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**Negotiating masculinities at the expense of health: a qualitative study on men working in long-term care in the Netherlands, from an intersectional perspective**

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## ORIGINAL ARTICLE

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Caring Masculinities at Work: Theoretical and Empirical Perspectives Across Europe

# Negotiating masculinities at the expense of health: A qualitative study on men working in long-term care in the Netherlands, from an intersectional perspective

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## Abstract

While some areas of care work show increased recruitment of men, the care-gap remains, especially in low paid occupations. Questions arise how masculinities play a part in this, and if *caring masculinities* obscure gender inequities while at the same time perpetuating them. This qualitative study focusses the negotiation of *hegemonic* and *caring masculinities* of men working in residential long-term care in the Netherlands, and its consequences for health. Semi-structured interviews ( $N = 16$ ) were analyzed thematically, drawing upon gender and intersectionality theory to understand inequities between respondents. Findings describe how men move through long-term care. On entry, men negotiated *hegemonic* and *caring masculinities* to gain access, with black men having to work harder. Once inside, men experienced status-loss and performed *hegemonic masculinity*, materializing in financial and sexual rewards, especially for white heterosexual men. In time, this performance of hegemonic masculinity backlashed with respect to their own health; herein racialized and homosexual men were hit harder.

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Consequently, all the men in this study aspired to move out or up from low-paid care work, with white heterosexual men doing so more successfully. Our study illustrates the importance of an intersectional perspective on *caring masculinities* at work, showing how *caring masculinities* perpetuate male privilege for some men more than for others, creating health and labor market inequities among men. In terms of health, this study shows that gender, racism and sexual discrimination need be on the occupational health agenda.

**KEYWORDS**

caring masculinity, health, hegemonic masculinity, intersectionality, long-term care

## 1 | INTRODUCTION

### 1.1 | Background

In gender studies, attention for men, masculinities and male privilege is substantial and increasing. Much of this work builds upon Raewyn Connell's concept of hegemonic masculinity (Connell & Messerschmidt, 2005). Connell explains hegemonic masculinity as the configuration of gender practice that embody the legitimacy of patriarchy, which guarantees the dominant position of men and the subordination of women. Connell also describes how certain forms of masculinity are dominant in different times and spaces; so-called idealized and socially desired ways of "being a man," while other masculinities are subordinated, complicit, or even marginalized. Therefore, there is no such thing as "masculinity," but rather many ways of doing masculinity, hence the term "masculinities." What constitutes dominant masculinities is socially constructed and thus, continuously contested and (re-)produced within a given context. Although masculinities vary over time and place, dominant masculinities tend to be white and heteronormative, display oppressive, aggressive and hierarchical attitudes, and value physical strength and leadership of men.

In the European context, Elliott (2016) describe how some men resist dominant masculinities by embracing and advocating for *caring masculinities*. The concept of caring masculinities rejects domination and its associated traits, and aims to integrate caring values and practices into masculine identities (Hrženjak & Scambor, 2019). Caring masculinities are conceived of as "*men's investment in gender equality*," aiming to engage with caring to support gender equality and social change. Embracing feminine-typed traits, such as caring, by men, is characterized by others as a strategy to "undo gender" or a transformation into "hybrid masculinities" (Bridges & Pascoe, 2014). Simpson and Lewis theorize these hybrid masculinities as emblematic of a postfeminist gender regime (Simpson & Lewis, 2019). While some have argued that this is a movement toward more "inclusive masculinities" (Anderson, 2009), others have raised question in how far these hybrid masculinities can be employed to obscure gender inequities while at the same time perpetuating them (Bridges & Pascoe, 2014; Elliott, 2016).

Empirical work on men, masculinities and male privilege is often carried out in the context of caring occupations. These are characterized by many as "feminized spaces." Understanding space as an embodied experience and materialized power relations, feminized spaces can be understood as held by women and noted for skills that are rendered feminine, for example, sensitivity and nurturing (Simpson, 2009; Taylor & Spicer, 2007). In long-term care for older people, not just the workforce, but also the clients, are predominantly women (Central Bureau for Statistics, 2021). Also, long-term care is at the bottom of the cure-care hierarchy, reflecting a gendered hierarchy between

feminine-typed care work that is “*low-tech-and-high-touch*” and masculine-typed caring occupations that are technical and heroic, such as emergency care (Kvande, 2010; Simpson & Lewis, 2019). Unsurprisingly, men's experiences in these “feminized spaces” provide a unique insight in how masculinities are experienced, resisted or reproduced in the health care sector (Hanlon, 2012).

In particular, important work on men in caring occupations has been done by Elwér, Williams, Schwiter, Lupton, Kvande and Simpson, amongst several others. For instance, Elwér et al. shed light on the horizontal sex-segregation, and the experienced status-loss of men in care work, describing how “... *men avoided or left woman-dominated jobs because of social reprisals in terms of being looked down on by friends and acquaintances that did not see caring work as a proper job for a man.*” (Elwér et al., 2012, p. 6; cf. Lupton, 2000). Williams illuminated the “*glass escalator*” of men in caring occupations, having disproportionate chances for promotion to specialty and leadership positions (Williams, 1992; cf. Kvande, 2010). Simpson describes how men adopt a variety of strategies to re-establish masculinities within non-traditional-work settings (Simpson, 2009), so does Lupton (2000), and describes how this is shaped in the context of post-feminism (Lewis et al., 2021; Simpson & Lewis, 2019). Schwiter et al. (2021) showed how men silence their privilege by actively re-framing it as an “individual achievement” or a “natural advantage of their male-bodies.”

## 1.2 | Theoretical approach

Only recently, studies on men in caring occupations are beginning to address class, race and sexuality and other intersections, illustrating how the above-mentioned dynamics do not play out for all men alike (Kalemba, 2020; Lupton, 2006; Wingfield, 2009). Intersectionality, first introduced by Crenshaw (1989) in legal and critical race theory, later embraced by gender scholars and now increasingly adopted by health scholars, aims to unravel and illuminate the complexity of lived experiences, shaped at an intersection of all their social identities, and by multiple and interlocking systems of oppression, altogether creating one's experiences and privileged or marginalized position. We take an intersectional approach to show that there is not one type of man or masculinity and to not reproduce intersectional invisibility. The latter refers to how people with “*multiple subordinate group identities are rendered invisible relative to those with single subordinate group identity*” (Purdie-Vaughns & Eibach, 2008, p. 377).

Intersectional perspectives on healthcare workers' work and health related experiences remain scarce, as studies often lack a critical gender and intersectional perspective. Studies, especially in *feminized and low status* care sectors, such as long-term care for older people, tend to focus on women, as they make up the vast majority of the paid workforce (CBS, 2021). A horizontal gender-segregation of our labor market, the division between masculine and feminine-typed occupations, is more pronounced in low-paid regions of the labor market, and plays out differently for women and men across diverse backgrounds (Kreimer, 2004).

