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Male Emergency Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

By

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ABSTRACT

Nursing is a high-risk profession with unique stressors experienced in male-identifying nurses. Being male in nursing adds more stress. Another layer of stress is working in a busy, high-stakes environment, specifically the emergency department. These multiple stressors among male emergency nurses may compromise their health and well-being, as well as the quality of care they provide to the public. Therefore, it is vital to address the workplace stressors of male emergency nurses and the factors that influence their help-seeking behaviour.

This study explored the experiences of male emergency nurses in the emergency department of a major urban hospital in eastern Canada. I examined workplace stressors and the factors participants considered when seeking help. In-depth, semi-structured interviews provided important information about the experiences of male emergency nurses. I also examined the cultural, social and political factors affecting male nurses' help-seeking behaviour. The findings from this research may inform communication between management and male emergency nurses regarding the development and/or improvement of existing guidelines and policies. In turn, this can better serve the needs of this crucial yet vulnerable population.

Keywords: Male emergency nurse, male nurse, workplace stress, workplace stressor, help-seeking behaviour, seeking help

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My MN journey taught me that it is okay not to be okay but still take a step. In the beginning, my feet were light, and I felt I was running. But as I progressed, there were stops along the way. I felt exhausted and out of breath, and I wondered when I could reach the finish line and asked myself if I could. Many times.

Well, I am near the finish line. It would not have been possible without the people who trained me, cheered me, and offered me water or coffee on the track. I am fortunate; I have many people cheering for me, and it made my feet lighter. So, I kept walking.

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Lastly, thank you God!

DEDICATION

This thesis is dedicated to every ED nurse, especially those male nurses who have experienced workplace stressors and internalized standards of masculinity from society that hinder seeking help – your struggles are recognized.

TABLE OF CONTENTS

Chapter I: My Reflections

My research has developed out of my practice experiences, and I will start with my reflection. Luckily, I started working at the age of 16 through a summer job for high school students with our local government in Iloilo City, Philippines. I remember that at a very early age, I struggled to meet the expectations of the professional environment, which taught me how challenging it is to navigate work dynamics, deal with people, and meet the demands of my supervisors. Nursing was not my initial career choice; professions such as law and medicine were deemed far more prestigious in Filipino culture. Growing up male in a highly Roman Catholic society and raised in the slums of an impoverished third-world country, I knew my choice needed to be practical. As my family's unwavering belief that education was the key to breaking the cycle of poverty, deciding my future was a daunting task, especially with our limited financial resources.

With limited financial resources, I needed to make a decision that would allow me to support my family and offer a pathway to a stable and prosperous future. After much contemplation and inspiration from my dedicated aunt, a nurse, I realized the nursing profession could provide the opportunity to make a meaningful impact on people's lives while also opening doors to a world beyond the confines of poverty.

There were few male nurses and instructors in nursing school, with the majority being females. I can vividly recall my clinical practice, where I often felt excluded and was rarely assigned to female clients to avoid any potential allegations of misconduct. This exclusion, coupled with the fear and uncertainty of navigating a predominantly female profession, was a source of considerable stress. Although I was equipped with general nursing knowledge, it did not adequately prepare me for the concept of seeking help when faced with stressors.

Over the past 18 years, I have practiced nursing in diverse countries, including Saudi Arabia, Bermuda, Canada, and the United States. Each location had unique challenges, including cultural differences, interpersonal conflicts, heavy workloads, and understaffing. My career milestones include becoming a certified emergency nurse, being one of the few racialized clinical supervisors at a large college in Toronto and becoming a Canadian citizen.

My curiosity about work stressors emerged when I noticed a decline in my energy levels. I faced numerous challenges in previous years, including car accidents, injuries from client care, and being assigned aggressive clients without proper orientation. The COVID-19 pandemic exacerbated these stressors, leading to feelings of depression and burnout. Despite experiencing these stressors firsthand, I remained determined to understand the broader impact of work stressors on nursing professionals.

Throughout my career in various emergency departments (EDs) worldwide, I observed that men in nursing are often in the minority and are typically reluctant to seek help. This observation of reluctance to seek help is quite commonly practiced in nursing, adversely affecting nurse well-being and client care. Reviewing the literature on work stressors has resonated with me the importance of addressing this issue to enhance nurse well-being and ensure quality client care.

Unexpected events often happen in nursing practice without warning. I experienced firsthand being a victim of a hate crime while teaching nursing students in one of the hospitals in Toronto. This incident highlighted the unpredictable nature of work stressors and the importance of robust support systems. The traumatic experience underscored the vulnerabilities that healthcare professionals can face and reinforced the necessity of creating a supportive and inclusive work environment.

I am now passionate about minimizing work-related stress and promoting gender diversity within the nursing profession. Through this research, I aimed to advocate for normalizing help-seeking behaviours among nurses and giving a voice to those who are often silenced or invisible. By fostering an environment where seeking help is encouraged and supported, we can ensure the well-being of nursing professionals and, by extension, improve the quality of client care. Additionally, I aspire to being a novice qualitative researcher, driven by my passion for listening to stories and engaging with people. This research is not only an academic endeavour but also a personal mission to understand and address the challenges faced by male nurses who work in an unforgiving ED setting.

Introduction

Background

In the nursing world, male nurses are like a thread often overlooked yet necessary to complete the beautiful fabric of the nursing profession. Men are rare in nursing, making up less than 15% of most nursing workforces worldwide (Sasa, 2019). While nursing is a high-risk profession with various stressors, being male can add layers of stress, such as facing stereotypes, internal conflict, and insufficient support network (Gadimova et al., 2023; Sawalma et al., 2024; Wu et al., 2023; Zabin, 2023). Aside from working as a nurse and being male, the emergency department (ED) environment can intensify workplace stress with its unpredictable nature as often there are heightened emotions, violence, and decisions are made in an instant (Asadi et al., 2023; Kyron et al., 2020). Sasa (2019) reported that men face unique challenges (I.e. societal perceptions, cultural barriers, etc.) in nursing while performing their role in client care. Men in nursing are less likely to seek help for mental health support (Sagar-Ouriaghli et al., 2019). This reluctance reflects multifaceted influences deeply embedded in social, political and cultural contexts.

Social influences, for instance, include pervasive gender stereotypes that discourage men from expressing vulnerability and seeking assistance (Teresa-Morales et al., 2022). Politically, the nursing profession has long been called to undergo a paradigm shift toward a gender-neutral image. This change in image is essential for enhancing nurse well-being and meeting clients' diverse needs (Flaskerud & Halloran, 2018; Sasa, 2019). Such a shift is not merely aesthetics but a fundamental reimagining of the profession's identity and inclusivity.

Culturally, while males may face stigmatization, they paradoxically benefit from the "glass escalator" effect, propelling them to higher ranks and income despite their minority status

(Brandford & Brandford-Stevenson, 2021, p. 295; Sasa, 2019; Woo et al., 2022). This invisible force highlights men's structural advantage over women, even within traditionally female-dominated fields (Brandford & Brandford-Stevenson, 2021). However, this advantage may temporarily lessen the psychological toll of the nursing profession.

Neglecting mental health support for male nurses can lead to detrimental effects such as increasing nurse mental health issues, increased medical errors, burnout and poor patient care (Arimura et al., 2010; Greenberg et al., 2021; Happell et al., 2013; Maharaj et al., 2018). Initially, male emergency nurses (MENs) may hesitate to seek help, exacerbating their psychological distress. Psychological distress is further compounded by contextual barriers that hinder access to and utilization of support services in the workplace. If nurses remain psychophysically imbalanced, the consequences extend beyond the individual, potentially affecting client care and safety (Starc, 2018). Raza and colleagues (2022) underscore that neglecting nurse health poses a significant risk to public health, increasing the likelihood of errors and substandard care. Additionally, work-related stress contributes to low job satisfaction, absenteeism and turnover intentions, intensifying the nursing shortage crisis. The following section discusses the research purpose of addressing these complexities.

Research Purpose

The purpose of this research is to explore male emergency nurses' (MENs) work stressors and their help-seeking behaviour through the lens of social, political, and cultural contexts. As a theoretical and systematic approach, I will use McLeroy and colleagues (1988) Ecological Model for Health Promotion (EMHP) to view the multiple and complex forces to understand MENs' work stressors as well as the personal and contextual factors of MENs' help-seeking behaviour for work stressors. EMHP will also address work stressors and help-seeking

behaviour at multiple layers to help improve nurse health, public health, and a sustainable nursing workforce.

Definition of Terms

A series of definitions for commonly used terms will be provided below to enhance clarity and comprehension of the various concepts discussed in this research.

Workplace Stress

For the purposes of this study, workplace stress is defined as "the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope" (World Health Organization, 2024, as cited by Pimentel, 2024, p. 331). Additionally, workplace stress can also be defined as a harmful physical and emotional response when job demands conflict with employees' control over meeting these demands (Canadian Centre for Occupational Health and Safety [CCOHS], 2023). Given the interchangeable use of terms as job stressor, work stressors and work-related stress based on the literature, this research consistently maintains the definition of workplace stress. The Job Demands-Resource (JD-R) model provides a robust theoretical foundation to understanding complexities of workplace stress (Baker & Demerouti, 2007).

Job Demands-Resources Model (Baker & Demerouti, 2007). A framework that evaluates the complex interplay of various factors of work and its impact on employees' well-being and performance while explaining the harms and benefits associated with the work environment (Pimentel et la., 2024). From this model, job demands and job resources will be further defined.

Job Demands. Job demands are the physical, psychological, social, or organizational aspects of the job that need continuous physical and/or psychological effort from its worker (Pimentel et al., 2024). It include factors like workload, time pressure, emotional labor, role ambiguity, and interpersonal conflicts (Pimentel et al., 2024). Job demands may be associated with increased workplace stress levels (Pimentel et al., 2024).

Job Resources. Job resources are the physical, psychological, social, or organizational aspects of the job that help individuals achieve occupational goals, lower demands at work and spark interests on personal growth and development (i.e., social support from colleagues and supervisors, autonomy, opportunities for skills development, feedback and a supportive organizational culture) (Pimentel et al., 2024). These job resources are the buffers to the negative effects of job demands to enhance motivation and produce a positive work environment (Pimentel et al., 2024).

Help-Seeking Behaviour

For the purpose of this research, help-seeking behaviour is defined as a process of actively and with intentions to seek help from others (Cornally & McCarthy, 2011; Rickwood et al., 2005, as cited by Horne et al., 2024; Rickwood & Thomas, 2012). The help-seeking process involves recognizing symptoms, assessing the necessary assistance, and expressing the symptoms experienced and the need for help (Rickwood & Thomas, 2012). Additionally, it requires awareness of accessible and available sources of help and a willingness to disclose difficulties (Rickwood & Thomas, 2012).

Formal help-seeking. Formal help-seeking refers to seeking support from mental health professionals (Rickwood et al., 2005, as cited by Horne et al., 2024).

Informal help-seeking. Informal help-seeking refers to receiving support from friends, family/partners who are not mental health professionals (Rickwood et al., 2005, as cited by Horne et al., 2024).

Male Nurse

This research explores the experiences of men in nursing. Male nurses included in this study are those who self-identify as male and have biological attributes of male working in the nursing profession. Male nurse is reported to be a stereotypical label that is often problematic because it further marginalizes men in the feminization of nursing (Sasa, 2019). Male nurses are often called "missing and needed demographic…with it, injustice and a call to action" (Cottingham, 2018, p.205).

Patriarchy

A system of social structures in which men are privileged, empowered, and hold positions of control and dominance over women in political, social, and economic sectors (Habiba et al., 2016)**.** Patriarchal universal ideology refers to a set of ideas and beliefs that justify male domination (MacKinnon, 1983). This social ranking is an important determinant of gender relations as it creates more favour of the male gender (MacKinnon, 1983).

Contextual Factors

Contextual factors in this research include social, political, and cultural factors. Social factors include MENs' social support, which affects their help-seeking beliefs and behaviour. Political factors are influenced by policies, laws, and guidelines to assess and address workplace stressors and help-seeking behaviours (Litchfield et al., 2021). Cultural factors may shape how MENs respond to workplace stressors and help-seeking behaviour. Culture influences thinking, decisions and actions (College of Nurses of Ontario [CNO], 2009).

Client

This research views the client as an individual, family, group, or community (CNO, 2009).

Sex

Sex are biological attributes linked with the physical and physiological features of man and animals (Canadian Institutes of Health Research, 2023; Hartig et al., 2024; Rich-Edwards et al., 2018). The attributes are the anatomy, physiology, genes and hormones, whether male, female or intersex (Canadian Institutes of Health Research, 2023; Hartig et al., 2024).

Gender

Gender are sociocultural factors that influence roles, behaviours, expressions and identities of girls, women, boys, men and gender-diverse people (Canadian Institutes of Health Research, 2023; Hartig et al., 2024; Rich-Edwards et al., 2018). This research views gender as an influence on how nurses perceive themselves and each other, how they act and interact, and the distribution of power and resources in society (Canadian Institutes of Health Research, 2023)

Summary

In this chapter, I presented my introspective reflection and experience on workplace stressors and help-seeking contexts. The introduction assisted in providing a deeper understanding of the research's significance. The research purpose and definitions of key terminologies were offered to ensure clarity and understanding of the concepts discussed throughout the research. An extensive literature review was conducted to delve further into the intricacies of work stressors and help-seeking behaviours among MENs. This literature review,

presented in the following chapter, explores existing research and provides critical insights into the challenges MENs face.

Chapter II: Literature Review

In the preceding chapter, I provided an overview of the research's context and inception. This chapter focuses on a literature review, presenting current research evidence on workplace stressors and the help-seeking behaviour of MENs. The following sections will detail the methodology employed to obtain and review various sources, including articles, books, and grey literature.

Databases Searched

A comprehensive search for peer-reviewed literature published between 2012 and 2024 was conducted using the EBSCO Discovery Service provided by Thompson Rivers University. In addition to peer-reviewed sources, grey literature was also reviewed. The search strategy involved the following keywords:

- (Male nurs* emerg* OR Male staff nurs* emerg*) AND (Occupational stress* OR Work stress*) AND (Help-seeking behaviour OR Help-seeking behavior OR Seek* help)

Inclusion and Exclusion Criteria

To ensure the inclusion of relevant evidence, the following criteria were applied: a) Primary and secondary sources; b) Studies utilizing qualitative, quantitative, and mixed methods that explore workplace stressors and the help-seeking behaviour of MENs; c) Seminal works addressing workplace stressors and the help-seeking behaviour of MENs. Studies published in non-full text formats and non-English languages were excluded.

Search Outcome

A comprehensive search across various databases yielded 377 article titles and abstracts. Given the limited research articles, ancestry and descendancy approaches were employed to broaden the search strategy (Polit & Beck, 2021). The initial screening process excluded 237

articles that did not contain relevant terms in their abstracts or titles, resulting in 136 articles for further analysis. However, six articles were not retrievable, leaving 130 articles available for review (see Appendix B).

The abstracts and introductions were printed and scanned to facilitate a detailed examination of terms related to work stressors and factors affecting help-seeking behaviour among male nurses. Due to the scarcity of studies explicitly focusing on male emergency nurses, the search was expanded to include male nurses. Rigour was assessed for each article by applying the Mixed Methods Appraisal Tool (MMAT), an evidence-based questionnaire that critically appraises research quality (Hong, 2019).

Following data extraction, 91 articles were deemed irrelevant and eliminated, leaving 29 studies selected for comprehensive review. The large volume necessitated categorizing the data into themes. Core themes were identified by analyzing which concepts were repeated and threaded through the literature. A secondary reviewer, the thesis supervisor, then confirmed these themes.

The identified themes were divided into two main categories. The first theme focused on work stressors centred on factors including the working environment, work relationships, the nature of emergency nursing, nursing task design, and career progression. The second theme was on help-seeking behaviour, focusing on intrapersonal, interpersonal, and institutional/community factors.

Work Stressors

Work Stressors and Working Environment

In a demanding and dynamic ED setting, nursing is a high-stakes profession where stress is a constant force. Male emergency nurses (MENs) navigate many stressors categorized into

physical, psychological, and social environments. This review delves into the depths of these stressors, revealing their profound impact on the well-being of MENs and the quality of care they provide.

Physical Environment. The physical environment of EDs presents an arena where nurses face challenges. Moustaka and Constantidinis (2010) and the Canadian Centre for Occupational Health and Safety (CCOHS, 2023) identified several hazards in hospital settings, including chemicals, noise, air quality, temperature, smell, ventilation, and lighting hazards. These stressors, often invisible yet injurious, are more than plain inconveniences; they pose significant risks to the nurses' health and safety. The job's physical demands are further intensified by the need for constant vigilance and rapid response, requiring emergency nurses to navigate overcrowded and chaotic environments while often working long hours without enough breaks. The cumulative effect of these physical stressors can lead to chronic fatigue, musculoskeletal injuries, and an increased risk of errors, ultimately compromising client safety.

Psychological Environment. The psychological environment in EDs is a container of stress, where the mental strength of nurses is tested daily. Starc (2018) describes nursing work as tremendously stressful, often accompanied by hostility and violence, short staffing, and client frequency. In this high-pressure environment, the mental health of emergency nurses is under siege. De Wijn and van der Doef (2021), Moustaka and Constantidinis (2010), and Shen et al. (2022) reveal that the psychological toll on emergency nurses is staggering, with many experiencing severe mental health issues. Malak et al. (2023) explained that 94.5% of 450 emergency nurses reported poor sleep quality, proving the relentless psychological stress, they endure. A toxic psychological environment can lead to dissatisfaction, absenteeism, and high turnover rates, creating a vicious cycle that further exacerbates the stress on the remaining staff.

Social Environment. The social environment for MENs in a predominantly female profession is full of complexity. Ahn et al. (2009), Blackley et al. (2019), Chan et al. (2013), Fung (2018), Heikes (1991), Mao (2022), and Sasa (2019) argued that male nurses often feel like outsiders, isolated by their minority status. The historical exclusion of male nurses from the Nursing Registration Act of 1919 in the UK (Sasa, 2019) casts a long shadow, perpetuating feelings of alienation. In Canada, it took 25 years for the Canadian military to rectify its discriminatory policy that prevented men in nursing from joining its Nursing Division (Care et al., 1996). Male nurses may find themselves excluded from social activities like bridal or baby showers (Ahn et al., 2009; Heikes, 1991; Inoue, 2006), reinforcing their sense of not belonging. Additionally, the perception that male nurses are unsuitable to care for female clients (Crossan & Mathew, 2013) can create barriers to forming nurse-client therapeutic relationships. Clients can perceive male nurses as superior to female nurses, often mistaking them for physicians and directing their questions to male nurses, which leads to conflict between male and female nursing staff (Tuna & Kahraman, 2024).

Nevertheless, amidst this isolation, there are sparkles of hope. Mao et al. (2021) and Christensen et al. (2021) suggest that harmonious working relationships between male and female nurses are possible, and a healthy social environment can exist. Starc (2018) notes that while female nurses often experience higher stress levels when dealing with co-workers, workplace violence, and clients, they also recognize the invaluable contributions of male nurses in handling physical tasks and managing aggressive clients (Chan et al., 2014). Tuna and Kahraman (2024) further supported that including male nurses in the nursing team significantly enhances the overall effectiveness and dynamics of healthcare delivery, underscoring the necessity of their presence in the nursing profession. With exploration of the multifaceted work

stressors and work environments of EDs, it is equally crucial to examine the intricate dynamics of work relationships and their impact on the stress levels of MENs.

Work Stressors and Work Relationships

Working with others is crucial to teamwork and mental health, yet it can also induce significant negative stress. In the workplace, these stressors often stem from gender role conflicts, perceived lack of support, harassment or threats to personal safety, and prejudice or discrimination (Blair & Littlewood, 1995; CCOHS, 2023; Sveinsdottir et al., 2006). Blackley and colleagues (2019) argued that gender role conflicts and perceived lack of support exacerbate the stress experienced by male nurses. Several researchers have documented that male staff nurses face gender role restrictions, devaluation, and violations in various sociocultural contexts, leading to increased negative stress (Azadi et al., 2016 as cited by O'Lynn et al., 2020; Feng et al., 2016; Kulakac et al., 2015; O'Connor, 2015; Zamanzadeh et al., 2013). In contrast, Christensen et al. (2019) found that entry-level nursing students do not experience significant gender role conflict. Xu and colleagues (2019) further supported the notion that emergency nurses report low conflict and anxiety regarding their roles. While evidence suggests that gender role conflict may vary, both its presence and absence can potentially induce stress to some extent.

Harassment, either sexual or physical, is linked with workplace stressors. Many researchers reported that male nurses experience sexual harassment at work (Jeong & Chang, 2022; Papantoniou, 2021). When male nurses experience sexual harassment, it has the same consequences when this is experienced by female nurses, which can be moderate to severe (Jeong & Chang, 2022; Papantoniou, 2021). Some examples of physical consequences of sexual harassment are headaches, exhaustion, nausea, sleep difficulties, suicidal behaviour, and

menstrual disturbances (Papantoniou, 2021). In addition, the psychological consequences are stress, hypervigilance, psychological burnout, avoidance, and depression (Papantoniou, 2021). Therefore, sexual harassment at work has physical and psychological consequences relative to male and female stress levels.

Male nurses are at a heightened risk of physical harassment due to their increased exposure to violent client behaviour. Binder and McNiel (1994) reported that physical attacks on male nurses are twice as frequent as those on female nurses, attributable to their more frequent encounters with aggressive clients. Additionally, Dafny and Beccaria (2020) explained that male nurses often face verbal violence from clients and their families. This exposure is compounded by the troubling perception of male nurses as bodyguards rather than professional healthcare providers, particularly when managing violent clients (Dafny & Beccaria, 2020). This perception may be linked to gender-based imbalances in client assignments, a phenomenon that warrants further investigation.

Although prejudice is inherently subjective, Wu and colleagues (2022) argued that higher levels of perceived prejudice among MENs are strongly correlated with increased psychological distress. While specific research on prejudice and psychological distress among MENs is limited, Feng and colleagues (2019) found that 82.2% of 460 new male nursing students in China experienced severe psychological distress due to perceived negative prejudice. Blackley and colleagues (2019) further extend this concept by suggesting that stress is influenced by self-perception and how others perceive them. Despite variations in the sources of perception, Wu and colleagues (2023) reveal that both male nurses and nursing students are at significant risk for psychological distress. This knowledge underscores the critical need for comprehensive mental health support and interventions tailored to address the unique challenges faced by male nurses

in a female-dominated profession. Having examined the intricate dynamics of work relationships and their impact on stress levels among MENs, it is essential to turn the discussion to the broader context of work stressors inherent in the nature of emergency nursing.

Work Stressors and Nature of Emergency Nursing

Working in an ED is inherently stress-provoking due to the frequent encounters with death, trauma, and biological threats, which are more prevalent in this setting compared to other hospital departments. For instance, during the peak of the COVID-19 pandemic, emergency nurses were repeatedly confronted with traumatic situations involving death, severe injuries, illnesses, and exposure to biological hazards (Caulfield et al., 2022; Moustaka & Constantidinis, 2010). This constant exposure to trauma can lead to significant psychological distress. Nia and colleagues (2016) found that death anxiety arising from caring for dying clients often drives nurses to leave the profession or adversely affects their work and personal lives. Although research on death anxiety among male nurses is limited, Brady (2013) reported that emergency nurses generally exhibit high levels of avoidance and fear of death, which can impair the quality of client care. However, Aradilla-Herrero et al. (2013) suggest that increasing emotional awareness among nurses can reduce anxiety, depression, and fear of death, thereby improving their mental health and client care. Raising awareness of death anxiety among male nurses could help normalize these feelings and promote better health outcomes for both nurses and clients, even in the face of traumatic events.

