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**LAUGHING IT OFF: UNCOVERING THE WORKPLACE
EXPERIENCE OF AGED CARE NURSES**

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Valerie Adams*

1. Introduction

Residential aged care facilities (formerly nursing homes and hostels) provide 24-hour nursing care to frail, elderly people. The staff who deliver the 'hands on' care are predominantly female, with registered and enrolled nurses being responsible for the clinical care of residents who often have multiple medical problems. Feminist economists and sociologists are studying marketised care services, such as nursing homes, as the intersection of the performance of 'care', traditionally unpaid and provided within families by women, and 'work' as a paid means of earning a living. The combination of these core economic activities involves strong personal and emotional involvement on the part of the person caring in order to provide good quality care. Feminist economists have sought to understand the nature of caring labour, what differentiates it from other forms of labour and, in the case of paid caring labour, how staff providing care negotiate the intersection between 'care' and 'work'. To this end, empirical studies of paid care work are both necessary and important.

In the process of conducting interviews for research towards a doctoral thesis investigating how aged care nurses experience their care work, aspects of nursing culture emerged that had implications for the analysis of the interview material. It became apparent that nurses understated the conditions in which they worked. It was my personal experience working as a registered nurse in residential aged care facilities that enabled me to identify this trend, making it necessary for me, as the researcher, to understand how nursing culture impacted on the way nurses described their work.

To do this, I have developed a 'toolbox' of reflexive methods comprised of a pluralist analysis of metaphors of nursing, emotion expressed as laughter during interviews, and autoethnography. Adding my own voice to the empirical data has facilitated a two-tiered analysis of the interview material incorporating an insider/outsider perspective. I have situated this rich combination of methods in an interpretive paradigm grounded in feminist epistemology. These pluralist methods have enabled me to uncover the workplace culture of nurses and to make explicit some of the effects of gendered socialisation roles and their importance for understanding marketised caring labour. This combination of methods has significance for uncovering workplace culture in other forms of marketised caring, such as teaching and child care. It also contributes to feminist methodology by providing a

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combination of methods useful for researching the impact of gender socialisation roles on women at work.

1.1 Reflecting on the data

One of the purposes of qualitative interviewing is to ‘hear and understand what the interviewees think and to give them public voice’ (Rubin and Rubin 1995: 19). Reflexivity in qualitative research means both that the researcher engages in a ‘process of critical self-reflection on one’s biases, theoretical predispositions, preferences and so forth’ and also that ‘the inquirer is part of the setting, context, and social phenomenon’ s/he is researching (Schwandt 2001: 224).

Understatement

The research methods described here were initiated when I discovered that nurses who were participating in semi-structured interviews consistently understated the conditions under which they work. An example is the following quotation from a nurse with twenty years experience who worked across the aged care sector:

- A: If I’m due off at 11 somewhere, it’s anywhere between 11 and 12 ...
That’s how I look at it.
Q: So it could be anything up to an hour?
A: Yes.
Q: So do you get paid for that extra time?
A: No, because I see it as maybe ... you know a time management thing
for myself (laughs). (Betty, agency registered nurse)

Rather than assert that the workload was too heavy for the hours allocated, this nurse passes the situation off as a possible inadequacy in herself. This is despite this interviewee’s extensive experience working in aged care, and the everyday nature of working past the end of her shifts. Her employment as an agency registered nurse means that, because she regularly works unpaid time, this is occurring across the aged care sector, not merely in a few nursing homes. As I continued to analyse the data, I noticed that the nurses interviewed presented problems they experienced in doing their ‘care work’ as ‘normal’, or due to something lacking in them. This tendency had the effect of providing an understated view of the conditions actually experienced on a regular basis. The research design evolved as I, as the researcher, *heard* the data (Rubin and Rubin 1995).

Laughter and what it communicates

I discovered that nurses laughed when saying anything that could be interpreted as them not being a ‘good nurse’. Closer examination revealed that this laughter was, most of the time, a rather self-conscious response to having said something about their work which, although true, fell short of an ideal of how nurses ‘should be’. I discovered that the deep-seated nature of nursing culture underpins how the empirical data needs to be interpreted. This gave rise to two questions regarding method: How can the understatement and self-

consciousness evident in the interview transcripts of aged care nurses be investigated? And what are the implications for the interpretation of the interview data?

1.2 Developing methods to answer the questions

Metaphor and emotion

To answer these questions, I used a combination of methods. The first step was to investigate the culture of nursing. To do this I used a historical perspective to look at the culture of nursing via the use of metaphors (Denshire 2002; Koro-Ljungberg 2004).¹ The second step involved researching the role of emotions and their analysis in qualitative research across disciplines, which included nursing (Chapple and Ziebland 2004), sociology (Denzin 1984; Griffiths 1998), psychology (Scheff 1979), communications (O'Donnell-Trujillo and Adams 1983), and gender studies (Allen, Reid and Riemenschneider 2004). The data was then analysed to see where nurses laughed during the interviews as a signal of a self-conscious moment, which often reflected on the mores involved in being a 'good nurse'.

Autoethnography and epistemology

An autoethnographic interview, as the third step, was then used to analyse differences between nursing culture and economics education. This led to the fourth step, which was to situate this 'toolbox' of methods within a suitable epistemological framework. Although I had worked as a registered nurse in residential aged care facilities for over a decade while studying economics to Honours level part-time, I had commenced this research project from the viewpoint of an academic researcher investigating issues around caring labour and public policy. As the research methods literature explains (Ellis and Bochner 2000; Patton 2002), the inclusion of an autoethnographic interview within the empirical data clearly situates the researcher within the research project. Not only did this step herald the inclusion of the researcher's voice in the first person to recount the research findings, it also meant that the data needed to be analysed from an insider/outsider perspective. While this combination of methods uncovered the scope and depth of nursing culture, it also centred this research firmly in the interpretive paradigm,² operating from an epistemological viewpoint in which all knowledge is situated and socially constructed.

1 Sally Denshire (2002) is an Australian occupational therapist who argues that metaphor analysis offers a new strategy for exploring implicit knowledge in the human-related professions. Mirka Koro-Ljungberg (2004: 341) discusses how metaphorical analysis within a poststructuralist perspective displaces the assumed meanings of metaphors and argues that a focus on metaphors can provide multiple insights 'challenging the epistemology of objectivism and positivist views of producing truth' and 'can be used to open up and create new meanings'.

2 Norman Blaikie (1993: 96) describes interpretivism as based on an ontology, or nature of being, that regards social reality as the product of processes by which social actors together negotiate the meanings for actions and situations. In other words, social reality is a complex of socially constructed meanings.