Social identities and systems of oppression shape peoples' social and economic disadvantages, which are generally reflected in health disadvantages (Hankivsky, 2012). But not necessarily so. Therefore, we need better understandings of the complex relationship between social privileges and disadvantages in relation to health (Hankivsky, 2012; Verdonk et al., 2019). In relation to masculinity, Verdonk et al. (2010) described how health promoting behaviors in the workplace were hampered by masculine ideals. In their study on worksite health promotion in particular company exercise, men distinguished two normative categories as regards masculinities and health. First, they perceived the “ideal man” as competitive and noticed by other men, and real men should not be whiners and not disclose vulnerabilities when they had health issues. Nonchalant attitudes toward health were therefore a display of masculinity as men continued behaving as if they could not be bothered by health issues.

## 1.3 | Information on policy system

In the Netherlands, the experiences of workers in long-term care are to be understood within their socio-political context. The health of healthcare workers is under pressure, with shortages of staff high job strain, high sickness

absence and staff turnover. This is not for all healthcare workers alike. In 2015, policy measures were enacted in response to the 2008 financial crisis and in the context of an aging society, aiming toward (financial) sustainability and cost containment (Maarse & Jeurissen, 2016). These policy measures allocated care responsibilities toward lower professional levels and from paid to unpaid care givers. In practice, these policies heavily impacted paid caregivers in long-term care, as they were required to attend to more and more complex care needs with less financial means (Maarse & Jeurissen, 2016). The Dutch context is comparable to other post-welfare states in Europe.

This has been further exacerbated by the COVID-19 pandemic, which exerted a great sudden pressure on the already worn-out sector and affected the health of many care workers (Ernst and Young, 2020; Pappa et al., 2020). In the last decades, neoliberal policies have fostered precarious and temporary employment and pushed tax regulations that made self-employment more attractive, also in the care sector (Stanford, 2017). Self-employment traditionally attracted high-paid care professionals, such as specialists and nurse specialists (Conen & Schippers, 2019). Recently, increasing numbers of low-paid care workers such as nursing aides opt for self-employment (CBS, 2020). Most self-employed take shifts in long-term care organizations (contracted care), doing more or less the same work as hired employees, but they can also have their own clients (non-contracted care). This may lead to precarious situations due to a lack of adequate social benefits and regulatory protection, and uncertainty of continuing work, all having an impact on health (Conen & Schippers, 2019; Duijs et al., 2021; Duijs, Abma, Plak, et al., 2022).

## 1.4 | Problem statement

The focus on women as default caregivers may cause academics to overlook men working in healthcare roles in general, and in long-term care in particular. Available studies cannot be applied to men, since research on men or women respectively, is not interchangeable (Watts, 2015). Furthermore, intersections of gender with other social identities are widely neglected and as a consequence some groups suffer from intersectional invisibility (Purdie-Vaughns & Eibach, 2008).

Hence, studies on the health of healthcare workers tend to focus on lower educated women in long-term care, and on higher educated men in hospital and mental health care, largely overlooking low-paid men in the long-term care sector (Watts, 2015), and even less is known about the experiences of racialized and gay/queer men in this sector. Exploring men's experiences is not only important for men's health but may also provide clues for further research on how to recruit and retain men for this sector, which might resolve problems such as staff shortages, low status and low wages (Elwér et al., 2012).

In our study, we aimed to understand how men in low-paid care work negotiate their paid and unpaid care work, especially in relation to health, and how this negotiation is shaped by *masculinities* in intersection with class, race and sexuality. To link our empirical findings to current academic debates on masculinities, we focus on the way men negotiate hegemonic and caring masculinities, and on their experiences as paid care workers in long-term care (Connell & Messerschmidt, 2005; Elliott, 2016). We focus on the different ways men “do” masculinity in long-term care as a feminized space (West & Zimmerman, 1987). The relevance for occupational health is illuminated by how the negotiation act of hegemonic and caring masculinities materializes in men's health, and in health inequities between men and women, and among men. We argue that the negotiation of caring and hegemonic masculinities results in the perpetuation of male privilege, for some men more than for other, and that this negotiation act backlashes in terms of health.

## 2 | METHODS

### 2.1 | Study design

The qualitative interview study is part of a larger Participatory Health Research (PHR) project “Negotiating Health” (Duijs, Abma, Schrijver, et al., 2022), which is conducted by academic researchers and co-researchers who have experiential knowledge as paid and unpaid caregivers in long-term care (Abma et al., 2019; Wright, 2015).

This sub-study was initiated by a male co-researcher (Mazurel), and focused on men and masculinities to gain a wide understanding of men's subjective experiences about health, working in long-term care, and perceptions of masculinities (Green & Thorogood, 2018). Our epistemological approach is grounded in critical theory, to recognize how subjective experiences are shaped by multiple and interconnected societal inequities (Green & Thorogood, 2018; Hankivsky, 2012).

## 2.2 | Research team

Understanding how researchers' social positions influenced the results contributes to the quality of the study (Frambach et al., 2013). The academic researchers were four white, highly educated, cisgender, women who were in a heterosexual relationship at the time of the study. The first author is a medical student. The second, fourth and fifth authors are academic researchers experienced in PHR, gender and intersectionality. The co-research team of consisted of four heterosexual women of different colors and one heterosexual white man (the co-researcher, Mazurel).

The male co-researcher (Mazurel) initiated the study, co-created the topic list and regularly reflected upon (pre)liminary findings. Due to personal circumstances and the pandemic, he did not want to participate in data-collection. The female co-researchers reflected upon the findings in a focus-group meeting, specifically focusing on the differences between their experiences as female paid care workers in long-term care.

The team allowed for investigator triangulation increasing the confirmability of the study (Frambach et al., 2013). Also, a critical friend (male, white, high-educated, cisgender, heterosexual) was consulted several times to provide a fresh perspective on the data, further increasing the critical reflexivity and confirmability (Cebrián, 2016).

## 2.3 | Research population

We included 16 men working in the long-term care sector for older people (see Table 1). What constitutes a "man" can be defined biologically in terms of sex (Fausto-Sterling, 2012) or seen as a social role shaped by gender, which is relational and performed (Connell & Messerschmidt, 2005; West & Zimmerman, 1987). In this study, we included people who self-identified as men. Three respondents had been previously included in the study. Additionally, 13 men were recruited and interviewed by the first author, until data saturation was attained (Frambach et al., 2013).

Respondents were recruited via the network of the researchers and co-researchers, yielding 10 interviews, including an interview with the co-researcher. The positionality of the researchers, and particularly our whiteness and the whiteness of our network, has shaped the recruitment process, leading to an overrepresentation of heterosexual white men in our sample. Additionally, we recruited three respondents through a Facebook page for self-employed care workers. We purposive sampled across age, race, migration status, sexuality, years of employment and occupational level. This both increased the transferability of the study and facilitated an intersectional approach. Although the overall diversity of our sample was limited, we were able to observe how men's experiences were not only shaped by masculinity, but also by racism and homophobia (Frambach et al., 2013).

