

A man could never do what women can do: Mental health care and the significance of gender

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Objective: The basic aim of this paper is to examine how women and men in mental health care understand their own strengths and weaknesses and those of the other gender.

Method: This is a qualitative study based on individual and focus group interviews with 49 participants. Content analysis was performed.

Results: Our findings indicate a gender imbalance in strengths and weaknesses on several levels. The female workers describe mothering as a female identity, and think women have a greater natural quality for caring than men. They orientate towards relationships and are inclined to take on too much responsibility. Men, on the other hand, use their gender power as a mobilizing attitude. However, they have a tendency to consider themselves too objective and too emotionally reserved. Female workers consider men's professional distance in caring as a strength. Although the latter's lack of handling emotions is considered a weakness. Male workers emphasize the women's willingness to offer care as a strength, although women taking on too much responsibility is described as a weakness.

Conclusion: The imbalance between genders in mental health care may have some consequences for decision-making in relation to patients and care planning. Thus there is a need for work organizations to focus on the influence of gender not only for the working milieu, but also to better use the competence that exists to the benefit of the patients.

Keywords: gender, mental health care, mental health

Introduction

The Scandinavian welfare state is well known for its strong collective values. Gullestad, a sociocultural anthropologist, comments that it is generally not interesting to talk about the individual person, without also talking about social relations.¹ During the post-war period municipalities in Norway have been an arena for implementing government policy in the country. During the last fifteen years a comprehensive reorganization of the mental health service has taken place, and the structure of mental health is now based locally with more service from district psychiatric centers and municipalities to patients.

The Norwegian government laid the foundation for the new strategy, and a new plan for mental health care was drawn up. Here perspectives changed from diagnostics to psychosocial functioning, and from suffering towards mastering.^{2,3} The White Paper claims that the service should be equal and hold the same quality for everybody, independent of gender. However, this document gives no advice about how gender should be taken into consideration. From the 1990s onward there has been a debate which opened up gender perspective, and in 2004 came another White Paper which

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emphasized that gender segregation is unfortunate to society and patients.⁴

In the wake of the government's new plan for mental health and its attention to increase quality in the mental health service, it is not surprising that those who have chosen to work in mental health care are concerned about whether their capacity for a relationship is sufficient. Their strengths and weaknesses should be used in the best interest of the patient when help is given and received. Such reflections are of importance because patients in mental health care cannot always make adequate decisions about their own care.

As far as we know, few previous Scandinavian researchers have dealt with the different genders' strengths and weaknesses among mental health care workers. Two reports indicate that there is slow progression in building up competence and providing education in mental health care that adjusts to new conditions in modern mental health care.^{5,6} Two studies about occupation and status,^{7,8} and two related studies about employment processes for managers in the sector were found.^{9,10} Several other studies have focused on regulations of public plans for education in mental health care.^{11–13} There are three studies on professional knowledge,^{14–16} and several Scandinavian studies regarding professions, empathy, and gender have been found.^{17–22} International gender studies have focused on gender as a tool for thinking,²³ interpersonal gender and behavior,²⁴ care and gender,^{25,26} gender differences,²⁷ men and masculinity,^{28–30} care and social integration,³¹ gender organization,³² men in nursing,³³ history in male care,³⁴ gender in care,³⁵ and selecting job applicants.³⁶

Based on these considerations the aim of this paper is to investigate how female and male workers understand their own strengths and weaknesses and those of the other gender. The implication for patient care will be outlined.

Theoretical framework

Mental health care and professionalism

The philosopher Buber defines caring as an activity and a concept of femininity, and even incompatible with conceptions of masculinity.³⁷ Gullestad emphasizes that caring includes understanding, empathy, and above all time and patience. Caring should focus on closeness in relations, which is associated with giving and receiving care.¹ In the debate about aspects of power and dominance among mental health workers, they have been accused of manipulating matters in their own interests.^{38,39} According to Hughes, professionals are inclined to present themselves as having

more knowledge than others on a special subject, knowing better than their patients what their problems are, and offer a service reserved for the selected few.⁴⁰ Klausen argues that the loyalties of the professionals are directed towards their own welfare regime.⁴¹ Ordinary people, however, have an opinion about professionals as people with special skills and ethical understanding.

