their assessments, the nurses could better evaluate the effectiveness of the medication for each resident:

You have to write on the back of the MAR [Medication Administration Record] . . . in lines, the date, the time, why you gave it, was it effective, and if they're writing it four to five times daily you might as well get it ordered as a regular order so you don't have to do as much writing. (RN)

Documenting was seen by nurses as an essential part of the process and not a task to be skipped. If documentation was missing, there were consequences, such as medication errors.

Barriers to Medication Management

Participants identified lack of time as the most common barrier in medication management. This barrier traversed all phases of the medication-management process. Other barriers described were as follows: lack of knowledge about medication, increased complexity of residents, resident refusal of medications, interruptions and distractions, excessive documentation, poor communication within the health-care team, and the position of nurses in a hierarchical and blaming climate (see Figure 1).

Lack of time clearly affected the way in which nurses moved through all phases of the medication-management process. Nurses expressed the view that more of a focus on “time, resources, and authority” would greatly impact how time is used in LTC:

The length of time it takes in doing medications. It takes a very long time . . . time crushing — the cost to the health-care system . . . (RPN)

Well, you’ve got 5 minutes to do your pills, and then you’ve got to sign all those forms to make sure everyone else has [done] their job. But that’s the management style here: “If people aren’t doing their jobs, we’ll just make it the nurses’ responsibility.” (RN)

Time pressures and an excessive workload prevented nurses from properly assessing and evaluating the effectiveness of medications. Nurses explained that because of time issues, this phase of medication management was often missed. They commented that if they did not administer a medication on time, then a medication-error report was completed.

Nurses explained that they lacked knowledge about the medications the residents were taking and relied on colour and shape to identify drugs. This knowledge gap was seen as an obstacle in the *preparing to race* phase. Interestingly, seeking advice about medications from managers was seen as a barrier, management being focused more on reprimanding nurses for their errors than on creating a supportive work environment. Nurses did not consider managers to be resources — “the majority of them in management don’t have the experience to answer your question” — which served to widen the knowledge gap.

According to some nurses, communication among nurses, physicians, and pharmacists was less than effective. When nurses tried to communicate information about residents to other members of the health-care team, particularly physicians, they met with resistance:

Whether they agree or they don’t agree, many of the doctors won’t listen to you, so you may have a resident who refuses pills every day for years. (RPN)

The complexity of residents' conditions increased the amount of time required to administer the large number of drugs and was an additional barrier in medication management. Swallowing difficulties, cognitive impairment (especially dementia), and complex medical conditions played a role in how medications were administered. Medication refusal was a major barrier for the nurses during this phase. The frustration was evident in nurses' tone when this issue came up in the focus groups:

You have to look at what point do we say they have the right to refuse and we don't give it, and at what point do you say they need their medicine, no matter what we have to do to get it into them. Let's take, for example, insulin. She'll practically kill you if she could and you don't want to give her any insulin. You have to just do your best to calm her down, get somebody else to talk to her. It's very challenging. When you have a person sitting with them to make sure they have all their pills, it's very challenging. Some of them will get smart and be able to lose the pill, without you even noticing that it's not in their mouth, and hide it. (RN)

Nurses reported that interruptions were an impediment to administering medications. They explained that the reality in LTC is that there are many interruptions and distractions, which affect not only *how* medications are administered, but *how safely*:

It can be quite lengthy, depending on the floor you're on. It can take as long as 3 hours in the morning. Plus the phone rings and you have family coming up to you. You need a big sign that says, "Leave me alone" on the cart. Especially when they teach you in school that you shouldn't be interrupted — you should really pay attention to administering. (RN)

Nurses agreed that during the *finishing the race* phase a major barrier was the excessive amount of documentation required, both on paper and electronic, which hindered effective assessment and evaluation. The participants stated that it was difficult to produce the amount of documentation expected in the LTC setting because of time constraints:

Paperwork. You've got to give the medication, sign for it on the MAR space for the RN. You've got to flip over the back and sign for that, put a little paperclip on top, go back and write in the effects later. Then chart that you've given them p.r.n. [and] whether it was effective, put it on the Kardex so the next shift knows. You have to do all that for one Tylenol because somebody's got a headache. (RN)

Another barrier involved concerns about the perceived hierarchical culture and lack of autonomy. Interestingly, nurses felt that they had little authority or control over the current expanded role expectations. For example, RPNs felt that they were less valued than RNs in this setting:

They [RNs] put us on the floor to do a job, then they're trying to dictate how to do our job . . . The problem for RPNs is really that we're sand-wiched. We're expected to pick up the slack from the RNs. (RPN)

Nurses also perceived a culture of blame and viewed it as a predominant factor in how medications are managed in LTC. Specifically, nurses believed that they were not living up to professional expectations, in that they had little time to make informed decisions and to engage in critical thinking. Much of this belief was rooted in what they considered “poor” RN medication-management practices, especially poor assessments directly attributable to time constraints, fear of being reprimanded for not completing assessments in a timely fashion, and a general lack of knowledge about medication specifics:

And all those things add up to what it is today, but it's not just one specific thing overall. Because we all get the blame for it. (RN)

Nurses expressed the deep conviction that although they knew the importance of a thorough assessment on a theoretical level, they were prevented from doing their job properly by systemic issues beyond their control — mostly involving time constraints and workload. They made it clear that they would simply “do the job” and conform. Nurses indicated both emotional “frustration” with the entrenched systems that discouraged them from challenging convention and an awareness of structural systems that limited their ability to manage medications — no matter how much they wished to do so.