## 2.4 | Data collection

Data was collected via semi-structured interviews. The topic-list was based on existing literature, the interview with the co-researcher, and themes emerging from transcripts from earlier interviews ( $N = 3$ , RA-RC). We drew upon Oliffe and Greaves' work on interviewing men about health (Oliffe & Greaves, 2011). Thirteen extra interviews (R1-R13) were conducted individually, in Dutch, by the main researcher. Before the interview, respondents were informed by e-mail about the topics. Respondents chose the locations, to provide a safe and comfortable environment,

TABLE 1 Respondents

	Age	Sexuality	Self-identified color of skin	Country of birth	Profession	Years in caring work	Sector (-mural)	Employee or self-employed
RA <sup>a,b</sup>	40	Heterosexual	Brown	Morocco	Advanced Nursing Aide (level 3)	11	Extra	Both
RB <sup>a</sup>	57	Heterosexual	White	The Netherlands	Advanced Nursing Aide (level 3)	25	Intra	Self-employed
RC <sup>a</sup>	48	Heterosexual	White	The Netherlands	Advanced Nursing Aide (level 3)	15	Intra	Employee
R1	62	Heterosexual	White	The Netherlands	Advanced Nursing Aide (level 3)	11	Intra	Employee
R2	43	Heterosexual	Black	Suriname	Nurse (level 4)	22	Intra	Self-employed
R3	46	Heterosexual	White	The Netherlands	Nurse (level 4)	14	Intra and extra	Self-employed
R4	32	Heterosexual	White	The Netherlands	Advanced Nursing Aide (level 3)	1	Intra	Employee
R5	34	Heterosexual	White	The Netherlands	Advanced Nursing Aide (level 3)	10	Intra	Employee
R6	43	Heterosexual	Brown	India	Nurse (level 4)	4	Intra	Employee
R7	26	Heterosexual	Brown	The Netherlands	Advanced Nursing Aide (level 3)	0.5	Intra	Employee
R8	40	Homosexual	White	The Netherlands	Nursing Aide (level 2+)	2	Intra	Self-employed
R9	31	Homosexual	Black	Ghana	Advanced Nursing Aide (level 3)	10	Extra	Self-employed
R10	25	Heterosexual	White	The Netherlands	Advanced Nursing Aide (level 3)	7	Extra	Employee
R11	27	Heterosexual	Brown	The Netherlands	Advanced Nursing Aide (level 3)	6	Intra	Self-employed
R12	43	Heterosexual	Brown	The Netherlands	Advanced Nursing Aide (level 3)	4	Intra	Self-employed
R13	31	Heterosexual	Brown	The Netherlands	Advanced Nursing Aide (level 3)	15	Intra	Employee

<sup>a</sup>Earlier interviews of the PHR-project.

<sup>b</sup>The wife of this respondent participated in this interview.

however due to COVID-19 and safety guidelines, plus personal preferences of the respondents, four interview were conducted face-to-face. Nine interviews were conducted via an online video-call, three by telephone. Listening was done according to the Integrative Listening model (Thompson et al., 2004). Respondents consented both orally and written to recording and transcription of interviews. Presenting a summary of the interviews plus the interviewer's impression to the respondents increased credibility of the study (Frambach et al., 2013). Further data were collected in a logbook with memos based on observations before, during and after the interviews, which enabled an audit trail.

## 2.5 | Data analyses

Data collection and analysis were done iteratively, allowing for emerging insights. Quality was protected by applying the principles of Frambach et al. (2013). Thematic content analysis was applied (Green & Thorogood, 2018),

alternating with Jackson and Mazzai's analytic of "thinking with theory" (Jackson and Mazzei, 2017). Intersectionality and gender theory (especially hegemonic and caring masculinities) were taken into account as theoretical framework which guided the analysis of our data. Coding of the data was done by first author, and first and second author compared, discussed and examined the codes and categories closely, unraveling themes from the data. These themes were critically appraised and fine-tuned together with the last author, in dialog with the critical male friend, and in two focus groups with the co-researchers and consortium partners of the study. Formulating for whom and in what context results are relevant increased credibility and transferability (Frambach et al., 2013). This repeated checking and adapting with others, increased the quality of the study in terms of confirmability, credibility and dependability (Frambach et al., 2013).

## 2.6 | Ethical considerations

In this project, we took both procedural and relational ethics into account (Wijngaarden et al., 2017). First, to address procedural ethics, the research project was presented and approved by the ethical committee of Amsterdam UMC. All researchers consent to anonymity and carefully handling all information such as informed consents and recordings were deleted after completion of transcripts. To address relational ethics, a logbook was kept by the first author to document ethical uneasy moments, which we reflected upon with the entire research team (Wijngaarden et al., 2017). One ethical issue stood out. Power dynamics of age and gender shaped the interview process and our data (Olliffe & Greaves, 2011, cf. Arendell, 1997; Pini, 2005). Being a young, white, heterosexual female student, the interviewer often felt that she was being underestimated, felt powerplay, and observed that men would sometimes try to impress her.

Even though such interactions render unique insights, two lessons are learned. First, a warning should go out to future researchers as such dynamics may lead to uncomfortable situations, experienced as bearable in video-calls, but triggering feelings of unsafety at the men's home; and second, it exemplifies how social locations of researchers influence results (in this case men's outspokenness about their male privilege), and how reflexivity toward this is essential when researching lived experiences in qualitative research.

Vis-à-vis, for the male co-researcher, the research process was also not always a comfortable place for him and therefore, after this study, he decided to stop participating in the broader PHR research project.

## 3 | RESULTS

We unraveled five themes based on the interview data, characterizing the experiences of low-paid men in caring occupations:

- (1) **Gaining access** through a (strategic) negotiation of hegemonic and caring masculinities;
- (2) **Clashing** with the feminized space of care work endangering their status as men;
- (3) **Re-claiming status** by performing hegemonic masculinity;
- (4) **Health as battlefield**: displaying hegemonic masculinity at the expense of health;
- (5) **The privilege to exit**: leaving long-term care to regain status and health.

### 3.1 | Gaining access through a (strategic) negotiation of hegemonic and caring masculinities

Most men gained access to paid care work by a *strategic negotiation* of hegemonic and caring masculinities. Hegemonic masculinities shaped men's motivation for care work and became visible in the interviews as several men

described themselves as breadwinners. They had started their careers in other, more masculine-typed sectors, but had experienced difficulty in finding work. The latter intersected, for at least two respondents, with being a migrant:

So, I arrived here [the Netherlands] to live together, with the goal to study IT, but I couldn't, due to circumstances. ... So, when I came here, I applied for a school, but it was very expensive. ... So, the only option I had, was the care sector.

(R9)

Care work provides job security and career prospects. Many considered their current job in long-term care as a steppingstone to move upwards, often toward a more masculine-typed healthcare specialty such as mental or hospital care, reflecting the gendered care-care hierarchy:

I figured: first, I will do a nursing course and once I would have finished that, I would immediately proceed and do a scrub nurse training, and then I'd find it appropriate.

(R10)

Most men implicitly or explicitly stated that they didn't enter paid care work as a deliberate or long-term career plan. For example, one respondent got in, to his own surprise, after sending a semi-joking application when a colleague told him that an organization was looking for "ass cleaners":

I thought I'd never hear of it again. But then I was invited for an interview. And I just went there with a clean slate, did the interview, and a day later my phone rang: "you're hired". "Well," I thought, "then I better go take a look at what it's all about [laughing]."