According to Ekeland and Heggen,⁴² mental health providers have great knowledge about their patients and their illness, but less knowledge about mastering that illness. They often have a common ideology, attitude, a system of concepts, and a fairly homogeneous approach to understanding the patient. A traditional model for understanding diseases combined with obedience, can be pleasant for both parts. The patient can entrust responsibility to the expert, but his or her own strategies for mastering the illness will not be strengthened. This outcome will not be in accordance with new government laws and patient ideology.⁴²

Mental health care and gender

Several authors have analyzed the relationship between women and the state in working life.^{31,43–45} Different countries, including those in Scandinavia, are characterized by high women employment in mental health care. According to Buber, men are almost absent as caregivers.³⁷ Benschop and Doorewaard claim that feminine attributes are actually part of the management thinking.⁴⁶ Nielsen has also criticized the institutional feminizing of society.⁴⁷ He focuses on feminine emotional and manipulative power. Furthermore, he argues that this power is a caring regime where women with support from research can prevent men from accessing care. Milligan presents a model for male care and suggests that men can manage patient independence satisfactorily.³⁴ By gaining experience men can develop a perspective for caring which implies sympathy and ability for support.

Mental health care and relationships

The concept of the relationship was introduced into social work by Richmond,⁴⁸ and later described as its "soul" and "heart".^{49,50} Woods and Hollis claim that no other treatment variable is as important as the quality of the patient-health care provider relationship.⁵¹ Here health care is concerned with the patient's well-being in this relationship. This implies taking interest in the patient's needs, being emotionally accessible, showing confidence and respect, and being able to give satisfactory treatment. Maaseide states that all professional activity has relational components.⁵²

In order to establish contact with the patient, it is necessary to start using one's empathic ability. Goldie thinks that emotions can go in two directions.⁵³ They can tell us things about life which reason alone cannot. On the other hand, emotions can disturb our view of the world and betray us. In relationships that involve regular care and touching, there is a great potential for intimacy.⁴⁴ Hart claims that by steering empathy towards a person in need may influence the decisions made about their care and well-being.⁵⁴ In addition, one can obtain insight into the ethical principles guiding the caregiver.

Methods

In this study the background for choosing interviews with those who work in mental health care is that they work in areas where widespread culture forms conceptions of gender.⁵⁵ These institutions are active producers of gender differences.⁵⁶ When approaching the mental health field, we have used interviews as a tool to get information about gender differences in mental health care.⁵⁷

Sample

This study is a qualitative approach, comprised of 49 individual mental health workers from different institutions in one health organization and two municipalities. Initially, the institutional managers were asked to select a purposive sample of participants in mental health care. Three focus groups with mental health care workers (total of 8 women and 9 men), from different psychiatric departments and with different professional backgrounds, were interviewed twice. The objective was to have equal gender balance in one group, and in the other two groups

male-only and female-only groups to investigate possible gender differences. In addition, there were 19 individual interviews with mental health care workers (total of 12 women and 7 men) performed. The sample also included 13 institutional leaders (12 women and 1 man) from five different institutions, with different professional backgrounds (Table 1). They were given three focus group interviews and four individual interviews. All interviews lasted approximately from one to one and a half hours. Inclusion criteria for all participants were specialization in mental health care and at least one year of work experience after completion of their education in mental health care. All participants were fully informed orally, and written instructions were delivered. It was emphasized that voluntary participation was required, and that they could leave the program at any time. Information would be handled confidentially and written informed consent was obtained before inclusion. The regional committee for Medical Research Ethics, Health Region West, Norway approved the study.