Facilitators of Medication Management

According to the nurses, key facilitators of the medication-management process were knowing the resident, medication knowledge, effective communication and collaboration within the health-care team, sufficient staffing, and support from management in the LTC environment.

Discussion

The participants described managing medications in LTC as “racing against time.” Time was a prominent contextual factor in medication management. Nurses voiced considerable concern about time constraints, particularly when they described trying to safely and accurately manage medications. A lack of time — real and perceived — limited the amount of detailed information that could be collected about residents’ medication and medical history. Time impacted how medications were delivered to patients, since the amount of time involved in medication administration influenced the behaviour of nurses to a significant degree. Time constraints resulted in nurses having to strategize and prioritize in order

to find alternative ways of ensuring that residents took their medications. At times the nurses even engaged in unsafe practices in order to respect the schedule. Time constraints had a measurable impact on the ability of nurses to effectively and consistently monitor, assess, evaluate, and document the administration of medications and their effects over both the short and long terms.

As described by Thomson et al. (2009), a considerable amount of time is required to administer medications in the LTC setting. Lack of time is documented in the literature as an issue for nurses as they perform various tasks, including medication management (Bowers et al., 2001; Crespin et al., 2010; Vogelsmeier, Scott-Cawiezell, & Zellmer, 2007). Time is reported to be the key concern associated with managing medications, with nurses finding it “impossible” to keep to the schedule for medication administration in the LTC setting due to the ever-increasing number of residents assigned to each nurse. In addition, nurses are reported as believing that, because of time constraints, medication-management practices are compromised.

As described by participants in this study, it is important for nurses to know each resident in order to manage medications properly — a conclusion that is supported by the literature on medication management (Cheek et al., 2004). The participants made it clear that “knowing the resident” involves the nurse gathering information from the chart and from other members of the health-care team to obtain a complete clinical picture of the resident. When residents are unable to communicate, interactions with family members are viewed as essential so that the nurse will become acquainted with the patient. Knowing the resident well is vital to the safe management of medications (Cheek et al., 2004), and in the present study *preparing to race* was the first phase of the medication-management process.

The participants also highlighted the importance of “knowing the medications,” to avoid the risk of medication error, and voiced particular concern over their lack of knowledge about medications. Leape et al. (1995) report that over 29% of all medication errors by nurses are due to lack of knowledge concerning medications.

Effective communication and collaboration within the health-care team was found to facilitate the medication-management process. This finding is consistent with the results reported in the literature (Binch et al., 2005; Dilles et al., 2011; Thomson et al., 2009). Specifically, nurses commented that poor communication within the health-care team hindered the effective use of medications, a finding that is supported by previous research (Binch et al., 2005; Cheek et al., 2004; Eisenhauer et al., 2007). An interdisciplinary approach has been recommended as best practice (Bergman-Evans, 2004).

The *running the race* phase of medication administration was the most difficult to complete due to time demands, interruptions and distractions, the number of residents and the complexity of their conditions, and polypharmacy in LTC. Safe practices dictate that nurses follow the rights of medication administration outlined in current standards (CNO, 2008). However, these practices are complicated by the high number and frequency of medications administered per day and do little to promote collaboration among members of the health-care team (MacDonald, 2010). According to Bergman-Evans (2004), to overcome barriers to the effective management of medications, nurses endlessly strategize and prioritize in order to deliver quality care within current limitations. This also was an important finding of the present study.

The participants conveyed a sense that *finishing the race* was regularly neglected because of time constraints. Nurses described how excessive documentation, both written and electronic, required them to focus on this aspect of the process instead of spending time with individual residents. Nurses felt that barriers connected to workload issues and time constraints had a direct impact on the evaluation and assessment of medication effectiveness because complete and thorough safety checks were not always possible (Bowers et al., 2001; Dilles et al., 2011). Moreover, nurses believed that if they did not document effectively, they would be reprimanded for medication errors and poor performance.

Strengths and Limitations of the Study

This study makes an important contribution to the small body of research available to guide our understanding of medication management for nurses working in LTC. Its strengths include the development of a new model illustrating the process of medication management, data collection from two LTC sites, and the use of both RNs and RPNs to gain a rich perspective of the barriers that nurses face while managing medications. Its limitations include the relatively small sample size and exclusion of the nurse practitioner (NP) perspective. It is within NPs' scope of practice to perform, as members of an interdisciplinary team, clinical tasks that are essential to the medication-management process (CNO, 2008).

Implications

The findings of this study offer health-care providers, senior managers, nursing leaders, and frontline nurses, as well as educators, valuable information related not only to the process of medication management, but also to the challenges that nurses face and the specific nurse, resident, organization, and system factors that together produce these challenges. Medication-management procedures, both those in place and those that are needed, should be acknowledged and documented, in order to help

decrease the number of adverse events and medication errors and, most importantly, to improve the quality of care. Deploing the prevalence of adverse events and medication errors is simply not enough. Understanding the context in which they occur, especially how it diverges from the theoretical or the ideal, is vital to getting at the heart of why medication-management problems continue in the LTC setting. The importance of knowing residents and their medications, of interdisciplinary collaboration and communication, and of moving away from a culture of blame has major implications for nursing practice and the implementation of best practice. Minimizing distractions and interruptions through proper staffing and providing dedicated time for the management of medications are essential for resident safety.

This study generated a conceptual model of medication management that can be used as a tool for educating nurses and other health professionals. By illustrating the different phases that nurses move through in striving to successfully and safely manage medications, this model can direct learning, address systems issues, and shed further light on the process of medication management. Though the metaphor of a “race” is not complicated in and of itself, it is the very familiarity of the concept of racing — to those within the LTC setting as well as those outside — that makes it so useful in conveying the practical realities of day-to-day medication management.