The ED is a primary setting for traumatic events, placing emergency workers, including male nurses, at significant risk for post-traumatic stress disorder (PTSD) and other stress responses (Chachula & Varley, 2022). De Wijn and van der Doef (2020) hypothesize that the higher prevalence of PTSD in this context is linked to less frequent, but more intense, critical

incidents. This hypothesis underscores the unique and severe nature of the stressors faced by ED personnel. However, the limited number of male nurses in research samples presents a challenge in drawing definitive conclusions about their specific experiences and needs (Trudgill et al., 2020). Despite this limitation, Trudgill and colleagues (2020) advocate for the ED as a crucial starting point for promoting preventive and therapeutic mental health interventions.

More widely, the disparity in funding and support further highlights the urgency of addressing mental health in the ED. The Ontario government recently allocated $32 million to support police officers, firefighters, correctional workers, paramedics, and other public safety personnel, yet emergency nurses were conspicuously excluded from this funding (Ontario, 2022). This exclusion is particularly concerning given the high levels of trauma and stress that ED nurses endure. The lack of targeted financial support for emergency nurses overlooks their critical role in the healthcare system. Also, this is most likely related to the reluctance to fund nursing as a large group and would thereby increase cost to the system. It fails to address the pressing need for mental health resources tailored to the exact need necessary for all key carers.

Emergency nurses, positioned at the forefront of healthcare, are often the first to encounter biological threats, which can be a significant source of stress. This unique exposure places them at a higher risk of infection, leading to elevated psychological stress compared to other healthcare workers (Nie et al., 2020; Rajcani et al., 2021; Walton et al., 2020, as cited by Garcia-Tudela et al., 2022). The heightened stress from this vulnerability can result in emotional exhaustion, burnout, depression, and poor mental health outcomes (Ahorsu et al., 2021; Huang et al., 2024). Holtz and colleagues (2023) emphasize that the identities of nurses are deeply affected by moral injuries and psychological damage, necessitating acknowledgment and healing. The evidence suggests that emergency nurses frequently witness the suffering and health transitions

of their clients, which can profoundly impact their psychological well-being. With exploration of the profound stressors inherent in emergency nursing, it is now essential to examine how the design of nursing tasks further contributes to the overall stress experienced by emergency nurses.

Work Stressors and Nursing Task Design

According to the Canadian Centre for Occupational Health and Safety (CCOHS, 2023), work stressors in nursing task design encompass workload, shifts or hours of work, and mismatches between skills or abilities and job demands.

Workload. Shen and colleagues (2022) highlight that a high workload threatens the quality of care and work performance. An example of a high workload is the prevalence of ED overcrowding. In the systematic review of Morley and colleagues (2018), researchers reported that crowding in the ED caused treatment delays, increased mortality, and poor client pain management. Additionally, Bolado and colleagues (2024) reported that workload and time constraints were significantly associated with moderate stress levels, while duty demands, availability of medical equipment and supplies, and witnessing death and dying were significantly associated with high-stress levels. Male nurses, as a minority in the nursing profession, often face gender stereotypes, which can exacerbate stress related to high workloads (Chen et al., 2020). For instance, Zhang and colleagues (2021) found that during the COVID-19 pandemic, nurses with heavy workloads experienced significantly higher levels of mental stress. This increased stress can lead to burnout, reduced job satisfaction, and higher turnover rates, ultimately affecting client care. It is crucial to assess perceived workload performance among MENs to understand the extent of their stress and develop strategies to mitigate it.

Shiftwork. In addition to workload, shift work is a significant source of stress. Robat and colleagues (2021) reported that hospital workers experience higher stress levels due to the

prevalence of shift work. Numerous studies have indicated that night shifts are particularly stressful and place emergency nurses at a higher risk of stress (Shen et al., 2022; Starc, 2018). The disruption of circadian rhythms and the impact on social and family life contribute to the heightened stress associated with night shifts. However, Badu and colleagues (2020) argue that morning and night shifts are more stressful than afternoon ones. This finding suggests that the timing of shifts plays a crucial role in stress levels, with afternoon shifts potentially offering a more balanced work-life integration. De Wijn and van der Doef (2021) further explain that work time demands and shifts are linked to emotional exhaustion, leading to decreased job performance and increased absenteeism. For mid-career male nurses in Korea, continuous shift work, regardless of shift time, leads to chronic exhaustion and lethargy (Shin & Lim, 2021). This chronic exhaustion can impair cognitive function, decision-making abilities, and client care quality. Understanding MENs' preferences for work shifts is essential, as existing literature lacks information on which shift options best support their mental health and well-being. Tailoring shift schedules to accommodate these preferences could mitigate stress and enhance job satisfaction, ultimately improving client care outcomes.

Skill-Job Mismatch. The nursing profession is often burdened by stereotypes that label nursing tasks as inherently feminine. This leads to doctors' lack of respect for nurses' knowledge and skills (Starc, 2018; Teresa-Morales et al., 2022). This situation often a consequence of patriarchal discourse, undermines and devalues care work as it is associated with women. As a result, structures of patriarchy significantly contribute to their stress levels. The specific impact of this stereotype on MENs' stress remains an area requiring further exploration.

Alinejad and colleagues (2023) highlight that nurses with longer tenure at a single hospital are better equipped to handle work stressors and tensions than their newer counterparts.

This extended experience allows them to develop effective coping mechanisms and build supportive relationships with colleagues. Conversely, Ruiz-Fernandez et al. (2022) found that the duration of an emergency nurse's career is crucial, as compassion satisfaction tends to decline over time. This decline negatively impacts the quality of client care, leading to emotional exhaustion and burnout, further exacerbating stress levels.

Raza and colleagues (2022) emphasized the importance of nurses' approaches to clinical situations. Their findings suggest that reflective nurses who use critical thinking in their clinical judgments experience less stress than those who act impulsively. This underscores the need for training programs to enhance nurses' critical thinking and decision-making skills.

Considering both work duration and approaches to clinical situations provides a broader perspective on work stressors. This understanding can inform the redesign of nursing tasks to support emergency nurses better. Addressing work stressors related to nursing task design requires a comprehensive approach that considers workload, shift work, and the impact of gender stereotypes. By understanding and mitigating these stressors, healthcare institutions can improve MENs' mental health and well-being, ultimately enhancing the quality of client care. Further research is essential to explore the specific experiences of male nurses and develop targeted interventions that address their unique challenges. Doing so may create a more supportive and effective work environment for all nurses. Building on the understanding of work stressors and nursing task design, it is crucial to explore how these stressors intersect with the career development of MENs.

Career Development as a Work Stressor

A nurse's career development can become a significant work stressor, influenced by factors such as under- or over-promotion and job security or insecurity (CCOHS, 2023). Ahn and

colleagues (2009) reported that while male nurses often receive promotions, they remain dissatisfied with the promotion system, leading to stress and dissatisfaction at work. Qureshi et al. (2020) argued that promotions are predominantly awarded to white Caucasian male nurses, highlighting a disparity within the profession. Sasa (2019) further elaborated on the "glass escalator" phenomenon, where an invisible force propels male nurses to higher ranks and income levels. These findings highlight that career development can be a significant source of stress for MENs due to disparities and systemic issues in promotions and job security.

Job insecurity is another emerging concern, with Prado-Gasco et al. (2021) reported its adverse physical and mental health outcomes. Evidence suggests that promotions are inequal among male nursing subgroups. Several researchers, including Qureshi et al. (2020) and Sasa (2019), debated that male nurses of colour face a "glass ceiling," an invisible barrier to career advancement. Abbas et al. (2020), Saleh et al. (2020), and Zeb et al. (2020) supported this view, specifying that male nurses from the Middle East and South Asia experience cultural and organizational discrimination in promotion and hiring processes. Job insecurity and promotion disparities adversely affect the health of male nurses, especially those of colour, who face systemic barriers to career advancement.

Conversely, some men find nursing to be a secure profession, which serves as a motivation (Ahn et al., 2009; Shudifat et al., 2023). Woo et al. (2022) agreed that nursing is a secure job but noted that some male nurses lack interest in advanced nursing roles or do not plan to remain in nursing practice. This dichotomy suggests that while nursing can offer job security, it does not necessarily equate to career satisfaction or advancement for all male nurses. Several researchers recommend supporting career growth and increasing awareness of nursing stereotypes and unconscious biases against male nurses (Abbas et al., 2020; Saleh et al., 2020;

Woo et al., 2022; Zeb et al., 2020). By fostering a more inclusive and equitable promotion system, healthcare institutions can mitigate stressors related to career development and enhance job satisfaction among male nurses. While nursing provides job security for some male nurses, it does not always lead to career satisfaction or advancement, highlighting the need for support in career growth and awareness of biases. Shifting from the broader topic of work stressors, it is essential to explore how these stressors influence help-seeking behaviour among male nurses.

Help-Seeking Behaviours

Despite the critical role of emergency nurses, there is a notable gap in research dedicated explicitly to their help-seeking behaviour. Help-seeking is a complex, multi-layered process that extends beyond a simple, one-dimensional act. Clark and colleagues (2018) elucidated that help-seeking involves a dynamic interplay of factors, requiring individuals to be ready for behaviour change and feel motivated with control over their actions. This highlighted the need for focused research on MENs' help-seeking behaviours to support their well-being better.

Research on help-seeking behaviours has predominantly focused on nurses, male students, and men in general, thus forming the basis of this review. The multiple layers influencing help-seeking behaviour include intrapersonal, interpersonal, and institutional/community-level factors. Men often seek help due to acute illness, pain, inability to work, and encouragement from partners (Mursa et al., 2022). Interestingly, some men prefer confiding in non-professionals about health issues before seeking professional help (Rooney et al., 2020). This review highlights the need to understand the diverse factors influencing help-seeking behaviours among men, including MENs.

The most common forms of help available to men include self-help/online resources, doctors/family doctors, counsellors/psychotherapists, and coaching (Kennedy & Moorhead,

2021). To fully understand the intricacies of help-seeking, it is essential to explore the reasons behind it, the individuals involved, and the types of help currently accessible to men. This exploration often begins with the individual's perception at the intrapersonal level.

Intrapersonal Factors

Cognitive situations. A man's cognitive abilities, including mental health literacy, insight into symptoms, and familiarity with available options, significantly impact their help-seeking behaviour. Researchers consistently agree that mental health literacy is closely linked to help-seeking behaviour (Clark et al., 2018; Mursa et al., 2022; Sagar-Ouriaghli et al., 2020). For instance, Clark and colleagues (2018) found that increased access to literacy programs and treatment options correlates with more positive help-seeking behaviours. This is further supported by Yilmaz and Beydag (2022), who observed that nurses with higher mental health literacy exhibited positive attitudes toward seeking psychological treatment. However, it remains uncertain whether men, in general, possess sufficient mental health literacy and how this affects their help-seeking behaviour.

On the contrary, Mursa and colleagues (2022) argued that while mental health literacy may exist, it is often superficial and limited due to time constraints. They suggested that this issue can be addressed by creating a more structured approach, such as making a checklist and conducting group discussions to build trust and shared control (Sagar-Ouriaghli et al., 2020; Seidler et al., 2018). For example, Clark et al. (2018) found that incorporating personal experiences of anxiety disorders into teaching sessions significantly increased help-seeking rates. In the context of MENs, the specific mental health literacy they receive, how it is conducted, and the potential content linked to their help-seeking behaviour have yet to be explored.

House and colleagues (2018) discovered that higher insights regarding mental health and symptoms result in positive help-seeking behaviour outcomes. In the case of male students, there is a tendency to face increased difficulties and challenges compared to female students in identifying mental health symptoms (Sagar-Ouriaghli et al., 2020). These challenges may stem from men focusing less on emotional symptoms and clinicians' assumptions that men who already understand their condition (House et al., 2018; Seidler et al., 2018). Moreover, if clinicians hold preconceived notions, this can negatively impact therapeutic relationships, causing uncertainty and disengagement (Seidler et al., 2018). Evidence suggests that increasing mental health insight can lead to positive help-seeking behaviours. However, it is crucial to understand MENs' perspectives on their stress symptoms to enhance their engagement in the help-seeking process.

The understanding of MENs' knowledge about resources, what is available, and their accessibility to various resources remains unclear. Some researchers have explained that in media and educational settings, the benefits and experiences of help-seeking are often missing (Clark et al., 2018; House et al., 2018; Sagar-Ouriaghli et al., 2020). A common misconception is that medication is the primary treatment for mental health issues or that it is only for suicide, as found in male veterans (House et al., 2018). Raza and colleagues (2020) suggested that advertising help-seeking benefits can normalize these behaviours. However, how many MENs use this knowledge to seek help remains uncertain. This gap highlights the need to understand how MENs use available resources for help-seeking. Transitioning from cognitive factors, it is also essential to consider how attitudinal situations influence help-seeking behaviour among MENs.

Masculinities and MEN's Help-seeking. The role of masculinity in men's help-seeking behaviour is a subject of ongoing debate, with some researchers arguing that it can both motivate and hinder this behaviour. Mursa and colleagues (2022) suggested that masculinity can act as a motivator by emphasizing elements of taking control, which positively influences men's attitudes toward help-seeking. House and colleagues (2018) supported this view, noting that taking control can increase help-seeking behaviour. Therefore, reframing masculinity around principles such as being a good provider and maintaining autonomy may enhance help-seeking behaviours among men (Mursa et al., 2022).

Conversely, masculinity can also hinder help-seeking if it is associated with stigmatization, risking personal self-worth and self-esteem (Kennedy & Moorhead, 2021; Yilmaz & Beydag, 2022). Researchers have found that men often avoid seeking help to avoid being perceived as incompetent, inadequate, or dependent, thereby preserving their autonomy (Mursa et al., 2022; Raza, 2022). Additionally, some men are reluctant to express their feelings or take medication as they do not want to appear vulnerable (Kennedy & Moorhead, 2021). Kellett (2021) further explained that early emotional suppression starts at an early age, leading to difficulties in identifying emotions, causing avoidance and engagement in hegemonic masculinities. Concerns about confidentiality further deter men from seeking help, as any breach could lead to ridicule from peers (House, 2018; Sagar-Ouriaghli et al., 2020). Adhering to traditional masculinity can result in adverse outcomes, such as increased psychiatric maladjustments (Berke et al., 2022). The extent to which MENs perceive help-seeking and masculinity may depend on their geographical location, societal norms, and environment. This highlights the importance of understanding the nuanced ways masculinity influences MENs'

help-seeking behaviours. Next, I review how structural situations impact help-seeking behaviour among MENs.

Structural Situations. Men's help-seeking behaviour is significantly influenced by their perceptions of treatment style, duration, and cost. Research indicates that men prefer treatments emphasizing reasoning, logic, and rationality over emotional approaches (Kennedy & Moorhead, 2021; Sagar-Ouriaghli et al., 2020). However, some male nursing students reported that traditional mental health support settings can often be intimidating and unwelcoming (Sagar-Ouriaghli et al., 2020). Regardless of the formality, targeted, goal-oriented, and action-oriented treatments tend to engage more men (Kennedy & Moorhead, 2021; Seidler et al., 2018). For instance, Seidler et al. (2018) found that action-oriented therapies are more effective than traditional talk therapy. Additionally, Kennedy and Moorhead (2021) noted a preference for coaching over conventional counselling or psychotherapy among men. Finally, mentorship creates a supportive environment that fosters the sharing of experiences that support the mentee's development (Seidler et al., 2018). This highlights the need for further research into the mental health treatment preferences of men.

The duration and transparency of costs are also critical factors in men's help-seeking behaviour. Sagar-Ouriaghli et al. (2020) found that a mix of short and long sessions is preferred, varying by individual needs. House et al. (2018) suggested that reducing wait times for mental health appointments could further encourage help-seeking. Mursa et al. (2022) recommended after-hours clinical services and teleservices to improve accessibility. Furthermore, Seidler et al. (2020) advocated for a monitored register of practitioners specializing in men's health. Transparency in costs positively impacts help-seeking behaviour, as Seidler et al. (2018) reported, who found that upfront cost information encourages men to seek help. The perspectives

of MENs on effective treatment structures remain an area ripe for exploration. Thus, understanding men's preferences for treatment style, duration, and cost transparency is essential for improving MENs' help-seeking behaviour. While intrapersonal factors are important, interpersonal factors also play a crucial role in men's help-seeking behaviour.

Interpersonal Factors

Evidence suggests that family physicians, partners, and support groups significantly influence men's help-seeking behaviour, though this is not specific to MENs. As Seidler and colleagues (2020) highlighted, meaningful relationships with family physicians are crucial. Kennedy and Moorhead (2021) emphasize that coaching is more appealing and less stigmatizing to men, potentially increasing client-physician engagement. This suggested that physicians could act as coaches for change, leading to greater outreach if offered through online platforms (Kennedy & Moorhead, 2021). Researchers generally agree that family physicians should innovate in engaging men in their health, with action-oriented interventions, coaching, or online methods potentially optimizing men's health and MENs' help-seeking behaviour. In sum, innovative approaches may be beneficial in optimizing men's health and enhancing help-seeking behaviour among MENs.

Partners also play a vital role in men's health. Rooney et al. (2020) found that female partners are essential during the precontemplation and action phases of the change model, guiding men to seek help until recovery. They often look for the best timing and communication strategies, initially discussing the benefits of seeking help from an individualistic perspective before considering others' views (Rooney et al., 2020). While heterosexual perspectives are well-documented, exploring the impact of same-sex partners on MENs' help-seeking behaviour would provide valuable insights.

Support groups further contribute to men's help-seeking behaviour. Vickery (2022) argues that support groups are more effective than cognitive behavioural therapy (CBT) because they create networks that reduce men's distress. These groups provide a platform for men to share their experiences, fostering a sense of community, mutual respect, understanding, and empathy (Vickery, 2022). By finding a community with similar struggles, support groups can also benefit MENs in managing stress and complexity. Family physicians, partners, and support groups are pivotal in shaping men's help-seeking behaviour.

Institutional or Community Factors

A cultural issue that remains debatable among researchers is whether the stigma of masculinity and help-seeking are incompatible and may act as either a barrier or facilitator to help-seeking.

Stigma as Barrier. Society's constructed view of help-seeking as feminine, weak, dramatic, and incompetent may hinder men's help-seeking because it violates hegemonic masculinity (Clarke et al., 2018; Kennedy & Moorhead, 2021; Sagar-Ouriaghli et al., 2020). Men tend to abide by hegemonic masculine norms of self-reliance, emotional control, and physical toughness (Kennedy & Moorhead, 2021; Sagar-Ouriaghli et al., 2020). Violating these norms increases the possibility of self-stigma or masculine discrepancy stress (Berke et al., 2022; Sagar-Ouriaghli et al., 2020). Many researchers support that social stigma may lead to self-stigma, which can minimize men's help-seeking (Rooney et al., 2020; Mostoller & Mickelson, 2024; Yilmaz & Beydag, 2022). Thus, to achieve a supportive environment conducive to MENs' help-seeking, it is vital to challenge societal norms that place a stigma on vulnerability and promote a culture that recognizes and values emotional well-being.

Masculinities as Facilitator. Depending on contemporary society's definition, a more positive outlook towards masculinity and help-seeking may improve men's health and outcomes. Most researchers agree that approaches like reframing help-seeking as a strength, avoiding mental health labels, and implementing more hegemonic masculine-like interventions may reduce stigma to engage men in their health and wellness (Kennedy & Moorhead, 2021; Sagar-Ouriaghli et al., 2020). Therefore, challenging the traditional notions of masculinity and promoting help-seeking as a sign of strength and self-awareness are possibly building blocks to the creation of a supportive environment where MENs may feel empowered.

In this literature search, I found limited research studies investigating MENs' experiences of workplace stressors and their help-seeking behaviour in an ED setting in Canada, thus indicating a gap in the literature.

Research Questions

Two research questions guided this research to illuminate MENs experiences in the Canadian healthcare context:

- What are the work stressors for MENs?
- How do social, political, and cultural factors impact MEN's help-seeking behaviour?

Significance of the Study

This master-level research, possibly the first of its kind, delves into the workplace stressors and help-seeking behaviour of MENs. The findings of this research are crucial for advancing men's health, ensuring safer public health, and enhancing organizational productivity. Men's mental health is a silent social and health crisis (Canadian Mental Health Association, 2023; Whitley, 2017). Men are less likely to seek help than women and often die from preventable causes. This research addresses a critical gap in understanding and improving the

MEN's experience of workplace stressors and help-seeking, ultimately contributing to a healthier and more productive healthcare environment.

Despite the urgent need for support, many researchers note that being a male nurse is a significant source of stress (Azadi et al., 2016; Feng et al., 2016; Kulakac et al., 2015; O'Connor, 2015; Zamanzadeh et al., 2013, as cited by O'Lynn et al., 2020). This stress is worsened by the stigma surrounding mental illness and the harmful belief that seeking help is not masculine (Clarke et al., 2018; Kennedy & Moorhead, 2021; Sagar-Ouriaghli et al., 2020; Yilmaz & Beydag, 2022). Therefore, it was essential to bring awareness and conduct this critically important research on men's health. This research can reveal the hidden struggles of MENs, leading to significant changes in healthcare practices and policies that could save lives and significantly improve the well-being of many men.

Summary

This literature review has set an essential foundation for understanding the workplace stressors and help-seeking behaviours of MENs. It reveals that MENs face numerous workplace challenges in the high-pressure environment of EDs, significantly impacting their willingness to seek help. There is limited research on these issues despite its critical importance. The review features the urgent need to explore the unique stressors experienced by MENs and their help-seeking practices. I presented the significance and the guiding research questions for this research. The next chapter will describe the approaches to designing and conducting this research.

Chapter III: Methodology

The knowledge gained from the literature review has been instrumental in selecting the research methodology for this study. In this chapter I describe the Ecological Model for Health Promotion (EMHP) as a method of inquiry to interpret and understand MENs experiences. Critical ethnography is the research design for this research as it provides a robust framework to uncover and address the complex dynamics and broader social, political, and cultural influences on MENs' help-seeking behaviours and workplace stressors. First, based on previous literature reviews, MENs experiences and behaviours in the workplace have multifaceted factors impacting workplace stressors and their help-seeking behaviour. Given the research is complex, the Ecological Model for Health Promotion (EMHP) is particularly well-suited to examine the multi-faceted environmental, social, and psychological factors influencing it (McLeroy et al., 1988; Rowley et al., 2015). Finally, following the theoretical framework and research design presentation, I will describe the research process: setting/context, recruitment, participants, data collection, data analysis, and ethical considerations.

Theoretical Framework

Ecological Model for Health Promotion (EMHP)

Rowley and colleagues (2015) highlighted that the EMHP allows for a comprehensive exploration of these multifaceted factors affecting MENs work environments. I used EMHP to conceptualize and analyze various aspects of a healthy work environment that is significant to managing work-related stress and foster positive help-seeking behaviour among MENs (Creswell & Creswell, 2018; Mertz, 2017). The EMHP's holistic approach ensures that I captured the interplay between individual, interpersonal, organizational, and societal factors, providing a robust framework for understanding and addressing the challenges MENs face in their

professional environment. Thus, the EMHP is a fitting lens for this inquiry and a powerful tool for meaningfully exploring MENs' experiences. I will begin to discuss the various levels of the EMHP.