Data collection

Our main instrument for data collection was individual and focus group interviews done by the second author. The use of individual interviews was to uncover the respondents understanding and experience of gender strengths and weaknesses in mental health work. Our impression was that the respondents were enthusiastic in getting involved in this study. A questionnaire was delivered beforehand to collect sociodemographic variables. In focus groups the research relies on interactions within the group based on a topic that the researcher and members of the group decide to explore further. The potential value of the focus group

Table 1 Data from six focus group interviews with 26 participants and 23 individual interviews, listing the participants' gender, profession, and institutional affiliation (n = 49 participants)

MENTAL HEALTH CARE WORKERS			LEADERS		
Focus Groups	Individual interview	Institution	Focus Groups	Individual interview	Institution
5 women (nurses)	3 women (nurses, social worker)	District psychiatric center	2 women 1 man (nurse, social workers)		District psychiatric center
3 women, 2 men (nurses, social workers, social pedagogues)	4 women, 3 men (nurses, social educators)	Municipal psychiatric service	3 women (nurses)	2 women (nurses)	Municipal psychiatric service
7 men* (nurses, social workers, social pedagogues)	5 women, 4 men (nurses, social workers, social pedagogues)	Four different departments in one psychiatric institution	3 women (nurses)	2 women (nurses)	Three different district psychiatric center

Notes: *One man is missing after the first focus group interview.

is to be found in taking the discussion a little further on the respondents' terms.⁵⁶ The focus group sessions were moderated by the second author. Discussions in the focus groups and in the individual interviews centered on main topics formulated in the interview guide related to gender and care (Appendix 1). Probing questions were used to deepen the discussion and ensure that the information was correctly understood. The second focus group interview centered on expanding the understanding of the topic and validating the findings. The combination of data from individual and focus group interviews about gender imbalance gave an expanded understanding of the field.

Data analysis

The whole data set comprised of six focus groups interviews (17 mental health care workers and 9 leaders), and individual interviews (23). This data was analyzed qualitatively by both authors. The phases for the data analysis were as follows. First, the interviews were tape recorded and transcribed according to guidelines from Morgan.⁵⁶ Second, the interviews were read in their entirety to gain a contextual understanding of the participants' experiences. By listening to all the interviews several times, important nuances were discovered, searching for common and distinctive features as well as variations. Third, content analysis was performed to identify major themes in the data, inspired by several authors.^{57–60} The researchers coded independently prior to finalizing categories,

sub-themes, and a main theme. A process of reflection and discussion resulted in agreement about quotes representing different categories within the sub-themes.

Results

Table 1 provides an overview of the sample of 49 participants (32 women and 17 men), listing their profession and institutional affiliation. Table 2 outlines the perceptions of strengths and weaknesses among the same gender in mental health care, indicating two sub-themes containing 4–6 categories describing different positive and negative qualities. In Table 3, strengths and weaknesses regarding the opposite gender are listed, indicating two sub-themes containing 4–5 categories describing different positive and negative qualities. To give an overview of our findings, we will now present some data from the interviews by direct quotations.

Women's perceptions of their own strengths and weaknesses

A majority of women argue that their gender is a strength and that they have greater natural quality for caring than men. They emphasize that "mothering is a natural part of our identity as carers". A few prefer listening instead of talking, as expressed in the following, "Concerning patients, I think I am a quite good listener engaged in patients' feelings. I am not a good talker, maybe ... do not use many words." One informant admits that many have a tendency

Table 2 Women's and men's perceptions of strengths and weaknesses of their own gender in mental health care (n = 49 participants)

Main theme	Sub-theme	Categories
Perceptions of strengths and weaknesses among mental health workers	Women health care workers perceptions of their own strengths in mental health work	Have a greater quality for caring Are good listeners Are engaged in patients' feelings Are patient Are partly aware of their limitations Are aware of patients' resources
	Women health care workers perceptions of their own weaknesses	Inclined to take on too much responsibility Decreased ability to solve specific situations Are inclined to feel responsible for sexual offences Inclined to overextend themselves
	Men health care workers perceptions of their own strengths in mental health work	Strength to be a man Are able to understand patients' feelings Openness about what may constitute problems Have a mobilizing attitude Conscious of not feeling responsible for sexual offences
	Men health care workers perceptions of their own weaknesses	Are often too emotionally reserved Are often too withdrawn Are often too objective Reveal feelings of sympathy and empathy Sometimes it is problematic to be a man