Time barriers also had a clear effect on the delivery of medications. However, nursing education must, over the short and long terms, examine “time” within the context of an aging population, increasing polypharmacy (whether justified or not), and the increasing need for — and desire of — nurses to be more familiar with new and ever more widely prescribed medications (especially antipsychotics). This simple and yet novel model highlights the specific barriers that LTC nurses and residents face and could be used to facilitate educational reform in LTC.

The implications of these results for future research are manifold. Additional research could help to develop the model presented in this study and could go a long way towards validating, or invalidating, its central assumptions. It would be particularly interesting to see if, and to what extent, knowledge gained through research on the medication-management process helps to direct educational strategies, assist with (and possibly reform) staffing and workforce planning, and ultimately improve the quality of care for residents.

The system issues that directly influence the medication-management process in LTC need to be addressed. For example, both human and financial resources must be increased in order to meet the needs of LTC residents with complex conditions; implement and sustain staffing models to improve the quality of the work environment, which impacts resident

outcomes; and improve the reporting of quality organizational indicators that promote accountability for the quality of care provided (Armstrong et al., 2009; Canadian Healthcare Association, 2009; Sharkey, 2008). The health and safety of LTC residents and those who work in this uniquely complex environment are a priority, and action is needed.

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**Métaphores et médicaments :
pour comprendre la question de la prise
de médicaments quotidienne chez les aînés**

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Cette étude avait pour objectif d'explorer l'utilisation de métaphores chez les aînés autonomes prenant des médicaments pour des maladies chroniques. Des témoignages tirés d'une étude plus vaste fondée sur des théories empiriques ont été soumis à une analyse comparative constante et un processus d'induction. Une deuxième analyse des témoignages de 21 participants a été réalisée. Chaque ligne des transcriptions ont été étudiées de façon à relever et cerner le langage pertinent et à déterminer les liens et les thèmes présents. Les témoignages contenaient diverses métaphores. Quatre catégories ont été relevées : l'enchaînement, l'espoir, l'autorité extérieure et les craintes relatives à la communication. Trois autres thèmes étaient également présents : le vieillissement et la mort, la personnification des médicaments et le corps en tant qu'objet. Les auteurs ont conclu que l'utilisation de métaphores chez les aînés révèle la présence de tensions et de dilemmes non résolus relativement à la prise de médicaments.

Mots clés : métaphore, prise de médicaments, aînés, maladies chroniques, témoignages

Metaphors and Medication: Understanding Medication Use by Seniors in Everyday Life

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The purpose of this study was to explore the use of metaphor by independent seniors taking medication for chronic health conditions. Narratives from a larger study using grounded theory were analyzed using constant comparative analysis and induction. A secondary analysis of the narratives of 21 participants was undertaken. Transcripts were read line-by-line and all relevant language was highlighted and reviewed with the aim of identifying relationships and themes. The narratives revealed a diverse range of metaphoric language. Four categories were identified: being shackled, hope, external authority, and communication fears. Three additional themes were interwoven into the narratives: aging and death, medication personified, and the body as object. The authors conclude that metaphor reveals the tension and unresolved dilemmas faced by seniors with regard to medication use.

Keywords: metaphor, medication use, older adults, chronic illness, narratives

Introduction

Nurses are among the many health-care providers concerned about increased medication use among community-dwelling seniors, who are largely unsupervised in their medication practices. Medication use by community-dwelling seniors takes place in a multifaceted context. Seniors with chronic health conditions are living longer as new drug-treatment options become available. Additionally, seniors are exposed to a culture of targeted advertising in which a pill for every ill is encouraged. Research in the area of seniors' medication use has been predominately influenced by the perspective of health professionals and is grounded in an empirical discourse of compliance and adherence (Belcher, Fried, Agostini, & Tinetti, 2006; Hughes, 2004; Lorenc & Braithwaite, 1993; Mirza, 2006). There is a much smaller body of work examining seniors' use of medication as consumers in a commoditized and heavily advertised milieu (Cruikshank, 2003; McKim & Mishara, 1987). Increased medication use, while potentially beneficial for seniors, also places this population at high risk of adverse drug events (Sikdar et

al., 2010). While many are keen to intervene and embark on strategies such as public education campaigns to address this issue, we believe it is important to first understand the experience of medication use from seniors themselves, especially those who are living with one or more chronic health challenges.

There is a paucity of information about unsupervised medication use. Perhaps more importantly, very little is known about how medication use by community-dwelling seniors is informed by their embodied, situational experiences. During an analysis of narratives as part of an overarching study to address this question, our research team was struck by the metaphorical language that emerged as participants tried to illustrate and describe their unique experiences related to medication use and practices. The realization that metaphors are embedded in everyday conversation and stories prompted us to undertake a secondary analysis of the narratives, focusing on metaphorical and figurative language. We wanted to know how older adults use metaphors to describe their use of medications. More specifically, our aim was to better understand how metaphors might capture the day-to-day experiences of independent chronically ill seniors who use medications. It quickly became evident that there is a knowledge gap in this area of inquiry. While much has been written about the use of metaphor in nursing, we found no studies focusing specifically on how seniors use metaphor to describe their experience of daily medication use. In this article we describe findings that extend this new area of inquiry.