1.3 *In summary*

The purpose in describing this approach is to present a collection of research methods that are useful tools in analysing the largely invisible influence of nursing culture. The processes described here would be useful in other contexts where a deep-seated workplace culture occurs. Using a reflexive process, this paper examines both ‘insider’ and ‘outsider’ perspectives (Franzway 2001: 6) of nurses working in residential aged care, and modes of behaviour that are discernible in workplace culture. It explores the research issue of how to analyse the effects of this culture in relation to the interview material collected so that nurses’ complex experience working in residential aged care is made explicit.

The following sections describe, firstly, the culture of nursing and the usefulness of metaphor, and then the importance of emotions and the use of laughter as a form of analysis. I then describe the use of an autoethnographic interview, the reason for the inclusion of myself in this research, and an analysis of the results. Finally, I discuss the epistemology underpinning this research project.

2 The importance of nursing culture

This project involves 17 interviews with registered and enrolled nurses giving ‘hands on’ care in residential aged care facilities, which provide 24 hour nursing care to frail elderly people. Five interviews were also conducted with management comprised of three Directors of Care, one CEO of a large non-profit organisation operating multiple residential aged care sites, and one private enterprise proprietor.

The interview questionnaire was designed to explore some of the issues raised in the literature on caring labour. This work has mainly been done, to date, by feminist economists and sociologists who began, initially, by looking at women’s unpaid caring in the home. However, there has been a move for some time in post-industrial western nations to higher levels of marketised caring, where the caring is provided as a service for a fee. Childcare centres and nursing homes are two examples of marketised care services. To date, there has been a lack of research on how aged care nurses experience their caring role and the implications for Commonwealth residential aged care policy. It is this gap in research that this doctoral project seeks to address.

2.1 *Metaphors of nursing*

It was discovered early in the data collection and analysis for this project that nursing culture affected the way that nurses delivered ‘hands on’ care, how they interpreted their workplace environment, and how they participated in the interviews conducted for this research. The effect of nursing culture on aged care nurses has implications for feminist economics – from both theoretical and policy perspectives – and sociology literature on caring labour, and a broader application to other caring professions. By taking a historical

perspective, this section explains how metaphors have been used as a methodological device to examine tenets of nursing culture.

Metaphors have been described as being pervasive in everyday life, not only in language but also in thought and action, with the essence of metaphor being that we understand and experience one thing in terms of another (Lakoff and Johnson 1980: 3, 5). Lakoff and Johnson (1980: 7) argue that since metaphorical expressions in our language are tied to metaphorical concepts in a systematic way, we can use metaphorical linguistic expressions to study the nature of metaphorical concepts and to gain an understanding of the metaphorical nature of our activities. The linguistic expression of conceptual metaphors may vary widely, but always involves a set of correspondences between two conceptual domains (Steen 2002: 20–1). Miles and Huberman (1994: 250) see metaphors as having ‘an immense and central place in the development of theory’, as people use metaphors constantly as a means of making sense of their experience.

Academic researchers have examined the use of metaphors across disciplines and within the philosophy of science.³ Thus analysis via the use of metaphors has been both prolific and multidisciplinary. While not fully developed in economics, which is situated in the positivist paradigm, there has been some analysis of the metaphorical concepts in economics including the use of the market metaphor in relation to child care (McCloskey 1995: 215) and a feminist economics critique of the central neoclassical economics metaphor ‘an economy is a machine’ (Nelson 2004).

Metaphorical analysis has also been used in nursing. Katherine Froggart (1998) found metaphors useful in examining the emotional work of nurses working in palliative care. Mary Ellen Wuzbach (1999: 95), in discussing moral metaphors present in nursing, explained that moral metaphors do not describe literally the state of affairs in moral discourse, but in some essential way they may convey a truth not yet recognised or acknowledged by a particular profession. Helga Kuhse (1997), in discussing nurses’ history of subservience, argued that metaphors not only draw attention to similarities that already exist, but *create* similarities. ‘Depending on whether they are forward or backward-looking they can be a tool or a toil – being supportive and productive of change, or giving implicit support to practices and institutions that we would be better off without’ (Kuhse 1997: 16).

Although metaphors can only impart a partial view, two separate but historically related metaphors have been identified that shaped the early days of nursing: a military metaphor, which appeared in both medicine and nursing (Kuhse 1997; Wuzbach 1999) and the metaphor of the virtuous woman (Kuhse 1997). Societal changes in the 1960s

3 For example, Laurel Richardson (1998: 351) describes social scientific writing as using metaphors at every ‘level’. Metaphors affect the interpretation of ‘facts’, and this ‘sense making’ is always ‘value constituting’, that is, it makes sense in a particular way in which one ordering of the facts is privileged over others.

heralded the emergence of a third metaphor – that of the patient advocate – while more recent nursing research has uncovered the ‘tyranny of niceness’, a metaphorical description of an aspect of current nursing culture. Understanding these metaphors is a necessary step towards a metaphorical analysis of the workplace culture of nurses, as undertaken in this research project.

The military metaphor

The military metaphor was pervasive in nursing, not only because modern nursing stems from the Crimean War, but also because nursing emerged at a time when medicine was adopting a military metaphor. Disease was described as the ‘enemy’; medicine ‘combated’ disease with ‘arsenals’ of drugs; and young doctors became house ‘officers’ (Winslow 1984, cited in Kuhse 1997: 22). Applied to nursing, the military metaphor required discipline, and loyalty and obedience to those of superior rank. As those of rank were of course doctors, nurses’ subservience to doctors as their proverbial ‘handmaidens’ came into being, and this relationship has proven very difficult to banish. ‘The military metaphor thus not only turned nurses into obedient soldiers, but also put them under the command of medical men’ (Kuhse 1997: 25).

The virtuous woman

Kuhse (1997) explores the history of nursing culture, which is embedded in a series of cultured norms that originated with Florence Nightingale and the Victorian notion of the virtuous woman. Florence Nightingale saw a need to attract educated women into nursing as a necessary step to improving nursing practice and outcomes. If nursing was to become an acceptable profession for a *better class* of women and their daughters, then strict insistence on high moral character was necessary. Kuhse (1997: 27) describes the metaphor of the virtuous woman as a ‘congruence’ between the ‘good woman’ and the ‘good nurse’, which was successful in turning nursing into a respectable occupation suitable for *ladies*: ‘nursing was not only an *acceptable* occupation for women, it was a natural and highly commendable one’ (Kuhse 1997: 28). Therefore modern nursing at its inception was brought into being with characteristics of dedication, self-sacrifice, submissiveness and intellectual passivity. This meant that nurses were easily exploited and discouraged from forming their own ethical or professional judgements.