Table 3 Women's and men's perceptions of strengths and weaknesses regarding the opposite gender (n = 49 participants)

Main theme	Sub-theme	Categories
Perceptions of strengths and weaknesses regarding the opposite gender	Women's perceptions of strengths regarding the opposite gender	Men are physically strong There could be a biological difference They have an orientation towards strong action They are less preoccupied with details
	Women's perceptions of weaknesses regarding the opposite gender	Too few are recruited to the profession They seldom speak about feelings They are less preoccupied with details They are inclined to leave their "mess" behind
	Men's perceptions of strength regarding the opposite gender	They are more willing to offer care They are skilful in small talk They are good listeners They offer intimacy that is not threatening They embrace a broader perspective on caring
	Men's perceptions of weaknesses regarding the opposite gender	They may have a too broad perspective on caring They seem to take on too much responsibility They sometimes suffocate with their care Their caring can be painstaking and protective

to take action and says, "It's easier to take charge and do somebody a disservice, instead of doing things together with them." One of the leaders commented, "I think they pamper their patients too much." Another informant continues, "Patients can be demanding and give us a feeling of exhaustion and difficulties in setting limits in care situations. As a matter of fact I am actually paying attention to people's resources." Furthermore, they are inclined to think that "sick women patients are sicker than men," and that they "may be responsible for sexual offences."

Men's perceptions of their own strengths and weaknesses

The findings reveal that men consider their gender as a strength, and their self-esteem seems to be attached to strength in role performance. One participant says, "I am conscious of my role ... and my capacity to analyze and widen my perspective." Another commented on masculine care, "I think I have room for ... masculine care ... at my working place." It seems that they challenge patients to express feelings, "We are talking ... about feelings ... with men during their stay in the ward." Another continues, "I have a capacity to act ... and I ask directly what is the problem without expressing too many feelings." Furthermore, a few men comment that they are often too withdrawn, "I may be withdrawn and judging, and am not emotional enough." On the other hand, they seem to give more attention to patients they like than those they do not like, "You get more enthusiastic about some patients than others." Some of their frustrations are indicated in this way, "Women can give

a hug. For me it would be ridiculous to give hugs. We men could never do what women can do." "I know that if people are in trouble I will be called to show muscle power in such situations. And then it could be problematic to be a man."

Women's perceptions of strengths and weaknesses regarding the opposite gender

Women admit that men are physically stronger, "There could be a biological difference," "Men are skilful hunters and fishermen." They continue, "Furthermore, they do not roam around and have a strong action orientation, although they leave their mess behind." Men are less inclined to be preoccupied with details and women consider this limitation to be a strength. They emphasize that too few men are recruited to the profession and explain, "Usually we meet men in temporary positions, such as summer workers." Men may have a deficiency in their upbringing and do not speak so much about their own feelings, "Their manners do not include expressions of emotions. Don't cry you are a boy!" "It is not that easy for men to talk about their feelings." "They may lack the ability to handle emotions among people of both genders."

Men's perceptions of strengths and weaknesses regarding the opposite gender

A major finding in the study is that men perceive women to "take on a great deal of responsibility." One of the participants

explained, “Women seem to have a great potential for caring and can have a wider perspective than men have.” “Women are good listeners with less need to assert themselves than men.” “They seem to offer close body intimacy that is not threatening and invading.” Several men in our study explained, “Strong attention from women workers may be overwhelming and in danger of developing a suffocating care towards patients.” They continued, “The patient almost ‘sits’ on the woman’s knee” or “The patients are declared to be without legal capacity.”

