Two male nurses' experiences of caring for female patients after intimate partner violence: a South African perspective

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Background: South Africa is perceived to be one of the countries with the worst reputation regarding the occurrence of intimate partner violence. The women who suffer from serious physical injuries are admitted to emergency care units and their first contact with healthcare is through the nurses in these units. Emergency care nurses become secondary victims of violence due to their exposure to the pain of assaulted patients. Female nurses tend to identify with these patients as some nurses are in similar relationships. Not much research has been done on the challenges that male nurses face when they are confronted with abuse of women inflicted by males.

Methodology: In this case study with a phenomenological research methodology two African male emergency care nurses were interviewed.

Findings: The participants experienced a dichotomy of being-in-nursing and being-in-society and had been confronted with the conflicting roles of being men (the same sex as the perpetrators) and being nurses (the carer of the victim). They tried to manage the situation by using the 'self' to care for the patient and to be a problem solver for the patient and her partner or husband.

Conclusion: The authors conclude that society expects men not to be in a caring profession and nursing is still a female-dominated caring profession that finds it difficult to move away from its engendered and caring image. The participants experienced role conflict when they took care of female patients who have suffered intimate partner violence.

Key words: intimate partner violence; male nurses; phenomenological study; caring image of nursing

South Africa is perceived to have one of the worst gender-based violence rates in the world (Mullic et al 2010) with a woman killed every eight hours by her intimate partner (Abrahams et al 2012).

Nurses in emergency units are the first healthcare contact of survivors of intimate partner violence (IPV) (Reisenhofer & Seibold 2007) and thus experience the huge emotional impact associated with providing care to them (Goldblatt 2009). At the same time it is expected that the nurses intervene appropriately to reduce IPV-related mortality and morbidity (Leppàkoski, Paavilainen & Ăstedt-Kurki 2011). Nurses respond to the challenge in different ways. Some avoid the situation, feeling too overwhelmed (Hàggblom & Mőller 2006) while others feel frustrated, as they are often unable to successfully resolve the patients' problems (Robinson 2010). Some nurses try to compensate for the trauma of their own experiences of IPV by providing excellent care to their patients (Christofides & Silo 2005).

Encounters with IPV survivors blur the boundaries between the personal and professional domains of the nurses' lives (Goldblatt 2009). Female nurses may identify with the trauma of their female patients and male nurses may feel ashamed by the behaviour of the men who have abused their partners. It is important to explore the experiences of male nurses as it may impact on the quality of care that they render to patients.

This study aimed to describe the experiences of male nurses who are taking care of intimate partner violence patients in an emergency unit in a public hospital in South Africa.

BACKGROUND TO THE STUDY

Violence against women is related to their social status in public and in the family. Much is done to improve the situation at public and governmental levels. Governments (including the South African government) support treaties to end violence against women. The Convention on the Elimination of all Forms of Discrimination against Women is such an initiative, as it rejects discrimination against women and has an agenda for national action to end discrimination against women. The Protocol to the African Charter on Human and Peoples' Rights on the rights of women in Africa (African Union 2003) tries to guarantee the rights of women in Africa. The member states of the South African Development Community (SADC) signed the Protocol on Gender and Development (SADC 2008) to foster gender equality in Southern Africa. In South Africa IPV is criminalised through the Domestic Violence Act (116 of 1998).

Notwithstanding all the public initiatives to end violence against women, it seems as if violence is tolerated as an acceptable way of dealing with conflict (Abrahams & Jewkes 2005) and that the people of South Africa have become desensitised to violence (Themistocleous 2009). Studies on prevalence rates of IPV in South Africa paint a dark picture. The estimated 12-month prevalence of IPV among South African women 15 years and older was 18.4% in 2000, with IPV the second leading cause of healthy years of life lost (Norman et al 2010). A study by Jewkes et al (2006) revealed that about 26.6% of women had experienced more than one episode of physical or sexual IPV in a rural South African area. It is further disturbing to note that 21.8% of women who attended an antenatal care clinic in Soweto had been exposed to multiple assaults by a male partner according to a study by Dunkle et al (2004).

Why are twice as many women killed by their intimate partners in South Africa in comparison to the situation in the United States of America (Abrahams et al 2012)? Does it relate to their social status or their lack of social status? It appears as if victims of IPV in South Africa are from low socio-economic backgrounds (Abraham & Jewkes 2005), have been sexually abused during childhood (Dunkle et al 2004) and have experienced violence due to their having transgressed to traditional inferior female gender roles (Abrahams et al 2006). These characteristics relate to the low status of women in society. It happens when gender-based subordination is present that results in male dominance and oppression of women (United Nations 2006). In societies where gender inequality is supported, the use of violence against women is tolerated (Ellsberg & Heise 2005), which explains the high prevalence of IPV in South Africa with a diverse cultural mix of people and a variety of perspectives regarding the role of women in society.