Background

Medication Experience

The experience of seniors using medication to manage chronic health challenges is complex and entails many small decisions, which in turn are influenced by situational and embodied changes due to the medications themselves. These changes can be positive or negative and can be intended or unintended. Little is understood about how community seniors experience living with chronic health challenges, which often increase in number with aging and necessitate the use of multiple medications instead of one or two. Shoemaker and Ramalho de Oliveira (2008) describe three studies with younger adults taking medication for chronic health conditions. They found the “medication experience” to be a useful concept for better understanding the meaning of medications for patients. The broad notion of lived experience from a hermeneutic perspective recognizes that life is full of experiences that move individuals to make meaning and to bring forth understanding based on the context

of their life world (van Manen, 1989), which most often occurs through the use of language.

Metaphoric Language

Metaphor is defined as “a figure of speech in which a word or phrase literally denoting one kind of object or idea is used in place of another to suggest a likeness or analogy between them” (Mish, 2000, p. 729). For example, medication is sometimes referred to as an anchor. Metaphor embedded in everyday language can reveal much about common experiences (Stephenson & Black, 1990), such as those of independent seniors who use medication. Metaphor is a novel way of looking at narrated life experience, as it can also create expectations, influence decisions, and epitomize our understanding of things and processes (Geary, 2009). Quite simply, metaphor is integral to the functioning of language (Abrams, 1993) and central to the creation of new combinations of ideas (Baldick, 1990). Our research focus was not the structure of language but the interpretive opening created within language. Metaphor is invitational and can help us to make sense of a complex world and reality, such as medication use by seniors. Metaphor “defamiliarizes” the familiar and causes us to pause; it “creeps up on you and surprises” (Janesick, 1994, p. 209). In her classic work, Sontag (1990) writes that we must remain open to illness experiences and what they truly mean, that the pervasive overuse of metaphor can also obscure. Herein lies the challenge for health-care providers: to be alert to what is heard so that we may be surprised again.

Metaphoric Understanding

Why is approaching understanding through metaphor important to nursing and other health-care professions? Those under the care of health practitioners are often vulnerable, overwhelmed, or faced with challenging life issues. Discerning what is really happening or making sense of the interwoven pieces is never a straightforward process. When health-care providers transcend the literal concreteness of terms and begin to listen with a metaphoric lens, they have an opportunity to gain new understanding in complex areas such as medication use. When patients use metaphor to describe their situations, practitioners can use it as an opening for further discussion. Metaphor invites practitioners to pause and contemplate what was said and what it might mean, to use patients' own words in order to explore their feelings and realities. This process can foster increased understanding on the part of the teller and the listener. We believe that metaphoric language offers a direct and available technique for exploring common understanding. In many instances, metaphor provides a safe way to say the “un-sayable.” Eisner (1991)

expands on this notion, stating that “for making public the ineffable, nothing is more precise than the artistic use of language. Metaphoric precision is the central vehicle for revealing the qualitative aspects of life” (p. 227). This is especially true for the ways in which people talk about their own impending death in intercultural clinical contexts (Burgess, Stephenson, Ratanakul, & Suwonnakaote, 1998; Stephenson, 2002). Metaphor also can act as “symbolic shorthand for understanding and communicating as one tells the narrative story of a life” (Malinski, 2009, p. 310).

Metaphor can serve as an entry point for meaningful exchange. Not only can metaphorical expression benefit patients, but, equally important, understanding through metaphor is a form of inquiry that is available to all health-care providers. This is a refreshing possibility given the current reality of overwhelming practice environments where compassion fatigue can take hold. Nurses need not be artistic, but must be able to tap into their best intentions and their genuine desire to understand those under their care.

Metaphor is also a way to amplify the voice of a group that is hidden or not easily accessible or that is understood in purely quantitative terms. When caring for the elderly, health professionals today tend to focus on medication management and adverse events; although this approach is an important empirical way of knowing, it is clearly insufficient for understanding the patient’s point of view, which often includes experiences of marginalization and powerlessness (Stephenson, 2001). Metaphor can be a doorway to how patients view themselves in the cultural discourse surrounding medications and medication use and can help to deepen our understanding in a more interpretive and individualistic way.

Use of Metaphor in Nursing

Examination of metaphor to understand nursing and nursing practice is not new. Fagin and Diers (1984) describe how nursing often evokes disturbing or discomfoting images, which make their way into metaphors: nursing as motherhood, class struggle, equality, conscience, and intimacy. A prominent metaphor in nursing is “hands on,” implying “touch, real work, technical expertise, and connection with patients” (Engebreston, 2002, p. 20). The nature of nurses’ emotional work has also been explored through root metaphors of the body as a container and emotions as energy (Froggatt, 1998). In nursing ethics, “boundary” is a metaphor used to describe how nurses conceptualize ethical connections (Austin & Bergum, 2006) as they navigate towards a “moral horizon” (Storch, Rodney, & Starzomski, 2004). Metaphor has also been used in nursing as a tool for self-reflection (Levin, 2006), to create personal narratives (Gaydos, 2005), and as a guide for engaging nursing theory (Pipe, 2008).

With regard to nursing pedagogy, Benner, Sutphen, Leonard-Kahn, and Day (2008) advocate for new metaphors such as “dance” to replace the manufacturing type of metaphorical language in which students are viewed as products and the curriculum as factory (Allen, 2006).