(R5)

Hegemonic masculinities were silenced in relation to possible employers, whereas caring masculinities were strategically emphasized. Most respondents expressed and identified with a caring masculinity by being attracted to the social aspect of care work. Some experienced how providing informal care for a relative had been gratifying, but most men had little to no involvement with informal care. Others compared their previous jobs in catering services with care work, framing it as socially acceptable to care for people as a man:

In the catering industry, I also tended to people, but with a nice plate of fine food. And now, I tend to people with basic healthcare: washing and showering, helping them by providing basic healthcare. So, in that manner, the catering industry and caring industry do not differ all that much. You just want to make someone happy or tend to them.

(R7)

Most men were seen as "caring" by others such as their partners who then advocated them into care work. Many respondents had a female relative recommending a job in long-term care as a career option. In heterosexual relationships in particular, the female partner paved the way for the men to start a new career.

... I wanted him to proceed you know, not to continue that job. ... And then we made his resumé ... And from there he got accepted for a job as nursing aide.

(wife RA)

Once they applied, they emphasized their caring masculinity, and as a consequence men felt welcomed with open arms. One respondent describes how he got told he had a “magnificent resume,” while he only had experience as an informal carer. In general, men were easily seen as competent carers, according to themselves:

If there would be five applicants, of whom four women and one man, then the man might be preferred. Provided that none of the women would have considerably better qualifications ... I would be picked first.

(R10)

The privilege of a swift entry was most dominantly present for men who identified as white or brown. However, the experience of a Ghanaian respondent who identified as a black migrant, stood in stark contrast. He had worked harder to be seen as a competent carer, and could only gain access to this privilege through formal education, and even then, he did not easily receive his qualifications due to experiences or racism:

**R:** And never have I been offered some sort of training. Never.

**I:** Never been offered?

**R:** Never. Never. Never. Never have I been offered a training by a supervisor.

[...]:

**I:** I also wonder, ... you think it might have had something to do with racism?

**R:** Now, you ask the question. Look. At [organisation] I have worked in paid employment for 2 years and it all went very well. Also, I did my training and I worked hard. And in the traineeship, we had to lead our colleagues, so, I took the lead, and I did well. We even had a client with a wound with MRSA, at whom all nursing procedures could be signed off, and I took care of her all by myself, which takes around 2 h, and I did it all good. And even then, when my teacher came for a review of the traineeship, she wanted to give me a failing grade.

(R9)

### 3.2 | Clashing with the feminized space as a man, endangering their status as men

After gaining access to paid care work, many men clashed with the feminized space of long-term care at different levels: personal, relational, job-content and institutional. Overall, men described long-term care for older people as a sector with low-status, which endangered their status as men.

On the personal level, they shared how they were seen as less of a man by their social environment because of their job. Some men engaged in this line of thinking themselves, which can be seen as a form of internalized oppression, saying that they “missed some kind of masculinity.” As a consequence, they felt out-of-place as men in a feminized sector:

Even my manager said: what is a man doing in a long-term care sector?

(RC)

Their experience was shaped by heteronormativity, making it more difficult for gay men to be perceived as embodying dominant masculinity. Many had to endure overt or covert comments that they were homosexual, assuming that gay men were less manly in the first place and thus less “out-of-place”:

...that I had a job in healthcare, it was immediately like: “oh, he must be gay”

(R1)

Similarly, experiences of racism gave less access to dominant masculinity for men of color. Men who identified as brown or black were seen as less “out-of-place” than white men.

...most people working in care are of colour.

(R9)

On the relational level, respondents struggled with primarily having female colleagues. According to them, women would “overly criticize men,” take things “too personally” and not tell directly if something was bothering them, which left the men feeling they had to be cautious and could not speak freely. They also stated that women would pass their duties onto others, as opposed to men, who would take on extra work. Interviewed men felt that women were preoccupied with social interactions amongst each other, leading to work delay, gossip and conflict. All assumed that having more men in the workplace would diminish this dynamic:

If there are men in the team, you just notice that it enhances the atmosphere.

(R12)

This negative judgment of feminized work spaces, also served to obscure their responsibility as men. For example, some interviewees described how they felt singled out “unnecessarily” to watch their (sexist) tongue, and one respondent was even asked to change his job because of offensive speech, implicitly placing blame on his female colleagues for this event:

But yes, when you work with women, things quickly turn into a #metoo story. [laughing] While it's unintentionally you know. One just makes a joke once in a while. But, yeah, then it's interpreted differently...

(R5)

On the job-content level, men expressed difficulties with feminine-typed caring approaches to care work. For example, they struggled with the requirement for emotional involvement rather than business-like relationships with clients and found it tiresome to be “*supposed to be caring from the heart*,” while it is “*just one's job*” (R3). We observed a class intersection, as men attributed this specifically to low paid care work, and expected this to be less of a predicament higher up the ladder:

One has to offer oneself and play nice and... And when you are a doctor or a surgeon, it is somewhat more from a business perspective, you know. Then it's not... It's all very much focused on the relations, in caring work. That's very tiring.

(R3)

On the institutional level, men experienced a jeopardy of their socio-economic status. Their work in long-term care was low paid compared to other occupations at the same educational level. Plus, the sector had its difficulties in accommodating fulltime jobs and regular work schedules. This is a problematic issue for both men and women, but the men in our sample particularly described how it endangered their status as man and their social role as breadwinners. The words they used expressed their anger:

They came up with... that we could only work six hours a day. And then ... the manager told me: “Yes,” she says, “then you can go home nice and early.” I say: “yes, but I'm unemployed for two hours a day. And how am I going to solve that? My payment is cut, hell with it.”

(R1)

### 3.3 | Re-claiming status by performing hegemonic masculinity

In reaction to the undermining of their status as men in long-term care, men employed strategies to perform their “hegemonic masculinity.”

First, on the personal level, men presented themselves in interviews according to hegemonic norms. Words that came to pass when describing themselves and other men at work were for instance: strong, leading, advisory, hard workers, courageous, stress-resistant, stable, pragmatic, straight-to-the-point, easy, and independent. They felt strengthened in this view by colleagues and managers. They presented themselves as “wanted,” and some even explicitly found men more suitable, or at least more cost-effective, for care work:

Look ... We have some clients here, when... when I cannot come to work, two women have to go there. One did not venture (?) going alone, another felt like it was too heavy... So, I feel like, for the employer, well, maybe when I take a shift, it's less expensive than if two women do

(RA)

Second, on the relational level, heterosexual men re-directed attention to the benefits of working primarily with women, as it granted them “sexual power.” They emphasized how working in long-term care gave them plenty of dating opportunities, that female colleagues liked a “caring man” and gave various example of female colleagues who fancied them. This explicit reference to their sexuality, may be understood as a response to the homophobic notion that men in care “must be gay.” The interviewed men were often quite explicit in describing this privilege or “sexual power” to the first author:

And I was the only man in the [nursing assistant] course. Well yeah, and there we went, with all those girls we went into town. And at a certain moment, well, bam, into the [lingerie shop]. And well, you know, like, I say: “and, does it look good on you?” “Well, yeah, take a look if you want” So there I went, taking a look.