Much earlier, Janet Muff (1984) discussed the ‘angel of mercy’ stereotype as creating an impossible ideal that ‘denies nurses important aspects of their humanness’ (Muff 1984: 28). Interestingly, this stereotype has been analysed in feminist economics in the context of women’s unpaid care in the home by Julie Nelson (1999). Known as the ‘angel in the house’, this is a white, middle-class notion that refers to the unpaid care women provide in the home for *love*, not money. This notion works against caring occupations, predominantly comprised of women, attracting an income commensurate with male ‘breadwinner’ wages (Nelson 1999: 49). This linking by Nelson (1999), in an economic sense, of the ‘angel in the house’ with paid caring work parallels Muff’s (1984) ‘angel of mercy’ in nursing, and connects with Kuhse’s (1997) metaphor of the virtuous woman. Although referred to as a stereotype by Muff and a notion by Nelson, Kuhse conceptually links the private (unpaid,

the ‘good woman’) and public (paid, the ‘good nurse’) domains of caring work in her metaphor of the virtuous woman.

2.2 *Attempted changes in the metaphor*

In the 1970s and the 1980s, a number of cultural/societal changes began to challenge the sex-role stereotyping inherent in the traditional metaphors of nursing, with many nurses indicating that they were no longer willing to play the submissive and passive role traditionally assigned to them. Rapid advances in medical technology raised ethical questions and gave rise to the awareness that patients could be potential victims of medicine because they lacked medical expertise and the power that conferred. Ethical uncertainty became coupled with consumer discontent at the same time as nurses were becoming better educated and more skilled. These changes coincided with a growth in feminism.

In 1973 the International Council of Nurses’ Code for Nurses shifted nurses’ primary responsibility away from doctors to patients or those in need of nursing care (Kuhse 1997: 32), and heralded the metaphor of the patient advocate, 120 years after the establishment of ‘modern’ nursing during the Crimean War (1853–56). This signalled the emergence of a new role which, within the wider social climate, gave rise to the possibility of more assertiveness and professional independence among nurses who were now being seen as accountable for their own actions⁴ (Kuhse 1997: 40).

In spite of social changes and the introduction of the element of patient advocate to the nursing metaphor, ideas of the virtuous woman, of niceness and of handmaiden to the medical profession have persisted. As discussed by Street (1992), nursing training until very recently was carried out in mainly public, acute care hospitals under an apprenticeship type arrangement. Although not indentured, hospital-based training was very hierarchical and rather ritualistic, with an emphasis on specific ways of doing each task. Rather than building a comprehensive knowledge base that nursing practitioners could draw on for informed decision making, hospital training focused on ‘hands on’ work in wards and following orders. As a result, many women still in the nursing profession reflect traditional attitudes and behave in ways that support traditional relationships between workers in the medical profession.⁵

4 This included refusing to follow a doctor’s order if avoidance of harm to a patient was the intended goal (Kuhse 1997: 52). This was a sizeable shift considering that, prior to this, nurses were under the command of doctors. This shift had legal ramifications, with the nurse being personally liable for the medications or treatment she administered.

5 As ‘nursing education has a long history of squelching curiosity and replacing it with conformity and a non questioning attitude’, Street (1992: 6) draws on Michel Foucault to discuss this situation as an enculturation carried out deliberately through rules and ritualised practices. This results in the making of passive bodies. The outcome is a workforce that responds with speed, efficiency and technical mastery (Street 1992: 9).

Therefore, although the idea of nurse as patient advocate is potentially part of the nursing metaphor, because nursing has traditionally not been expected to flow from a careful analysis of the needs of the patient, but from an unquestioning adherence to rules and rituals (Street 1992: 8), this image of the nurse has been slow to establish itself in the medical establishment, including among nurses themselves, and the wider community.

However, there is evidence of nurses advocating on behalf of nursing home residents in the interview material. I have therefore used the metaphor of the patient advocate as a third metaphor present in nursing culture but placed it in a residential aged care context by renaming it the metaphor of the resident advocate, acknowledging that these elders are not hospital patients but residing in supportive accommodation that is now their 'home'.

2.3 *The identification of a contemporary metaphor?*

Nursing has also been deeply affected by what Annette Street (1995) has called the 'tyranny of niceness',⁶ a label that nurses related to and identified with whether they were working in a hospital, community setting, or in nursing academia (Street 1995: 31). Street's 'niceness' appears to be linked to Kuhse's metaphor of a virtuous woman. The traditional stereotype of a 'good woman' since Victorian times has been someone who is patient, caring, kind, hard working, and never complains or criticises, and therefore is *very nice* to be around. This social conditioning is not only inherent in nursing. It affects women in all western societies, and is particularly evident in all caring occupations which, after over 30 years of equal opportunity legislation in Australia, are still predominantly comprised of women, and is an expectation that remains alive and well despite over 30 years of active feminism.

While Street refers to the phrase that grew out of the research she did as a 'label', I am using it as a fourth metaphor because, by definition, in describing 'niceness' as a 'tyranny', this phrase certainly describes one thing in terms of another and maps across two conceptual domains (Lakoff and Johnson 1980). However, I suspect that it is a contemporary manifestation of the gendered socialisation inherent in nursing culture that speaks back to the Victorian notion of the virtuous woman. Although contemporary social mores concerning women are not focused on virtue or angels, either 'in the house' or demonstrating 'mercy' as nurses, Street's research clearly demonstrates that the 'tyranny of niceness' is present in contemporary nursing culture, widespread, and recognisable by nurses themselves. This is dealt with again later in relation to the interview data.

6 Annette Street's (1995: 30) empirical work in a paediatric unit revealed nurses were negating their feelings because of the unit stereotype of nurses as *nice, caring* people. Because nurses were not able to express their frustrations, disappointments or anger in the work context, issues were not resolved creatively. Individual nurses were blaming themselves for legitimate concerns. The relationship between being nice and being caring had blurred to such a degree that these clinical nurses believed that they were being genuinely caring when what they were doing was fitting in with the unit's expectations.

