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Emotional Competence in a Gender Perspective: The Experiences of Male Nursing Students in the Sexual and Reproductive Health Clinical Teaching

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Abstract

In the Nursing Degree clinical teaching, gender stereotypes can influence the emotional experience of male students, with implications on their learning and competence's development in a health care area that is predominantly female, since it is consensual that the emotional dimension of learning can stipulate the experiences of caring. The development of emotional competence promotes a greater capacity for adaptive resilience in the face of stressful situations; consequently, to be emotionally competent is to be able to find solutions in internal resources that emerge from emotions (especially its management) and from the motivation of each individual. This interrelation between emotions and gender prompts the understanding of the male nursing students' emotional experience of provision of care in sexual and reproductive health. In order to understand this phenomenon, is proposed a research project with a qualitative approach, exploratory and descriptive. The data will be obtained from narratives written by nursing degree male student and also from clinical teaching supervisor nurses. Understanding students' emotional experiences in clinical teaching of sexual and reproductive health, related to possible gender stereotypes and restrictions to care in this area, leading us to understand how emotion itself manages these genderized experiences, what sense it gives them and how it incorporates them into learning in clinical teaching.

Keywords

clinical teaching nursing, male students, gender stereotypes, sexual and reproductive health, emotional

competence

1. Introduction

Historical findings reveal that Caring is associated with female, who traditionally is the one who assumes the role of caregiver, to whom is attributed greater sensitivity, availability to help the other and greater predisposition in affective and emotional sphere. To man were meant other tasks such as hunting, work and war. This social division of labour allowed the maintenance of life (Collière, 2000).

Moreover, the nursing history refers to the associated care of female labour, in the case of a profession in which health care is "instinctive", which led to the current health care being provided by religious and still imminently feminine. However, the multiple changes in the roles of men and women in recent decades in the public and private sphere, allowed both to coexist in the same space and to perform the same functions. Nowadays, men intervene in a series of activities and tasks, gaining a new role in the sphere of caring. Nonetheless, multiple gender stereotypes persist that condition individual and collective behavior, especially in the area of health and education (Oliveira, 2016).

With regards to healthcare, gender issues arise in Portugal linked to sexual and reproductive health, historically a dimension of women's care; so ensuring equal opportunities in this area of care also implies creating similar opportunities for nursing students, female or male, analyzing how health services are organized according to gender, perceive how male students emotionally experience these genderized experiences and generate the emotions that result from eventual gender stereotypes, likely to influence their learning in clinical teaching in this area. Nevertheless, it is important to dwell on the fact that nursing care is distinct if provided by a man or a woman. They are distinguished in the intersubjective encounter, since gender crosses all our behaviors, all our attitudes and relationships (Renaud, 2010). It therefore seems important to reflect on how the concept of Caring has been presented socially and culturally, since it has been shaped by compliance with the female stereotype.

2. Literature Review

2.1 Gender and Health Care

Over time stereotyped representations of care have been questioned leading to changes in organizational contexts which are supported by values that promote gender equality. However, distinguish between concepts of sex and gender seems crucial. While the former refers to physical characteristics which identify the sex each person belongs to (Amâncio, 1994) the latter refers to the socially constructed differences between female and male (Aboim, 2007), corresponding, on the theoretical level, to the purpose of placing the question of gender differences in the social research agenda, removing it from the domain of biology (Amâncio, 2003).

This last concept emerged from women's studies in the 1970s, conducted by women's movements demanding equal rights, and intended to report on the psychosocial and cultural differences that existed at a particular social, historical and political moment (Scott, 1995; Amâncio, 2004; Louro, 2008). For

Scott (1995), it is defined as the social discourse produced on the biological sex itself. Thus, when we talk about gender we are referring to social symbolism and not only centered on biological determinism (Crespo, Ferreira, Couto, Cruz, & Joaquim, 2008), so the terms sex and gender should not be used as synonyms.

Through social learning this "incorporation" of gender has its genesis in the early years of childhood; it is a process that precedes the perception of the body itself sexed by the child and is translated into a set of social expectations (for example the color of the clothing, toys, how to behave) and internalization of gender roles conveyed by family, school or media which are essential for this process (Giddens, 2008). It acts as a social "filter" that allows the child to understand the world and its own existence in a social discourse on biological assumptions (ibid). Gender can be considered as an important social marker (Giddens, 2008) identifying us as male or female (nowadays with a greater tendency to break this polarization) and is also one of the social determinants of health.