Nursing has also attended to patients’ use of metaphor, but in a more limited way. In particular, nurses have examined patients’ use of metaphor to understand their experiences of dying (Breslin, 1996; Hutchings, 1998; Jones, 1991) and living with serious illnesses such as HIV (Jones, 2003) and myocardial infarction (Jairath, 1999). We undertook a literature search to determine whether researchers have explored the metaphors that seniors use to describe their daily medication use. Using combinations of the keywords “metaphor,” “medication,” “drug,” “senior,” and “elderly,” we were unable to find published research in this unique area. There is a diverse range of research with the elderly that alludes to metaphor in broader areas: policy (Boxenbaum, 2001), pain and pain management (Ferrell, Ferrell, Ahn, & Tran, 1994; Zalon, 1997), abuse and neglect (Lachs & Pillemer, 1995), delirium (Beresin, 1988), depression (Pang, 1998), alcohol use (Johnson, 2000), computer accessibility (Yousef, 2001), and how time is experienced (Strumpf, 1987). Two studies look at the efficacy of using metaphor with medication reminder systems (van Veldhoven, Vastenburger, & Keyson, 2008; Vastenburger, Visser, Vermaas, & Keyson, 2008). We found no studies focused on how seniors use metaphor to describe their experience of daily medication use. This knowledge gap is significant; once researchers better understand the experience of older adults with medication, an opportunity can be created to build on positive aspects and address negative aspects. By understanding what is important to older adults, researchers can strive to make their experience with medication use safe and congruent.

Methodology

Study Design

The research presented here was an extension of an overarching interpretive hermeneutic study (Holroyd, Vegsund, Stephenson, & Beuthin, 2012) aimed at helping health professionals to better understand the day-to-day experience of medication use and related decision-making by community-dwelling seniors in a context that did not involve “the gaze” or supervision. Hermeneutics is the philosophy of understanding and elucidating the conditions by which meaning can become apparent (Geanellos, 1998). According to Schwandt (1999), to understand “is literally to stand under, to grasp, to hear . . . or comprehend the meaning of something” (p. 452). The research involved one-on-one interviews with large open-ended segments that captured rich, often unanticipated,

narratives. As interpretive researchers, we realized that our preconceptions about medication use would likely be different from those of the participants. For this reason, we were mindful, during the interpretation process, of the need to maintain a stance of openness to the many meanings that emerged. Additionally, as health professionals we were challenged to transcend the tendency towards self-confirmation as it relates to the phenomena of interest. We took care to not assume what the participants' experiences with medication use would be.

Sample

Older adults with one or more chronic health conditions were recruited from two seniors' centres and one community seniors' group on Vancouver Island on Canada's west coast. Posters were placed in the seniors' centres and e-mails were sent to members of the community seniors' group. Inclusion criteria were as follows: age 65 or older, one or more prescription medications, one or more chronic health challenges, and ability to take part in an English-language interview. There were 21 participants, 9 male and 12 female, of whom 11 were aged 65 to 74 and 10 were 75 or older. Education levels ranged from high-school graduation to university degree. Once consent was obtained, participants were offered a choice of interview site; 11 opted for one of the seniors' centres and 10 opted for their own home.

The study was approved by the Research Ethics Boards of the University of Victoria and Vancouver Island University.

Data Collection

The data for this secondary analysis were taken from one-on-one interviews with participants concerning their everyday medication use. The interviews were conducted by a nurse researcher and a graduate student in anthropology. Participants were requested to bring a list of any medications they were currently taking, including non-prescription, over-the-counter, and alternative medications. The participants were also invited to bring along, in a Ziploc bag, all the medications they were taking so that the researchers could record this information. (The 10 participants who were interviewed in their homes were invited to simply show their medications to the researcher.) Of the 21 participants, 15 produced their medications and the researchers recorded the information. This self-reported information revealed that participants took a mean of five prescription medications regularly and seven over-the-counter or herbal/alternative medications intermittently. Each participant was randomly assigned a pseudonym, which was used throughout the study. Demographic data were recorded and collated. Information on use of medication reminder systems was not recorded.

The interview guide was designed to give participants ample opportunity to elaborate on their lived experiences related to their medication and its use. This guide was iterative and although all participants were asked similar questions, interpretation of the question being posed, and the degree of attention it was given, depended on the individual participant and his or her unique situational, embodied experiences with medication use. The interview questions were developed in collaboration with key interlocutors from among “expert” seniors recruited through the Centre on Aging at the University of Victoria. Each interview was audiorecorded and transcribed to form a written narrative account of the lived experience.

Data Analysis

In the knowledge that metaphors can reveal much about everyday experiences, a member of the research team undertook a secondary analysis of all 21 transcripts. The goal was to examine how independent older adults use metaphors to describe their day-to-day experience of taking medication to manage chronic disease. The researchers extended the interpretive approach of the original study by drawing on the spirit of Janesick’s (1994) approach, which emphasizes metaphor and embraces the intention to carefully and thoughtfully “describe, explain, and make understandable the familiar in a contextual, personal, and passionate way” (p. 217). Janesick is a proponent of supporting assertions by drawing heavily on direct narrative quotations, as the researchers have done here.

To explicate expressions and language used, each transcript was read line by line and relevant language was manually highlighted. The term “metaphoric language” is used to illustrate how metaphor became more fluid as the narratives progressed. Had we adhered to a strict definition of “metaphor,” much of the rich descriptive language used by this population would have fallen away. All highlighted language was reviewed across participants with the aim of identifying relationships and themes. A second team member, who had conducted interviews for the larger study, reviewed the emergent findings. Researchers went back and forth, using constant comparative analysis and induction to develop themes. Janesick (2003) describes this approach to analysis as a way of staying grounded in the data. Within this circular process, researchers remained mindful of the need to be open and committed to engaging with the seniors as they shared their unique and complex subjective reality. As researchers listened, interpretive themes began to come forward, consistent with Janesick’s (2003) belief that “staying close to the data is the most powerful means of telling the story” (p. 63). A process of ongoing adjustment, using what is referred to as the hermeneutic circle, eventually led to agreement by the researchers on the narrative phrases and language

identified. It was through the natural questioning and movement between the textual data and the researchers that validity was achieved to the extent that it was. Researchers grew confident, as this process resulted in the clustering of data so that the overarching themes were reduced from thirteen to four. These broad themes were then shared with the full research team to determine whether the emerging interpretations rang true. This process allowed researchers to achieve the greatest validity possible for an interpretive study.