Intrapersonal Level. At the first level of the EMHP, MENs' knowledge, beliefs, and skills can be understood at the individual level. Golden and Earp (2012) emphasized that personal characteristics—knowledge, beliefs, and skills—are pivotal in shaping health behaviours and outcomes. Lisnyj et al. (2021) further illustrated this by identifying key factors influencing undergraduates' stress levels and academic success. This includes general health status, adaptation to post-secondary life, and socio-demographic factors like age, gender, and financial security. In the context of MENs, the intrapersonal factors explored were age, a lack of knowledge and understanding of workplace stressors and symptoms, years of experience, and pervasive stigma associated with male nurses' help-seeking. The next dimension to consider is the interpersonal level.

Interpersonal Level. The interpersonal level sheds light on the critical role of social networks, relationships, and support systems in shaping workplace stressors and their impact on MENs' help-seeking behaviour. Kern et al. (2020) asserted that social networks and relationships significantly influence health behaviours and outcomes, promoting overall well-being. However, existing literature predominantly focuses on the social networks and relationships of men and male nurses with family physicians, partners, and support groups (Kennedy & Moorhead, 2021; Rooney et al., 2020; Seidler et al., 2020; Vickery, 2022). This body of work does not explicitly address the unique social networks and relationships of MENs and their influence on help-seeking behaviour. Lisnyj et al. (2022) reported a nuanced approach by dividing the interpersonal level into two distinct components: (i) the workplace culture, encompassing a sense

of community and peer influence, and (ii) social support, which includes both personal and professional lives of MENs, highlighting the positive and negative influences of colleagues. The next dimension to consider is the institutional level.

Institutional Level. At the institutional level of the EMHP, one gains crucial insights into how workplace influences and stressors impact MENs' help-seeking behaviour. The Rural Health Information Hub (2018) highlighted that institutional factors could constrain or promote healthy behaviours through organizational rules, regulations, policies, and informal structures. Green et al. (1996) argued that prioritizing economic and social support within institutions can foster a healthy environment. However, institutions exercise significant power over rules and regulations, such as ensuring adequate safe staffing and managing stress levels.

Furthermore, several authors emphasize the importance of examining the access and availability of employee services and their utilization (House et al., 2018; Mursa et al., 2022; Sagar-Ouriaghli et al., 2020; Seidler et al., 2020). Key factors to explore include hospital programs for managing workplace stressors, the availability and delivery modes of services and resources, and the presence of policies and procedures to create a healthy work environment. This includes mental health initiatives, education and training, and financial support. The next dimension to consider is the community level.

Community Level. At the community level, McLeroy et al. (1988) proposed that the extent to which values and cultures are respected or neglected can significantly influence behaviour and health outcomes. They hypothesized that closer-knit communities provide higher levels of support, but similarities in work can lead to competition, potentially causing conflict that affects productivity and effectiveness. They also suggested that coalition building could mitigate such competition. Several researchers have highlighted the prevalence of social stigma

faced by male nurses and its impact on their help-seeking behaviour (Rooney et al., 2020; Yilmaz & Beydag, 2022). Yilmaz and Beydag (2022) hypothesized that increased societal acceptance could benefit public health by reducing individual perceived social stigma. Lisnyj et al. (2022) examined the community level by assessing community resources, including the diversity of support, local community strengths, and limitations. Consequently, nurses should be invited to participate in coalition building, which can be achieved by raising awareness of community attitudes, social inequities, cultural norms, and media influences. The next dimension to consider is the public policy level.

Public Policy Level. The public policy level critically examines current regulatory policies, procedures, and laws to ensure MENs have healthy working environments and to protect the mental health of the community (McLeroy et al., 1988). For instance, the Canada Health Act aims to provide all Canadians access to quality health care (Government of Canada, 2005). The Government of Canada (2023) recently identified eight core themes to support nursing: optimizing working conditions, achieving work-life balance, and promoting mental health, including organizational mental health and wellness supports and safe staffing practices. However, while the Canadian Centre for Occupational Health and Safety (CCOHS) supports health and safety programs and the prevention of workplace injuries and illnesses, it does not explicitly address work stressors or help-seeking behaviour (CCOHS, 2023). Golden and Earp (2012) emphasized that public policy can encompass community education and creating or modifying public policies. Lisnyj et al. (2022) highlighted the financial implications of program changes and the adequacy of funding to support mental health initiatives. Therefore, public policy analysis is essential for addressing the contextual factors contributing to work stressors

and health challenges. Promoting a broader scope can create a healthier and more supportive workplace for MENs.

Critical Ethnography

I utilized critical ethnography to investigate how gender influences MENs' experiences with workplace stressors to highlight the broader social, cultural and political factors that shape their help-seeking behaviours. The nursing profession is deeply infused with power dynamics, and critical ethnography provides the tools to investigate who holds power in this context, how power is distributed, and how the disempowered contribute to maintaining power imbalances (Madison, 2011). Additionally, critical ethnography examines the broader social, political, and cultural influences on MENs' help-seeking behaviour by considering contextual factors, thereby providing a comprehensive understanding of workplace stressors (Harrowing et al., 2010; O'Mahony et al., 2012). Furthermore, critical ethnography goes beyond surface-level observations to delve into the lived realities of MENs, allowing for a rich, immersive exploration of their experiences of workplace stressors and help-seeking behaviours (Palmer & Caldas, 2016). Thus, critical ethnography was deemed as almost fitting research design, offering a robust framework to uncover and address the complex dynamics at play.

This research adopted a qualitative critical ethnographic approach with the aim of using the findings to challenge unnecessary forms of social domination that have impeded gender diversity in nursing for many decades (Thomas, 2021). Critical ethnography was particularly suited to this inquiry as it allowed for an in-depth exploration of the dominant discourses that dictate the 'right way' to think, see, talk, or act as a nurse in society. It provided a framework for recommending ways to redress social power inequities (Ross et al., 2016, p. 4). Given the inherent power dynamics within the nursing profession, this approach investigated who holds

power in the context of MENs' help-seeking behaviour for work stressors. The research uncovered how power is distributed, how the disempowered contribute to maintaining power imbalances, and how the powerless manage to have their voices heard. A critical ethnography approach helped me to explore power relations and contextual factors influencing MENs' help-seeking behaviour for work stressors.

With critical theory as a guide, critical ethnography critiques the culture and examines the wider social, political, and historical differences that influence MEN's workplace stressors and thus shape their help-seeking behaviour (O'Mahony et al., 2012). It is different from the conventional because it goes beyond and understands the health inequities and structural constraints to further examine the broader determinants of health, social isolation, and discrimination that might affect MENs (O'Mahony et al., 2012). This approach focused on MENs' perspectives, employing an interpretive nature and immersion in the local context to understand what they say, do, and use (Castagno, 2012 as cited by O'Mahony et al., 2012; Creswell, 2016). I developed an active dialogical researcher-participant relationship by narrating their positionality and reflexivity, ensuring that the voices of MENs were authentically represented and findings may contribute to meaningful change in the nursing profession.

Setting/Context

This research was conducted within the Greater Toronto Area in Ontario, Canada. Ontario has a land area of 808,699.33 square kilometres (Statistics Canada, 2017). The province of Ontario has several major urban centers, including Toronto, Ottawa, and St. Catharines-Niagara. According to Statistics Canada (2017), the population of Toronto was recorded at 5,928,040. As of December 2023, the Office of the Auditor General of Ontario (2023) reported 163 EDs within the province, providing care to Ontarians, including those in remote and rural

regions. Moreover, data from the Canadian Institute for Health Information (CIHI) (2024) indicated that, as of 2023, there were 9,304 male nurses registered in Ontario. That is about 9.2% of the registered nurse workforce (CIHI, 2024). However, the number of Ontario MENs remains undocumented.

The setting includes a network of hospitals equipped with full-service EDs that receive at least 150,000 clients visits annually. Centred on a metropolitan or urban setting, MEN's experiences were captured within a high-volume, culturally diverse, urban healthcare environment, similar to the prevailing conditions for many EDs in Canada. Thus, the findings are likely applicable and transferable to similar contexts, offering insights into the broader experiences of MENs in Canada.

Recruitment

Various methods were applied for participant recruitment. Review ethics board-approved posters were posted on three hospital sites inviting MENs to participate in the research (see Appendix D). Since there were no responses from the poster, I constructed a welcome kit. The welcome kit (Appendix E) included an informational letter highlighting research details, eligibility criteria and information on informed consent if interested in participating. This welcome kit was distributed to MENs working during my in-person visits to the unit. Before releasing the welcome kit, participants could sign a tracking sheet to "buy in" or become committed and engaged in the research study. Advertising was also conducted by word of mouth, referral, and snowball sampling (eligible participants who met research criteria were invited to participate).

Following the critical ethnography approach, this research included participants with experiences related to the phenomena of interest–workplace stressors in ED and help-seeking

behaviour in Toronto, Ontario, Canada. In this vein, purposeful sampling was used to gain the necessary data that allowed meaningful data from MENs. To facilitate this focus, eligibility criteria guided the collection of participants who could convey their experiences effectively and were open to conveying their experiences to support effective qualitative data collection (Madison, 2011). More specifically, the inclusion criteria for the participants of this research were: biologically and self-identified as male with an Ontario nursing license (Registered Nurse or Registered Practical Nurse), aged 21-65, English-speaking, and with direct client care of one year or more.

Participants

Acknowledging that qualitative research involves intensive data collection and data analysis rather than extensive sampling (Creswell & Poth, 2016; Morse, 2015), eight participants for this research were deemed appropriate. Eight participants were recruited over time. This number aligns with established qualitative research practices and facilitates the achievement of data saturation (Creswell & Poth, 2016; Morse, 2015). While there is no universally mandated sample size in qualitative inquiry, selecting these eight participants was guided by their relevant experiences and capacity to reflect on and report their experiences (Richards & Morse, 2013).

Data saturation, the point at which new data no longer contributes perspectives or themes to the phenomenon of interest (Morse, 2015), served as the determining factor for the sample size. As Higginbottom and colleagues (2013) reported, the sample size in qualitative research is not pre-determined, but the data saturation dictates the sample size. The focus was on depth over breadth, rich, contextual perspectives and power dynamics in the nursing culture, particularly in the ED setting (Cresswell & Poth, 2016).

To ensure data saturation, I monitored for indicators like data redundancy and verification of facts among several participants (Richards & Morse, 2013). My analysis confirmed that saturation was reached, as evidenced by the recurring familiarity with information during transcript review and a sense of understanding that the data sounded familiar and felt "I heard it all" (Richard & Morse, 2013, p. 196). Participants no longer create new themes on the seventh or eighth interview; through immersion, detailed, nuanced data is taken from each participant (Richards & Morse, 2013).

To provide context for the participants, a demographic questionnaire (Appendix E) was offered as part of the welcome kit and was reviewed at the start of the interview, and the results are present in the (Appendix C).

Data Collection

This research used a qualitative critical ethnographic approach to uncover power dynamics, challenge dominant narratives and promote social change (Carspecken, 1996). Aligned with this paradigm, the data collection process was dynamic, flexible, and shaped by the participants' unique preferences and constraints. At the same time, maintaining a critical lens on the phenomenon of interest – workplace stressors and contextual factors affecting MENs help-seeking behaviour.

Respecting the importance of participant comfort and accessibility, prospective participants were asked to participate in interviews either in person or via one-to-one audio/video calls. Most participants opted for the latter, with consented audio recording, reflecting their preference for modern digital communication. Notably, one participant chose to engage via email—a decision embraced after the student researcher consulted the thesis supervisor as an

opportunity to enrich the data. This approach adjusted to the participant's comfort and featured the flexibility and adaptability required in qualitative research.

I am a registered nurse with dedicated training in therapeutic communication and qualitative research, and I carried this therapeutic empathy and scholarly rigour into the interview process. This approach aligns with Madison's (2012) assertion that rapport and trust are foundational to meaningful data collection (Calif & Stumpf, 2018). Creating a safe and non-judgmental space facilitated a conversation where participants were free to voice their perspectives, even if they were critical of their current workplace culture.

The participants selected interview schedules at their convenience in a quiet, private space that encouraged openness and authenticity. Before each interview, the research project was explained in detail, and participants were allowed to ask questions. Then, I asked for written and verbal consent to participate in the research project. A semi-structured interview approach with pre-prepared open-ended questions (see Appendix E) allowed for a conversational tone that assisted participants to feel at ease. In turn, this supported a shared exploration of their experiences relevant to the phenomenon of interest.

However, the process was not without its challenges. Some participants required prompting to share their stories, which necessitated patience and skill. The opening question—"Tell me about the workplace stressors you experience working as a MEN"—served as a foundation for deeper? probing, with follow-up questions personalised to each participant's storyline until their experiences were thoroughly illuminated. There was some hesitancy at first, probably due to potential repercussions for speaking out and social expectations toward masculinity and emotional expression. However, active listening, reflective questioning and validating feelings helped them navigate their experiences better.

The data collection phase emerged both as a challenge and a valuable learning opportunity. Initially intended as a two-month endeavour, the process was extended over five months due to the unpredictable schedules of MENs, many of whom strive to manage flexible shifts and overtime. This extended timeline initially caused me some emotional strain, prompting a period of reflecting and rethinking engagement strategies. As a result, I implemented a new approach to connect with potential participants, including the development of personalized welcome kits and the use of tracking sheets to monitor, follow up, and schedule interviews. From this, an initial interview was booked, and all interviews were completed in five months. Each interview's duration was 45 to 70 minutes, indicating the intensity and focus required for qualitative research (Polit & Beck, 2021). Although an unexpected extended timeline occurred, I respected the pacing of data collection.

Reflexivity

I, as a student researcher, utilized reflexivity in this study to increase awareness of my impact on the research and to ensure qualitative rigour protected the participants' experiences. Engaging in reflexivity meant conducting written self-reflection in a journal and debriefing with the supervisor following each interview to ensure appropriate and thorough reflection. These approaches allowed me to remain cognizant of participants' narratives while critically interrogating the researcher's positionality, biases and assumptions (Castleberry & Nolen, 2018; Dey, 1995, as cited in Creswell & Poth, 2016). Documenting personal reflection and insights helped me to reflect on personal reflections and insights based on my own experiential and informational knowledge of workplace stressors and help-seeking behaviour. My entries into the reflexive journal also included thoughts on the participant's non-verbal cues, like tone of voice, which often involved revealed unspoken tensions.

Reflexivity opened realization to set aside the researcher's assumption and create a space for participant voices to emerge (Berger, 2015; Dodgson, 2019). This process of reflexivity helped me realize the influence of my ideologies, values and belief systems on the whole research process and findings (Cruz & Higginbottom, 2013). Moreover, through reflexivity it widened the awareness of the context, focus and purpose of this study, which is to mitigate the risk of excessive focus on self (Doyle, 2012). Reflexivity ensured that my interpretation was grounded in the data from the participant's experiences.

Furthermore, reflexivity was used to balance the inherent power differentials among myself and participants – a central concern in critical ethnography (Dodgson, 2019). As I continuously reflected on the role and influence, this helped to mitigate the risks of imposing my narratives into the data and foster a robust, equitable research process. Thus, the commitment to reflexivity strengthened the trustworthiness of the findings while aligning with the emancipatory aims of critical ethnography as it amplified the marginalized voices of MENs and challenged dominant nursing power structures (Madison, 2012; Thomas, 1993). Therefore, reflexivity moved beyond being a tool and became a powerful practice that helped me capture participants' voices.

Data Analysis

I transcribed the interview audio recordings with a transcription service (see Appendix F). The transcriptions obtained were checked against the recordings twice with support from the supervisor.

Carspecken's (1996) Five-Stage Process for Critical Qualitative Research (CQR)

The data analysis of this research was rigorously guided by Carspecken's (1996) five-stage process for Critical Qualitative Research (CQR). It is a framework designed to discover

the hidden interplay of cultural, political, and social dimensions within qualitative data. This analytical approach systematically explored MEN's experiences while engaging in the broader sociopolitical structures that shape their realities. The five stages – primary record compilation, preliminary reconstructive analysis, dialogical data generation, description of system relations and application of system relations to explain findings are robust steps and structures that support the identification of cultural themes and meaningful data (Georgiou & Carspecken, 2002). These stages were linked with a recurring coding process, which sought to uncover common themes that best captured participants' experiences and responses (Oladele et al., 2012). Reconstruction techniques were central to this analytical process as they emphasized dialogue and reflexivity to reconstruct cultural meanings and render social action understandable. With a focus on exposing the personal, political, and cultural dimensions of MENs' experiences, the analysis raised critical questions about social organization, cultural norms, and institutional policies (Hardcastle et al., 2006; Fetterman, 1998). Thus, the analysis captured the experiences and the impact of systemic forces. Through Carspecken's five stages and coding process, the dynamics captured the complexity and depth of MENs' experiences while sustaining a critical lens to the broader sociopolitical context.

I led the data analysis for this data under the guidance and support of the supervisor, representing a rigorous and intensive process. Utilizing this approach illuminated MEN's experiences while critically viewing the cultural, political, and social contexts that shape their experiences.

Stage One. The first step is focused on compiling primary records. I uploaded the transcript to the Dedoose platform. From this online software, the researcher compiled transcriptions and read participant's responses at least twice to understand the content and the

research topic in mind. Jotted notes were uploaded to the software, including field notes or observations during the interview. Audio recordings were reviewed alongside notes on the non-verbal nuances through interviews to enhance interpretation. Each interview transcript was printed so I could write notes on the margin to any points relevant to the research questions. Reflexivity at this stage helped mitigate personal biases and power distortions (Hardcastle, 2004, as cited in Ross et al., 2016).

Stage Two. This is where the preliminary reconstructive analysis begins. The focus was on describing the cultural context of MENs' work environments in detail. Open coding was employed at this stage, reading each transcript and systematically identifying and extracting themes. The researcher highlighted certain lines on the transcript and created a code that best describes the MEN's experiences relevant to the research topic. New themes were then reviewed and finalized. The average number of initial emergent themes within each transcript was, on average, 20-30 themes. I incorporated axial coding by identifying relationships between categories and sub-categories that emerged during open coding. Finally, I integrated and organized the categories that were closely related based on data.

Stage Three. This was a dialogical approach stage, where observations and transcription notes were validated through participant interviews. The content was critically examined and re-reviewed until themes were redefined according to participants' interpretations and experiences (Georgiou & Carspecken, 2002). Some guiding questions the researcher reflected on were: Do all data fit the category? How are categories related? What main patterns reoccur? (Oladele et al., 2012), which facilitated a deeper data exploration, ensuring the analysis remained rigorous and participant centred. Following each interview analysis, I interpreted the results and was then cross-examined by the supervisor to enhance reliability.

Stage Four. I analyzed the themes and categories related to the larger social, cultural and institutional systems at this stage. I explored how nursing care in the ED shapes the perception of MEN's work stressors and their help-seeking behaviours. Also, I reflected on the recurring patterns or systemic issues that emerged from the data. For instance, how systemic inequities in mental health services at the hospital level affected MENs' health. Lastly, to contextualize the findings, I situated findings according to the EMHP framework to explain how micro-level interactions reflect macro-level structures.

Stage Five. The final stage uses all information from stage four to comprehensively explain the phenomenon of interest. At this level, I explained how individual experiences link with the broader sociopolitical systems. An analytical level to decipher how personal narratives and experiences of MENs are interconnected with the systemic structures, highlighting the influence of social, cultural, and political factors on MENs' lives. This is also a point where emerging data may challenge existing assumptions to highlight areas for systemic change. The Carspecken framework often concludes with a recommendation for policy reforms or interventions to address systemic inequities (Fetterman, 1998). In this work, I am applying Carspecken's method to uncover the culture of addressing workplace stressors and help-seeking behaviour within ED, linking MENs experiences to larger systemic issues in MENs' health.

Data analysis was practiced as an iterative process, initiated with each interview and expanded as the research progressed. By the end of the interview cycle, the data saturation was evident through recurring themes and no new significant information, indicating a comprehensive understanding of the phenomenon of interest was achieved. After analyzing all eight interview recordings and associated transcriptions, Dedoose software was employed to organize and code the data systematically. This tool facilitated the colour-coding of data, and a

clear cluster of themes was reviewed with ease as the patterns and connections across interviews were visually appreciated. This data analysis stage took approximately six months to allow complete immersion into data and enough time to reflect and finalize the content appropriately.

I initially reviewed and finalized the analysis, offering five themes with 19 sub-themes. Following iterative review and collaborative discussion between researcher and supervisor, titles best reflecting the experiences represented within the themes were determined, and a finalized number of focused themes was created as …. (composing the … major findings chapters), and … subthemes. Carspecken's (1996) five-stage framework for Critical Qualitative Research provided a structured and flexible approach to analysis, enabling the researcher to navigate the data complexities while maintaining a critical stand.

Ethical Considerations

Ethics approval for this research was obtained through a two-tiered process, reflecting the rigorous ethical standards required for research involving human participants. Initial approval was obtained by the Thompson Rivers University (TRU) Research Ethics Board via the TRU Romeo Research Portal before the commencement of the research study. Approval was obtained from the hospital network's research ethics board to ensure academic and institutional ethical guidelines compliance. These approval processes highlight this research study's commitment to ethical integrity and participant safety.

To safeguard participants' autonomy and protection from harm, informed consent was obtained from all participants prior to their involvement (see Appendix E for Consent Form). I explicitly explained their right to withdraw at any time without question and if they did not want an audio recording. As the research focuses on workplace stressors, potential risks that may trigger negative memories or emotional distress were carefully considered and addressed in the

consent process. In mitigating risks, a detailed resource handout summarising potential accessible mental health support services (see Appendix E) was distributed to have immediate access to professional help if needed. All participants were offered A post-interview debriefing session to process any emotional responses.

The student researcher's role as a registered nurse with specialized training in counselling and therapeutic communication further reinforced the ethical foundation of the research. His nursing background helped him approach participants with empathy on sensitive topics, recognize any signs of distress, and respond appropriately to reduce potential harm and promote a safe and supportive environment during the interview for the participants.

Participants were offered the choice of having their interview in person or via audio call. Participants did not select the in-person option. Rather, the audio call option afforded more flexibility in scheduling and the comfort of participating from a chosen location. This, in turn, reduced barriers to participation and fostered a more convenient and open interview milieu. Interviews were conducted via Microsoft Teams using TRU email, a secure online communication platform, to safeguard the highest standards of security and privacy. Microsoft Teams was selected for its robust end-to-end encryption, which safeguards against potential eavesdropping and ensures the confidentiality of sensitive conversations (Bhattacherjee, 2012; Creswell & Poth, 2016).

I further secured participant privacy by conducting all interviews alone in a private, secure space, free from interruptions or distractions. This approach adhered to ethical guidelines for protecting participant confidentiality and reinforced the trust and rapport essential for meaningful qualitative research (Kvale & Brinkmann, 2009). This remote participation with

strict privacy measures ensured that participants felt comfortable and secure throughout the interview.