(R5)

Third, on the job-content level, men reframed their job in line with norms of hegemonic masculinity. They emphasized the required medical expertise, resilience, the many challenges and responsibilities, and the need of “masculine” competences summed up earlier. One respondent even described care work as being “*all technic*,” because of his skills in applying medical circuits and drains. Others opted for self-employment, which allowed them to foreground a more masculine-typed entrepreneurial identity as care workers.

I can imagine, when one has children and a wife and a mortgage and that kind of stuff ... one thinks: I'm opting for self-employment for the next ten years, and from there we'll see.

(R8)

Fourth, on the institutional level, behaving according to hegemonic masculinity resulted in privileges, such as better contract conditions and a higher salary. Some explained how they negotiated themselves a better salary. Others mentioned how they received larger contract (i.e., more working hours) than their female colleagues. They judged this as fair, referring to their role as breadwinners, in doing so re-producing the idea that women are not financially dependent upon their paid care work:

They often have a partner taking care of the main income ... In general women just work to keep themselves busy.

(R5)

Although men of color said to exhibit similar hegemonic behaviors, they generally did not gain similar privileges as white men. They had to work harder, proving their competence through education before gaining a better salary. One man of color got paid a whole salary scale lower than his educational level allowed, which he and his colleagues interpreted as racism. A self-employed white man explicitly told how he learned to ask for more for the same job than his colleagues of color.

Men who experienced discrimination (racism, homophobia or both) responded by opting for self-employment. Self-employment allowed control over education opportunities, financial rewards and emotional distance. Self-employment granted agency to avoid working environments in which they experienced discrimination:

Why? [...] How people treat each other. ... Oh no. Yes, often enough you think like: "o, well, I will not come here again", being self-employed. You think like: "oh no, not doing this again."

(R2)

### 3.4 | Health as battlefield: Displaying hegemonic masculinity at the expense of health

Although adhering to norms of hegemonic masculinity helped to gain access to privileges in low-paid care work, their behavior backfired in relation to health. Care work is physically demanding, and although hegemonic norms of masculinity required men to be fully equipped for heavy work, their bodies were not. Men recurrently mentioned that they were asked by colleagues to lift a client who had fallen on the floor. Also, assistive instruments designed for heavy lifting of clients were left unused and seen as "unnecessary for strong men." However, their bodies did not keep up with their efforts. Physical injuries arose, including back problems, wrist injuries, tennis elbow and upper arm and shoulder strains:

And they said: "yes you're a man, you can do this easily, because you are strong." But, well, I got a tennis elbow and other hassle. So that didn't really go well. It was just too heavy.

(R1)

Although self-employment provided distance from discrimination, it also allowed for risky health behavior, due to the lack of managers or regulations guarding their health. Many self-employment men reported working many shifts in a row, resulting into tiredness and diminished self-care, but felt compelled by the financial rewards:

It really only had an impact on my self-care. Because you just say yes very easily, like, "one more". But after those eleven shifts, you are just tired and tired.

(R2)

Mental health issues were also amplified because of hegemonic behaviors, according to the respondents. Being a breadwinner was considered a psychological burden, and even more so as a self-employed due to the lack of social security. Also, being put forward as a leader was said to increased job responsibilities, which weighted heavily on the men's shoulders. Men often obscured the impact of misery, illness and death they encountered in long-term care, and hegemonic masculinity required them to appear unaffected and deny help, as became visible in the story of this men after being involved in an incident where a client died:

R: Yes, it was a shock of course ... And at one point, you start to wonder, "what if?" What if I had continued or something? [...] ... And I was allowed to go home after that event, but I didn't. ... After telling it to all your colleagues, you have something like: "Well, now I know the story. It happened.

And yes, it comes with the job" [...] I still remember that after it happened, I spoke to my supervisor, who said: "We have a counsellor, etcetera, so if you want to use that, just say so." ... Then I had something like "dude, it still has to sink in" So I had something like: "No, if I need it, I will let you know."

(R10)

Men of color and sexually diverse men experienced an extra mental burden from discrimination, coming from clients, colleagues and managers. Men who identified as homosexual described how they responded to homophobia by employing strategies to pass as straight. Men of color had endless examples of racism, for example, being refused by clients and being held excessively accountable for mistakes. These men had to put in energy to make their identity invisible or a non-issue, and dealing with (the risk of) discrimination took a lot of extra energy and created self-doubt, impacting their health and wellbeing:

...that pain [of a racist remark], what it does to me... now and then it makes me think that I'm less than another, and sometimes I forget I'm not.

(R13)

Expressions of mental health issues were gendered and the men in our study tended to show more masculine-typed symptoms of burn-out such as apathy and depersonalization. Interviewees talked rather casually about burdensome experiences or spoke about them as if it had not happened to them. Also, mental health issues were framed as more "normal" for women according to the respondents, but appeared to be taboo among men, which became visible during interviews. One respondent spoke at length about "all those women with burn-outs," only to admit that he himself suffered from a burnout in the very last minutes of the interview. Such distancing and depersonalization are in line with hegemonic masculinity, which prescribes that vulnerability should be seen as weakness, and thus, inferior:

That (acting vulnerable) evokes the weak little boy in a man. That he shouldn't be vulnerable. Because you have to carry your family. You have to take your wife and children by the hand when things go wrong.

I: And that is at the expense of your mental health?

R: Exactly. Yes, because it has to... it is going somewhere.

(R7)

Despite the silencing, denying and hiding of mental health issues, stress and burn-out appeared to be highly prevalent among the interviewees. About half of them had a (work-related) burn-out, and several others sought professional psychological help for problems developed in the workplace. Also, interviewees said to continue work while experiencing mental exhaustion.

### 3.5 | The privilege to exit: Leaving long-term care to repair status and health

As a result of the status loss and subsequent health risk, all men in our study had the intention to leave their current job in long-term care, either now or in the near future. Respondents entrusted the interviewer that they left to improve their health, their social status as man, and for financial reasons. Publicly, they predominantly showed the latter. As described in the first theme, some respondents already had exit plans on entry and never fully committed themselves to their current job. Many already held another job in the side, as a possible escape strategy:

That can indeed cause moments of stress. But yes, the nice thing is, of course, I'm also a bus driver. ... And that is actually a very good, a good distribution. So, that makes it easier to let go. ... That's why I now have made the decision to work a little more in the bus.

(R5)

Live events, such as becoming a parent, moving, a new partner or reaching a certain age, often fueled their decision to leave:

And when I am older [now 31], from 45 or 40, and I have a family, I will choose a different career, a different job. Maybe I can... at least, do something with IT or do something with management. That's why I went back to college.

(R9)

Four exit strategies were mentioned: opting for self-employed care work, moving to a more masculine-typed care sector, moving up into a higher function, or leaving the care sector all together. Exiting low paid care work in long-term care was aided by hegemonic masculinities and male privilege. On a personal level, men felt entitled to have a better job. On an institutional level, it granted them opportunities to move up relatively easy compared to women. Many men were offered opportunities, such as being asked to go in training for a higher degree, sometimes even in a short track. These privileges felt fair "*win-win situations*" (R10), being both profitable for the organization as well as for the interviewees:

Yes, a location manager, she said: "you are going, you are going, just try." "Just start the training" they said. And I was allowed to do an internship at the time, and yes, after a few hours I actually already knew. Yes, and then I started the training for advanced nursing assistant. And I completed it. And then, I was immediately hired for the training to become a nurse.