2.3 *Out of the positivist paradigm*

Evidence of the effect of the metaphors of nursing culture in the interview material meant that it was necessary to dig deeper in order to understand nurses' experience of care work. In other words, empirical investigation of the provision of care in marketised settings is important to the development of theoretical explanations of caring labour and an understanding of the degree of commodification present in different care markets. However, identifying a means of analysing interview data to uncover workplace culture situates this research firmly in the interpretive paradigm rather than the positivist paradigm central to neoclassical economics. Martha MacDonald (1995: 175) argues that 'the standards for empirical research and data collection in mainstream economics create difficulties in dealing with feminist concerns'. Feminist economists draw on methods from other social sciences because, just as neoclassical theory gives rise to certain data needs, so does feminist theory:

Whereas economic methods were designed to test rather abstract models explaining economic behaviour, the sociological methods reflected a desire to tease out of the data an understanding of relationships. (MacDonald 1995: 176)

The interpretive paradigm recognises that meaning emerges through interaction, and emphasises understanding the overall text of a conversation, and the importance of seeing meaning in context. It 'accepts the importance of culture and the necessity of a relativistic approach to culture in the interview' (Rubin and Rubin 1995: 31–2).⁷ In this project the first step in identifying the effect of nursing culture on the interviewees was to analyse where nurses laughed. The next section explains the importance of emotions, the relevance of laughter to nursing culture, and the results of this analysis.

3 An analysis of laughter

As mentioned previously, nurses often laughed in a somewhat self-conscious manner whenever talking about anything that might be interpreted as 'not being a good nurse'. Although they sometimes laughed when relating enjoyable moments in their caring work, I noticed as I worked with the data that many times interviewees laughed when recounting difficult situations where they were not reaching the ideal of a good nurse even though their responses were readily understandable as normal human experiences:

Q: Does it take a lot out of you to do this?

7 Interpretive social science regards the ways people understand their worlds and how they create and share meaning about their lives as important. To understand the experiences and meanings of interviewees, interpretive researchers look in the areas they are studying for 'thick and rich descriptions of the culture and topical arenas' and try to develop 'an empathetic understanding of the world of others' (Rubin and Rubin 1995: 34–5).

A: Yes ... some days ... it's not only physically but it's emotionally tiring as well ... especially if you've got someone who's a wanderer or someone who's a bit aggressive ... there is different behaviours you've got to challenge ... so it's not just physically tiring ... sometimes you get ... it tries your patience, put it that way (laughs). (Lesley, registered nurse)

As I discovered that every nurse laughed either in the context of not being a 'good nurse', as in the extract above (indicative of the metaphor of the virtuous woman or the proverbial 'angel in the house'), or in the context of downplaying or understating difficulties (indicative of the military metaphor or 'soldiering on'), my continuing analysis of the participants' discourse and their behaviour during interviews led me to look at metacontext as the site at which nursing culture is located. Hinds, Chaves and Cypress (1992: 36) define the metacontext as a layer of a socially constructed source of knowing that operates continuously and results in a generally shared social perspective. It is a source of explanation for and an indirect influence on behaviours and events. Although the metacontext reflects and incorporates the past and the present and sets conditions for and shapes the future, its predominant orientation is to the past.⁸ By locating the nursing metaphors within this metacontext, I then researched the nature of emotions and the role of laughter as an expression of various forms of emotion in social exchanges. The contexts in which nurses laughed during the interviews were then analysed using metaphors as a methodological tool.

My first step in seeking to understand the role of laughter was to draw on Denzin (1984) for a comprehensive discussion of the role of emotions. In a singular work on understanding emotion, Denzin (1984: 49) defined emotions as 'temporally embodied, situated self-feelings that arise from emotional and cognitive social acts that people direct to self or have directed towards them by others'. However, many of these feelings and the reasons people give for having them are 'social, structural, cultural, and relational in origin' (Denzin 1984: 53). He also argued that 'individuals are connected to society through the emotions they experience', which means that mood and emotion are important for the study of society and social organisation (Denzin 1984: 24). Lupton (1998: 15) builds on Denzin's work and discusses a social constructionist perspective on emotion which describes emotion as socially constructed, meaning 'that it is always experienced, understood and named via social and cultural processes'. Emotions are therefore viewed to a greater or lesser degree as 'learnt rather than inherited behaviours or responses'.

I discovered through Denzin's reference to the work of Goffman (1956) that in an early study linking embarrassment with social organisation, Goffman (1956: 266) identified laughter as a gesture that individuals can hide behind while bringing their feelings 'back into tempo' and themselves 'back into play'. Because people dislike feeling embarrassed,

8 Because it is omnipresent, this contextual layer often goes unrecognised unless it is intentionally sought. It is changeable but unlikely to show considerable sudden change (Hinds, Chaves and Cypress 1992: 31–42).

tactful people will often pretend not to know that someone has lost composure or had grounds for losing it. From this point of view, poise plays an important role in communication (Goffman 1956: 267). Scheff (1979: 48) linked spontaneous laughter with anger and embarrassment, with both of these states of tension being able to be resolved through spontaneous laughter. However, in the feminine role, ‘much anger and embarrassment lie outside of the woman’s awareness’ (Scheff 1979: 64).⁹ This is borne out in my research where nurses’ laughter when speaking of situations that fall short of the idealised ‘good nurse’ occurred naturally as a usual form of conversation behaviour.

According to Allen, Reid and Riemenschneider (2004), even though laughter is universal, it remains a surprisingly understudied communication behaviour. Using focus groups comprised of 39 female IT employees, Allen et al (2004) studied the role of laughter in meeting workplace barriers and challenges. It was found that laughter can occur when people discuss the paradoxes and ambiguities of organisational life and taboo topics. Laughter, as a non-verbal form of emotion, provides a valuable opportunity to identify how women communicate nonverbally about those conditions that potentially act to hinder or restrict their satisfaction with work conditions. I saw this study as important because it examined how laughter may help women to cope with working conditions that are problematic, especially those they cannot change (Allen et al 2004: 177). Using laughter as an indication of self-consciousness, or an indicator of a departure from the prescribed *manner of being*, there is evidence that nursing culture affects how people relate to, and talk about, situations of concern to them and some of the work experiences they encounter.¹⁰

In this study, every participant laughed at some time and laughter was the prevalent emotion throughout the interviews.¹¹ The segments of each interview where people laughed were coded into categories. Interviewees laughed when they talked about situations where they:

9 By contrast, he notes that due to social training men have largely screened fear and grief out of their awareness and believes that these emotions are ‘stored as muscular tension and other physical anomalies’, making it difficult for men to form emotional ties with other people (Scheff 1979: 54).