All data collected were secure documents and locked in a protected location. Computer files and Dedoose were password protected, with authorization for data access only for those directly involved in the research. In Dedoose, I anonymized the data by removing the identifying information before uploading it to the platform. Dedoose has added a layer of protection by using Secure Socket Layer (SSL) encryption for data transmitted between users and servers.

Computer files shared with the research team were through the university email and stored in a password-protected computer, with expectations for data privacy communicated to all individuals involved. In addition, participants were assigned a Research ID, so each participant has been numbered as "P1, P2...", etc., within the stored data. Backup data was placed separately in an encrypted USB hard drive and locked in a secure location. All data will be destroyed after 5 years: audio recordings will be deleted, computer files will be deleted via software to overwrite or encrypt data, USB hard drives will be physically destroyed to prevent data from being recovered, and paper documentation will be shredded and cross-shredded.

Rigour and Trustworthiness

Ensuring rigour and trustworthiness in qualitative research is a working obligation and commitment to ethical honesty. A multifaceted approach was utilized to support these principles, drawing on two frameworks: Lincoln and Guba's (1985, 1986, 1994) criteria for trustworthiness (credibility, dependability, confirmability, and transferability) and Whittemore and colleagues' (2001) expanded framework for validity in qualitative research. Both frameworks were enacted through many strategies, including reflexivity, triangulation, and careful documentation, to confirm that the research's findings were credible, dependable, confirmable, and transferable.

Credibility. Credibility refers to the accuracy and authenticity of the findings in representing participants' experiences (Lincoln & Guba, 1985). I engaged numerous strategies to promote credibility. First, this research uses extensive participant quotes to represent the voice of their experiences, allowing the readers to relate to the authenticity of the data (Guba & Lincoln, 1989). Second, researcher triangulation as a form of triangulation was achieved as the thesis supervisor provided careful oversight and input, cross-checking interpretations to ensure consistency and accuracy (Lincoln & Guba, 1985; Schwandt et al., 2007). Third, Carspecken's (1996) five-stage process for Critical Qualitative Research (CQR) data analysis framework warranted systematic and in-depth analysis, enhancing the credibility of the findings through its structured approach (Rennie, 2012). Fourth, reflexivity was entrenched throughout the research process, with the student researcher keeping a reflexive journal and engaging in regular debriefing sessions with the supervisor to bracket personal biases and remain grounded on participants' perspectives (Dodgson, 2019; Teh & Lek, 2018). Fifth, prolonged engagement—from June 2024 to December 2024—permitted me to build trust with participants, developing rich, detailed data and interviews lasting 45–70 minutes each (Lincoln & Guba, 1986).

Dependability. Dependability refers to the potential replication and consistency of the research process rooted in a systematic and transparent methodology (Lincoln & Guba, 1985). This study ensured dependability through the vigilant documentation of every step, from data collection to analysis, as detailed in this chapter. A well-written audit trail—including field notes, reflexive journals, transcripts, and coding records—rendered the research process transparent and replicable (Forero et al., 2018; Korstjens & Moser, 2018).

Notably, contextual inclusion made it clear that findings were rooted in the realities of the participants' environments. For example, the research on urban healthcare settings in Canada

provided a rich scenario for understanding the workplace stressors MENs face while highlighting the systemic factors that shape their help-seeking behaviours.

Furthermore, the ongoing initiatives of Canadian healthcare institutions supporting stress management and mental health access provide a contextual background that enhances dependability. Initiatives such as wellness programs and policies on promoting mental health awareness are likely to continue to be relevant for future studies, and the findings of this research can be tested and validated in similar contexts (Duchscher & Cowin, 2004; Forero et al., 2018).

Confirmability. Confirmability certifies that the findings are rooted in the data rather than the researcher's biases (Lincoln & Guba, 1985). This study achieved confirmability through a multi-layered approach emphasizing transparency, reflexivity, and rigorous oversight. In this research, the thesis supervisor's oversight played a focal role by reviewing and validating each step of the research process, from data collection to analysis. This collaboration minimized the risk of researcher bias and ensured that the interpretations were grounded in the data and aligned with the research questions (Forero et al., 2018; Korstjens & Moser, 2018).

An audit trail was enacted to document every aspect of the research process. This included audio recordings of interviews, reflexive journals, transcript tracking using Dedoose, and detailed documentation of the analysis process (Korstjens & Moser, 2018; Lincoln & Guba, 1985). An audit trail was essential to a transparent record of the research journey, allowing for verification of the findings and enhancing the study's credibility and confirmability (Shenton, 2004).

The reasoning behind the interpretations were explicitly outlined in the findings and conclusion chapters, supported by reflexivity and secondary reviews by the thesis committee and external reviewer (Forero et al., 2018). I followed reflexivity that involved continuous self-

scrutiny and critical reflection on the researcher's assumptions, biases, and positionality (Dodgson, 2019; Teh & Lek, 2018). This reflexive practice was further strengthened through regular debriefing sessions with the thesis supervisor, which provided an additional validation layer and ensured that the interpretations continued faithful to the data (Lincoln & Guba, 1985).

Transferability. Transferability refers to the extent to which a study's findings can be applied to other settings, groups, or contexts to make it relevant and impactful (Lincoln & Guba, 1985). I promoted transferability through methodological rigour, rich contextualization, and strategic sampling, ensuring the findings resonate beyond the current research setting.

I put effort into providing thick, rich descriptions of participants' experiences contextualized in an urban healthcare environment in Canada. These thick, rich descriptions include participant quotes and nuanced narratives so readers can immerse themselves in the realities of MENs and assess the applicability of the findings in relation to their own contexts (Dangal & Joshi, 2020; Korstjens & Moser, 2018; Schwandt et al., 2007). As the findings were situated in Canadian healthcare's cultural, social and institutional dynamics, the research can be extrapolated to similar settings, such as urban hospitals in other high-income countries or healthcare or corporate systems facing comparable workplace stressors.

This study used purposeful sampling, which also ensures the inclusion of diverse experiences, roles, and perspectives within MENs. This approach strengthened the research findings by enhancing the representation of the broader MENs population and increasing the potential for transferability to similar contexts (Forero et al., 2018). Furthermore, the study adopted a critical ethnographic approach, aligning with the work of Thomas (1993), Carspecken & Apple (1992) and Madison (2011), which advocates for emancipating marginal groups from systems of power and privilege. Reaching data saturation confirmed that the study exhausted all

possible understanding of workplace stress and help-seeking behaviours since no new themes or insights emerged from the data. Therefore, this research is not only to understand the experiences of MENs but also to offer insights on possible interventions that promote empowerment and social justice.

Summary

This chapter outlines the methodology for researching MENs' workplace stressors and help-seeking behaviours, employing the EMHP and critical ethnography. The EMHP provides a holistic framework to analyze individual, interpersonal, institutional, community, and public policy factors influencing MENs' experiences, while critical ethnography uncovers power dynamics and sociocultural influences. The data collection involved semi-structured interviews with eight MENs in several urban Canadian hospitals and was analyzed using Carspecken's five-stage process for critical qualitative research. Ethical considerations, including informed consent and participant privacy, were strictly upheld, and reflexivity ensured that the researcher's biases were minimized. The study aimed for data saturation, with findings offering insights into systemic inequities and potential policy reforms to support MENs in high-stress healthcare environments. Next the participant experiences are described and analyzed in the following chapters.

Chapter IV: Findings and Discussion: Power Dynamics in ED

Although nursing was originally male-dominated before the establishment of professional nursing by Florence Nightingale, this fact is often hidden since it is no longer the case (Kaur et al., 2022). These historical roots continue to shape the experiences of men in nursing today. In this chapter, I explore key findings and the manifestations of hierarchical power dynamics and how they relate to MENs' experiences. I also delved into the emotional impact of these power dynamics, specifically fear and anxiety as core problems. The shared experiences of participants revealed a power imbalance that eroded MEN's confidence and created a challenging work environment. Appendix G displays the themes and subthemes.

Hierarchical Power Dynamics

Exploring the hierarchical power dynamics, I delve deeper into understanding MEN's fear and anxiety related to physician interactions, the influence of physician pace, devalued knowledge, speaking up vs. staying silent, and conflicting priorities.

Fear and Anxiety Related to Physician Interactions

Many participants recalled interactions with ED doctors that brought them into a state of fear or anxiety. Participant seven described:

> When I was a new nurse working… a patient that needed blood work …I guess the doctor put in the blood work, like, 30 minutes. And I was busy with other patients … think the doctor was kind of pushy or what? I missed it twice…I was so nervous already because the doctor had already come in and asked me to do blood work as soon as possible …. The charge nurse wasn't helpful, as well. It was really stressful. I feel like … Being young and very inexperienced makes you really anxious… you know, doctors, tend to always ask if it is not done. And you get scared, you get anxious… I wouldn't be

> able to go to sleep because I was always worried …Those kinds of negative remarks can also affect you and see how your day goes. Yeah. Like it does tend to affect you."

This physician's behaviour was also echoed by Participant four, who also experienced:

> If you are a new nurse and encounter... you know, the attitude of doctors, you will be like thinking a second time … approaching the doctor. Yeah, you don't want to clarify something … that's why you cannot be like putting it personally.

This shared experience of participants four and seven reveals a power dynamic wherein pressure to perform quickly may create some form of fear or weaken nurses' confidence. Based on the data, new nurses may be hesitant to ask questions in this context of interacting with physicians for fear of appearing incompetent. This may cause a possible psychological toll, eventually leading to preventable harm.

Influence of Physician Pace

MENs spoke about how the pace of ED doctors in seeing clients directly affects nurses' workload, and related stress. Participant four shared:

> …. The high volume of patients…. It depends on the doctors. How they see the patients. It's…. just so slow to look at the patient. It will be like delaying our, you know, movements of the patients and delaying longer waiting time in the ER.

This quote highlights the existence of a power imbalance in the ED whereby ED physicians often act as gatekeepers and their availability can become a bottleneck in the ED system. This often causes longer wait times and increased pressure on nurses. Research data also suggests that physicians' attitudes are one of the reasons ED overcrowding affects client waiting times. If not addressed, the persistent overcrowding may intensify nurses' stress while managing complex

client cases, that can lead to burnout, compromised care, and increased mortality rates (Akboga & Gelin, 2024; Guerrero et al., 2024).

Devalued Knowledge

Beyond the bottleneck, two participants expressed concern about the pattern of ED doctors' dismissal of nursing concerns and input. Participant six stated: "…the doctors stop coming, …. patients can be waiting for hours and hours and hours. … longest wait time before someone got seen was three hours..." In the same vein, Participant eight shared the same sentiments and shared his story:

> A doctor sent a patient home…I advocated for the patient to stay, but the doctor chose not to listen…I informed the charge nurse and advised the patient to be triaged for a second opinion…The patient was sent to the ICU (Intensive Care Unit).

Similar findings on nurses' experiences of being dismissed were reported by Mawuena and colleagues (2024). Participants six and eight experienced some form of dismissal as their knowledge and contributions to care were somewhat disregarded. To have MENs' professional knowledge disregarded and then see patients suffer as a result creates a traumatic experience for any nurse.

Speaking Up vs. Staying Silent

Many participants felt they were responsible for their actions and could not rely on others for support. Participant two explained: "They say protect your license, protect your license, ... All your coworkers won't stick their necks out if something happens, or the doctor won't stick their necks out for you if something happens." This excerpt illuminates the broader context of potential reprisal that may discourage some nurses from speaking up. When ED nurses fear raising concerns and become silent, it can expose clients to avoidable harm

(Mawuena et al., 2024). Therefore, encouraging a culture of open communication, where nurses may feel empowered to speak up about workplace challenges and concerns without fear of reprisal, is instrumental in protecting nurses from increased workplace stressors.

Conflicting Priorities

Despite the inherent power imbalance, all participants acknowledged the importance of a good working relationship, even some with challenging attitudes. Participant four also shared:

> In my experience when we work together in emergency room, especially the doctors and nurses …you cannot please everybody. Some doctors …have their own attitude, … personally, I'm not dealing with it. I'm just, like, dealing whatever is better for my patients? Yes, I will ask whatever. … I don't care if you're having an attitude

This quote demonstrates potential conflict between prioritizing client needs versus adhering to the hierarchical structures or deferring to the ED doctor's authority. This finding also suggests that being mindful of power in exchange for ideas is needed to maintain a therapeutic relationship despite any conflict (Gutgeld-Dror et al., 2023). These hierarchical power dynamics not only manifest in the interpersonal realm but also extend to some control over resources and existing management structures within the ED setting.

Management and Resource Control

The participants' experiences are further explored in the context of management and resource control as one of the power dynamics in ED. The concerns discussed were related to management's role in work distribution, inadequate staffing as control, lack of resources especially at night, minority status and stereotypes.

Management's Role in Work Distribution

Many participants in this research reported an unnecessary workplace stressor involving inequitable workload distribution of management's control. Based on Participant seven's story:

> …A male nurse (colleague)…. He kept getting all the patients in one of our busiest areas.. … I felt like he was having a really hard time managing the stress…he always complains to me how …he's always gets all like, difficult patients and nobody comes up to him and checks on him how he's doing…. Because people just people just tend to ignore him… it does feel there's not enough rotation in the air. He just put in the same place over and over again. And I think it does affect him quite a bit.

Participant seven further added:

> I feel like a lot of the time, male nurses, we tend not to get rotated all the time in different areas. … because they think, oh, yeah, he can handle it. Or, you know, that kind of notion… And putting people in areas that are busy all the time, just the constant and no rotation… I think we get put in certain areas in the busiest areas all the time thinking that we can handle it. The stressors. Yeah. Without, you know, support because they think, oh, we can, we should be able to manage up to the speed and we should be able to handle it.

Another related story is explained by Participant four, who said: "We have an RPN (Registered Practical Nurse) and usually … get the busiest patients assignment…And the other patients of other nurses are just like chill or something like that."

In both contexts, data exposed a problematic pattern of client assignment that burdens MENs and even those with an RPNs designation. This is revealed by heavier workloads, challenging clients and a lack of adequate support. McLeroy and colleagues' Ecological Model on Health Promotion (1988) illuminated multiple influences contributing to this inequity (see

Appendix B). At the individual level, increased workload and challenging client assignments often lead to feelings of unfairness or resentment, leading to further heightened stress and potentially poor nurse health outcomes. This stress is further amplified at the interpersonal level due to a lack of support from peers and supervisors, exacerbating inequitable client assignment. However, the core of the problem likely lies at the organizational level. Perhaps the lack of clear and objective criteria for client assignments allows potential bias and inconsistencies in assigning workload to emergency nurses. Utilizing an ecological framework widens the understanding of the complex interplay of factors contributing to inequitable workload distribution. This approach may help find solutions to address the problem at its roots rather than treating only the symptoms.

Inadequate Staffing as Control

The persistence of inadequate staffing stood out in the accounts of many research participants, putting MENs well-being temporarily at risk. As Participant six shared:

> I want to see an extra nurse on night shifts … We can get bombarded.... It also doesn't help if the charge nurse doesn't step in to help. There are some charge nurses who will step in and help. There are some that just sit back and relax.

Participant four echoed and further expanded details on the charge nurses' role on resource allocation as he shared:

> We need support when we have a high volume... We need ..more nurses…You know…Especially when they (doctors) are working slow…Yeah, especially if there's a lot in the waiting room (clients), too. That's right... But it depends on the charge nurse sometimes... if there's a lot of to be to be pending to be seen by the physicians. We (charge nurse) are calling the on-call.

This quote illuminates the nurses' lack of control over situations while subtly acknowledging management's control over resource allocation. The participants' use of the word " bombarded" may have meant feeling pressure when understaffing exists. This data also highlighted inconsistency in support coming from charge nurses, who often hold power over resource allocation. A random support system often creates a culture of unpredictability, affecting MEN's level of stress as they rely on the mercy and willingness of charge nurses to help.

Lack of Resources, Especially at Night

There was some awareness among research participants surrounding the diminished support system during the night shift. This reality adds a layer of complexity and stress to their taxing roles. Participant eight shared, "I find it hard as working .. nights. … less resources and little to no support from management." Participant three also agreed, and he narrated:

> I guess more support for patient because, … I mean, they're homeless. They're still your patient, right? Yes… finding support for them, like shelter, especially at night… It's difficult because at nighttime you don't have social work to help you. You do have support, like in the morning. … at nighttime there's no support. I think more support at night, especially at night for this kind of problems, is very helpful not only for male nurses. I guess it's for the whole department.

The quotes from Participant eight and three reveal difficulties MENs faced working night shift with scarce resources and support. For example, the absence of social workers at night may create additional worry for the nurse and the ED team, especially in addressing complex social issues like homelessness.

Minority Status and Stereotypes

The intersection of experiencing minority status, night shift work and limited resources produced more stressors, as shared by Participant one:

> Once a patient is kind of like sick, nobody kind of comes and checks on them…. But yeah, because we're a minority and …. people think they can handle, you know, ourselves. … Especially as you're doing night shift. People, … will complain how you're kind of alone ... without any help. After the chaos, even though you still need help, people leave and you're kind of stuck in the, you know, in a difficult situation, but you're not able to express yourself because of the stigma. People say, oh, you should be able to handle it, you know?

This quote highlights concerns of lack of support, an assumption that MENs can handle it because they are men. It may be expected of all nurses but this particular quote seem to suggest unique workplace stressors for MENS. All nurses are linked with "superhero" stereotype, thereby dismissing the fundamental human need for support that reinforces a culture of neglect.

Pressures from Admitted Clients on the Floor

The men in this study experienced persistent pressure from a busy ED, which can take an emotional toll on even an experienced nurse with six to ten years of ED nursing experience. As Participant eight described: "I've faced tough situations, especially with staffing shortages or particularly challenging patients. We had 26 admits in the department. ... I communicated with the team to ensure patient safety as well as finding a safe workload forms (union)." The increase in the number of admitted patients in the ED added more weight to nursing tasks, and Participant six, with less than five years' experience, shared: "I feel a little more under pressure in the sense that I got to see all these people…sometimes I won't get my breaks on time. Sometimes I got to

go back early…" The personal sacrifices of emergency nurses were vivid in the data to keep up with the demands of nursing work.

A further complexity, is the pressure to expedite the flow of admitted clients as Participant one, with lesser experience, shared: "We need to move the patients up to the floor as soon as possible…" This quote sheds light on the power dynamic where emergency nurses feel pressured to prioritize client flow at the risk of overlooking client needs. The pressure to move clients through the system can create a dilemma between client-centered care or prioritizing efficiency. The bottleneck, which is initially the wait time in the ED, is effectively shifted elsewhere rather than solving the problem.

Summary

The participant experiences illuminate nuanced power dynamics that contribute to MENs workplace stressors, particularly in the context of help-seeking and interactions with physicians, charge nurses and hospital decision-makers. The interviews revealed power imbalances in MEN's daily work with colleagues and implicit societal pressures that impact their experiences with workplace stressors. In the next chapter, I present the complexities of help-seeking behaviour.

Chapter V: Findings and Discussion: Complexities of Help-Seeking

The healthcare system is more complex than ever due to the Covid-19 pandemic (Shudifat et al., 2023), resulting in more challenges. As estimated by the World Health Organization (WHO), there will be a shortage of nine million nurses worldwide (WHO, 2022). Thus, nurse retention is one of its primary solutions. MENs navigate nursing differently than female nurses because being male in nursing is a significant source of stress (Azadi et al., 2016; Feng et al., 2016; Kulakac et al., 2015; O'Connor, 2015; Zamanzadeh et al., 2013, as cited by O'Lynn et al., 2020). A further layer of being male is the stigma surrounding seeking help, which is not considered masculine (Clark et al., 2020; Kennedy & Moorhead, 2021; Sagar-Ouriaghli et al., 2020; Yilmaz & Beydag, 2022). Aside from being male and the stigma of seeking help, the ED adds more significant mental health injury to all nurses working there (De Wijn & van der Doef, 2021; Moustaka & Constantidinis, 2010; Shen et al., 2022). If these multi-layered issues of MENs are left unaddressed, there could potentially be an exodus of the current MENs workforce and or difficulties in recruitment. I will review key findings and discuss emerging themes on the complexities of help-seeking for workplace stressors. This includes evolving masculinities and help-seeking behaviour, organizational culture and help-seeking, and organizational support systems and help-seeking.

Evolving Masculinities and Help-Seeking

Traditional masculine norms often describe men as "the strong silent type" (Nordin et al., 2024, p.10), discouraging them from seeking help. However, this research revealed more nuanced scenario. Many participants expressed in their interviews their willingness to seek help, challenging these traditional masculine norms. Participant one stated, "…if it's something that I don't really know, or I haven't done in a while. … I would ask for help." The quote highlights a

proactive approach to addressing knowledge and skills and a culture that values competence and continuous learning to protect the public. Thus, the data aligns with principle six of the College of Nurses of Ontario Code of Conduct (College of Nurses of Ontario, 2025). Principle six states public confidence in nursing is necessary. This can be achieved through the nurse's self-reflection and seeking help. Ultimately, this may affect the nurse's ability to practice.

In support of Participant one, Participant six shared "(seek help) …so that I can be a better nurse, so that I can manage my stress…and help out the department better." This quote illuminates the culture of reciprocity and mentorship by highlighting the importance of peer support to both manage stress and promote models of positive help-seeking behaviours. Consequently, it seems that seeking help and mentorship are key tools for professional development, enhancing support and nurse retention. This exchange of knowledge and skills through mentorship contributes to overall team effectiveness.

Notably, Participant five acknowledged the psychological toll of being MENs, stating, "…whenever I'm stressed or whenever I feel overwhelmed … I ask for help because obviously you can't do everything by yourself..." This quote sheds a light on some nurses' ability to openly admit that they are feeling stressed and overwhelmed; that indicates some degree of emotional vulnerability that is often a challenge even to some MENs participants in this research. This seems to portray a shift in some MENs towards recognizing and addressing mental health needs, challenging the notion of men as "the strong silent type" (Nordin et al., 2024, p.10).

However, the journey towards seeking help is not always a straight line. While Participants one, six, and five acknowledged their need for support in certain situations, Participant four shared a different angle, he revealed: "I'm not experiencing like asking help, … I think my mechanism of my dealing with my stress is okay, but … if I need some, you know,

help, for sure I will go." This quote reveals the complex interplay between self-reliance and the recognition of needing support. This tension highlighted the dynamic nature of help-seeking, where individuals may navigate between self-sufficiency and asking for help depending on their perceived needs and coping abilities.

Organizational Culture and Help-Seeking

While individual attributes toward seeking help are considered, the organizational culture within the ED plays a significant role in shaping MENs' help-seeking behaviour. This research revealed a mixed picture of both supportive and hindering aspects. Participant one observed, "…there are resources … maybe sometimes people just don't know… they're just not aware …of kind of services …organization puts out that is available for them." The quote reveals a communication breakdown. Despite the existence of support programs, a lack of awareness or unclear communication channels can potentially keep resources out of the reach of MENs who need them.

The communication gap is further emphasized by Participant eight, stating: "…create a clearer system for accessing mental health resources, such as counselling services, without stigma…making support resources more accessible.". The quote highlights the inadequacy of the current processes in making services accessible to staff. Despite the organization's efforts to promote resources, it may be inadequate, or the channel used may be ineffective in reaching its targeted audience. There seems to be a cultural mismatch between how the organization communicated and how MENs prefer to receive information. Perchance, traditional emails or intranet postings are overlooked. It is possible that a need exists for more personalized outreach to all nurses, including MENs.