Findings

The researchers found a range of metaphoric language in the narratives. There was heavy overlap of metaphorical language from which four key themes emerged: being shackled, hope, external authority, and communication fears. Further interaction with the data revealed three interwoven themes: aging and death, medication personified, and the body as object. The researchers were surprised by the degree to which the participants' statements began to form clusters that led to the emergence of the seven metaphorical themes. True to Janesick's (1994, 2003) approach, the researchers struck a balance between description and interpretation.

Metaphors of Being Shackled

Medications were frequently viewed as having elements of danger and imprisonment. Undertones of tension were expressed by many of the participants who questioned whether they should be taking medication. Bill said, "We don't mess with danger" and spoke of "getting bombarded with the medication." He wondered about "the cure being worse than the disease." Similarly, Polly spoke of having one pill for this and one for that and wondered if "they do more harm than good." Bernie, too, wondered if she was "better or worse off" by taking "heavy-duty" medication. She also expressed concern about getting "hooked on the codeine." Mica referred to one medication as "poison," while Maddie used the terms "rat poison" and "painkillers." Bridget referred to medication as "heavy" and something "I don't play around with." Two participants described their medication as "a pain in the butt." Molly said that her drugs were "taking over my life." Holly spoke of "hoping to get off" her glyburide. Gord expressed the opinion that the pharmaceutical industry "is using the public as a guinea pig." He added that "your masculine pride is gone up in smoke" in reference to being dependent on little pills, day after day. Ignatius said he was not depressed "but ticked that I'm shackled to medicine." His frustration was further evident in what his wife described as a "balancing act," in that "when you're taking them you're not going to feel like doing anything." Ignatius elaborated: "There

are days when I take them and I think, this is the pits, this is the absolute pits." Mary expressed it this way: "I'm leery as hell of taking any medications."

The participants used figurative, literal, and colourful language when speaking of how many pills they took. While not purely metaphoric, the expressions create an opening to gain insight into the experience. Dan spoke of the challenge of travelling while on medication: "You take one suitcase with pills in it." Polly said, "I ended up with a fistful of drugs" and spoke of the medical system as "pushing the pills." Also expressed was a desire to take fewer pills. Three participants used similar phrases: "smaller is better," "little is better," and "less is better," as well as "more is not better." And yet, amidst the questions and expression of uncertainty, the participants did comply and took their prescribed medication. Molly said, "I'm very religious about taking them." The desire to take fewer medications and to not feel so imprisoned by the drugs revealed a tension when considered in light of the next theme, hope.

Metaphors of Hope

Bridget saw the benefits of her medication in controlling seizures: "It made me able to live a productive life . . . thank you, medication." Personification is related to metaphor (Abrams, 1993) and we see it here with an inanimate object, the medication, being addressed directly. Bridget then said, ". . . a fine line you're walking," with regard to taking drugs. She added, "I'd be lost without it" and yet "you take them with water and hope for the best." Dan was dubious about taking medication, saying, "It's a toss-up one way or the other," yet cheerfully described his nasal spray as "a godsend." Gord acknowledged that his medication gave him "peace of mind" but tempered his words by adding, "but on the other hand it gives you a negative feeling." This tension was also evident in Ignatius's referring to his medication as "an anchor": "When you take them, you know that you're just going to have this anchor, so there are days when you think, maybe, to hell with them, I just won't take them." Ignatius believed that if he stopped his medication he would "go downhill," so he continued with it, saying, "I'm happier dragging the anchor."

Metaphors of Doctor as Authority

Many of the participants expressed the feeling that they were under the authority of their doctor. Bernie said, "I'd hate to upset the apple cart sort of thing." Carlos was more direct: "I just follow the doctor's orders and I respect his judgement and that's it." Mica felt "assured that my doctor is sort of doing the right thing to protect me." James echoed this view: "I don't change anything myself, because I'm not a doctor." Peggy, however, took the opposite stance: "I think that medical relationship — the patient

and doctor — the doctor shouldn't be thinking that he is 10 miles above the patient."

Metaphors of No Voice, Not Being Heard, and Misbehaving

Molly wanted to voice her concerns but believed that the doctor "wasn't open to hear." Similarly, Bridget wondered if her medication was too strong but did not speak up, saying, "but I'm not the doctor . . . I'm only a layperson . . . he knows better than I do." She indicated that she would like to speak up and said that she encouraged her friends to "make waves" if need be, yet did not raise questions and chose to view her medications as "all legitimate, all under the doctor's care." Gord was sceptical, believing that the doctors "play along" with pharmaceutical companies and have "pushed the envelope." Polly, too, wondered if doctors were "pushing the pills" and if they "lose the touch of the patient."