10 In the health care sector humour has been more widely analysed. Griffiths (1998: 874) discusses an extensive literature on humour and health care, with much of it centred on the affiliative and emotional functions of humour. While social scientists have recognised the significance of humour as a mechanism for managing tension in social relationships for a long time, in the health care sphere it has been portrayed as ‘something that helps staff to deal with difficult communications, comfort and reduce anxiety in patients, express frustration and anger, relieve tensions, bond together and enhance work satisfaction’ (Emerson 1973, cited in Griffiths 1998: 874). Humour also allows staff and patients to raise forbidden topics that it would be difficult to disclose in more ‘serious’ discourse (Emerson 1973, cited in Griffiths 1998: 875). Humour, however, is not necessarily the same as, or always linked to laughter.

11 The interviews were audiotaped and transcribed with any audible emotion that occurred being recorded in brackets. All identifiers were removed to promote confidentiality and each participant was given a pseudonym. When it was noticed that the nurses displayed a tendency to understatement and often laughed, a software package for qualitative

- were anxious
- experienced difficulties
- found the work demanding
- felt something was unfair
- found a situation unrealistic
- felt inadequate
- felt uncertain
- felt self-conscious or
- felt cynical.

On a positive note, they also laughed when they talked about their caring role and aspects of their work that contributed to their job satisfaction. The final category is where I, as the interviewer with a strong nursing background, also laughed.

After analysing the data into categories where nurses laughed, these categories were used to analyse the different contexts in which nurses laughed. These contexts where nurses laughed were used as indicators of where nurses felt some level of emotion, as identified by their laughter, which were then related to the metaphors derived from the literature on nursing culture.

The military metaphor requires nurses to be efficient and always able to cope, in effect to 'soldier on'. Analysis of the interview data showed that there are elements of the military metaphor still present in nursing culture. It was quite usual for nurses to laugh when talking about 'soldiering on'. As an example, one registered nurse laughed:

- twice when talking about being interrupted during her meal break and not usually getting back to finish it
- when talking about not usually getting off on time
- when explaining that she was often feeling rushed and was not having time to finish her documentation
- when she explained that her main job satisfaction came from getting all she needed to get done in a shift without leaving little bits behind
- when talking about doctors calling in of an evening and how she could do with half an hour more than she gets paid for; and she
- also laughed when she said she didn't plan to keep working in aged care but doing something about it is another thing (Glenys, registered nurse).

research, NUD*IST (Non-numerical, Unstructured Data; Indexing, Searching, Theorising) Version N6 was used to perform a text search which located all interview segments where laughter occurred. This data was then analysed and the text segments where interview participants laughed were categorised according to the context in which the laughter occurred.

While reducing tension, this strategy also has the effect of downplaying or understating the degree to which these factors in the work environment are an ongoing problem to the point where this particular nurse would like to leave her job in aged care.

The metaphor of the virtuous woman, through which nurses are seen as dedicated and self-sacrificing, is possibly a major contributor to the 'tyranny of niceness', with nurses supposedly liking to care for everyone they come across. In the interview material, nurses laughed when talking about having any sort of difficulty with residents or relatives. One nurse laughed twice when talking about the time and effort involved in settling a very fussy resident each night (Pat, registered nurse). Another nurse laughed when talking about some situations between family members being difficult. She later laughed twice when talking about difficulties with the son of a resident who hid alcohol for his father in the kitchen cupboards (Sandra, registered nurse). Not only do nurses feel they must be always nice, their level of self-esteem drops if they do not manage the impossible. A registered nurse, when talking about a resident she could not 'get along with', said:

I think I was disappointed in myself in the end because I couldn't give her that sort of caring nature that I give to others ... just because she was such an awkward old biddy basically (laughing). (Susan, registered nurse)

The situation is markedly different in relation to the metaphor of the resident advocate. There is only one instance of laughter where an interviewee is advocating a rehabilitation program for residents:

the rehabilitation nursing background really made me value rehabilitation programs so I put one in here. And it's had some fantastic outcomes for residents and really good outcomes for staff and it's ... I just see it as the basis of delivering a decent lifestyle for residents is to keep them as well as possible, as fit as possible and then try and give them a good time (laughs) so ... pretty simple philosophy really. (Meryl, director of nursing)

This participant is describing a two-way benefit for both residents and staff and laughter here is associated with positive responses. In the numerous other instances of advocacy in the interview material the nurses do not laugh. They talk seriously and mostly confidently because this is a valid role for nurses:

meals, sometimes meals are an issue. They're not hot enough and they need looking at. It's up to the registered nurse to make sure that the meals are of good standard, and that the residents appreciate them cause you know, there is times when the meals aren't. (Glenys, registered nurse)

And

Q: What ... because of the way they were speaking to a resident?

A: Yes, condescending, non-respectful, judgemental, impatient. Yeah ... I had one girl say, a third year nursing student, said to a resident; and this lady was fully alert mentally; and this carer took away a dessert the lady started eating and said, 'Don't be such a naughty girl' and I actually had to get the girl aside and say that is inappropriate ... and I actually said to the girl, 'When I'm 85 years old, if anyone talks to me like that they had better look out.' (Fiona, registered nurse and nursing agency manager)

Because these nurses are confident in their role as the residents' advocate, they do not feel at all self-conscious in talking about it, and so they do not laugh. The advocacy metaphor came out of the 1960s, a period characterised by second wave feminism and the growth of the consumer movement. This resulted in increased educational opportunities for women and nurses, with nurses asserting that being the patient's advocate was both a valid and a necessary role for nurses. This metaphor refers to behaviour that is realistic and achievable, is now supported within nursing culture, and relates to a rise in professional status for nurses. The presence of resident advocacy in these nurses' interviews indicates a positive aspect of nursing culture present in residential aged care.

In this analysis laughter has been identified as a marker of what constitutes a 'good nurse'. The four metaphors – the military metaphor, the metaphor of the virtuous woman, the 'tyranny of niceness' and the role of the resident advocate are all present in the nursing culture evident in residential aged care facilities. What constitutes a 'good nurse' is shaped by this culture. These metaphors are present at different times but, as evidenced by the interview material, also appear to intertwine. The metaphor of the virtuous woman, although it appears superficially as an anachronism, probably is expressed most often in contemporary nursing settings as the 'tyranny of niceness'. Both the metaphor of the virtuous woman and the 'tyranny of niceness' have a gender focus; in this case the characteristics inherent in these metaphors are embedded in behaviour characteristics historically designated as desirable feminine traits. However, unlike the metaphor of the resident advocate, the other metaphors are to do with Victorian notions of womanhood. Nurses are doomed to fail to maintain these characteristics all the time. Although outside the scope of this research, changing these metaphors could assist aged care nurses to reconceptualise their role and promote realistic expectations of their own performance (Tobin 1990).