While previous participants observed this lack of awareness, Participant five offered insight into potential solutions, emphasizing the importance of active promotion and education. He said, "…advertising, ..getting it out to people … these resources are out there for them. I think that's the first step. Just educating people…" The quote emphasizes the importance of active promotion and education. Although resources may be available to staff, the organization could devise a more proactive approach to access and promote resources. Potentially, this could be included in various targeted campaigns, an agenda in staff meetings, or during orientation initiatives and post-orientation.

Expanding on the idea of proactive communication, Participant two suggested a more direct and visible approach is necessary, stating that "I think … it would be nicer if it was more in your face." This illuminates the need for more practical and visible actions to address the problem of support resources being inaccessible to ED nurses. Most participants expressed the desire for resources to be easily accessible and available within their busy work environment.

This research aligns with Mursa and colleagues' (2022) assertions that while mental health literacy can be present, it often is superficial and limited. This suggests potential persistent underlying barriers or reluctance among MENs to engage with mental health discussions and resources, despite their growing prominence over the years. Further studies may be essential to ascertain MENs perception of mental health literacy or access to it and its impact on utilization.

The participant data stating "more in your face" calls for more visible posters if placed in more prominent ED locations. To enhance mental health literacy and support utilization among MENs in ED, hospitals may need to prioritize visible communication strategies. This includes prominent posters and requesting EAP representatives to regularly present to ED. This proactive

and visible measures would keep staff engaged in their mental health while ensuring resources accessible and reinforced.

These excerpts indicated several organizational factors affecting MEN's help-seeking behaviours. First, current communication strategies may not effectively reach its targeted audience – ED staff, including MENs. Second, cumulative quotes identified the need to continue efforts to disrupt cultural barriers related to masculinity and help-seeking. In turn, this can promote a culture that values help-seeking as a strength rather than a weakness. Third, visible support from leadership can further shape a culture whereby help-seeking is normalized and powerful help-seeking messages are valued and encouraged. Finally, fostering a culture where help-seeking is normalized requires a concerted effort to improve communication strategies, dismantle traditional notions of masculinity and demonstrate visible leadership support.

Organizational Support Systems and Help-Seeking

Moving beyond the broader organizational culture, a support system's specific design and implementation impacts its use. The following will examine existing support systems and how these can be reimagined to address and improve the complex needs of MENs.

Ongoing Efforts and Call for Transformation

Some participants were aware of the available help to address their workplace stress. For example, Participant four confirmed: "…. we have also a wellness program, …visiting the unit … they give you some exercise or something … give you treat after the exercise." While some participants acknowledged specific programs and resources, their interviews were filled with opportunities for improvement and transformation to better address the complex needs of MENs.

Supporting New Nurses. Moreover, Participant three commented on the need to revamp support for new nurses: "If you're new nurses … dealing with … code blue, code pink, … I think

they really need a backup. It's going to be traumatizing, right? We had such a good backup in our department." Despite mentioning that there is a "good back up," He further stated, "… probably for the new people, new nurses, they really need a backup…" The quote highlights new nurses' challenges, including being present and witnessing traumatic events and dealing with life-and-death situations. Perhaps an expert nurse preceptor, as a source of support, can help new nurses voice their concerns and not feel ridiculed (Winters, 2016). Also, MENs often hesitate in sharing, so Participant four suggested "… a hotline, … to encourage them (male nurses) to talk. … they need to focus on the male". A critical incident stress management might be a good option to support novice nurses.

Tailored Support Programs. Beyond the accessibility of social work services, Participants two and four also raised concerns about the scope and relevance of the existing support programs, precisely their non-binary approach. Participant two said: "I don't think it's tailored to male or female nurses... It's non-binary. … a general resource. I don't think…it's really towards any specific people." The quote suggests that the current approach may be so generic that it may not touch or affect different demographics within a diverse nursing staff in ED. One of the research participants provided a reason for having a male-targeted program; Participant Six stated: "… develop a program or policy … to help support the men …experiencing stress because not everyone is the same."

Possible Financial Incentives. Participant eight shared possible financial incentives: "…. also providing initiative incentives …, retention for experienced nurses to stay financially, etc." This highlights the potential of financial incentives to attract and retain male nurses. The indirect request for more income is aligned with Nerges and colleagues' (2022) research findings that participants revealed more have left ED bedside nursing to hunt for more income.

Timing Matters. The timing of support was another key discussion for some participants. Participant six was concerned about the timing of support programs: "develop a program or policy … to help support men … where maybe it could be like an after-work thing... Or maybe it could be like where on …day off… but it should definitely be something in place to support our male nurses." The excerpt sheds light on the need for MENs for flexibility and accessibility. Emergency nurses often work long and irregular shifts, making attending certain programs during traditional business hours difficult. Although teleservices were not mentioned, the findings are aligned with previous researchers' recommendation of possible after-hours clinical services (Mursa et al., 2022).

Social Work Services. Participant three called for more social work availability in the ED; he stated, "At least if you have somebody like Social Work 24 hours, it's a very great help." This highlights ED nurses' need for accessible and timely support, given the demands and unpredictability of ED work. Perhaps the current structure may not adequately address the social service needs of the clients, affecting how nurses perform their work during nights or weekends. Hence, MENs could potentially feel unsupported during critical times. Furthermore, some participants also discussed the non-binary nature of the existing program and possible relevance for male nurses.

Debriefing Dynamics

Many participants revealed the efficacy of debriefing sessions in help-seeking and receiving support. Moreover, facilitating help-seeking can assist with addressing the nuanced contextual forces that shape MEN's help-seeking behaviour. While debriefing is intended as an avenue for support and learning, this research pointed out the crucial role of debriefing with impacting MEN's help-seeking behaviour. Half of the participants identified debriefing as a

necessary platform in ED for accessing help and a potential channel of support. Participant Eight articulated: “It would be helpful if there were more structured debriefing sessions where nurses can openly discuss their experiences and stressors.” The quote highlights the urgency of having safe spaces where nurses can process traumatic events and normalize emotional responses. Ultimately reframing help-seeking can be seen as a sign of strength rather than weakness.

However, some participants have contrasting views on the tension between the desire for emotional sharing and the discomfort associated with vulnerability, particularly among MENs. Participant three shared, “…post huddle, debriefing or something…we always tell …How you feel something.” The quote highlights a culture that encourages emotional expression. Yet, Participant Two had a contrasting view:

> There was like the code … right after there was a debrief moment... the second they started talking about their feelings, I was like, okay, I got to go. Like, I'm okay, I'm mentally intact. I just I just want to know, how can we improve the next code.

This quote reveals a difference in showing vulnerability that may need some considerations in a diverse workforce.

Participant seven’s comment further highlighted this tension, “debrief … male nurses on the physical challenges they're experiencing, you know, getting pushed to do CPR first …maybe every month” The quote conveys a message to promote discussions on the physical challenges of MENs. It may be difficult to express vulnerability without directly addressing emotions. As in the context of this research, some participants, like Participant three, want to embrace the opportunity to express their feelings. In contrast, others, like Participant two, may unconsciously conform to the masculine norm of self-reliance. Hence, they may distance themselves from emotional discussion as they may believe that seeking help can be a weakness (Milner et al.,

2019). Thus, this highlighted the vital aspect of recognizing individual differences, being inclusive, and respectful of the diverse needs of the ED team.

Debriefing sessions need to be sensitive to the individual differences of nurses working in the ED and potentially considering the influences of masculine norms in a female-dominated profession. Creating an inclusive and respectful environment where emotional expression is valued but not mandated may be necessary. The participants' focus on "how can we improve the next code" prompted a preference for problem-solving and action-oriented discussions. A professional and performance improvement opportunity may appeal to some men but can potentially disregard those other men who wanted emotional processing. With these ideas in mind, striking a balance during the debrief session or inviting the ED team to collaborate on how the debrief will run may be necessary.

Supporters and Help-Seeking

In the busy and often chaotic environment of the ED, MENs rely on a network of supporters to navigate the workplace stressors they encounter. The following section traces out various sources of support identified by MENs in this research, highlighting the significant roles of internal and external supporters in facilitating help-seeking behaviours.

Internal Supporters

Power of Teamwork. Many participants described how teamwork had contributed to their help-seeking behaviour. Two participants expressed how having a good environment makes them ask for help. As for Participant three, "a good environment...you can ask anyone, you can talk to anyone." Participant three's words point out the importance of a supportive and collaborative work environment where nurses may feel comfortable asking for assistance.

Many participants understood the value of teamwork, which was evident during critical incidents, often concerning life-death situations. Whether dealing with challenging clients (Participant three), clinically declining clients (Participant four), or those needing intubation (Participant six), participants emphasized how teamwork helped them cope as help was readily accessible. Participant eight shared, "My colleagues are always there to lend a hand…. simply offering moral support during hectic times, …often share advice or reassurance." His quote illuminates the sense of camaraderie and mutual support to help nurses manage immediate stressors. Such support fosters a culture where seeking help is normalized and encouraged. Participant one gave some examples of how he received help. He shared, "Charge nurse or someone floating … help around a little bit, … workups, doing some blood work, vital signs, assessments…"

Visible Manager. More than half of the participants in this research agreed that managers and CPLs (Clinical Practice Leaders/Educators) were instrumental to their help-seeking behaviour experiences. The findings suggest visible leadership has a role in shaping help-seeking to be more acceptable. When nursing leaders promote support services and demonstrate willingness to help, they reinforce that seeking help is a sign of strength and self-awareness.

Participant two described how his manager proactively communicated the availability of resources, stating, "…Manager sent out a department-wide ... to …let everybody know… there are resources available." His quote illuminates the manager's proactive approach to communication that ensured ED staff were aware of supports available and more comfortable to access resources. Furthermore, Participant four shared how his manager went beyond sending emails and tried to connect with staff on a personal level, stating,

> …we received email …saying thank you. … because you are working short, and you manage it…. (Manager)… coming on us telling …if you need help or something, like what's going on … that, I feel like, relieved just because …(manager) care for us.

These experiences highlight the value of personal touch in creating a sense of touch and connection so staff may feel more comfortable seeking help when needed.

While some participants, like Participant five, also experienced their manager checking on them, there was also a critical moment with his CPL. He said:

> …any time …we have a code, …at least during the daytime, the manager comes in. The manager and the CPL do come and assist us and check up on us …. you can speak to them one-on-one whenever you're getting stressed out or need your assignment changed.

This quote highlights the importance of timely support, particularly during incidents when nurses may experience high stress levels. However, this quote may also mean there is a need for more support during the night shift since there was emphasis on "during the daytime."

In addition to providing direct support, managers and CPLs can also play an essential role in facilitating access to certain ED protocols. Participant seven shared how his CPL was instrumental in helping him navigate a stressful situation:

> …My CPL was very helpful …(CPL) sat with me, and …kind of went through how I should manage the DKA (Diabetic KetoAcidosis) protocol… (CPL) was able to guide me through the stressful situation…. our management ..are really open to helping members on getting more help …

The excerpt describes how leaders can advocate for their staff and connect them to resources; therefore, providing quality care to their clients and manage workplace stressors.

This qualitative data describes that visible and supportive leadership from nurse managers and CPLs significantly influences MENs' help-seeking behaviours. Many participants reported receiving support from leaders, which they found valuable in seeking help. More participants knew about the available resources, as they were communicated verbally and in email. This cultivated a positive culture where leaders proactively offered support and made themselves visibly accessible to all ED staff, including MENs. ED leadership can amplify this culture by integrating regular staff appreciation, peer-to-peer recognition and celebrating successes in team meetings to embed positive contributions to the ED's work culture.

Colleagues. While work relationships provide a sense of support within the ED, the dynamics of MEN's seeking help from individual colleagues can be more nuanced, particularly regarding sex. The research findings revealed that some participants preferred support from other men, highlighting the influence of colleagues' gender in help-seeking behaviours.

Participant Six shared his experience of finding support through out-of-work activities with male co-workers, stating,

> I've played basketball with some of the doctors and nurses…. that's always fun….That's a good mental break, … to join a basketball team.… Also, I do have a good friend at work … I always go out, either …breakfast or … dinner after work, …just kind of wind down... I tell him all the problems and stuff.

Participant six illuminates the importance of social connection in some safe spaces, even recreation, where advice may be sought.

Other participants echoed the influence of colleagues, describing it as a valuable source of support for "venting to" (Participant two), having "a talk" Participant four), and "helpful talk… about emotional support and practical solutions" (Participant eight). These descriptions

from various participants send a powerful message that MENs may feel more comfortable discussing their challenges and seeking help from colleagues with similar experiences and perspectives.

The tendency to seek support from colleagues is further emphasized by the participants' preference for male colleagues. Participant seven observed,

> I think it's …hard for us to… ask other female nurses… when we're having a bad day. I think …when other male nurses…I think we tend to open up to each other rather than to other females …. because I feel, They (female nurses) tend to kind of think that their day is harder. … I feel more comfortable opening up to another male nurse.

Participant seven's insight points out the potential influence of gender on help-seeking behaviour dynamics, suggesting that male nurses feel more understood and less judged if they share with another male colleague.

The data suggested that while supportive colleagues can be essential, the organization may need to consider the role of gender that shapes help-seeking behaviour among male nurses. Creating opportunities for male nurses to connect with and support each other formally and informally can produce a culture of help-seeking.

External Supporters

A Nurse Friend Outside Organization. Interestingly, some participants indicated that support often comes from outside the organization. Participant one shared:

> …just … having someone to speak to …like your friends…is definitely helpful when dealing with stress … or outside of the organization you can speak to…. someone that can relate, especially maybe like another nursing friend, because they can always relate to a situation like that.

The quote reveals the value of having an external confidant who listens and provides empathy without the constraints of workplace hierarchies.

Furthermore, Participant five explained that "friends in healthcare…. can just brief and help me navigate how to be better prepared for the situation next time…" Analysis of the quote suggests that external support from fellow nurses can go beyond emotional support through mindful discussion of practical advice and professional guidance. These external professional networks often offer fresh ideas on challenging situations, helping MENs to learn and grow from their experience.

Family/Partner: The Bedrock of Support. The MENs in this research emphasized the importance of the support they received from their family and partners. These relationships provided a safe space for emotional release, stress reduction and navigating the challenges of achieving a healthy work-life balance. Participant five described being able to "confide" in his girlfriend, while Participant one had "de-stressed" when speaking to family. Participant Two found a safe haven, as he stated, "…talk to her sometimes…mostly about…interpersonal conflict or not." These intimate conversations often allow MENs to process experiences and share burdens. Furthermore, it is a way to receive empathy and understanding to mitigate the emotional toll of ED work.

Participant four further highlighted the importance of familial support. Despite acknowledging the traditional masculine norm of keeping problems to oneself, he revealed vulnerability by admitting,

> If you are a male nurse, you're not really always talking about your problem to others …. I'm always putting my keeping to myself, and that's why. … it will build up … because you're not talking to somebody…Although my family, I can tell my wife.

The participant revelation emphasizes the essential role of family in breaking down the barriers of stoicism and expressing emotions in a safe space, like at home.

However, the availability and strength of familial support is not universal. Participant Two admitted that social support for men is weak, affecting his help-seeking behaviour. He stated:

> …the social support is a little … little weaker…. it's less acceptable to talk about your issues... I guess it's hard to kind of come up with a policy that would help…I think … they (male nurses) die early, or we die early because apparently as you get older, you're only your only friend and your wife

Participant two's insight illuminated a potential isolation for MENs, particularly as they get older, and their social circles decrease.

Summary

This chapter examined the complexities of help-seeking among MENs. The deeper dive provided valuable insights on the multi-faceted challenges for MENs. This chapter also challenges traditional assumptions about masculinity and help-seeking. The interviews revealed a nuanced interplay of evolving masculine norms, organizational culture, organizational support systems and supporters. In the next chapter, I present MENs-Client Dynamics.

Chapter VI: Findings and Discussion: MENs-Client Dynamics

The ED is a chaotic place with many client admissions, transfers, discharges and other nursing practices usually done under time pressure (Castner, 2019). In this highly demanding environment, approximately 70% of healthcare workers have high stress levels, which have demonstrably negative consequences for client care (Rink et al., 2023). Most interviews reflected experiences of workplace stressors that frequently originate from direct client interactions about their challenging conditions, needs and behaviours. In this chapter, I explore sources of workplace stressors experienced by MENs in an urban ED, focusing on client characteristics and client-related challenges.

MENs and Violent/Aggressive Clients

The quotes throughout this chapter reflect the participants' interpretations of the sources of workplace stressors within the client encounter. The following descriptions reflect their experiences of violence and aggression. These understandings were internalized in varying degrees and ultimately contributed to experiences of workplace stressors: verbal abuse, physical abuse, life threats.

Verbal Abuse

Most participants believed that violence and aggression were the ultimate source of workplace stressors in client-nurse dynamics. According to the story of Participant six:

> My colleagues got verbally abused by a patient...I called security on them. Our hospital used to have a board that said zero-tolerance policy for any verbal abuse... you know what's insane? They took that board down. So, what are we supposed to be, a rag doll for these patients?... I want to know why we took that down. Because my job is not to be a

> rag doll. How come we're the only profession that allows people to kind of. Excuse my language, sh** on us.

Participant six's experience highlights the potential normalization of abuse and the weakening institutional support for nurses. It described Participant six's feelings about the client's violence and aggression, revealing a systemic issue of fostering a culture where such interaction is considered a 'part of the job.' Challenging this acceptance of violence, Steene and colleagues (2015) advocate for a cultural shift by providing comprehensive education, accessible reporting mechanisms, and robust leadership support to create a safer ED environment for all.

Unfortunately, the removal of the "zero-tolerance policy" board sends a conflicting message. Potentially this can be viewed as a sign of decline in hospital administration support for nurses facing abuse and lack of prioritization of ED staff well-being. This perceived lack of support may motivate potential aggressors, increasing the risk of workplace violence (WPV) against nurses. As defined by Li and colleagues (2024), WPV are incidents where staff are abused, intimidated or assaulted while working. The absence of this board may send a dangerous signal. To illustrate the reality of physical violence against nurses, consider the experience of Participant seven.

Physical Abuse

Despite being there to provide immediate care and support, Participant seven experienced physical abuse from a client, as he described here:

> … a lot of patients do get aggressive…. female nurses…they're scared, and they tend to call us…. And we do have a lot of the security …. they don't feel safe. They do tend to call us when the patients are aggressive…. So, we do restrain multiple times I got spit on or, you know, people punching us.

Participant seven's experience aligns with research on the heightened risk of physical abuse faced by male nurses (Binder & McNiel, 1994), particularly in situations involving violent clients. Most participants' experiences revealed this increasing risk of workplace violence. Dafny and Beccaria (2020) reported a disturbing pattern: male nurses are disproportionately targeted with abuse as clients view them as bodyguards rather than professional nurses. The participant's quote requires urgent attention to enhanced safety measures, including improved security measures and a zero-tolerance policy for violence against MENs. Without these safeguards, ED staff will continue to experience severe incidents, and spiralling threats to their life.

Life Threats

However, the injuries of most participants were beyond physical abuse; Participant three shared his experience involving a threat to his life:

> Probably... aggressive patients… very aggressive… especially (ones) not following instructions…sometimes patients are threatening you…. like, I'm gonna punch you. I'm gonna knock you down. I'm gonna wait for you in the parking lot or something like that. So that's a stressor.

The client's verbal life threat to Participant three is an example of Type II WPV in the ED, a form of client-initiated aggression that threatens the safety and well-being of Participant three. Type II WPV is a type of WPV defined as violence directed to workers by customers or clients in the workplace (McLaughlin & Khemthong, 2024; Tiesman et al., 2012). In the face of such threats, nurses are often vulnerable. A meta-analysis reported that nurses are at a heightened risk of Type II WPV because almost 70-90% of nurses have encountered such during their careers (Cai et al., 2021). As nurses, they are expected to endure abusive behaviour to uphold the image of nursing as a 'caring profession.' The expectation to endure abusive behaviour to uphold the

image of nursing as a caring profession may create moral conflict for nurses who are placed between their duty to care and their need to protect themselves from harm. In some ways, many participants implied an unsustainable situation and called for a change in how nurses are treated and supported. The complex situation is made even worse due to the lack of consequences to those who are making threats.

MENs and Mental Health Clients

The preceding quotes illustrated the verbal and physical violence experienced by MENs in the ED. However, the challenges faced by MENs extend beyond the physical and verbal violence; caring for clients with mental health problems often presents a different set of stressors that may contribute to nurse burnout.

Nurse Burnout

Participant four revealed his emotional toll of caring for mental health clients in the ED, highlighting also the issue of nurse burnout:

> …I am experiencing … emotional stress, … some patients are, like, verbally abusing you …, you know, the mental health patients… they don't know what's going on…. they just like keeping you emotionally … down because they …verbally … abusing you at the time of …your work…. sometimes … I feel like so burnout when …you are always taking care of patients (mental health patients) … which is always every day. You know what I mean? Yes. So, I feel like burnout. Like, I want something else to be, like, easy, you know.

The participant's open admission of experiencing nurse burnout aligns with Hetherington and colleagues' (2024) findings that WPV, like verbal abuse, is a significant workplace stressor. Their research reported that WPV often leads to burnout, decreased job satisfaction and

diminished client care quality among ED nurses (Hetherington et al., 2024). Furthermore, the quote emphasizes the cumulative burden shouldered by nurses, highlighting a key factor to nurse burnout. Workplace violence, especially verbal abuse, has detrimental effects, jeopardizing nurses' well-being and client care quality. The situation demands urgent attention to address the nurse burnout issue. While there may be a need to address this nurse burnout, it is also essential to understand other factors contributing to this, like substance use or crisis.

Substance Use and Crisis

Participant eight shared: "We also deal with a lot of violence or aggression, particularly from clients who are either under the influence or in crisis." The quote reveals the potential for violence and aggression from clients or visitors under the influence or in crisis. Such situations can be challenging for ED staff, including MENs. As Stevenson and colleagues (2015) reported, individuals may often experience increased anger, frustration and intolerance when dealing with substance-related violence, potentially leading to stigmatizing attitudes. Thus, confronting the challenges posed by clients and visitors under the influence or in crisis is valuable to ensure MEN's safety and for promoting compassionate, non-stigmatizing care for these vulnerable populations.

Type II Workplace Violence

However, while some MENs may have experienced stress and burnout due to violence and aggression, others, like Participant five, seem to be less affected, as described in the following quote: "Some of them. … might be stressed out … whereas I'm not. …I don't really get stressed out when they're like more violent or aggressive." The quote first suggested that he is unaffected by WPV. However, further questioning revealed a more nuanced perspective:

> The only stress I think would be a …a psych (mental health) patient that came in that was a bit more aggressive. I …. stressed out. Maybe compared to my other female counterparts…I don't think being a male influences whether or not I receive a different level of stress.

The revelation describes a complex interplay of social expectations, gender norms and power dynamics that shaped Participant five's experiences and responses to WPV. The initial denial of stress and later acknowledgement of it highlighted the challenges often felt by men when they try to express their vulnerability or seek support. Thus, there is a need for interventions that address not only the physical and psychological effects of WPV but also consider the influence of culture and societal pressures. These factors contribute to the continuation or exacerbation of WPV in the ED.