Male nurses are part of a privileged group in society on the notion of their male superiority (Morrell, Jewkes & Lindegger 2012), but are at the same time associated with nursing, which compromises their prestige in society as nursing is associated with poor social values (Evans 2004) and the work of women (Sullivan 2000). In the nursing fraternity male nurses are often a minority group (Patterson & Morin 2002; Wilson 2005) and often have to study and work under supervision of women (MacIntosh 2002). Male nurses who take care of survivors of IPV belong at the same time to the carer group (nurses) and the perpetrator group (men), a contradictory position that may affect the care rendered to survivors.

AIM

Female emergency care nurses tend to identify with IPV patients as some of them are in similar relationships or know friends and family members who have experienced IPV or because their gender makes them vulnerable to abuse. The contradictory position of being a nurse of IPV survivors and belonging to the same sex as the perpetrators has lead to challenges in the caring role of the male nurse. Little research has been carried out on the challenges that male nurses face when they are confronted with abuse of women inflicted by males, as in the case of IPV.

The aim of the research was thus to explore and describe the experiences of male nurses from a South African perspective who are taking care of female patients who have suffered intimate partner violence.

METHODOLOGY

A case study design with a descriptive phenomenological approach in the constructivist research paradigm was implemented with two male emergency care nurses who are taking care of survivors of IPV. A phenomenon such as the focus of this research can best be studied through an exploration of the content of the intentional consciousness of the people involved (Solomon & Higgins 1996). The content of the consciousness of the male nurses (as subjects in the phenomenological tradition) who are taking care (intentional action) of IPV survivors (as objects in the same tradition) (Zahavi 2003) was studied to understand their experiences. As experiences are not without meaning (Dahlberg, Dahlberg & Nystrőm 2008), it was possible to obtain information from the research participants regarding both their experiences and the associated meaning of their experiences.

Method

Informed consent to participate was obtained from the participants after permission was granted by the hospital authorities that the research could be conducted in the hospital. The Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria approved the research proposal (no 125/2010).

Unstructured in-depth interviews were conducted with two African male nurses who were at the time of the study working in an emergency unit of a specialised public hospital in an urban area in South Africa. They were frequently in contact with patients who suffered IPV and were thus purposively selected to participate. In descriptive phenomenological research a small number of participants can provide a rich description of their experiences as was the case with the two

participants. The aim of the research was also not to generalize the findings to a population. Only one question was put to them: *"What do you experience while/when taking care of patients who suffered IPV?*" Probing questions were used to get a rich description of the phenomenon.

The verbatim transcriptions of the interviews were analysed to identify the essence of the experience and the associated constituents (Dahlberg et al 2008). The researchers dwelled long with the data to get a clear understanding of the experiences (Holloway & Wheeler 2010) and 'intuiting' was used to get a grasp of the essence of the experiences (West 1996) as it is experienced as the 'thing itself' (Moran & Mooney 2002). Through 'eidetic reduction' the natural dimension of the experiences (the concrete way it happened) was abandoned for the phenomenological dimension of the experiences to enable the researchers to feel as if they "had personally lived the participants' experience" (Kumar 2012: 798). The 'initial whole' of the experiences as it was presented by the participants through the interviews was studied. The data were divided into meaning units, clustered together according to similar meanings and summarized in the essence that constituted the 'new whole' (Dahlberg et al 2008).

Trustworthiness of the findings

In phenomenological research the trustworthiness of the findings is reflected in the way "the researcher engages with the analysis as a faithful witness to the accounts in the data" (Starks & Trinidad 2007: 1376). The researchers made use of bracketing of their pre-understanding of the phenomenon during the data collection and analysis to ensure that the essence of the data was revealed as it was experienced by the participants (Flood 2010). A reflexive analysis of researchers' own perspectives was done before, during and after data collection and analysis. Once the essence and supporting constituents were formulated, 'un-bracketing' enabled the researchers to re-integrate the findings into the study context and existing literature (Gearing 2004). Quotations from the verbatim transcription of the interviews were used to substantiate the constituents that support the essence of the experiences.

FINDINGS

The ages of the two African male participants were 25 and 32 years. They both had more than one year experience of working as professional nurses in the emergency unit of a specialist public hospital in South Africa.