Following the research trail through developing an understanding of some of the reasons why nurses may have laughed frequently through the interviews to then assimilate the gendered and restrictive culture embedded in aged care nursing, I decided to act on a suggestion from an experienced researcher and include autoethnography in my research. This decision was also influenced by the style of research I wished to engage in. On reflection, I preferred to make my presence explicit so that my influence on the processes of inquiry could be seen and understood by others as part of an evolving search for

understanding (Sword 1999). This is in keeping with feminist methods where research centred on the lives of women seeks to avoid treating the participants as simply a source of data (Maynard 1994), and lessens the unequal relationship between the researcher and the researched (Glucksmann 1994).

3 The inclusion of 'I' in this research

Ellis and Bochner (2000: 739) define autoethnography as 'an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural'. It is usually written in the first person and appears in a variety of forms. Autoethnographers vary in their emphasis on the research process (graphy), on culture (ethnos), and on self (auto), while feminism has contributed to legitimising the autobiographical voice associated with reflexive ethnography (Ellis and Bochner 2000: 740). Michael Quinn Patton (2002: 86) explains that 'what distinguishes autoethnography from ethnography is self-awareness about and reporting of one's own experiences and introspections as a primary data source'.

The decision to engage in autoethnography was a struggle because neoclassical economics is situated in the positivist paradigm with an emphasis on 'objectivity'. In this paradigm the 'personal' is excluded but there is considerable debate about such objectivity. Feminist research methods accept an involved role for the researcher, with reflexivity and voice being important (Harding 1987; King 1996). Feminist economists agree but feminist economics and work on caring labour are emerging areas with much work to be done, and they are open to new approaches.

Banks and Banks (2000: 233) describe the emergence of autoethnography as 'a long-wave transformation that in all likelihood is preparadigmatic'. They note a shift towards qualitative research and an increasing number of books and journal articles containing experimental forms of writing. These authors link this change with the crisis of representation in ethnographic writing, which emerged as a 'seeping of doubts about objectivity and neutrality into anthropology, sociology and related fields'. Tedlock (2000) describes this form of scholarship as working to bridge the gulf between self and other as it reveals both parties as vulnerable experiencing subjects working to co-produce knowledge. Writing for and about a community in which one has achieved some degree of insider status should produce engaged writing 'centring on the ongoing dialectical political-personal relationship between self and other' (Tedlock 2000: 467). After considering different options and the many forms autoethnography has taken (Patton 2002: 85), I decided to be interviewed using the same questionnaire to provide a similar and comparable record of my experience to that of the nurses I had interviewed.

When I as the researcher conducted my interviews, I was a nurse who had worked for twelve years in nursing homes while studying an economics degree part-time conducting interviews with nurses currently working in residential aged care facilities. However, as a postgraduate researcher doing doctoral work around the concept of caring labour, my

awareness of the issues this body of theory invoked was not shared by the participants in my research. The rationale to include an autoethnographic interview in my research was therefore based on the premise that studying economics subjects while working in nursing homes had led me to view nursing homes with a somewhat different lens to nurses. I saw issues around the efficient use of resources, for example, that I would not have been aware of without my economics training. My decision to incorporate autoethnography into my research led to a closer examination of my position within the research project, that of insider/outsider, and the issue of voice.

Merriam et al (2001: 405, 411) argue that as researchers we can be insiders and outsiders to a particular group of research participants at different levels at different times; that positionality is determined by where one stands in relation to 'the other'; and that these positions can shift. When interviewing participants I had *insider* status in that the interviewees were aware that I was a registered nurse who had worked in nursing homes. This had a positive effect on the nurses who participated as they were friendly, cooperative and relaxed in talking about their work. However, it had a negative effect in the pilot interviews in that I did not clarify some statements because I knew what they meant. I needed to be aware that my supervisors and future readers of my thesis were not likely to know what these nurses meant.

My *outsider* status stems from my Honours degree in economics and some of the questions I was asking were linked to the feminist economics theory on caring labour. A positive effect of my outsider status was that I realised early in the interview process that the nurses were understating problems. Also that laughter during the interviews was linked to varying degrees of self-consciousness around not being a 'good nurse'. Although there was no apparent negative effect of my outsider position because the participants were unaware of my economics training, some questions exploring the nature of caring labour puzzled some of the interviewees because they were not used to viewing their role in those terms:

Q: How do you feel about doing caring work?

A: (Pause) I don't quite understand? (laughing)

Q: Well um do you get a sense of satisfaction out of doing that type of work as opposed to another type of work?

A: Yeah I guess I do ... because it's people ... it's not like ... OK I used to work as a shop assistant years ago, and it's nice to look at a nice tidy shelf and things like that, but this is ... yeah it's different. I don't think I've really answered that question either (laughing). (Susan, registered nurse)

And

Q: Your work involves a lot of responsibility in caring for people ... Can you describe how you meet this responsibility?

A: (Pause) Um ... help me.

- Q: (Laughing) You just do it as a matter of course ... I'm just looking for what you see you do, um, to ensure that you are responsible ... like on a shift where you are in charge, um, what would you do so that you yourself would feel that you are being responsible for the shift ... or for the residents?
- A: Summon my inner resources (laughing) which have come from many years of experience and a good training background, I guess ... (still laughing). (Betty, registered nurse)

Because these questions would have puzzled me when I was a nurse without feminist economics training, the autoethnographic interview provided a means of analysing the depth of nursing culture and to what extent it could be dissipated by alternative forms of education. By putting myself 'under the microscope', I could compare and contrast my experience of working in residential aged care facilities with that of nurses working from a singular nursing perspective. My analysis of laughter had also raised some personal questions concerning how 'my lens' was affected by nursing culture.

Once the autoethnographic interview was completed, I then needed to look at the issue of 'my voice' and the reflexivity required to analyse my participation in the research process. Goodall (2000: 131) argues that the persona the researcher creates and the voice that carries it through the narrative is the source of your authorial character, which is derived from how you as a person narrate the story, reflect on experiences, and provide explanations. 'Your persona also creates perceptions of the kind of person you are'. Reflexivity refers 'to the process of personally and academically reflecting on lived experiences in ways that reveal the deep connections between the writer and her or his subject' (Goodall 2000: 137).

This assimilation of *my voice* within the project and the reflexivity required to analyse my experience of working in nursing homes created a dual-layered analysis, as shown in Figure 1.