(R6)

Again, these benefits were different for men of color, especially black men, who did not share white men's privileges and felt more "stuck" in long-term care. They did not have the same amount of privilege to protect their health and to enhance their financial situation, as white men had:

I have to say ... several times I've heard that as a native person one gets admissions more easily at caring organisations than as a foreigner.

(R8)

## 4 | DISCUSSION

In this study, we analyzed how the lived experiences and health of men working in low-paid caring occupations are shaped across social identities. Masculinity as a privilege is extensively discussed, especially in gender studies (Elwér et al., 2012; Evans, 1997; Fletcher, 2001; Kahn, 2009; Williams, 1992). Our study shows how men strategically negotiate hegemonic masculinity and caring masculinity to gain privilege through paid care work. They can draw upon caring masculinity to gain access to paid care work, and were encouraged to do so by their environment, but also have the privilege to abandon this masculinity once their status or health is at risk in the workplace. Academic debates resolve around the question whether caring or inclusive masculinities can be seen as men's investment in gender equality (Anderson, 2009; Elliott, 2016) or not (Bridges, 2014; Bridges & Pascoe, 2014). Our empirical findings are in line with Elliot's later argument that the autonomy to shift between different expressions of masculinity perpetuates

male privilege (Elliott, 2019), but not for all men alike, since especially white, heterosexual men can capitalize upon this negotiation act. Therefore, our findings show that this question requires a diversity perspective.

Our empirical findings also shed light on the different experiences of men and women in labor markets. Although both men and women suffer from the gendered devaluation of (paid) care work in our society and the impact this has on the long-term care sector (Fraser & Jaeggi, 2018), their experiences in labor markets are distinctly different. This devaluation of care work has been extensively theorized by social reproduction theorists (Fraser and Jaeggi, Vogel). In the Netherlands, recent budget cuts and policy reforms further lowered the “status” of the care sector (Maarse & Jeurissen, 2016). Our study shows how men resort to care work in times of limited labor market opportunities in male-dominated sectors, keeping one foot out of the door, being able to move up or move out when their health is at risk. Therefore, we argue that (some) men can be characterized as *passers-by* or *stopgappers* in low-paid care work (Simpson, 2009; Torre, 2018) and that their careers are shaped by both a “*glass-escalator*” and a “*glass-revolving-door*” (Williams, 1992). These findings can be understood by Joan Tronto’s notion of men’s “privileged irresponsibility” in relation to care (Tronto, 2013). While men can and do care, they can more easily draw a “get-out-card,” due to the privilege they acquire in the workplace, which makes it easier to leave when their health, status and finances are under pressure. This also implicates that catering to the needs of men in caring occupations does not necessarily translate in prolonged engagement in paid care work. This contrasts with women’s experiences in the labor market (author, X; McGrath, 2006). Yet, the abovementioned experiences are not true for all men. The “*glass-escalator*” and the “*glass-revolving door*” are distinctly shaped by race and sexuality, as has been shown by other scholars (Wingfield, 2009).

Remarkably, several men turned to self-employment to repair their social and financial status. Yet, their experience contrasted with female self-employed care workers. While self-employment allows men to foreground an entrepreneurial identity, which allows for profit-making, often at the expense of their health, women tended to make financial sacrifices as a self-employed to foreground their caring identities and to protect their health (Duijs, Abma, Plak, et al., 2022).

New to our study is the backlash of masculinities for health in male long-term care workers. These insights are especially relevant since the health-related experiences of low-paid men in long-term care are understudied. Nursing in long-term care comes with high physical job demands (Ernst and Young, 2020) and men’s physical strength and muscularity could make men particularly suited. However, we found that norms of hegemonic masculinity rendered men vulnerable when their physical and mental strength was treated as an inexhaustible resource, also by men themselves. Their “privileged irresponsibility” toward informal care enables risky health behaviors, such as working ongoing shifts, illustrating how multiple social roles can also be protective in terms of health (Hyde, 2016).

These findings resonate with literature on men and health, showing that men associate masculinities with invulnerability and nonchalant attitudes toward health (Verdonk et al., 2010). Verdonk et al. describe that men as a consequence present themselves as invulnerable, which realistically they are not, and therefore at least they should keep silent about how vulnerable they really are. As such, masculinities can endanger health by “*celebration of heroism, physical strength, toughness and stoicism*” (Stergiou-Kita et al., 2015, p. 216), and that men, more than women, feel the need to endure and stifle health complaints. This invulnerability act has negative health consequences, leaving men working in health care in relatively poor health compared to women, as shown in studies among higher-educated male nurses (Watts, 2015). Our study shows that this gender dynamic also plays out among low-paid men in long-term care. This invulnerability act does not have to be performed, when caring masculinities are more embraced. As such, men’s investment in caring masculinities might benefit their own health. Yet, more research is needed to understand caring masculinities’ potential for health. In addition, we understand men’s performance of hegemonic masculinity as a response to the lack of societal appreciation for long-term care work. More political, societal and financial appreciation for paid care work, might give space for embracing caring masculinities at work.

Occupational health was not only shaped by gender, but important intersections occur with race and sexuality. Racialized and homosexual men encountered a lot of racism and homophobia in the workplace, which impacted their health. We know from literature that discrimination has a direct and indirect effect upon health (Priest & Williams, 2018). Discriminated men in our studies suffered from high stress levels, were offered lesser career opportunities, and had less

access strategies to support, protect and maintain their health. Several of them resorted to precarious work to distance themselves from racism in the workplace, which is, in turn, a risk factor for poor health (Benach et al., 2014).

## 5 | CONCLUDING REMARKS

Our study shows that it is important to take an intersectional approach into account in the study of masculinities, men and care, both regarding respondents, since we found experiences to be different at various intersections, and regarding researchers, we could see their social locations influence the results.

In relation to the strive for gender equality, it is relevant to consider that new non-traditional forms of masculinity may perpetuate male privilege by allowing men to strategically shift between masculinities and opt for a more beneficial mode of masculinity in a given situation. These privileges play out in labor markets, providing (some) men with more career opportunities than women and men of color and non-heterosexual orientations.

In relation to occupational health in long term care, our study shows that increasing the status of residential long-term care work by society and politics is decisive to prevent and tackle health issues for men (and women) working in long-term care, and to prevent their turnover. Our current gender order should be targeted and revolutionized, as currently both men and women are victimized by it. And so should racism and sexual discrimination need to be targeted by institutions and policymakers, being both a human rights issue as well as a health issue.