"Psych"

Participant five used the word 'psych' to describe clients with mental health conditions, while common in some nursing and ED settings, may reveal a tendency to downplay the emotional impact of such encounters. The fact that only one participant explicitly used the term 'mental-health patient' is interesting because it mirrors a broader pattern observed among most participants. A pattern that starts with reluctance to acknowledge stress, followed by gradual identification of workplace stressors through further conversations. Participants may have initially downplayed or suppressed their emotional responses to workplace violence, potentially due to social expectations or maintaining a professional stance. Perhaps this illuminated the need for interventions that promote emotional awareness among MENs and encourage open communication about WPV. This in turn can foster increased psychological safety and a

supportive environment in the ED. The next section will explore the emotional and ethical dilemmas faced by MENs when caring for critically ill, dying and deceased clients.

MENs and Critically Ill, Dying and Deceased Clients

Aside from the challenges MENs face due to violence and aggression, another emotionally charged dimension demands attention: the shared experiences of MENs as they cared for critically ill, dying and deceased clients. This transition will shift the discussion from examining the dynamics of conflict and stress to exploring the emotional and psychological toll associated with end-of-life care in ED, a vital yet often untold source of workplace stress for MENs.

Critically Ill

Participants four and seven revealed the emotional burden of caring for critically ill clients and felt stressed about it. While most participants likely encountered similar situations, Participant four's story provided valuable insight into the psychological and emotional toll of such experience:

> For me, …when I'm assigned in resus (resuscitation area) … patients are critical patients, …taking care of critical patients, …. just …mentally draining… and emotionally because we are only human, you can …feel …. the psychological impact to the patients or .. family members… I can't even continue my work. I just want to rest. I want some break… So, it depends on the nurses. Some nurses are able to manage it, but it depends on person to person.

The story of Participant four highlights the human impact of caring for a critically ill person in the resuscitation area. It reveals a complex and nuanced perspective on the emotional demands of caring for critically ill clients. While Participant four acknowledges his vulnerability and the

need for support, he also demonstrates some empathy and professionalism. The analysis suggests that empathy and vulnerability can co-exist within the same person, especially in nursing. Participant four's willingness to openly express his emotional experiences and need for support challenges the notion of the "strong silent type" prevalent in men in the nursing culture (Nordin et al., 2024, p.10). The willingness to openly express emotions may suggest a potential paradigm shift towards greater emotional awareness and help-seeking among MENs. The data emphasizes the need for a cultural shift within the nursing profession to recognize and support the emotional experiences of MENs.

Dying

Participant four's expressed vulnerability and a need for support paved the way to a more open dialogue about emotional challenges faced by MENs in the ED. In contrast, Participant six's experience with a dying client revealed a different emotional landscape navigated by MENs in the ED:

> … I might be in a little bit more under pressure … like a code pink (pediatric cardiac arrest) …that might make me a little bit more stressed … I have very little experience with that… there is a code pink that happened two weeks ago …I was thinking about it … I don't want to talk to anyone … I … kept it to myself. We talked about it at work, but when I got home, I wanted to tell my mom about it. But then I got to go into too many details … It's not worth it…Just kept it to myself. I don't want to put my burdens and my issues on others…. And I always just like time heals everything.

In contrast to the emotional distancing described by Martinez-Morato and colleagues (2021), male nurses maintained neutrality by separating themselves from their emotions or emotional distancing. Participant six's experience reveals a different technique: suppression of emotions

and reluctance to seek support. This is seemingly more aligned with the traditional masculine norms that discourage emotional expression to others (Nordin et al., 2024). The unspoken rule of keeping this stress inside on most participants can probably harm MEN's health and affect how well they care for the clients. Therefore, the ED is also responsible to address these systemic issues. Issues may be addressed by re-evaluating training for pediatric cardiac arrest and end-of-life care. It also requires challenging the notion that "nurses are heroes." It is important for MENs to voice their needs and access support without fear of judgment or reprisal. The burden for change also rests on the hospital, not solely on the nurse.

Deceased

As demonstrated by the experiences of Participant four and six, the hospital pressures and cultural norms within ED can exacerbate workplace stressors through emotional challenges felt in caring for critically ill clients. The ED environment also involved frequent encounters with death of their clients and the deceased. Participant one said:

> I've dealt with situations where patients have unfortunately, like, passed. I don't believe I have that anxiety… It's a very stressful situation. So maybe sometime. …after that event, you can take time after to, like, reflect. That's why sometimes I notice, especially when a code blue (cardiac arrest) or code white (violent patient) happens. There's usually a huddle if anyone had any concerns.

This quote highlighted a complex interplay of personal coping, hospital practices and potentially, unspoken expectations. While most participants acknowledged being stressed, some participants denied having some mental health issues, like anxiety, to reinforce a performance of "strong silent type" masculinities (Nordin et al., 2024, p. 10). Perchance, this denial may be due to

pressures within ED and broader societal expectations for nurses, particularly men, to maintain emotional control, even after the client's death.

Furthermore, a potential disconnect between the intended support huddle and nurses' actual experiences illuminate dimensions of cultural norms, time constraints and individual willingness to disclose emotions. The disconnect means the hospital system may rely on nurse self-identifying their needs rather than proactively offering support, potentially leaving some MENs to cope in silence. The implication raises a question about how effective the ED's formal and informal structures are in addressing the emotional toll of clients' death on all nurses, including male nursing staff.

MENs and Emotional Clients

While previous sections explored the various forms of ED nurse-client dynamics in the form of violent and aggressive clients, mental health clients, and critically ill, dying and deceased clients experienced by MENs, it is essential to recognize that other client behaviours in ED are not always negative. Some participants felt the client's range of emotions and behaviours, including those driven by hunger, anxiety, confusion, and gratitude.

"Hungry" Clients

Participant six shared, "Every time (patient) someone comes to the hospital, they're hungry. …Like, I don't know, sometimes, like, it can get frustrating, but I always try my best to not lose my composure..." While seemingly simple, the evidence highlights the tension within the ED affecting MENs-client dynamics. A few participants of this research acknowledged frustrations due to the recurring nature of client requests. From a critical ethnographic perspective, a client presenting with hunger may be experiencing some systemic issues beyond the control of the ED. For example, food insecurity, lack of access to healthy meals, or possible

underlying social determinants of health concerns that manifest as hunger upon arrival at the hospital. Since the ED may not be adequately equipped to address broader needs, clients and staff will likely have frustrations.

This ED nurse-client dynamic revealed an inherent power imbalance. It was evident that the nurse was in a position of relative power over a hungry client. The client depends on the nurse or hospital for care, while the nurse often has limited resources and prioritizing nursing care. The nurse-client power dynamic may create a sense of responsibility and potential frustration, especially if there will be repetitive non-medical needs.

Female Clients

Some participants experienced stress when dealing with requests from female clients. Participant seven observed, "You know, females (patient) … they feel uncomfortable male nurse changing them." Participant seven's words highlight the potential restrictions to the type of care a male nurse provides. If MENs are excluded from certain tasks, the workload may be disproportionately shouldered by female nurses.

Participant three also shared issues when dealing with female clients and specifically mentioned a type of task restriction: "And you need to respect their culture too. I think that's the only hindrance for being a male nurse. Like, you cannot really like, let's say, do the full health management to a client if they are female." The quote highlights a restriction for MENs caring for female clients because of 'cultural' considerations. The restriction seems to create a dichotomy of 'us vs. them' dynamic. The dynamic views female clients as 'different' due to cultural background and male nurses limited by their sex. Hospitals may need systemic changes to include policies and support systems that empower male nurses to provide culturally sensitive care. However, nurses may be given such resource, but it is up to the nurse to enact care that is

culturally safe and acceptable to the client. The provision of care should be guided by evidence-based practice that prioritizes the voices and experiences of female clients from different backgrounds.

Inquisitive Clients

Many participants have experienced clients requesting more time, and informational support, yet depriving other clients of their nursing time. Here is the story of Participant six:

> You know, sometimes it really shocked me with these patients. Oh my gosh. If they know that they're (colleague) a doctor…. Oh, they change their behaviour. And then after the doctor leaves, they will ask a lot of questions of us.… (Patient asks) when is it my turn? Are my results ready yet? Am I going to be seen next? I've been here for an hour… patients… who are trying to, like, hinder or hindering my progress forward, like it can get a little tough… They don't know that. So… I always manage to kind of explain it to them… if you have any health care needs, I'm more than happy to help.

The evidence sheds a light on a problem surrounding how changes in interaction related to societal and healthcare power-relations; clients often treat doctors and nurses differently, making it hard for most nurses to perform their jobs due to this workplace stressor. Clients often demonstrate more respect and are less questioning of physicians, as if their title alone grants power and authority. It may be due to intimidation brought by cultural norms that emphasize respect for authority figures, like doctors in healthcare (Freytag et al., 2018; Puplampu, 2020). Consequently, the clients may suppress their inquiries about their concerns with the physician based on their perception of respect toward them.

However, nurses deal with clients' confusions and frustrations, due to their role as primary care providers. Participant six's comment about 'hindering my progress' illuminated the

difficulty most participants experienced in performing efficient care was due to lack of respect. Gadimova and colleagues (2023) posit that male nurses' avoidance of emotional labour can impede their ability to calm clients effectively. However, the experience of Participant six challenges this assumption. While he did not exhibit overt emotions, his interaction with an inquisitive client revealed a different form of emotional labour. He may have calmed this client by providing a sense of security and control, a less traditional form of emotional labour. MENs may find themselves needing to spend extra nursing time calming clients and providing clearer explanations. Most participants' experiences highlighted a lack of understanding for MENs knowledge base and expertise in society, often grounded on unjustified biases. The lack of respect affects how MENs view themselves as a professional and the standard of care delivered.

Clients with Implicit Biases

There were only a few participants who admitted that some clients have preconceived notions of what nursing is and exhibit behaviour often characterized by gender stereotypes. Some MENs felt uncomfortable when asked about their career choices. In the data, Participant seven shared, "People think I am a doctor…" or "…a male nurse… it's for money…we tend to have that questioning behind us all the time" and felt judged when asked "why…chose nursing. These conversations is really difficult." But Participant seven further explained, " I think it's just the culture of us, … we're macho or … we're good at handling stress." From these quotes, it appears that male nurses are still under scrutiny and questioning about their career choices. While being mistaken for a doctor or perceived as a 'macho' might seem flattering, it may also indicate lack of recognition of their actual nursing skills. However, there are some participants who had some positive experiences. Participant seven said, "When people do see us, they tend to be a little nicer." The quote highlights the conditional visibility of MENs. It may suggest that

MENs may sometimes be overlooked or unrecognized as nurses. The findings align with Ng and colleagues (2023) that male nurses are often held to a different expectation compared to female nurses. The expectations may be rooted in social assumptions that male nurses allow them to excel in non-nursing duties, like technical tasks or leadership roles, rather than the emotional and interpersonal aspects of caring. Thus, there is a need to address these stereotypes to foster a more inclusive nursing profession for supporting male nurses and ensuring their contributions to client care are valued.

Summary

This chapter explored various sources of workplace stressors experienced by MENs in their relationships in MENs-Clients Dynamics. These workplace stressors often stem from MEN's care for clients who are violent/aggressive, with mental health issues, critically ill, dying and deceased, and emotional clients. The next chapter outlines and discuss the workload stressors of MENs.

Chapter VII: Findings and Discussions: Workload-Related Workplace Stressors of MENs

Workplace stressors can be costly for individuals, organizations and society (Babapour et al., 2022). In the United States alone, the estimated cost is $200-300 million annually with nearly 90% of employees' medical problems being work-stress related (Hassard et al., 2018). In nursing, high workload has contributed to burnout, a response characterized by emotional exhaustion, detachment, and reduced feeling of competence (Dall'Ora et al., 2020). While workplace stressors affect nurses across genders, Zhang and colleagues (2022) reported that male psychiatric nurses have a higher prevalence of burnout than female psychiatric nurses in China.

In this chapter, I explore specific workload-related workplace stressors for MENs. Specifically, I present what, when, why, and how of workload, the challenge of time-consuming equipment searches and the practical coping strategies MENs used to cope.

Workload: What, When, Why, How

Workload

All participants discussed their experiences dealing with workload in ED. This included the nature, triggers, underlying causes and coping mechanisms. All participants acknowledged workload as a workplace stressor. To fully elucidate this workplace stressor, participants described their workload experiences.

Workload: The What

Participants revealed that the hospital system had excessive demands. High-client ratios and task accumulation mostly exceed MENs' capacity to provide optimal care. Overwhelmed feelings expressed by participants signalled an extensive workload which extended considerably beyond their defined roles and responsibilities. This suggests a dynamic and often imbalanced workload. Participants agreed that constant shifts between the demands placed on them and their

capacity to meet those demands within the constraints of the resources was unreasonable. This was especially emphasized given the lack of support and time. As Participant Two said, “Work exceeds what you’re capable of catching up… you catch up one task, another task appears… there is no true downtime.” This quote highlighted some nurses’ feeling of falling behind tasks and often not reaching a point of stability. This constant state of catch-up often creates chronic stress.

To further illuminate this complex dynamic, Participant four explained: “(nurse-patient) … ratios here are high,” directly connecting this systemic issue to a perceived imbalance in an already unforgiving ED context. This finding challenges the established understanding of workload, which traditionally focuses on the quantity of tasks. This research demonstrates that nurse-to-client ratios also determine nursing workload intensity in the ED. Elevated nurse-to-client ratios increase tasks and complexity, urgency, and emotional burden, which heighten workplace stress. This insight is a reminder that mitigating workload needs to consider not only the quantity of tasks but also linking staffing levels to client acuity.

Moreover, several participants emphasized that workload is not an individual problem but a system-generated one. Participant five stated, “tasks...orders…can be overwhelming we are just not equipped to handle the numbers that we are seeing.” This quote illuminated not his nursing care capacity but the systemic failure to address and provide necessary resources. For example, sufficient staffing, functional equipment and robust support systems to meet the high client demands in an unpredictable ED setting is needed. This systemic issue needs urgent attention to prevent further stress and burnout among MENs and all nurses.

Finally, MENs spoke about the relentless workload. Participant two described,” You do your work and then chart, you do more work and then you chart.” This portrays a sense of an

endless, iterative cycle. This lack of short rest periods may contribute to the experience of workplace stressors. As a result, it may hinder MEN's ability to effectively manage their workload and potentially impact their job satisfaction, retention and well-being. Echoing this insight, Participant eight stated, "There's always a pressure to keep up with the workload." This quote highlighted some form of anxiety and expectation to perform without thinking about the possible circumstances. The pressure to maintain a relentless pace often led to feeling overwhelmed and losing a sense of control, thus increasing workplace stressors.

In summary, all participants experienced workload that generated pressures and lowered their ability to provide high-quality care to clients. While it may initially sound like complaining, these participants powerful words allude to a potential system failure of MENs and their clients. They were often forced to compromise care due to some system limitation, like lack of downtime, that may put MENs at higher risk for heightened stress or burnout. The collective voices of MENs in this research provided evidence that the system may be failing emergency nurses and needs urgent, comprehensive attention. Perhaps redefining how "workload" assignments are determined can create a more sustainable and humane system. This redefinition may consider complex factors of nurses' experiences, including client acuity, resource availability and emotional labour.

Workload: The Why

Many participants conveyed that being short-staffed significantly increased workload, thereby exacerbating workplace stressors. This phenomenon was often attributed to sick calls, as Participant six said, "We're short almost every day…", and Participant one added, "Sick calls…workload will be a little more." These short quotes highlighted the impact of unexpected absences on the workplace stressors of MENs in an already busy ED environment. The

unreplaced staff meant that the remaining nurses had to endure the workload of the absent colleague. As a result, staff in the unit may have increased pressure and potential strain on their physical and emotional well-being.

However, participants also revealed that short staffing due to sick calls is not the sole driver of increased workload. Another potential reason is the nature and distribution of client assignments. According to Participant seven, "It could be heavier… because people... tend to get a lot of confused patients…" This quote suggested that the client's acuity and the complexity of the assigned client condition can influence individual workload. For example, this can occur when nurses are assigned to an unequal distribution of clients requiring complex care in the ED. Participant five further elaborated, stating, "four patients are admitted (out of five), sometimes it can be overwhelming" This quote highlighted how workload can suddenly increase with assigned clients admitted and adding more orders to carry out. These additional tasks must be accommodated alongside other acute clients needing care in the regular ED setting. A few participants shared that the transition of managing clients to prepare for admission requires coordinating with other units, transfering of accountability and facilitating transport that intensifies the workload.

Participant six elaborated on what happened if there are admitted clients, and an ED nurse has a non-admitted clients in ED:

> On days where it's a high turnover, if your patients are not getting admitted, it can be a lot to handle because you've still got to work them up, do your full head-to-toe assessment, get discharged, and then get another one. You kind of rinse and repeat.

The quote illuminates how high client turnover and client admission delays contribute to increased workload. Participant six's experience supports Park and colleagues' (2016) research

finding that high client turnover increases workload due to Admission, Discharge, and Transfer (ADT) tasks. These ADT-related tasks consume valuable nursing time that could otherwise be used to provide direct client care and manage other ED client needs. According to some participants, client admission delays forced them to extend ED care, intensifying their workplace stress, especially with staffing shortages. They observed that delayed admission exposes a systemic bottleneck, probably due to bed shortages or administrative issues. Interestingly, the observed "rinse and repeat" work pattern suggested potential burnout characterized by emotional exhaustion or detachment. If this pattern is left unaddressed, it may engender job dissatisfaction and sense of meaninglessness.

Workload: The When

Most participants reported an increased workload from various time-sensitive situations, often due to system issues within their ED work. The Ecological Model for Health Promotion (McLeroy et al., 1988) provided a theoretical framework to explore MENs heavy workloads. The participants' narratives revealed that multi-faceted factors contributed to this workplace stressor.

At the intrapersonal level, Participant five highlighted impact of short staffing, to the point that it led to sense of isolation and lack of support: "not having enough staff to do the (work)...of the appropriate staff…sick calls… if you're short (short-staffed), it'll just be you alone." Participant five's words illuminate the pressure and isolation felt by Participant five when there are inadequate staffing levels, leading to increased workload and higher risk of burnout for nurses. Similarly, Participant one described challenges at the individual level, stating, "Just thinking that you might be short-staffed… because you can't really do anything, and people do get sick." The quote highlights how ED nurses' anticipation of potential staffing shortages can create a psychological stress, adding to the present workload burden. The situation

highlights the interconnectedness of individual thoughts and perceptions with broader systemic issues.

However, the challenges related to workload extend beyond the individual level. The interpersonal level, which deals with relationships and interactions, also adds to the challenges related to workload experience. Participant seven stated, "…we have to do…two jobs at the same time, … helping people out, and… our job as well". The evidence describes a potential issue regarding the division of labour or responsibilities among ED nurses. ED nurses often need to accept additional responsibilities beyond assigned clients and stretch their coverage of clients. Potentially, the situation may be due to staff shortages or inefficient workflow processes. If the pattern persists, it can lead to an increased workload and feeling overwhelmed with too many responsibilities. The problem can often lead to stress and exhaustion.

Beyond the relationships and interactions in the ED, the broader healthcare system within the institutional level also plays a significant role in participants' workload experiences. Many of the participants pointed out that systemic understaffing leads to some nurses shouldering additional tasks and responsibilities. Although some participants mentioned help coming from other support, MENs still bear the weight of caring for clients beyond their capacity. Participant one said, "…stressful just because …. working short staffed and… having extra load… like extra assignment." Similarly, Participant four provided more detail by stating, "…everybody is busy, and we are short staffed unfortunately…. You… give medications and insert IVs (intravenous lines). That's a lot going on; it's stressful. It's just stressing myself like this is… too much work." The quotes highlight how short staffing may lead to additional workload impacting their stress levels. Several participants mentioned that accumulated tasks, such as medication

administration and intravenous insertion, coupled with the pressure of working in a short-staffed ED, made them feel stressed.

Workload: The How

The previous sections explored the multifaceted nature of the workload by examining what, why, and when. The following section explores how MENs navigated and managed the workload. Many participants revealed a complex interplay of resilience, acceptance, and at times, resignation.

Participant seven's statement, "Oh, it's just the ED, …you should be used to stress." The quote illuminates a common sentiment within the ED culture. That unoffensive statement may have some pinch of normalizing stress, an expectation that nurses should probably endure the pressures they confront. However, this can be detrimental because it masks the actual consequences of stress and may hinder help-seeking behaviours.

Similarly, Participant three's response was, "It's kinda heavy, but you deal with it." The quote suggests some form of acceptance in managing workload. While it can be some form of resilience, there is a potential for internalizing stress and potentially neglecting one's well-being.

In similar vein, Participant six also shared, "We just kind of have to suck it up and then do our job…if we're short, I'm going to be a little annoyed, don't get me wrong, but it is what it is, right?" The quote highlights that while it is understandable that the ED setting is a high-stakes environment, the sentiment suggested that ED nurses often do not have control over their work. Such a sentiment can be helpful in the short term, but its long-term impact may lead to adverse health outcomes for nurses and compromised client outcomes.

Many participants shared their experiences navigating and managing the heavy workload in the ED. While resilience and acceptance can be the coping mechanisms utilized in the short

term, normalizing stress and internalizing pressure can raise concerns. The concerns are about the long-term well-being of MENs and potential implications for client safety and care.

Facility and Equipment Issues

Aside from the nursing workload, MENs also expressed a lack of control over the facility and equipment issues. They stated it was likely due to the outdated equipment they used, and the competing priorities of the hospital administration felt by MENs. Participant seven described the situation he encountered while using the male locker room provided by the hospital:

> … the female changing rooms are so much bigger than the male changing rooms… we don't have enough places to shower and our locker rooms downstairs and it's not even …accessible …of lockers for males to, … change …I still don't have access to the lockers. … it's really small and the showers are not working a lot of the time.

The excerpt highlights there may be some inequity in the resource allocation as evidenced by the contrast between the size of female and male changing rooms. The discrepancy may indicate a difference in perceived value for MENs and priority, a pinch of an ongoing systemic issue. While subtle, such disparity may be a form of discrimination. Moreover, the malfunctioning showers contributed to few of the participants' stress and frustration.

While the changing room situation highlighted the inequities in staff facilities, the challenges also extend to client care. Participant one shared his frustrating experience of searching for necessary equipment:

> Sometimes it can be hard to find certain equipment… You have to fight, run around the department and find some … sometimes there's some malfunction… it does just adds time. And just depending on the area you're working. It's just not readily available.

The experience highlights a workplace stressor directly linked to the shortage or mismanagement of resources. Many participants voiced that the need to search for equipment added unnecessary stress and workload, hindering their efficient client care. Furthermore, malfunctioning equipment exacerbated these challenges, potentially delaying care. They needed to tag the equipment or tell the unit clerk to make the repair request. So, finding unexpectedly faulty equipment was another time-consuming task. Participants felt this 'time' could have been better used other clients needing care in the ED. Ultimately, this sends a message that essential equipment is often not easy to access and has been a source of stress and inefficiency in care.