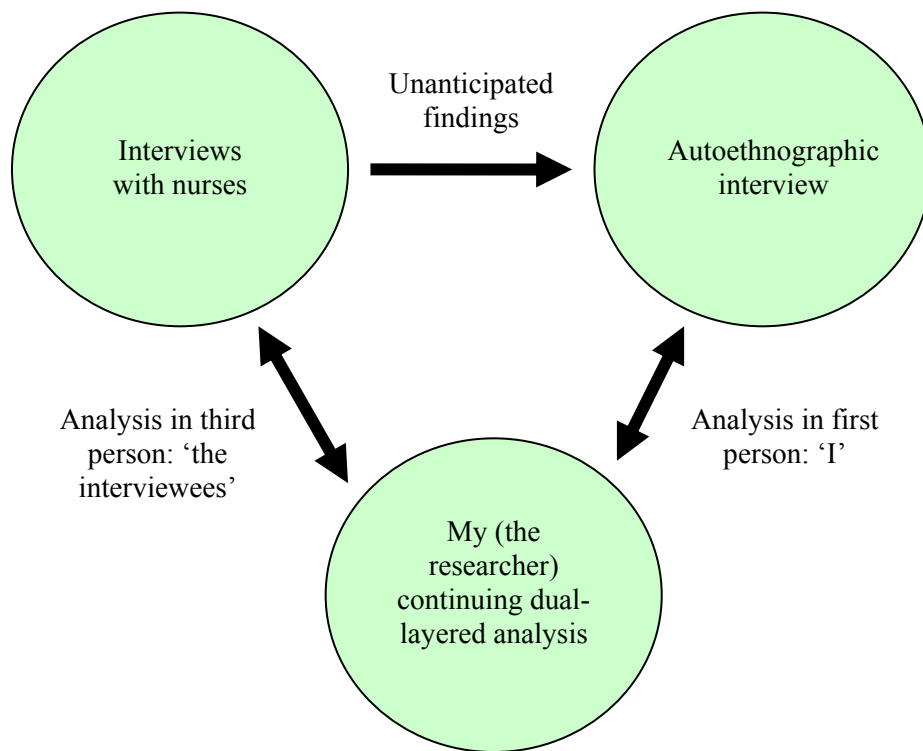


Figure 1: Data-based development of dual-layered analysis

The project began with the researcher interviewing nurses, analysing the data, and reporting the findings in the third person. Due to unanticipated findings and the investigation that ensued, the decision was made to include the autoethnographic interview. This entailed analysis in the first person. To report the findings, I now need to reflexively move in and out of first and third person, comparing and contrasting the contents of my interview with those of my participants in a dual-layered analysis.

5 The results

Similarities and differences between the nurses interviewed and my autoethnographic interview were readily apparent. My answer to the interview question regarding the meaning of ‘being caring’ was very similar:

You’ve got to interact with people. You’ve got to spend time talking to them, make them feel that they’re important to somebody. (Sandra, registered nurse)

So you, spend time again trying to be supportive and (pause) calm them down, and, you know, help them to (pause) give them some positive feedback, try to raise their self-esteem. (Valerie, researcher)

As was the way in which I talked about the notion of holistic care:

It can be different from day to day to day ... and caring is not only materialistic ... it includes the whole person – the physical, the psychological and the spiritual. (Cheryl, registered nurse)

So it's, it's trying to think of them as a whole person, and meet all their needs and enhance their quality of life as much as possible. (Valerie, researcher)

However, there were also marked differences. One of the interview questions asked about 'money on the job' as there is a deep-seated belief that caring should not be associated with the sordid subject of money. With the move to more marketised forms of caring, people involved in caring work, predominately women, are supposed to be above thinking about money, even when their livelihood depends on it. This concept appears to be very gendered in that no one expects doctors, traditionally predominately male, to earn anything less than a good income. However, money and caring seems to be linked to the Victorian notion of the virtuous woman and has proven difficult to shift. In one of the pilot interviews a nurse said that she did not think about money at all 'on the job'. When the interview finished and the tape recorder was turned off, she commented that she had only lied once, adding 'Of course I think about the bloody money!'¹²

When the interviews proper were conducted, 12 out of 17 nurses said that they did not think of money while working, but for the four nurses who said they did it was:

- 'sometimes but only in a round about way' (Susan, registered nurse)
- 'I tend to brag about it on a Sunday' (Thomas, registered nurse)
- 'If I'm having a bad day or I've got too many bills' (Louise, registered nurse), and
- 'When there are notes from management about being over budget' (Estelle, enrolled nurse).

There is a noticeable difference between the male nurse who is outgoing about earning shift penalty rates and the reasons the female nurses give. In contrast to these women, I was more outspoken about thinking about money, and about it being a reason for working:

Q: um ... but we've been talking about pay, and I'm wondering, um ... do you think about how much you're paid while you're on the job?

A: I actually did, um ... because I was, I was actually studying part time, I had two young children and I had no family here at all other than a husband

12 The discussions that took place with participants before and after interviews were recorded as field notes (Richards 2005: 38).

who often worked overtime when I went home of a weekend, and it was a bit like changing of the guard, and I did think about the money and in fact, the reason I worked weekends was because I got paid more. (Valerie, researcher)

While the above quotation illustrates a more detached, business-like view of being employed in a caring occupation, there was also (sadly) evidence of nursing culture. The military metaphor is evident and the following statement provides an example of ‘soldiering on’:

A: every time we needed someone new it was yet another inexperienced nursing student, they were first year students, some of them had done one placement in nursing homes and that was all the nursing they’d done in their life ... and I actually said to the Director of Care, um ... and they were all coming word of mouth from other people who worked there, I said, couldn’t we just advertise once in a while for an experienced person? And she then informed me that she really hated doing interviews, and she went home and I was furious ... I fumed with anger all evening to think that myself and this other carer, who happened to be a Cambodian woman who weighed about 7 stone and who went home to a family, her and I were busting ourselves to train one totally inexperienced nursing student after another, so we had three of them and only us, because she didn’t like doing interviews. And I couldn’t believe it (laughs). (Valerie, researcher)

Although I am more forthright about the difficult working conditions that I encountered than most of the nurses that I interviewed, I laughed in the same manner that the interviewees did, which has the effect of downplaying the account. Similarly, there was also evidence of the ‘tyranny of niceness’. At the end of a long segment in which I described the work that I did as a registered nurse working in a nursing home, I made the following statement:

The carers tended to work on their own and refer problems to the RNs. And that ... that’s a difficulty too, because the RN is still responsible for all the care given on the shift, and it’s particularly difficult with new carers, or a carer who you may feel (long pause) is not as caring as you would like to be. Um ... (Valerie, researcher)

Although I was well aware of the ‘tyranny of niceness’ metaphor before the interview, this did not stop me succumbing to it. An interesting exchange followed the transcription of this segment. The transcriber, who knows me well, commented that he nearly typed ‘pregnant pause’ because it went on for so long: ‘I was waiting and waiting and it went on and on’ (transcriber). When I commented that I could not remember pausing for a long time he

replied, ‘You sounded as if you had to think hard how to be nice and not slag off¹³ a whole lot of people.’ Interestingly, my immediate reaction was to laugh, leaning forward as I did so! He then explained that it was when I was talking about some carers not doing their job properly.¹⁴ While doing an economics degree has certainly re-educated my notions of caring work and money, it is layered on top of the hospital-based nursing training that I received as a young school leaver. Some forms of gendered socialisation run deep.