Some participants also revealed how they viewed their own actions or behaviour. Holly said, "I don't really have any major complications associated with it, as long as I behave myself, but I don't behave myself well." She added, "I'm bad, I don't do the blood test . . . I push my luck a bit." When Gord mentioned that he altered his dose, he was asked if he told his doctor: "No, I didn't — I kept that for myself, because I didn't want to appear that I was a sloppy patient with bad habits." Mary referred to herself this way: "I'm a bad subject because . . . I'm leery as hell of taking any medications."

Metaphors of Aging and Death

While the focus was on everyday medication use, interwoven into the narrative of that experience were beliefs about aging and death. Participants used strong metaphors to offer glimpses of their perspectives. With regard to aging, indirect language used by Fred included "gone downhill." Jack said, "I haven't got much time left, it's all on the way out now." Molly put it this way: "I still have to keep going." Brian, too, spoke of wanting to "keep going" as long as he felt well. He added, "That would be a horrible way, to have your mind alert inside a shell of a body." Wally shared this view: "They sort of put them out to pasture and that's the end of that." Dan alluded to older people as "wanting to go" and as "[lying] there like a vegetable. It's not the answer." Ignatius said, "I've got way too much stuff to do to go and jump off a bridge." He later added, "As soon as you can't accomplish something, you're a drag on society." He referred to death as a "face plant": "As far as I'm concerned, there's nothing wrong with trying to live a full life until you do the face plant." An indirect reference to death is also found in a comment by Debbie: "They're still alive, not sick enough to die." Bridget said of an ill friend, "I thought she was going to leave us that day." Madge spoke at length

about a suicide attempt but never used the word “suicide,” referring to the act only indirectly: “I left a note on the kitchen table.” The reference to “a note” is a figure of speech related to metaphor, known as synecdoche, when the part is used for the whole (i.e., the note stands in for the suicide) (Abrams, 1993).

Metaphors of Medication Personified

Participants used colourful personifications to describe how the drugs acted in and on the body. An inanimate object, the medication, was endowed with human attributes. Fred described how his medication worked: “The cholesterol comes out, does a U-turn, comes back — this catches it before it does an L-turn.” He also spoke of his experience with narcotics: “Painkillers never really touched that pain . . . I realized that there was nothing that was cutting that pain, nothing could touch it.” Molly spoke about an adverse reaction; the medication made her sick “in my stomach — it was hitting my ulcer and everything else.” Madge described her prednisone as “chewing up the bones”; she also described talking to her medication: “I take all [of] them in the morning and I think, oh my god, I hope you guys all know what you’re doing down there because I think — heaven forbid. I mean, they all go in the stomach and it’s not the stomach where they have to be.”

Metaphors of Body as Object

The language used to describe the body and how it functions was often mechanical and concrete. In speaking of his cardiovascular system, Fred said, “You’ve got a pump and you make the pipe bigger, the pressure is less.” Fred described pain as something that could not be “touched.” Holly had been given information on how her medication worked, “but it just went in one ear and out the other, as usual.” She laughed and added, “But then memory is a sad thing at times.” Jack spoke of his heartburn, saying, “I found the heartburn was just faintly talking to me.” He had gone to the emergency department, “and they fixed me up.” Molly described her restless legs as “really jump[ing],” her ulcer as “weeping,” her bones as “breaking down,” and her atrial fibrillation as “that one that’s flying around in there, that butterfly.” She also described her inability to vomit: “My little gate won’t do it.” Maddie made reference to her rapid heart rate: “He explained that it happened to be that part of the wiring system breaks down.” Debbie spoke of having survived many things, and therefore knowing “what makes us work and what doesn’t make us work.” Ignatius explained that a body can “shut down.” He described genetic material being “plugged into your heart,” adding, “How they did this was they laid me out on a slab.” He described how he would “throw down a couple of aspirins.” Gord spoke of other patients having

informed him, “people that have gone through the procedure or the mill, so to speak.” Mary described her sciatic nerve as “doing a tap dance” and her body as talking to her: “I just feel like my whole body is saying, ouch, ouch, and it’s a ridiculous thing to say.” She also spoke of bacteria: “It takes a good one to knock me down.” Brian said that one should “listen to your own body,” which “the doctor comes in and pokes and prods and leaves.”

Discussion

Findings from this study extend the literature on the use and value of metaphorical language for understanding patient groups. Examining the use of metaphorical language brought forth the voice of a new component of the experience of independent seniors who use medication on a daily basis: an inherent ambivalence towards taking drugs. We found a wide range of metaphors embedded in the language used by this population that reveal feelings of both gratitude and resentment centred on medication use; feelings of “hope” and being “shackled” often occurred simultaneously. The view of metaphors as paradoxical, in that they reveal and conceal, say and do not say, in ways that can be both personal and universal (Gaydos, 2005), is not new. For example, one is not literally shackled to one’s medication with chains, and yet medication can cause a sense of very real restriction on social outings. The metaphor of being shackled reveals a dependency but also hints at a more concealed but palpable sense of resentment of and imprisonment by the medication regimen. While tension associated with metaphor is also not new, we were surprised by the degree of tension expressed by the participants. Another example is the metaphor of “living a full life until you do a face plant,” which reveals thoughts about death, and yet use of the term “face plant” to symbolize death may conceal the discomfort of naming death directly and the use of hyperbole fused to dark humour. This is not euphemistic, yet it is a form of indirect speech. Hope is reflected in the metaphoric language of medication as “a godsend” and “I’d be lost without it.”