In the phenomenological research tradition the essence is first described followed by a description of the constituents (Dahlberg et al 2008).

In **essence** the participants experienced a dichotomy of being-in-nursing and being-in-society. Through professional socialization nurses adopt a supportive caring role that encourages them to be empathetic towards their patients. They put themselves in the 'shoes of their patients' and feel the pain that they feel before they step out of 'their patients' shoes' in order to provide the necessary support to enable healing. When their patients are victims of IPV, female nurses very easily take up their supportive empathetic roles. They are women and are taking care of abused women. They 'feel the pain' of their sisters.

The participants were in conflict with what they observed and who they are. They are men who have nursed patients who have been abused by men. When they 'get into the shoes' of the victim they also feel the pain of the patients, but they also experience the pain of being ashamed of being men. They thus experience more than just the pain of the victim. They also experience anger towards their brothers who have done so much harm to the patients in their care. For the participants 'being-for-oneself' implies that they became aware of their consciousness of the wrong doings of the gender that they belong to. They also became aware of the negative consequences of belonging to the male gender under these circumstances and were concerned about how the victims and the perpetrators of IPV viewed them. The participants experienced the uncomfortable situation of being-for-others in which they became the objects of the judgment of others.

The participants found it difficult to make meaning of the conflict between men and women that results in IPV and asked: "*what kind of world are we living in*"? Their repeated exposure to severely injured patients caused them to say that they "*could not understand what drives a person to do such a horrible act*". In their attempt to find meaning they distanced themselves from the act by declaring "*I will never do that...I will never do that...I know that I am not perfect, but it is something that I don't do*". With these comments they acknowledged that they were not only nurses, but men. They also acknowledged that they were in relationships with women and that they thought about the way they treat women.

One of the participants described himself as "*a nurse during* (his) *work shift, but after* (the) *work shift,* (he is) *also somebody*". He described it as extremely difficult to have to live in two worlds, as he had been exposed to the pain of abused female patients in the hospital and outside the hospital (in society) some men easily resort to violence. He wanted societal violence to be stopped as he witnessed the horrible consequences of violence in the emergency unit. In society he was living among people who regularly made use of violence to solve problems and who do not want other people to interfere in their private lives. He could thus not tell his violent neighbour to change. He described it as: "*difficult to move from one place and change to be this person and move again back to that place and change to be that person*". For him being-in-nursing and being-in-society made him 'a bystander' in both worlds. In nursing the 'bystander' does not become involved in the pain of the patient and in society the 'bystander' does not become involved in the violent behaviour of people.

Two **constituents** were identified that substantiate the essence: *using the 'self' to care for the patient*; and *the male nurse as problem solver*.

The participants acknowledged that they were of the same sex as the perpetrators: "*I acknowledge that the perpetrator is a man*". They were not only nurses, but were men in the nurse-patient relationship and they acknowledged that they had to deal with their being-in-nursing and being-in-society. Being-in-nursing does not take away the partcipants's position of being-in-society. The same happens to abused women. Being in the hospital does not take away their experiences of being-in-society where they were abused by men. They encounter men in both scenarios. In the one scenario (the society) they were hurt by men and in the other (the hospital) they were nursed to health by men.

The participants used themselves to try and provide healing to the patients by making themselves available for the women to express their anger towards: "*when I talk to her she can show me that anger...trying to respond to...* (a) *person who looks like the one who committed all* (these) *things*".

The self (being-for-others) had been offered as an instrument towards healing. By projecting their anger towards a man in a non-threatening situation could have helped the patients to express and work through their hurt and anger and to view them in a healing perspective. The participants also wanted the patients to experience men not only as perpetrators, but as carers who wanted to help them: "*Once she is not in the same position.... with the person who committed that* (the IPV)*.... they feel safe because of the one who could provide help*". According to the participants the patients did not make use of the opportunity. Instead of projecting their anger towards them, the women exposed their vulnerability and their needs to feel safe and to be cared for. Evolving from the dichotomy of being-in-nursing and being-in-society patients considered male nurses as being strong (societal expectations) and being caring (nursing expectations). In a caring environment in the presence of male strength the women felt safe enough to show their vulnerability. The same dichotomy of being strong and caring, however, posed problems in the female patient/male nurse relationship. The participants were hesitant to become too involved as that could have lead to problems: "*the patient will end up looking for you with every problem and help she wants to get*". Overdependence in any nurse-patient relationship poses problems and even more so when the overdependence is between a female patient and the male nurse who is providing care.