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## CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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## REFERENCES

- Abma, Tineke, Sarah Banks, Tina Cook, Sónia Dias, Wendy Madsen, Jane Springett, and Michael T. Wright. 2019. *Participatory Research for Health and Social Well-Being*. Cham: Springer International Publishing.
- Anderson, Eric. 2009. *Inclusive Masculinity: The Changing Nature of Masculinities*. Routledge. <https://doi.org/10.4324/9780203871485>.
- Arendell, Terry. 1997. "Reflections on the Researcher-Researched Relationship: A Woman Interviewing Men." *Qualitative Sociology* 20(3): 341–68. <https://doi.org/10.1023/a:1024727316052>.
- Benach, Joan, Alejandra Vives, Marcelo Amable, Christophe Vanroelen, Gemma Tarafa, and Carles Muntaner. 2014. "Precarious Employment: Understanding an Emerging Social Determinant of Health." *Annual Review of Public Health* 35(1): 229–53. <https://doi.org/10.1146/annurev-publhealth-032013-182500>.
- Bridges, Tristan. 2014. "A VERY "GAY" STRAIGHT?: Hybrid Masculinities, Sexual Aesthetics and the Changing Relationship between Masculinity and Homophobia." *Gender & Society* 28(1): 58–82. <https://doi.org/10.1177/0891243213503901>.

- Bridges, Tristan, and Cheri Jo Pascoe. 2014. "Hybrid Masculinities: New Directions in the Sociology of Men and Masculinities." *Sociology Compass* 8(3): 246–58. <https://doi.org/10.1111/soc4.12134>.
- Cebrián, Gisela. 2016. "The Role of the Critical Friend in Supporting Action for Sustainability: Exploring the Challenges and Opportunities." In *Research and Innovation in Education for Sustainable Development. Exploring Collaborative Networks, Critical Characteristics and Evaluation Practices*, edited by Wim Lambrechts and James Hindson, 211–26. Vienna: Environment and School Initiatives – ENSI.
- Central Bureau for Statistics. 2020. "Meer zelfstandigen in zakelijke dienstverlening en zorg. (More self-employed workers in business services and health and social care)." <https://www.cbs.nl/nl-nl/nieuws/2020/05/meer-zelfstandigen-zakelijke-dienstverlening-en-zorg>.
- Central Bureau for Statistics. 2021. "Procedure for Using Data of SHARE (Survey on Health, Ageing and Retirement in Europe) Netherlands Linked to CBS Microdata."
- Conen, Wieteke, and Joop Schippers. 2019. *Self-employment as Precarious Work: A European Perspective*. Cheltenham: Edward Elgar Publishing.
- Connell, Raewyn W., and James W. Messerschmidt. 2005. "Hegemonic Masculinity: Rethinking the Concept." *Gender & Society* 19(6): 829–59. <https://doi.org/10.1177/0891243205278639>.
- Crenshaw, Kimberlé. 1989. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics." *University of Chicago Legal Forum* 140: 139–67.
- Duijs, Saskia Elise, Anouk Haremaker, Zohra Bourik, Tineke A. Abma, and Petra Verdonk. 2021. "Pushed to the Margins and Stretched to the Limit: Experiences of Freelance Elder care Workers during the Covid-19 Pandemic in the Netherlands." *Feminist Economics* 27(1–2): 217–35. <https://doi.org/10.1080/13545701.2020.1845389>.
- Duijs, Saskia Elise, Tineke Abma, Janine Schrijver, Zohra Bourik, Yvonne Abena-Jaspers, Usha Jhingori, Olivia Plak, Naziha Senoussi, and Petra Verdonk. 2022. "Navigating Voice, Vocabulary and Silence: Developing Critical Consciousness in a Photovoice Project with (Un) Paid Care Workers in Long-Term Care." *International Journal of Environmental Research and Public Health* 19(9): 5570. <https://doi.org/10.3390/ijerph19095570>.
- Duijs, Saskia Elise, Tineke Abma, Olivia Plak, Usha Jhingori, Yvonne Abena-Jaspers, Naziha Senoussi, Casper Mazurel, Zohra Bourik, and Petra Verdonk. 2022. "Squeezed Out: Experienced Precariousness of Self-Employed Care Workers in Residential Long-Term Care, from an Intersectional Perspective." *Journal of Advanced Nursing*. <https://doi.org/10.1111/jan15470>.
- Elliott, Karla. 2016. "Caring Masculinities: Theorizing an Emerging Concept." *Men and Masculinities* 19(3): 240–59. <https://doi.org/10.1177/1097184x15576203>.
- Elliott, Karla. 2019. "Negotiations between Progressive and 'Traditional' Expressions of Masculinity Among Young Australian Men." *Journal of Sociology* 55(1): 108–23. <https://doi.org/10.1177/1440783318802996>.
- Elwér, Sofia, Lena Aléx, and Anne Hammarström. 2012. "Gender (In)Equality Among Employees in Elder Care: Implications for Health." *International Journal for Equity in Health* 11(1): 1. <https://doi.org/10.1186/1475-9276-11-1>.
- Ernst&Young. 2020. "Barometer Nederlandse Gezondheidszorg 2020 (Barometer Dutch Healthcare)." [ey.nl/health](http://ey.nl/health).
- Evans, Joan. 1997. "Men in Nursing: Issues of Gender Segregation and Hidden Advantage." *Journal of Advanced Nursing* 26(2): 226–31. <https://doi.org/10.1046/j.1365-2648.1997.1997026226.x>.
- Fausto-Sterling, Anne. 2012. *Sex/gender: Biology in a Social World*. Routledge.
- Fletcher, Joyce. 2001. *Disappearing Acts: Gender, Power, and Relational Practice at Work*. MIT Press.
- Frambach, Janneke, Cees van der Vleuten, and Steven Durning. 2013. "AM Last Page: Quality Criteria in Qualitative and Quantitative Research." *Academic Medicine* 88(4): 552.
- Fraser, Nancy, and Rahel Jaeggi. 2018. *Capitalism: A Conversation in Critical Theory*. John Wiley & Sons.
- Green, Judith, and Nicki Thorogood. 2018. *Qualitative Methods for Health Research*. SAGE Publications.
- Hankivsky, Olena. 2012. "Women's Health, Men's Health, and Gender and Health: Implications of Intersectionality." *Social Science & Medicine* 74(11): 1712–20. <https://doi.org/10.1016/j.socscimed.2011.11.029>.
- Hanlon, Niall. 2012. *Masculinities, Care and Equality: Identity and Nurture in men's Lives*. Springer.
- Hrženjak, Majda, and Elli Scambor. 2019. "WHY DO RESEARCH INTO MEN'S CARE WORK?" *Teorija in Praksa* 56(4): 969–84.
- Hyde, Janet Shibley. 2016. "Women, Men, Work, and Family: Expansionist Theory Updated." In *Gender and Couple Relationships*, edited by Susan McHale, Valarie King, Jennifer Van Hook and Alan Booth, National Symposium on Family Issues, Vol. 6, 93–109. Cham: Springer. [https://doi.org/10.1007/978-3-319-21635-5\\_4](https://doi.org/10.1007/978-3-319-21635-5_4)
- Jackson, Alecia Youngblood, and Lisa Mazzei. 2011. *Thinking with Theory in Qualitative Research: Viewing Data across Multiple Perspectives*. Routledge.
- Kahn, Jack. 2009. *An Introduction to Masculinities*. Wiley-Blackwell.
- Kalemba, Joshua. 2020. "Being Called Sisters': Masculinities and Black Male Nurses in South Africa." *Gender, Work and Organization* 27(4): 647–63. <https://doi.org/10.1111/gwao.12423>.
- Kreimer, Margareta. 2004. "Labour Market Segregation and the Gender-Based Division of Labour." *European Journal of Women's Studies* 11(2): 223–46. <https://doi.org/10.1177/1350506804042097>.