Delving into each of these areas has the potential to add to our understanding, but when they are considered together a deeper tension is revealed: the dilemma between being shackled and maintaining hope is that seniors are left wondering if they are “better or worse off” by taking their medications. This tension is further illustrated by two other emergent metaphorical themes: the doctor as authority and fear of speaking up, of not being heard, or of misbehaving (suggesting a timid and child/parent type of relationship). These dilemmas seemed to be holding the seniors back, in that they were not addressed, remained unresolved,

and appeared to be recurrent — if not cyclical. It is as if the seniors moved in an untenable, uninterrupted way between living with their condition, seeing their doctor, and taking their medication, as though caught in a web woven partly by themselves and partly by external factors that they felt helpless to control.

Adding weight to these tensions were three additional metaphorical themes that were unsolicited and yet closely interwoven into the narratives. These were aging and death, medication personified, and the body as object. Such a modernist and mechanistic view of the body as an object to be fixed (Armstrong, 1983; Gadow, 1990) can be problematic for health because it oversimplifies and shifts the potential of and reliance on solutions from internal knowing to entirely external forces — the physician as body mechanic. The researchers became aware of how the seniors actually lived in their body, which consumed pills. The concerns expressed through metaphor were often subtle, hidden within the everyday language of interviews. To a casual listener, these clues might be taken for granted and easily missed. Perhaps ideas about aging, life, death, and the body cannot be separated from the type of discussion about medication use that is common in contemporary health-care discourse. The metaphors used and interpreted here reflect the societal meta-narrative of medication as the all-powerful cure, a meta-narrative that can inadvertently silence other very real and related concerns of older adults. In health care, “the medication history” is taken as if it were a stand-alone entity, and the medication cart and medication delivery are the top priority in care settings for the elderly. Exactly what the metaphor of “delivery” within a discourse of efficiency may entail is a topic for another study, but it may be linked: If metaphors of medication use as embodied experience characterize patients, what metaphors are used by the health practitioners who “deliver” the care?

Implications for Practice

This study examined how metaphor can help us to understand older adults’ experience of medication use on a daily basis. Any approach that adds to our understanding is of value, as achieving understanding can be a challenging process. The participants expressed uncertainty in this regard. Their metaphors point to dilemmas between being hopeful about the benefits of medication and being concerned about highly disruptive drug regimens and side effects. In-depth conversations about medication use and its impact on their personal lives, and related decisions about quality of life and death, appeared not to be part of their experience. If health professionals try to more fully understand the experience of daily medication use — what is important and meaningful — we can strive to make medication use by seniors as safe as possible. Such a discussion

could include whether it is worthwhile continuing with the medications. From the patient's point of view, the embodied experience of medication use may render it not worthwhile, even if it falls short of actually being iatrogenic.

The findings of this study indicate that health-care providers should challenge their beliefs and understandings about the role of medications and the lived experience of seniors in their care. How might the findings from studies such as this one act as a bridge to deeper understanding and more informed practice? Health-care providers are encouraged to listen intently and with curiosity for hidden meanings within patients' stories, to listen for what is said and not said and what lies in between (i.e., uncertainties). Remaining open and listening for opportunities to engage in conversations with seniors, to let go of preconceptions and beliefs, and to be willing to glean deeper understandings of the reality of seniors' medication use may help to identify, name, and make explicit previously unheard but very real concerns. Once named, these concerns can be addressed in safe and respectful ways.

We encourage nurses to make the time to engage in meaningful conversations with seniors about what is important, to be aware of what conversations need to take place. Attending to metaphor is but one way of doing so, and it is not limited to nurse/patient relationships. Using the metaphoric language of this population to engage in collaborative conversations with other members of the health-care team may also prove effective. What are important are having the conversation, making concerns explicit, and removing barriers that impede the conversation from taking place. Discussions about medications and their impact on one's day-to-day life provide such an opportunity and can inform all aspects of one's well-being, including aging and death.

Lastly, as health-care providers, we are reminded of the importance of helping to amplify the voiced concerns of those in our care and to resist making our voice the dominant voice. Seniors may need support in finding ways to express their concerns so that their health behaviours are less ambivalent and more congruent with their life beliefs. Researchers must keep exploring and must continue to seek understanding of often taken-for-granted, everyday health-care experiences such as medication use in seniors with chronic disease. The metaphoric language described in this study may help to inform the development of public education campaigns aimed at addressing very real concerns related to adverse medication events in this population. The findings remind researchers and health-care providers to be aware of and to question beliefs and health-care practices that influence, dominate, and/or silence independent older adults who use medication on a daily basis.

Limitations

This study has some limitations. The sample size was small ($N = 21$) and the sampling strategy was intentionally purposive. Participant recruitment was limited to two seniors' centres and one seniors' group, thereby excluding older adults who may not have accessed this community resource. Also, the population sample was representative of a unique geographical and social setting in western Canada. Additionally, while it would have been ideal to return to participants for validation of the themes, this did not occur. Our findings, as is the case with all qualitative research, are thus not generalizable in the strict sense of the word. Yet it is our belief that they will be of broad theoretical interest to other researchers wishing to explore this topic and to health practitioners seeking to explore patient stories and to reach a deeper understanding of their medication experience.

Conclusion

Community-dwelling older adults living with chronic disease use metaphors to help them describe the reality of their day-to-day experience of using medication. Developing an awareness of and listening for metaphoric language can be a way for health-care providers to achieve an interpretive understanding of the dilemmas faced by this vulnerable group. Keeping an open ear and attending to what lies hidden in everyday language can be helpful strategies for nurses to engage more deeply in meaningful conversations about what is real and yet often ineffable for older adults in their medication experience. Extending what is currently known about seniors and how they experience multiple medication use can lead to new possibilities for creating and influencing strategies for safer medication use in the community setting.

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