The participants wanted to solve problems quickly and effective within the nursing context. Nurses are considered by themselves and society to be competent people who intervene efficiently in crisis situations. Society similarly expects of its male members to have physical strength and solve problems effectively. The patients who had been physically abused relied on the participants to utilise their physical strength to intervene and protect them from future abuse. The participants were very willing to intervene and they felt obliged to solve not only the immediate trauma-related problems of their patients, but also the inter-partner problems that caused the IPV. They were, however, frustrated by the hospital situation of over-crowdedness and a lack of privacy so that the patients' problems could not be addressed: "*there is not that much privacy around; you find there are lots of patients lying next to her so... not able to speak to that person and ask her what happened; what are you feeling*?" At the same time the patients were transferred to other wards and units after the wound care was done and their conditions had stabilised: "*You take the patient to different departments; I cannot follow the patient; it is not like working in the ward where you see the patient until she gets discharged*". The participants felt frustrated when they were not allowed to do what they knew they were capable of: "*your ability to be an effective problem solver.... is taken away from you*". They wanted to counsel their patients to cope with the trauma and also involve their partners in order to prevent repetitions of IPV: "*If you don't engage both of them, the victim and the perpetrator, you end up having a patient coming to hospital time and again"*.

The participants felt strongly that the counselling should involve both partners to prevent misinterpretation from the patients, using the participants' guidance to threaten their partners. Survivors of IPV often feel insecure and they learn to rely on other people whom they believe are strong. In this case they relied on the participants and specifically the masculinity of the participants to warn their partners not to abuse them again while they at the same time denied their own responsibilities to solve their inter-partner problems: "*they said I* (the male nurse) *told them to go to the police so it doesn't involve* (the women) *in the situation*". The participants related this misuse of their masculinity to women's dependent position in society: "*the girlfriend is dependent on the boyfriend and she is trying to please the boyfriend*". She could thus not challenge her partner and

has resorted to tell him that it was the male nurse who encouraged her to report the abuse to the police.

The IPV survivors expected the participants to intervene as nurses (being in nursing) and as men (being in society). Their expected their partners to pay attention rather to what men (being in society) have said than to what a female nurse has advised. Their partners were viewed by them as being in a powerful position and they thus used the advice of men (viewed as being in a powerful position in society) to try to solve their problems.

In order to cope with the dichotomy of being-in-nursing and being-in-society related to taking care of patients who suffered IPV the participants distanced themselves from the situation: "*I drew a line especially on the issues of gender, sex and race and so usually it is not going to be difficult for me to interact*". They used instead other members of the healthcare team to counsel the patients: "*involve... people from the pastoral services and social workers*". This they have done to protect themselves from the discomfort of being aware of the needs of the women and not being in a position to help them: "*Feeling pain and not responding is causing* (one) *problems;* (one) *ends up not even... want*(ing) *to understand what the patient is going through*". Being in nursing and being in society has resulted in a situation where male nurses experience frustration and render less than optimal care of their patients.

DISCUSSION

The participants experienced a dichotomy of 'being-in-nursing' and 'being-in-society'. They were men who nursed patients who were abused by men. The participants used their 'self' to create non-threatening environments where the patients could work through their pain caused by men while being supported by them.

Male nurses live in society and, like all men, are identified by their maleness and their manhood, where maleness refers to their sex and manhood to the behaviour that they as men are expected to portray. Their maleness is a given, but their manhood has to be developed and society plays a dominant role in the development of what is considered as successful manhood or masculinity (Connell & Messershmidt 2005). Men's understanding of their masculinity is determined by their relationships with their sexual and marital partners, their male and female friends and with their colleagues at work. All these relationships are influenced by the society in which they live (Ratele 2008). During boyhood men learn that there are behaviours that are associated with successful masculinity and that there are behaviours that should be avoided when they want to show to society that they meet the requirements of being men (Morrell, Jewkes & Lindegger 2012). Acquiring a well-muscled body, having a deep voice and dominating women and other men are too often associated with masculinity (Ratele 2006) while taking care of children and, for that matter, of other people are not considered as masculine (Ratele 2008). An image of real men is perceived not to include nurturing and emotional characteristics (Connell & Messershmidt 2005). The dichotomy that male nurses experience relates to the conflicting expectations by society that they should be non-nurturing and dominating, while they work in a caring context.