The time spent searching for equipment is further compounded by the need to create client care kits. Participant five said, "Sometimes, I have to go through the unit. …I mean… not having the appropriate setup sometimes and having to do it all, like make a kit by yourself." The quote highlights the lack of standardized or readily available systems for essential items. A few participants mentioned they need to locate each item one-by-one. In doing so, the process adds to their workload and workplace stressors. Perhaps addressing this systemic issue through improved resource management could free ED staff from logistical burdens and empower them to prioritize client care.

Summary

This chapter explored the specific challenges of ED workload for MENs by examining the 'what, when, why, and how' of this workplace stressor. It also illuminated how inaccessible and unavailable equipment can increase MENs' workload burden and stress. Furthermore, ED workload is a dynamic imbalance of how unpredictable the demands are and the scarcity or unavailability of certain resources. Unpredictable demands and unavailable resources in the ED often produce a dynamic imbalance defining ED workload. In the final chapter, I will summarize

key findings from all chapters and present recommendations, limitations and the research conclusion.

Chapter VIII: Key Findings, Recommendations and Conclusions

In this thesis, I explored the workplace stressors experienced by MENs in ED and the social, cultural and political factors influencing their help-seeking behaviour. In this chapter I summarize the key findings, providing new knowledge to support several recommendations. Specifically, this chapter focuses on the implications for nursing practice, nursing education, research and policy. The knowledge gleaned from this study may enhance the MENs lives. Furthermore, the information learned can promote the development of practice guidelines and policies to meet the needs of MENs in the nursing workforce.

Key Findings

Four major themes were discussed and explored: power dynamics in the ED, complexities of help-seeking, MENs-client dynamics, and workload-related workplace stressors of MENs (see Appendix G). Two key findings emerged from these four significant themes: MENs' challenges with ED overcrowding and dealing with insufficient mental health support.

MENs' Challenges with ED Overcrowding

Supportive managers, while vital, cannot fully alleviate workplace stressors faced by MENs due to systemic issues like ED overcrowding. Some participants reported feeling burnt out, meaning current programs do not currently mitigate their workplace challenges. Despite positive relationships with managers who encouraged help-seeking through visible leadership, ED overcrowding remained an unresolved source of workplace stressors. This paradox highlights the tension between perceived managerial support and the systemic constraints that limit interventions to ED efficiency. Managerial support alone is insufficient to address MENs' workplace stressors, highlighting an urgent need for more comprehensive solutions.

ED overcrowding creates substantial workplace stressors for MENs, yet managers' adherence to administrative mandates often fails to tackle its root causes. This top-down approach, while maintaining ED operations, has significant drawbacks. It restricts managerial autonomy and hinders the development of innovative strategies to address workplace stressors stemming from ED overcrowding. As a result, this reliance on a top-down approach may perpetuate workplace stressors and hinder the development of the best solutions to address the challenges of ED overcrowding. The limitations of the top-down approach demand a more nuanced strategy to address the complex issue of ED overcrowding.

Utilizing a critical ethnographic lens offers a robust framework to holistically address the challenges MENs face in ED overcrowding. A central tenet of critical ethnography is examining and understanding power dynamics and establishing open communications (Madison, 2011). This approach identifies hidden power imbalances by revealing how knowledge, expertise, power, and social constructed hierarchies shape MEN's experiences. Consequently, it serves as an invitation to work collaboratively to find the best solutions, emphasizing that all voices deserve to be heard and considered in the name of equitable solutions. This inclusive process can mitigate feelings of oppression and powerlessness that arise when MENs felt they are not valued nor supported. The additional challenges in Canadian hospitals, such as budget cuts and increased workloads further intensify these feelings.

Additional Challenges in Healthcare Context. Most Ontario hospitals are immersed in budget cuts and escalating workloads, which worsens ED overcrowding (Kim & Kim, 2023). Contrary to expectations, this ED crowding develops job dissatisfaction and drives nurse staff turnover (Guerrero et al., 2024). The emotional toll on MENs witnessing clients suffering and struggling to provide timely care further exacerbates the situation (Atakro et al., 2016). As a

result, MENs report heightened moral distress (Jalali et al., 2019), feelings of powerlessness and inadequacy to manage complex client cases efficiently (Chen et al., 2018)., These interconnected challenges are often detrimental to public health, nurses' health, and the sustainability of the healthcare system. However, targeting systemic issues may need to confront the central, yet often overlooked, role of power dynamics.

Issues with Power. To address ED overcrowding, we must delve into issues of power that perpetuate it. Barriers to problem-solving can be dismantled by acknowledging the systemic disempowerment of MENs (Al-Hamad et al., 2021; O'Mahony et al., 2012). Often, traditional hierarchical structures dominate individuals through power (Ciccia & Guzman-Concha, 2021; Thomas, 2021), limiting opportunities for open dialogue and collaborative solutions. Yet, a critical ethnographic lens reveals that power can be a force for positive change, not just control (MacDonnell & Buck-McFadyen, 2016; Madison, 2005). Best solutions for ED overcrowding are often achieved by addressing these power dynamics. For instance, participants shared that hierarchical structures in management communication often hinder open dialogue and effective problem-solving at the grassroots level. These seemingly benign practices, such as not actively seeking input from all staff, can perpetuate power imbalances and reinforce existing hierarchies. Consequently, it leads to increased errors and an unhealthy work environment and exacerbates the challenges of ED overcrowding.

Uncovering Areas of Oppression. Critical ethnography exposes oppression, centers the voices of the oppressed, and fosters collaborative action to overcome injustice (Hagues, 2019; Kia et al., 2021; Madison, 2012). A critical ethnographic lens reveals the oppressive reality of ED crowding, where low funding, high workload, and top-down communication create a system

that marginalizes and disempowers ED staff, including MENs. The lack of response to MENs' workplace challenges and concerns fosters a milieu where oppression can take root and thrive.

Despite hope for improvement, some participants felt frustrated by the lack of action or change on their workplace issues. Unresolved workplace issues create a toxic environment, leading to decreased job satisfaction, increased turnover intentions, workplace stress and burnout (Huang et al., 2020). Thus, critical reflection and action are a must to dismantle these systemic barriers and create a truly inclusive and equitable environment for all. One aspect of creating an equitable environment is addressing MENs' and other nurses' insufficient mental health support that influences workplace stressors and their help-seeking behaviour.

Dealing with Insufficient Mental Health Support

The second key finding is the insufficient support for MENs despite the chaos of ED overcrowding. Participants felt there were inadequate mental health supports. This can result in potentially devastating consequences for MENs and the healthcare system. Past research has reported insufficient access to mental health worsens nurses' health, leading to more stress, anxiety and feelings of powerlessness (Gadimova, 2023). Furthermore, despite high alarming rates of occupational stress and trauma, ED nurses, including MENs, are excluded from mental health support initiatives available to other first responders in Ontario (Ontario, 2022; Weiland et al., 2011). This disparity in mental health support exposes a critical blind spot in the Canadian healthcare system. It perpetuates a cycle of inequity and threatens nurses' health and public health.

To address insufficient mental health support for MENs amidst ED overcrowding, McLeroy's EMHP (1988) offers a robust framework for analysis. This framework recognizes that health promotion activities, including those aimed at improving mental health support, occur

within complex social and environmental structures (Tan & Black, 2019). By examining the five multilevel factors of the EMHP—intrapersonal, interpersonal, institutional, community, and public policy—one can understand the factors influencing MENs' mental health and develop targeted interventions. This framework helps analyze the interplay between individual factors, social interactions, organizational structures, community resources, and public policies. Moreover, multilevel factors can provide a holistic approach to address the complex challenge of insufficient mental health support.

Intrapersonal level. Participant interviews revealed the hidden struggles of MENs amidst the chaos of overcrowding of the ED, where insufficient mental health support was a key concern. Participants' voices highlighted the urgent need for change. "Reflecting thought" and "staying productive and proactive" are strategies suggested by participants to cope with workplace stressors, but these comments also risk putting the burden solely on MENs. They recommended some self-care practices like "bringing a good meal," "staying hydrated," and "taking breaks" which are vital, but a holistic approach integrating these strategies into organizational interventions will be more beneficial. Additionally, regulating cognitive and emotional responses to stress is crucial. Suggestions like "look for humour in the moment" and "listening to music" often offer coping mechanisms. However, a comprehensive approach that addresses systemic issues is essential to cultivate a supportive and equitable environment for MENs in overcrowded EDs.

Interpersonal Level. Conversations with the participants revealed power of interpersonal connection to mitigate oppressive conditions of ED crowding and insufficient mental health support. "Talking to colleagues" emerged as a top strategy for MENs navigating the challenges of a gendered profession, highlighting the importance of solidarity in challenging oppressive

systems. MENs often stay in touch with colleagues for emotional support, finding safe spaces in peer support networks to express feelings and share coping mechanisms (Zeb et al., 2021). By nurturing a culture of collective action and mutual support, MENs can challenge the individualistic and competitive culture often found in healthcare settings. Many participants agreed that open communication, sharing experiences, and validating their emotions helped to boost their work health. Moreover, interdepartmental collaboration can potentially positively impact MENs' health by enhancing ED client flow and reducing workload stress. Establishing clear communication channels and protocols can minimize misunderstandings and conflicts, fostering a more collaborative culture. While not a direct solution to mental health issues, interdepartmental collaboration contributes to a less stressful workplace for all, indirectly improving MENs' mental health. Thus, prioritizing collaboration and communication between departments is vital to the interpersonal level that benefits nurses' health, including MENs.

Institutional Level. There was a concerning discrepancy between participants' perceived need for a gym membership and their actual availability. This highlights the potential gap in communication and resource availability. It also raises questions about equitable access, making it only available to some who know about it. A culture that values transparency will likely ensure that resources are effectively utilized. Moreover, a deeper issue is the need for proactive policy changes to address insufficient mental health support. MENs can critically evaluate existing policies, collaborate with colleagues, and leverage institutional strategies. These institutional strategies may include transparent communication, equitable access and collective action. For example, joining unions and professional associations can amplify their voices. Thus, it is essential for nurses to recognize their collective power and advocate policy changes that prioritize their mental health needs.

Community Level. Continuance of basketball recreation is necessary at the community level. As the participant mentioned, this offered them some stress relief. Some participants mentioned “going to the mall” and “going to the park/biking”. While these activities can offer some mental and emotional decompression, it is saddening that only a few knew about the basketball recreation. It highlights some power imbalances as not all were aware. This perpetuates a system where those with more knowledge and connection have greater access to support. In contrast, others are left out to rely on individual coping that may not adequately address their mental health needs. Many participants hoped for more community-based initiatives and resources to help them manage their stress and have healthier lifestyles. The continuation of more group-based activities can potentially make the MEN's community more inclusive and supportive.

Public Policy. At the public policy level, a paradigm shift from female-centric mental health disparities toward a more nuanced, intersectional framework is warranted. Instead of simply comparing different male and female nurses’ experiences, efforts may be better invested in using an intersectional lens to interrogate specific mental health vulnerabilities of male nurses. For example, how workplace stressors interact with multiple and overlapping social identities like race, abilities, and sexual orientation to understand their unique challenges. This requires a bold stance in challenging implicit biases that perpetuate a system where MENs mental health within nursing is often overlooked, under-researched, and inadequately addressed. To promote inclusivity, policymakers must prioritize mandates that have targeted research funding tailored to the needs of male nurses and implement policies that promote a respectful workplace.

Recommendations and Implications

Enhancing Support in the Workforce

Nurse leaders *must* implement a data-driven assessment of workplace stressors to understand the impact of help-seeking behaviours. These data should be used to point out specific workplace stressors impacting MENs' mental health and inform targeted support systems. Nurses and nurse managers in the ED collect thorough data and analyze wait times, client acuity and flow to identify bottlenecks and issues in resource allocation. For instance, knowing admission rates and inpatient bed availability is critical to addressing ED crowding, often caused by bed shortages (Michael et al., 2019; Morley et al., 2018). This is important because prolonged ED crowding may compromise patient safety and lead to increased errors and delays in emergency care while adding to the workplace stressors among nurses. Thus, improving inpatient care coordination and departmental allocation is essential. Data analytics and process mining are vital for tracking inefficiencies (Bemthuis et al., 2021). Organizations can then make informed decisions to optimize resource allocation, improve processes, and enhance client care by regularly assessing performance and client outcomes.

Following data-driven assessment, immediate action to address unreplaced sick calls is vital for workforce stability. Absenteeism increases workload, burnout, and compromised care (Gohar et al., 2020; Mahmood et al., 2023). Nurse managers must act: first, improve and communicate wellness programs to boost staff awareness (Shanafelt et al., 2017). Second, incentivize consistent attendance through rewards or certificates to reinforce positive behaviour. Third, to prevent stress-induced absences, managers can communicate staffing needs so staff may feel more comfortable discussing availability and challenges in the schedule (Schnall & Liu, 2014). This multi-pronged approach will create a healthier and more stable workforce, benefiting clients and the organization.

Coping with Insufficient Mental Health Support

Nurses' mental health, particularly that of MENs, in a violent, traumatic, and high-stress ED environment is a critical determinant of the overall health and efficacy of the healthcare system. Occupational stress levels among ED nurses are alarmingly high, ranging from 70 to 90% (Lasalvia et al., 2022; Xu et al., 2024). Neglecting nurses' mental health needs leads to increased burnout, decreased job satisfaction, and poorer client outcomes (Diehl et al., 2021; Gao et al., 2023). The financial implications are also significant, estimated at $200-300 million annually in the United States (Hassard et al., 2018).

Given these challenges, policymakers and hospital leaders need to prioritize mental health support for MENs as an essential ingredient to sustainable healthcare systems. This includes regular manager check-ins, male-specific mentorship programs and trainings in emotional regulation and stress management (Dai et al., 2023). Investing in nurses' mental health is not an expense but a long-term investment to safer and happier clients.

Furthermore, organizations should implement ongoing, tailored support for male nurses to enhance workforce stability and ensure effective client care. Since MENs often face verbal violence due to their frequent exposure (Dafny & Beccaria, 2020), targeted interventions are necessary, as general wellness programs often prove inadequate. Participants have identified the need for regular manager check-ins to address exposure to violence, heavy assignments, and inflexible scheduling. Male-specific mentorship programs can also potentially mitigate feelings of isolation (Mahmood et al., 2023).

To effectively manage the emotional demands of nursing, MENs would benefit from training in emotional regulation, resilience, and stress management, enabling them to recognize their mental health needs and seek timely support (Dai et al., 2023). These targeted initiatives can transform nurses' health, consequently, enhancing quality client care.

Hospital leadership plays a powerful role in fostering a culture prioritizing mental health, paving the way for implementing effective support systems and interventions. MENs have unique challenges in accessing mental health that need to be acknowledged. Fear of appearing weak (Stroth et al., 2024) and lack of awareness can (Gadimova et al., 2023) hinder help-seeking behaviours.

Hospital leaders can combat this by promoting a culture that normalizes help-seeking through awareness campaigns. Town hall meetings and internal communication platforms are a starting point in engaging MENs in discussing mental health, which can help reframe help-seeking as a strength (Sagar-Ouriaghli et al., 2020). Peer support groups, continuing preceptor-preceptee mentorship, and educational workshops can provide safe spaces for connection, learning and growth. By taking action, hospital leadership significantly impacts the workplace, empowering MENs to prioritize their mental well-being. Thus, investing in MENs' mental health is an investment to improve the efficacy of the healthcare system.

Nursing Education

The literature suggests that many nursing programs lack structured educational programs targeting stress management, which affects their academic and psychological health (Lu et al., 2019; Ratanasiripong et al., 2015). For example, the Mental Health Commission of Canada (2023) has valuable Mental Health First Aid (MHFA). However, it is underutilized to respond to mental health concerns; therefore, not reaching its full potential due to lack of promotion and integration in ED nursing. This oversight has significant consequences, as ED nurses, including MENs, combat high stress. This can have adverse effects on nurses' health and public health.

To empower MENs with knowledge and skills to navigate the complexities of their workplace stressors and their help-seeking, the integration of MHFA is a necessity. MHFA

offers a robust foundation for stress management education, improving mental health literacy and equipping individuals with knowledge and skills to manage mental health challenges (Mental Health Commissions of Canada, 2023). It includes various mental health-related modules like dealing with suicide, panic attacks, reactions to trauma, and interactions where mental health may be an issue (Mental Health Commissions of Canada, 2023). This gap is potentially detrimental to MENs, who face unique workplace pressures and societal expectations that discourage help-seeking. Addressing this deficiency can help disrupt traditional masculine norms and masculinity to empower MENs' to prioritize their mental health and improve overall nursing workforce health.

To bridge this identified education gap, a collaborative, multi-level effort is crucial. Nursing schools must prioritize integrating structured stress management education, including simulation-based learning and mindfulness techniques, directly into clinical rotations. They should receive guidance from Mental Health Commissions of Canada to promote resources like MHFA, tailored to the ED setting and accessible through multiple media and flexible scheduling. Policymakers must provide institutional support through policy changes that mandate mental health education and increased funding for sustainability. This multi-pronged approach can empower ED nurses to thrive in demanding nursing roles and transform a mental healthier healthcare workforce.

Future Research

To gain more understanding of the workplace stressors and help-seeking behaviour among male nurses, future research can potentially prioritize several areas. First, it is interesting to explore nuanced experiences of diverse cohorts within the nursing profession, including male administrators, female nurses, and LGBTQ+ individuals, across various clinical settings. Second,

examining the perceptions and behaviour of nurse managers and colleagues toward male nurses' stress management and help-seeking behaviours can reveal the social and organizational factors through their lens. Additionally, utilizing validated questionnaires like the Nursing Stress Scale (Pavek et al., 2024) can provide measurable data. This different methodological approach can further support targeted interventions. Finally, future research should investigate the prevalence and underutilization of workload forms like the Professional Responsibility Workload Form (PRWF) among nurses in Ontario.

Health Policy

Nurses' participation in health policy development is essential to building supportive work environments that benefit the nursing profession and the public they serve (Hajizadeh et al., 2021). At the organizational level, standard policy utilizing walkie-talkies for efficient communication can optimize ED workflow and client placement. Equipping the triage nurses and environmental services team with a walkie-talkie optimized the ED workflow through efficient communication on bed availability (Chartier et al., 2016). To address staff shortages, current staffing policies need to include an analysis of client inflow and implement flexible staffing models to address peak times and when staff call in sick (Mostafa & El-Atawi, 2024). Finally, hospitals should mandate MHFA training for all ED nurses to have a mentally healthier workforce. This policy empowers nurses with the knowledge and skills to effectively respond to their mental health concerns and those of others.

International and national policymakers must prioritize targeted policies that address MENs' unique mental health needs to ensure a robust healthcare workforce. These unique needs are stereotypes, violence and aggression and lack of access to mental health support. The nursing profession, while increasingly diverse, still has gender disparities. During COVID-19, male

nurses provided emotional support to clients, and Gadimova and colleagues (2023) reported that they experienced different mental health difficulties than female nurses.

To promote gender equity in nursing, the World Health Organization (WHO) or International Council for Nurses (ICN) should develop and disseminate international guidelines, drawing best practices from countries like Australia. These guidelines should include unconscious bias awareness, respectful communication, and men in nursing etiquette (Australian College of Nursing, 2021). Implementing such guidelines can promote a more inclusive environment, dismantling stereotypes and biases that may hinder male nurses. Ultimately, boosting gender equality improves health outcomes and advances human rights (Gupta et al., 2019).

Study Limitations

There are several limitations to this study. First, this study was conducted in hospitals within Ontario, Canada. This can imply geographic bias since Ontario may have specific healthcare facilities, funding models, and demographic characteristics not representative of other areas. Second, MENs participants were from Asian and Black backgrounds. Thus, the findings of this qualitative study cannot be generalized to all male nurses or to other geographical contexts. Third, a sample size was chosen to discover the meaning and richness of the data. A larger sample and a mixed methodology design could broaden the research scope.

Knowledge Translation

Knowledge translation is a term used to effect systemic change in clinical practice (Polit & Beck, 2021). To achieve systemic change, I will disseminate my research findings and recommendations through various communication channels. First, I plan to conduct in-service sessions for ED managers and nurses to empower MENs and raise awareness of their unique

challenges. Additionally, I will collaborate with my research supervisor to publish a manuscript in a reputable nursing journal and present my findings at local, provincial, or national conferences. Finally, I would like to present my findings to community groups, patient advocacy organizations or other stakeholders. For example, partnering with local nursing association or men's health organization to have a webinar or community talk. These strategies can help raise public awareness and generate interest in my topic.

Conclusion

This research set out to explore MENs' experiences of workplace stressors and help seeking through semi-structured interviews. Workplace stressors and help-seeking behaviours were explored and contributed to the growing body of knowledge in this important area of nurses' health. This research elucidates a need for a paradigm shift in ED management from fragmented interventions to a systems-level approach. This approach integrates financial, cultural and social factors to mitigate MENs' workplace stressors and help-seeking behaviours. Continuing with top-down mandates will only perpetuate systemic issues, leaving ED overcrowding unaddressed and MENs' health compromised. There is a need for a long-term vision for health policy that values MENs' health as an investment for the future of healthcare. Overall, the result of this study yields rich, in-depth knowledge of the experiences of MENs who experienced workplace stressors and help-seeking. These findings are meaningful to Canadian hospital administrators, ED managers, MENs, and health policymakers in advocating for systemic changes, confront workplace stressors and help-seeking behaviours in overcrowded EDs. Future research should explore the efficacy of tailored interventions, such as MHFA, in addressing workplace stressors and help-seeking among ED nurses.