Discussion

The basic aim in this paper is to examine how women and men in mental health care understand their own strengths and weaknesses and those of the other gender. Gender can be seen as one of our tools for thinking. This way of understanding gender can also be integrated into working life. As such, processes of gender take place both inside and outside the health care institutions. We can also say that an occupation is gendered.²² Thus in a two-way process people have a gender and their gender influences their focus and work.²³ Findings in this study clearly indicate an imbalance in understanding the strengths and weaknesses of the genders in mental health care which may have implications for patients.

Women’s perceptions of their own strengths and weaknesses

Women health care workers in this study are prepared to give care, and have a strong responsibility in offering good service. Health care is perceived in relation to something women learn at home and is transferred to a professional context.⁶¹ Although institutions in mental health care are bureaucratic, it seems that women think they have the greatest power in defining close care and understanding, and interpreting emotional feelings.⁴¹ A dependent care relationship can also be seen as an attempt from female workers to adjust to the institutional schematic thinking, and may also be an attempt to defend their central roles in care, as strong professions often do.⁴

To be successful, female workers who engage in emotions must be aware of their own emotions and be able to manage them.⁶² They must also be aware of their tendency to overextend themselves in their strategy as health care providers and in taking on too much responsibility. Perhaps this behavior is a misunderstanding of genuine and true caring, as described by Lindström.⁶³ It appears that women who are health care providers are inclined to behave in a personal rather than a professional way towards patients

as they try to “mother” them. This finding is concurrent with another Norwegian study where patients were referred to as harmed children.¹⁶ Women’s ignorance of placing responsibility for sexual offences on the male patients may reveal that they partly blame themselves for not setting limits. Thus a mothering focus may also limit the ability to solve problems for helpless women and young men, and is in contrast to governmental policy which encourages patients to develop independent lives.²

Men’s perceptions of their own strengths and weaknesses

The majority of men health care workers agree that they are not as caring as women, and they regard this attitude as a strength. Almost on a daily basis they have to use their physical strength. They seem to use their power as a mobilizing attitude in role performance and problem solving.³³ Success in work and toughness falls into the masculinity ideology.⁶⁴ This is in accordance with Sommerseth who claims that “men are both figureheads and guardians.”⁶⁵ This understanding may also be concurrent with the gender’s stereotype of men. On the one hand they are engaged in other people’s emotions, as they argue that they can place themselves in the other person’s feelings, although their behavior may differ from women. On the other hand, they admit that they may be too emotionally reserved, but do not go into detail how this influences their work. Emotional strength may indicate suppression and control over emotions as a favorable masculine identity. However, one can look at their presence as making a difference in clinical practice, even if they are ambivalent towards their own use of emotions. They take a stand against treatment that is disadvantageous for patients. They also admit that they feel more comfortable and give more attention to patients they like.⁵³ In this way they openly reveal feelings of both sympathy and antipathy, which may limit their professional work. As opposed to women, they do not feel shame or responsibility for sexual offences from female patients. This could be explained by men often having the professional distance in their work to find good solutions, which women seem to easily lose because of their mothering attitude.

Women’s perceptions of strengths and weaknesses regarding the opposite gender

A majority of women argue that men are physically stronger than themselves because of biological differences. Our data

reveals several gender stereotypes where women put forward several utterances about men such as “men are skilful hunters and fishermen,” “they have a deficiency in their upbringing,” and “do not speak about their own feelings.” These statements indicate categories that men are expected to have as active subjects.³⁰ We can also interpret these findings as an underlying ambivalence of admiration and devaluation of men at the same time.³³ One can find that men’s relational competence is a matter of silent practice, not announced in words, and difficult for women to understand.²⁰

Male professionals may believe they have more knowledge than others on special subjects, knowing better than their patients what their problems are. This may indicate that they offer a service reserved for the chosen ones.⁴⁰ It seems that men take less responsibility for practical tasks, like cleaning up their mess. This may be that men are identifying themselves with old fashioned standards appropriate to their gender. Women seem to prefer modern men who participate equally on a daily basis. The women in this study are also concerned about the lack of men working in care. Despite women’s ambivalence, men seem to be wanted for several reasons, and they are well known to stabilize work environments.