The ongoing strive to dominate people around them becomes hegemonic when men receive reinforcement of their behaviour from women and other men (Hearn 2004). Alternative forms of masculinity such as the sexual activities of gay men (Wetherell & Edley 1999) and the behaviour of subordinate and marginalized men (Jefferson 2002) are rejected as activities that real men do not do. Men who are choosing a caring job are not doing what 'real men' do means that male nurses often have to defend their choice to be nurses. Their frustrations of being in two worlds (being-in-society and being-in-nursing) become aggravated when they have to deal with accusations of not being' real men' and at the same time having to take care of the abused women of 'real men'. It is understandable that they find it difficult to make meaning of what society views as successful manhood when that leads to abuse of women.

African male nurses in South Africa experience a unique situation of having previously been dominated by white men. The hegemonic masculinity of the dominant racial group has the power to impact negatively on men of other racial groups (Jefferson 2002), which was the case in South Africa in the 'apartheid' era. Notwithstanding the ruling of white men till 1994 the indigenous social structures of the Southern African black people influenced the position of black men. In the homesteads and kinship groups masculinities were created that were particular to Africans. As agricultural production sustained the household, patriarchal relations were supported in the world of work. When black men started to move to cities to work on mines their constant contact with their homesteads ensured that their African masculinity remained hegemonic (Morrell 1998).

Against the backdrop of patriarchy in both white and black societies in South Africa it is understandable that till the end of the first half of the twentieth century white and black men found it extremely difficult to become nurses. It portrays the gendered position of nursing (Morrell 1998). As elsewhere in the world, nursing is a female-dominated profession in South Africa.

Historical accounts that date back to the fourth and fifth centuries indicate that men performed nursing duties to the wounded and sick as members of religious orders. The founder of modern day nursing, Florence Nightingale, however, established nursing as a women's occupation (Evans 2004). The emphasis was on caring (Stott 2006) and nursing obtained a feminine culture (Sullivan 2000) and became a "symbol of the monumental struggle faced by women to find a profession that was respected and valued" as a women's profession (Davis & Bartfay 2001). The feminist movements of the twentieth century benefitted nursing as it moved away from the feminine image to a feminist culture, but it could not since then succeed in attracting large numbers of men (Kermode 2006). While African males became the dominant group in the South African society, male nurses, including African male nurses, are still a minority group in their work place.

Men in nursing are not only a minority group (Wilson 2005); they also have to continuously defend their career choice and their sexuality (Evans and Frank 2003), as they are often stereotyped as homosexual (a spoiled or compromised sexuality according to society) (Evans 2004) and for being in the 'wrong' profession. They are men who have joined a female profession and their male peers (and often even female peers) in society do not understand or support their decisions. If they are 'real men' according to the prescriptions of masculinity and more specific hegemonic masculinity what are they doing in a female profession where they have to work under the supervision of women (the inferior sex in society)? Why did they choose to do a caring job that is typically a female responsibility?

Research provides some answers. Male nurses are often found in management positions in nursing because of the division of labour based on gender that is even found in a female-dominated profession (Evans 2004) and other prestigious well paid positions in health care (Stott 2004). They also have an advantage over their female colleagues in that male physicians, who are in some countries still the majority, treat them as equals while male physicians often tend to look down on female nurses as a result of their being female and of a lower status professionally (Ellis, Meeker & Hyde 2006). This advantage favours them to get promoted to management posts, as physicians are often consulted in the promotion of senior nursing staff.

The technical skills of male nurses and their desire to work independently and less under supervision of others, which includes their female colleagues, encourages them to work in emergency care settings (Ellis, Meeker & Hyde 2006). It also places them in positions where the focus of caring is more technical and less on touching and the delivering of personal care. Caring behaviour comes more naturally for female nurses than for male nurses (Anthony 2004). The touch of patients by a female nurse is also perceived by society as caring, nurturing and soothing and thus desirable by patients while touching by men is stereotyped by society as often sexual of nature (Evans & Frank 2003). The participants in this study also preferred to attend to the psychological needs of their patients when they offered themselves (being-for-others) so that their patients could vent their emotions. They also wanted to solve the patients' immediate trauma-related and their long-term inter-partner problems rather than deliver personal care. They were also concerned about the problems that a relationship of overdependence between a female patient and a male nurse could lead to.

CONCLUSION

The frustrations that African male emergency care nurses experience in rendering care to IPV patients are explained by the dichotomy of being-in-society and being-in-nursing. In the two settings different rules apply and confusing expectations exist. Society expects men not to be in a caring profession and nursing is still a female-dominated caring profession that finds it difficult to move away from its engendered and caring image.

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