Hence the use of an autoethnographic interview is successful in engendering a dual-layered analysis to answer the questions raised by the evidence of nursing culture in the interview material. Likewise, the analysis of both metaphor and laughter facilitate the uncovering of understatements and self-consciousness inadvertently triggered when any account of the day-to-day experiences of nurses giving ‘hands on’ care in residential aged care facilities can be perceived as not being a ‘good nurse’.

6 Epistemology and ontology

The development of the above spawned a need to clarify the epistemology and ontology of my research. The ontological claims of feminism are that both the natural and social worlds are social constructions. Therefore these worlds are constructed differently by people who are in different social locations, or have different life experiences, as do men and women. This means that multiple realities are possible (Blaikie 1993: 100). Feminism has been seen as presenting a manifesto, which provides a useful summary of the ‘involved’ alternative by arguing that social scientists should use their thoughts, feelings and intuitions as part of the research process. Social research should mediate the experiences of the researcher and the researched, and facilitate understanding and change in their lives and situations (Blaikie 1993: 210).

However, this approach is not confined to feminist methodology. Creswell (1998: 76) sees a similar ontology as applying to qualitative research generally as reality is constructed by the individuals involved in the research situation. Multiple realities exist because there is the reality of the researcher, that of the participants, and the reality of the readers interpreting the study. In my study the reality of nurses working in residential aged care facilities exists alongside my reality of nurse/researcher/feminist economist. The validity of my voice in reporting the study will rely on other feminist economists, researchers and readers finding the presentation of my empirical data convincing within their reality.

Epistemology as a ‘theory of knowledge’ defines what are acceptable, relevant data (MacDonald 1995: 176). To do this, it is necessary to provide a philosophical grounding for what kinds of knowledge are possible and to decide how we can ensure that they are both adequate and legitimate (Maynard 1994: 10). In qualitative research this is based on the relationship of the researcher to those being researched. It is now widely accepted that

13 A colloquialism that, when used in this context, means to criticise someone.

14 Recorded as field notes.

qualitative researchers interact with those they study and seek to minimise separation between themselves and the researched (Creswell 1998: 76). To this end my autoethnographic interview placed me in a similar situation as my participants and reduced the degree of separateness that existed originally when, as the researcher, I analysed and reported in the third person.

Banks (1998: 5) states that it is necessary to uncover the values that underlie social science research. He argues that, even though social science research has a significant value dimension, objectivity should be an important aim. Because there is no other reasonable way to construct public knowledge that will be considered legitimate and valid by researchers and policy makers in diverse communities, objectivity must be an aim in the human sciences. However, there is a need ‘to rethink and to reconceptualize objectivity so that it will have legitimacy for diverse groups of researchers, and will incorporate their perspectives, experiences, and insights’ (Banks 1998: 6). This rationale has been endorsed within feminist epistemology, as Sandra Harding (2003) explains:

we can still have a world ‘out there’ beyond our historically local discourses, but we cannot have one that authoritatively chooses for us which knowledge claims to believe. Observations must always be interpreted within socially meaningful frameworks. We can still have justifiable standards for defending our beliefs and practices, but we cannot have ones that do so apart from investments in the perceived strengths of the social values and interests that make conceptual frameworks meaningful. (Harding 2003: 129)

The epistemological crisis during the 1960s and 1970s was characterised by heated discussions and debates around who speaks for whom and whose voice is legitimate. While insiders claim that only a member of their ethnic or cultural (or gender) group can really understand and describe the group’s culture because socialisation within it provides them with unique insights, outsiders claim that outsiders can more accurately describe a culture because group loyalties prevent individuals from viewing their culture objectively (Banks 1998: 6). Merton (1972 in Banks 1998: 6) concluded that both insider and outsider perspectives are needed in the ‘process of truth seeking’. Collins (1990 in Banks 1998: 7) discusses ways in which gender interacts with race to provide African-American women with a unique standpoint, which she calls the outsider-within perspective.

Both Merton’s *insider-outsider* and Collin’s *outsider-within* conceptualizations help to clarify and add needed complexity to the ideological debates and discussions about whose knowledge is authentic, who can know what, and who speaks for whom. (Banks 1998: 7)

7 Conclusion

The reflexive methods used in this research, that of metaphorical analysis, tracking laughter (nursing culture) and autoethnography (voice) have generated an approach that teases out important but overlooked strands of workplace culture and the way it is lived by workers, in this case nurses. From the analysis presented here, it is obvious that the Victorian metaphors and the resident advocacy metaphor send contradictory messages to nurses, which affects their perceptions and shapes their experiences.

I have presented evidence that the military metaphor is still influencing nurses' response to their working conditions. While laughing and thereby understating the difficulties that they encounter on a daily basis, these aged care nurses are indeed *soldiering on*. Their self-conscious laughter in any circumstances where their comments might indicate being a less than perfect nurse signals that the metaphor of the virtuous woman or the 'tyranny of niceness' also influences these nurses to have unrealistic expectations of themselves. While the resident advocate metaphor acts to enhance their professional autonomy and improve resident care, changing the military metaphor and the 'tyranny of niceness' would allow nurses to do their job better.

The autoethnographic interview allowed me to add my voice to that of the nurses that I interviewed. While reducing the power differential between researcher and participants, it also facilitated a deeper analysis of the effect of the gendered socialisation embedded in nurses' training in the hierarchal hospital system. The two-tiered analysis demonstrated that this type of enculturation is not displaced easily by other forms of education, in this case an economics degree.

Situating this research in the interpretive paradigm and incorporating an insider/outsider perspective has generated a form of analysis that allows not only a dual perspective, but also is useful in uncovering the gendered norms embedded in the workplace culture of nurses. The methods presented here, singly or in combination, are likely to be useful in analysing the effects of workplace culture in other caring occupations, such as teaching and child care, and in other nursing settings. These pluralist methods and their epistemic base contribute to the development of methodologies useful in feminist economics for empirical work on caring labour.

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