Men’s perceptions of strengths and weaknesses regarding the opposite gender

The men felt that women have a strength in using empathic behavior including small talk when promoting care. The women’s way of behaving may be more in agreement with Bakken, who claims that they carry a women-friendly welfare state on their shoulders.²¹ Women are more willing to offer care, but men sometimes find their care in danger of being too involved in relationships with patients they view as helpless. This might not be as simple as it might first appear.

According to male respondents, women also seem to take on too much responsibility for patients, and have difficulties in setting limits. Several men criticize women for being too intimate and close, and may also develop relationships which may have harmful effects, such as suffocating care.⁶⁶ This background indicates that women’s strength in empathy seems to be a double-edged sword. It may imply that they overreach themselves both towards management and towards patients. One impression from the male colleagues is that they plead a right to decide when female care is expressed as harmful. This can contribute to a downgrading of women

care because women are not looked upon as individuals, but as a whole indistinguishable mass. As women in the study are 10–15 years older than the men, this may also represent cultural differences, as the mothering role is under continuous change, and there is more equality between genders in everyday life.

Implication for patient care

Gender is almost a blind spot in the mental health arena, but simultaneously both genders have an opinion about the strengths and weaknesses of each other’s gender when providing care. There seems to be an imbalance between the genders in mental health care as women are more prominent. Secondly, this imbalance also seems to reveal different attitudes to patient care. It is about gender stereotypes in relation to when to be distant and when to be close in relational work. Thirdly, there is an imbalance regarding genders’ attitudes about how to use each other’s capacities and capabilities in patient care. When a gender-blind perception of reality is linked to power, it may have consequences for decisions made in relation to patients.

We suggest that educational preparations of health care workers and practitioners have to take gender into account to a greater extent. To succeed in this direction, we will supplement our earlier model, illustrating the supportive system, with a gender perspective.⁶⁷ Still, a number of mental health institutions need to develop a culture that is more in accordance with modern society, where the gender issue is less stereotypical and based on a more integrated understanding of the strengths and weaknesses of men and women. Findings in this study may indicate more teamwork including both genders, and also supervision which focuses on a gender perspective to secure professional aid. In this way the patients of both genders will hopefully get a better and more reflective service in mental health care.

Methodological consideration

We admit that the findings are not for generalization, only for discussion. However, the use of content analysis gave an overview of commonly occurring categories and sub-categories that may be used to form future research. Strength in this study is based on a combination of individual interviews and focus group interviews, and a gender balance which gives an expanded understanding of the field. The selection of female and male managers was varied, but reveals that women are in the majority as mid-level managers. Gender strengths and weaknesses is a complex area and more studies are needed.

Conclusion

A number of findings in this study reveal gender as a more important issue than mental health workers are willing to admit. When we look closer at the different genders' strengths and weaknesses, several dimensions indicate that gender is of significance. This complexity is revealed in different ways by women and men, both having different forms of expression. However, gender does not seem to be questioned among mental health care workers or in national policy documents about mental health. Men see themselves as problem-solvers and believe they can make a difference. Women, on the other hand, are more orientated towards care and relations, and can take on too much responsibility for patients. But they regard themselves as experts in relational work and with their standards they can unintentionally push the men to one side. Influence from gender research has to a small extent reached the mental health care field. There is a need for work organizations to focus on the influence of gender not only for the working milieu, but to use the competence that exists to the benefit of the patients.

Disclosure

The authors report no conflicts of interest in this work.

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Appendix I

Interview Guide

Focus group interview 1 and individual interviews:

1. Is a gender perspective clear in your working place?
2. Is gender of significance when planning care?
3. What kind of challenges are men and women confronted with?
4. How does gender have significance in men's and women's mental health care?

5. What do women perceive as men's strengths and weaknesses in performing care?
6. What do men perceive as women's strengths and weaknesses in performing care?

Focus group interview 2:

1. Are there other important issues related to gender in mental health care that we have not discussed and that we should take into consideration?

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