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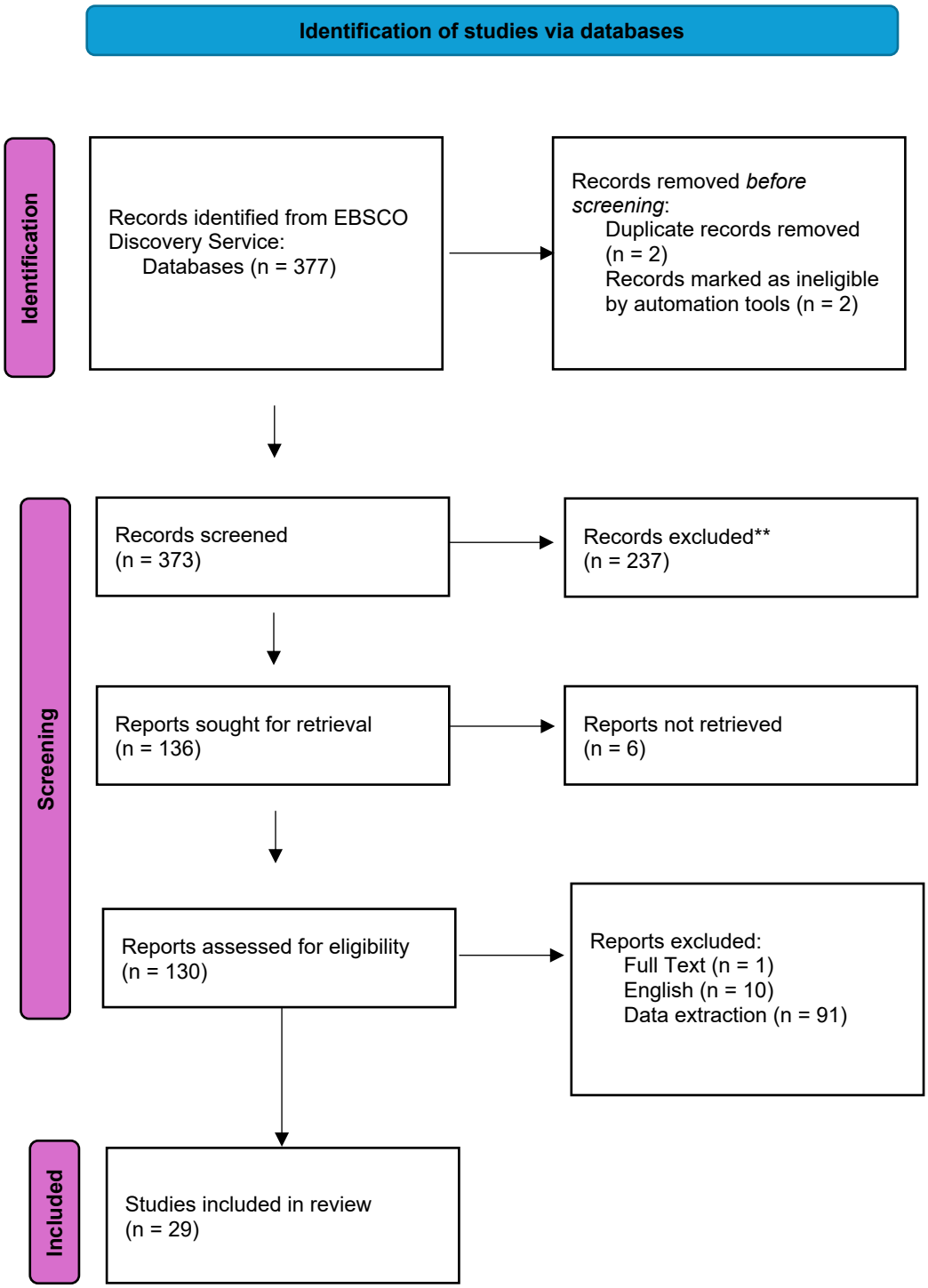
Appendix A

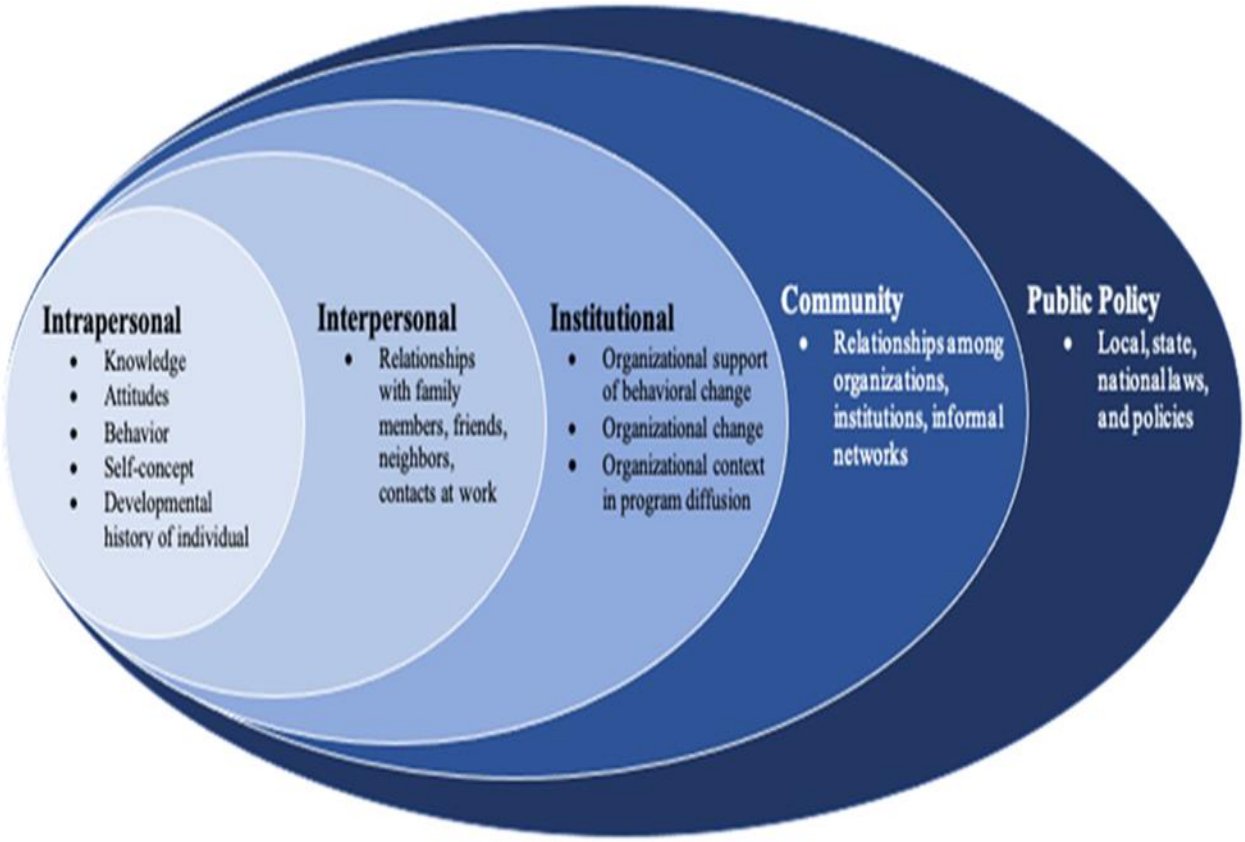
PRISMA Flow Chart



Haddaway, N. R., Page, M. J., Pritchard, C. C., & McGuinness, L. A. (2022). PRISMA2020: An R package and shiny app for producing PRISMA 2020-compliant flow diagrams, with interactivity for optimised digital transparency and open synthesis. *Campbell Systematic Reviews*, *18*(2). https://doi.org/10.1002/cl2.1230

Appendix B

Ecological Model for Health Promotion



Ecological Model for Health Promotion (McLeroy et al., 1988)

Appendix C

Demographic Questionnaire Results

Participant	Age	Ethnicity	Years of Exp	Education	RN/RPN	Work Status
1	30-39	Asian	1-5	Diploma	RPN	Part Time
2	18-29	Asian	1-5	BSN	RN	Full-Time
3	30-39	Asian	11-20	BSN	RN	Full-Time
4	50-59	Asian	11-20	BSN	RN	Full-Time
5	18-29	African/Black	1-5	BSN	RN	Full-Time
6	18-29	Asian	1-5	BSN	RN	Full-Time
7	18-29	Asian	1-5	BSN	RN	Full-Time
8	30-39	African/Black	6-10	BSN	RN	Full-Time

Appendix D

Advertisement Poster

THOMPSON RIVERS UNIVERSITY

DO YOU IDENTIFY AS MALE EMERGENCY NURSE EXPERIENCING WORKPLACE STRESS?

JOIN OUR RESEARCH

WE WANT TO HEAR FROM ER NURSE:

- Identify as male gender, may not be biologically male.
- Age 21 and above.
- Experience of at least one year.

PARTICIPANTS WILL RECEIVE A $25 GIFT CARD TO TIM HORTONS

- Image credits to: iStock iammotos

WHAT ARE WE RESEARCHING:

- What are the work stressors for male emergency nurses?
- How do social, political, and cultural factors impact male emergency nurses' help-seeking behaviour?

WHAT WILL YOU BE ASKED TO DO:

- Fill out a questionnaire about yourself.
- A choice of in-person or Zoom interview.
- It will take 60-70 minutes.

To learn more, you can contact the principal investigator:
***Christopher John Fernandez**, who is a Master's Student in Nursing*
Email: cfernandez@shn.ca, Phone: 437-213-1551

Adapted from: https://bit.ly/3UPuoQq

Appendix E

Welcome Kit: Participant Letter

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

Dear **Prospective Applicant**,

My name is Christopher John Fernandez, and I have 18 years of diverse nursing experience, including nursing education, emergency nursing, and general ward care for male patients. I am currently pursuing a Master of Nursing degree at Thompson Rivers University under the supervision of Professor Joyce O'Mahony, RN, Ph.D.

To ensure the highest ethical standards, my research has undergone thorough review by the Research Ethics Boards (REB) at both Thompson Rivers University (TRU) and Scarborough Health Network (SHN). These boards ensure compliance with ethical guidelines, safeguarding participants' rights and well-being. Approval from both REBs highlights the robustness and integrity of my research methodology, reflecting a commitment to ethical excellence and rigorous academic standards.

I am personally funding this research without any external sponsorship, highlighting my dedication to advancing nursing knowledge and practice. I am seeking your support and assistance to complete this important work. Your help will be invaluable in ensuring the success ‹and impact of this research.

Research Focus: This study aims to:

- Explore the work-related stressors experienced by male emergency nurses.
- Investigate their help-seeking behaviours in response to these stressors.
- Highlight the importance of a healthy working environment for all nurses.
- Emphasize the need for accessible workplace support structures for male nurses.

Participation Details

- Sample Size: 8-10 male emergency nurses.
    - Inclusion Criteria: Proficiency in English, Identification as a male emergency nurse.

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

- Interview Details: Single semi-structured interview lasting 30-70 minutes. Interviews will be recorded with consent. Participants will receive a summary of the findings.

Data Collection

- Method: Questionnaire with open-ended questions.
- Timeline: September to November 2024
- Format: In-person interviews or Zoom

Contact Information

For more information or to participate, please contact: Phone: (437) 213-1551;
Email: fernandezc20@mytru.ca or cfernandez@shn.ca

Thank you for your interest in and potential participation in this important research study. Your insights could significantly contribute to improving men's health and mental health services and providing enhanced support for male emergency nurses.

Respectfully yours,

Christopher John Fernandez

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

Informed Consent Form for Participation in a Research Study

The Principal Investigator for this study is Christopher John Fernandez, telephone 4372131551.

INTRODUCTION

We invite you to join a research study because of your valuable experience as a male emergency nurse. This consent form is to inform you about the study. Please read it carefully and ask any questions you have. Make sure all your questions are answered before you decide to join.

Take your time to think about participating. It might help to talk with friends, family, or your healthcare team. The principal investigator will let you know the timeline for making your decision.

The researcher will explain the study in detail. You can join the study or not, with no consequences. This research aims to understand male emergency nurses' stress and how they seek help. The goal is to create a healthier work environment and better support for male nurses.

Your participation is voluntary. You can choose not to join or to leave the study at any time without any penalty or effect on your healthcare or job. If you decide to leave, please inform Christopher John Fernandez, the Principal Investigator, or Dr. Joyce O'Mahony, the Supervisor. You don't need to give a reason, and your data will be removed from the study records.

Why Your Participation Matters

By joining this study, you're helping to improve men's health worldwide. Here's why your contribution is so important:

- **Your Voice Matters**: Your unique experiences and challenges are crucial to this study. Sharing your story helps us understand and support other men in similar situations.
- **Improving Health and Safety**: The information we gather could lead to better health strategies, creating a safer and more supportive work environment, especially for men who might hesitate to ask for help.
- **Breaking the Stigma**: Your participation sends a strong message against the stigma surrounding men's mental health. You're encouraging others to seek the help they need.
- **Creating Change**: The insights from this research can shape policies and practices, fostering a healthier and more supportive workplace for everyone.

Your involvement is incredibly valuable.

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

WHY IS THIS STUDY BEING DONE?

This study aims to explore the experiences of male emergency nurses (MENs) by examining their work pressures and how they seek help. It will also consider social, political, and cultural factors affecting their behaviour and decisions. The goal is to understand these influences better to support MENs in their jobs and create a healthier work environment.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

The study will involve about 8-10 participants, with around five from each location within the Scarborough Health Network: Birchmount, General, and Centenary sites. The study will last about one and a half months, and results are expected around six months after the analysis is complete. As a participant, your involvement will also be for one and a half months.

WHAT WILL HAPPEN DURING THIS STUDY?

Once selected as a participant, you'll need to fill out a short demographic questionnaire and participate in a one-on-one interview. You can choose to do the interview in person or via Zoom. All interviews will be recorded for accuracy. The interviews will be in English and guided by open-ended questions. You'll get a summary of the findings at the end of the study.

We'll ensure the sessions are secure for Zoom interviews. If you prefer, you can use a nickname for privacy and turn off your camera or microphone.

Study Schedule:

- Screening and Baseline: Complete the demographic questionnaire (see attached)
- Study Interview: Participate in a 60-70 minute interview.(see questions attached)

During the interview, you'll talk about your experiences with work stress and seeking help. If you feel emotionally distressed at any point, please let a study team member know so we can support you. If the interview brings up distressing memories or feelings, the principal investigator will pause the interview to help you and offer **counselling resources**, such as:

- ConnexOntario: A free, confidential helpline for mental health support at 1-866-531-2600.
- BounceBack: A free program by the Canadian Mental Health Association for managing mood, depression, anxiety, stress, or worry at 1-866-345-0224.

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

- Mental Health Support for Healthcare Workers: Self-referral support for frontline healthcare workers dealing with COVID-19-related stressors is available at this link or by calling 416-535-8501, option 2.

Your well-being is our priority, and we're here to ensure you have a positive experience throughout the study.

WHAT ARE THE RESPONSIBILITIES OF STUDY PARTICIPANTS?

What to Expect if You Participate?

Complete a Short Demographic Questionnaire: Provide some basic information about yourself to help us understand the background of our participants.
Participate in a One-to-One Interview: Have a private interview with the researcher to discuss your experiences and perspectives as a male emergency nurse.
These steps are essential for gathering comprehensive data and ensuring your unique experiences contribute to our understanding of the work environment for male emergency nurses.

CAN PARTICIPANTS CHOOSE TO LEAVE THE STUDY?

You can leave this research study at any time without explaining why. If you decide to stop, please contact the principal investigator or Dr. O'Mahony, the thesis supervisor.

If you want to withdraw your information from the study, inform the principal investigator. Note that withdrawing your information means you are also withdrawing from the study. You can withdraw up to 30 days after the study is completed.

CAN PARTICIPATION IN THIS STUDY END EARLY?

The principal investigator can end your participation in the study early, even without your agreement. This might happen if the research team stops the study or the Research Ethics Board revokes its approval. If this happens, the principal investigator will explain the reason to you.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

Participating in this study doesn't pose any medical risks. However, you might feel uneasy sharing personal experiences. Remember, you have the right to skip any questions or leave the interview if you feel uncomfortable at any time.

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

WHAT ARE THE RISKS TO ELECTRONIC COMMUNICATION: Zoom

If you choose a virtual interview using Zoom, there are some risks because it uses electronic communication.

Privacy is Not Guaranteed: We can't fully guarantee your privacy even though we use secure platforms. There's always a small chance of a security breach. We take all possible precautions to minimize these risks, but you need to be aware of them before deciding to participate.

IS THERE A CONFLICT OF INTEREST?

There are no conflicts of interest to declare related to this study.

HOW WILL PARTICIPANT INFORMATION BE KEPT CONFIDENTIAL?

During the study, the principal investigator will collect personal information about you, such as your name, age, gender, ethnicity, work status, and nursing role. This information will be kept private and confidential, following Ontario's privacy laws (PHIPA).

To protect your identity, your data will be assigned unique codes. Only the principal investigator will have the key to these codes. After analysis, the data will be anonymized.
The analyzed data will be aggregated with organizations like Thompson Rivers University and the Scarborough Health Network to ensure accuracy and legal compliance. They will only receive de-identified information.

Audio recordings will be securely stored and destroyed after analysis and anonymization.
While every effort is made to protect your privacy, there is a small risk of accidental information disclosure. However, strict measures are in place to minimize this risk, including secure identification methods, limited access, and robust data security measures. All materials will be ethically disposed of after the study concludes.

Your privacy is a top priority, and we are dedicated to maintaining the confidentiality of your information.

HOW LONG WILL MY SAMPLES AND DATA BE STORED?

The principal investigator is committed to maintaining the integrity and confidentiality of the study data. As such, all data collected during the research will be securely stored for at least seven years after the study concludes. This retention period ensures that the data can be reviewed if necessary while adhering to ethical research standards and regulations.

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

WILL MY DATA BE PUBLISHED

The data from this study might be shared in scientific circles or presented at conferences. If any results are published, your personal identity will remain confidential. The collected information could be used for in-depth analyses and might be included in journal publications or community presentations, contributing to the broader field of knowledge.

WHAT IS THE COST TO PARTICIPANTS?

By participating in this study, you may not incur any extra expenses.

ARE STUDY PARTICIPANTS PAID TO BE IN THIS STUDY?

If you decide to join this study, you'll get a $25 gift card after the interview. If you experience any negative psychological or physical effects, you'll be referred for appropriate medical care.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

As a participant in this study, you'll get all important updates that might affect your decision to stay involved. When the study ends, you'll be informed about the results. For more details, you can contact the main researcher.

You have the right to access and change your study file, but some information might only be available if you decide to leave the study to keep its scientific integrity. Your privacy is protected by law, and signing this form doesn't take away any of your legal rights or the responsibilities of the researchers. You'll get a signed copy of this consent form before you start participating.

WHOM DO PARTICIPANTS CONTACT FOR QUESTIONS?

If you have questions about taking part in this study or if you suffer a research-related injury, you can contact the principal investigator. That person is:

Christopher John Fernandez	*4372131551*
Name	Telephone

This study has been reviewed and approved by the Scarborough Health Network REB. If you have any ethical concerns about the study or the way it is conducted, please get in touch with the Chair of the REB office, Dr. Nisanthini Ravichandiran at shnreb@shn.ca

If you have questions about this study, contact the graduate thesis supervisor. That person is:

Dr. Joyce O'Mahony	2503776138
Name	Telephone

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

SIGNATURES PAGE

As the participant, I confirm that I have read or have had the above Informed Cconsent Form (ICF) read to me and agree that:

- All of my questions have been answered.
- I understand the information within this informed consent form;
- I do not give up any of my legal rights by signing this consent form;
- I agree to take part in this study.

_____	_____	_____
Signature of Participant	PRINTED NAME	Date
_____	_____	_____
Signature of Person Conducting the Consent Discussion	PRINTED NAME & ROLE	Date

Complete the following section only if the participant is unable to read or requires an oral translation:

- The informed consent form was accurately explained to, and apparently understood by, the participant, and
- Informed consent was freely given by the participant

_____	_____	_____
Signature of Impartial Witness/Translator	PRINTED NAME	Date

(If participant were unable to read/required an oral translation)

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

Socio-Demographic Questionnaire

Please provide a name (feel free to use a pseudonym. This will be used when quotes are used in the study. No identifying information will be disclosed and will be kept confidential. The following information will only be collected to help guide the interview.

Name/Preferred Code name: _____

Age: _____ 18-29 _____ 30-39 _____ 40-49 _____ 50-59 _____ 60 and above Sex on original birth certificate: _____ Male _____ Female _____ Other, please specify: _____ Gender: _____ Man/male _____ Cisgender _____ non-binary/genderqueer/gender-fluid _____ I use different term, please specify:_____ _____ Prefer not to say Ethnicity/Cultural Background _____ White/Caucasian (European descent) _____ Indigenous (First Nations, Metit, Inuit) _____ Asian (China, India, Japan, Philippines, etc.) _____ Hispanic/Latino (Spanish-speaking countries like Mexico, Colombia, etc.) _____ African/Black (African Descent) _____ Others (please specify) Years of experience _____ 1-5 years _____ 6-10 years _____ 11-20 years _____ >20 years	Educational Level _____ Hospital Certificate _____ Diploma _____ Bachelor's Degree _____ Graduate Diploma/Certificate _____ Masters _____ Doctorate What best describes your role (The majority of your work hours)? _____ Direct clinical _____ Managerial/Administrative _____ Education _____ Research _____ Others (please specify) Nursing Role: _____ RN _____ RPN Work Status _____ Full-time _____ Part-time

THOMPSON RIVERS UNIVERSITY

Participant Packet: Male Nurses' Work Stressors and Help-Seeking Behaviour in the Emergency Department

Sample Interview Questions

Intrapersonal Level

- What are your work stressors in ED? How does being male influence how you perceive and manage these stressors?
- How do your age, marital status, and years of experience influence how you perceive and manage these stressors?
- At a personal level, how do you seek/seek help for these work stressors? What influenced your decision to seek help?

Interpersonal Level

- How do your social network and peers influence how you perceive and manage work stressors?
- In ED, how do these social supports mitigate the impact of work stressors? How has this affected your help-seeking behaviour?
- Do solid social relationships at work encourage you to seek help? How?

Institutional Level

- How does SHN promote healthy behaviour among staff, particularly among male nurses? Can you give an example?
- What available resources in SHN influenced your propensity to seek help when needed?
- Informal structures often influence behaviour and are often not explicit/exposed, such as social networks, role modelling, informal learning, and informal roles. How do you think informal structures in ED impact your stress levels and your help-seeking behaviours? Do you think these structures are supportive or hindering?

Community Level

- How do current cultural norms and values of the Canadian community shape the attitudes toward men, particularly concerning the social stigma associated with seeking help for stress or mental health issues?
- Have you noticed media reinforcing or challenging the social stigma of men seeking help for workplace stress or mental health concerns? What happened, and what do you think about it?
- How do social inequities in the community impact men's perception of workplace stressors and their willingness to seek help? Can you provide specific examples?

Public Policy Level

- How do Canadian policy/law and regulatory policies affect your perception of work stressors and help-seeking behaviour?
- How do laws of the land address the challenges male emergency nurses face? If none, what changes do you want to suggest?
- To what extent do you believe that the Canada Health Act or CCOHS (Canadian Centre for Occupational Health and Safety) policies promote the protection of mental health for male nurses?

Appendix F

Transcriber Confidentiality Agreement

Transcriber Confidentiality Agreement

Please read through the entirety of this form carefully before signing.
The transcriber should keep a copy of the *Transcriber Confidentiality Agreement* for their records.

CONFIDENTIALITY OF A RESEARCH STUDY:

Confidentiality is the treatment and maintenance of information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others in ways that are inconsistent with the understanding of the original disclosure (the consent form) without permission. Confidential information relating to human subjects in a research study may include, but is not limited to:

As a transcriber you will have access to research information (e.g. audio or video recordings, transcripts, data) that include confidential information. Many participants have only revealed information to investigators because principal investigators have assured participants that every effort will be made to maintain confidentiality. That is why it is of the upmost importance to maintain full confidentiality when conducting your duties as a transcriber during a research study. *Below is a list of expectations you will be required to adhere to as a transcriber. Please carefully review these expectations before signing this form.*

EXPECTATIONS FOR A TRANSCRIBER:

In order to maintain confidentiality, I agree to:
1. Keep all research information that is shared with me (e.g. audio or video recordings, transcripts, data) confidential by not discussing or sharing this information verbally or in any format with anyone other than the principal investigator of this study;

2. Ensure the security of research information (e.g. audio or video recordings, transcripts, data) while it is in my possession.

3. Not make copies of research information (e.g. audio or video recordings, transcripts, data) unless specifically instructed to do so by the principal investigator;

4. After discussing it with the principal investigator, erase or destroy all research information (e.g. audio or video recordings, transcripts, data) that cannot be returned to the principal investigator upon completion of my duties as a transcriber.

I acknowledge that by signing this form I have reviewed, understand, and agree to adhere to the expectations for a transcriber described above.

_____ _____

Signature of Transcriber Date

_____

Print Name

Dec 1, 2020

Appendix G

Overview of Themes and Subthemes