- Kvande, Elin. 2010. "Doing Masculinities in Organizational Restructuring." *NORA: Nordic Journal of Women's Studies* 10(1): 16–25. <https://doi.org/10.1080/080387402317533853>.
- Lewis, Patricia, Nick Rumens, and Ruth Simpson. 2021. "Postfeminism, Hybrid Mumpreneur Identities and the Reproduction of Masculine Entrepreneurship." *International Small Business Journal* 40(1): 68–89. <https://doi.org/10.1177/02662426211013791>.
- Lupton, Ben. 2000. "Maintaining Masculinity: Men Who Do 'Women's Work'." *British Journal of Management* 11(s1): 33–48. <https://doi.org/10.1111/1467-8551.11.s1.4>.
- Lupton, Ben. 2006. "Explaining Men's Entry into Female-Concentrated Occupations: Issues of Masculinity and Social Class." *Gender, Work and Organization* 13(2): 103–28. <https://doi.org/10.1111/j.1468-0432.2006.00299.x>.
- Maarse, Hans A. M., and Patrick Jeurissen. 2016. "The Policy and Politics of the 2015 Long-Term Care Reform in the Netherlands." *Health Policy* 120(3): 241–5. <https://doi.org/10.1016/j.healthpol.2016.01.014>.
- McGrath, Alison. 2006. "Should I Stay or Should I Go? Towards an Understanding of Leaving Nursing." Oliffe, John, and Lorraine Greaves. 2011. *Designing and Conducting Gender, Sex, and Health Research*. Sage.
- Pappa, Sofia, Vasiliki Ntella, Timoleon Giannakas, Vassilis G. Giannakoulis, Eleni Papoutsis, and Paraskevi Katsaounou. 2020. "Prevalence of Depression, Anxiety, and Insomnia Among Healthcare Workers during the COVID-19 Pandemic: A Systematic Review and Meta-Analysis." *Brain, Behavior, and Immunity* 88: 901–7. <https://doi.org/10.1016/j.bbi.2020.05.026>.
- Pini, Barbara. 2005. "Interviewing Men: Gender and the Collection and Interpretation of Qualitative Data." *Journal of Sociology* 41(2): 201–16. <https://doi.org/10.1177/1440783305053238>.
- Priest, Naomi, and David Williams. 2018. "Racial Discrimination and Racial Disparities in Health."
- Purdie-Vaughns, Valerie, and Richard P. Eibach. 2008. "Intersectional Invisibility: The Distinctive Advantages and Disadvantages of Multiple Subordinate-Group Identities." *Sex Roles: A Journal of Research* 59(5–6): 377–91. <https://doi.org/10.1007/s11199-008-9424-4>.
- Schwiter, Karin, Julia Nentwich, and Marisol Keller. 2021. "Male Privilege Revisited: How Men in Female-Dominated Occupations Notice and Actively Reframe Privilege." *Gender, Work and Organization* 28(6): 2199–215. <https://doi.org/10.1111/gwao.12731>.
- Simpson, Ruth. 2009. *Men in Caring Occupations: Doing Gender Differently*. Palgrave MacMillan.
- Simpson, Ruth, and Patricia Lewis. 2019. "Men in Caring Occupations and the Postfeminist Gender Regime." In *Routledge International Handbook of Masculinity Studies*, edited by Gottzén Lucas, Ulf Mellström and Tamara Shefer. Cheltenham: Routledge.
- Stanford, Jim. 2017. "The Resurgence of Gig Work: Historical and Theoretical Perspectives." *Economic and Labour Relations Review* 28(3): 382–401. <https://doi.org/10.1177/1035304617724303>.
- Stergiou-Kita, Mary, Elizabeth Mansfield, Randy Bezo, Angela Colantonio, Enzo Garritano, Marc Lafrance, John Lewko, et al. 2015. "Danger Zone: Men, Masculinity and Occupational Health and Safety in High Risk Occupations." *Safety Science* 80: 213–20. <https://doi.org/10.1016/j.ssci.2015.07.029>.
- Taylor, Scott, and André Spicer. 2007. "Time for Space: A Narrative Review of Research on Organizational Spaces." *International Journal of Management Reviews* 9(4): 325–46. <https://doi.org/10.1111/j.1468-2370.2007.00214.x>.
- Thompson, Kathy, Pamela Leintz, Barbara Nevers, and Susan Witkowski. 2004. "The Integrative Listening Model: An Approach to Teaching and Learning Listening." *The Journal of General Education* 53(3): 225–46. <https://doi.org/10.1353/jge.2005.0011>.
- Torre, Margarita. 2018. "Stopgappers? The Occupational Trajectories of Men in Female-Dominated Occupations." *Work and Occupations* 45(3): 283–312. <https://doi.org/10.1177/0730888418780433>.
- Tronto, Joan. 2013. *Caring Democracy*. New York University Press.
- van Wijngaarden, Els, Carlo Leget, and Anne Goossensen. 2017. "Ethical Uneasiness and the Need for Open-Ended Reflexivity: the Case of Research into Older People with a Wish to Die." *International Journal of Social Research Methodology* 21(3): 317–31. <https://doi.org/10.1080/13645579.2017.1399621>.
- Verdonk, Petra, Hannes Seesing, and Angelique De Rijk. 2010. "Doing Masculinity, Not Doing Health? A Qualitative Study Among Dutch Male Employees about Health Beliefs and Workplace Physical Activity." *BMC Public Health* 10(1): 1–14. <https://doi.org/10.1186/1471-2458-10-712>.
- Verdonk, Petra, Maaïke Muntinga, Hannah Leyerzapf, and Tineke Abma. 2019. "From Gender Sensitivity to an Intersectionality and Participatory Approach in Health Research and Public Policy in the Netherlands." In *The Palgrave Handbook of Intersectionality in Public Policy*, 413–32. Cham: Palgrave Macmillan.
- Watts, Jacqueline. 2015. *Gender, Health and Healthcare: Women's and Men's Experience of Health and Working in Healthcare Roles, 1–206*. Routledge.
- West, Candace, and Don H. Zimmerman. 1987. "Doing Gender." *Gender & Society* 1(2): 125–51. <https://doi.org/10.1177/0891243287001002002>.
- Williams, Christine L. 1992. "The Glass Escalator: Hidden Advantages for Men in the 'Female' Professions." *Social Problems* 39(3): 253–67. <https://doi.org/10.1525/sp.1992.39.3.03x0034h>.

- Wingfield, Adia Harvey. 2009. "Racializing the Glass Escalator: Reconsidering Men's Experiences with Women's Work." *Gender & Society* 23(1): 5–26. <https://doi.org/10.1177/0891243208323054>.
- Wright, Michael. 2015. "What Is Participatory Health Research? A Position Paper of the International Collaboration for Participatory Health Research: Michael T. Wright." *The European Journal of Public Health* 25(supplement 3). <https://doi.org/10.1093/eurpub/ckv167.066>.

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