It is, therefore, crucial to study gender in healthcare and to explore the inequities created by it in order to reduce and even eliminate them (Prazeres, 2009). This, however, requires a greater clarification of the complex matrix of variables that support it, from the conceptual point of view to the daily aspects in which it manifests (ibid). Whilst there has been an effort in the social field to empower female, inequalities still persist with regards to the various spheres of male's life including healthcare, and gender studies by women have been increasingly problematizing issues related to masculinities (Wall, Cunha, Atalaia, Rodrigues, Correia, & Rosa, 2016). The classic representations of masculinity and femininity coexist in contemporary times with new representations about what it is to be a man and a woman, which affect the way we look at care, people cared for and caregivers. Health institutions, on the other hand, are not "alien" to these processes and often appear as privileged spaces for the reproduction of gender relations, thus justifying the present research proposal.

2.2 Sexual and Reproductive Health

The concept of sexual and reproductive health emerges from the International Conference on Population and Development, held in Cairo in 1994, and originated the designation of "Reproductive Rights and Reproductive Health" defined as "a state of complete physical, mental and social well, and not only the absence of disease, in all matters related to the reproductive system, in its functions and process" (United Nations, 1995, p. 17). However, in order to have reproductive health it is necessary that "people are able to have a satisfactory and secure sexual life, that they have the capacity to reproduce and the freedom to decide to do so, whenever and as often as they wish" (United Nations, 1995, p. 17). It is a matter of human rights to "ensure that women and man have access to the information, education and services necessary to achieve good sexual health and to exercise their reproductive rights and responsibilities" (United Nations, 1995, p. 18).

Sexual health, understood as life-enhancing and interpersonal relations (DGS, 2008), integrates the issues of sexuality considered an important human dimension that influences the quality of life; it includes not only factors of a biological nature but also psycho-affective, sociocultural, ethical-legal,

political, and historical factors (WHO, 2006). Sexuality exists throughout the entire life cycle of the individual and can be expressed in multiple ways, enriching life and interpersonal relationships; it is not limited to reproductive function, but can be translated as the search for intimacy and pleasure, fulfilling also the need for communication. Identity issues (related to sex and gender identity), roles and gender relations, also integrate this comprehensive concept that is not just about sex (WHO, 2006).

The concepts of sexual health and reproductive health are thus closely related (although nowadays in the face of a new paradigm that dissociates reproductive sexuality) and the inherent rights are deepened throughout the 1990s, at the International Conference on Women in Beijing (1995), were embodied in the Sexual and Reproductive Rights Charter (IPPF, 1996) and later, in the Declaration of Sexual Rights (IPPF, 2008), documents aimed at their promotion and protection. These initiatives made it possible to understand that, by intervening in sexual and reproductive health issues involving female and male, positive relations between the two were also being promoted, and so was equality and gender equity.

In recent years, it has come to affirm the importance of investing in sexual and reproductive health issues as drivers of development and sustainability. Some of the eight Millennium Development Goals were linked to sexual and reproductive health (issues such as maternal morbidity and mortality, improved maternal health, fighting HIV/AIDS, fighting poverty, hunger or gender equality); some have been achieved but many are still to be met (United Nations, 2015). It is therefore necessary for the health care and nursing interventions in sexual and reproductive health to focus on a diversified set of services, techniques and methods that contribute to the health and reproductive well-being, giving appropriate responses to the needs of man and women in this area, throughout the life cycle (DGS, 2008).

2.3 Male Students' Difficulties in a Traditionally Feminine Care Area

Concerning the context of nursing clinical teaching in the area of Sexual and Reproductive Health, issues related to gender stereotypes, understood as prejudices or models that are established as standard, may arise and create obstacles to care (the caregivers, the supervisors or the clients); likewise, they can, simultaneously, influence the emotional experience and, simultaneously, the teaching-learning process of the male students. These stereotypes are based on social roles that historically have associated women to expressive function and man to instrumental function (as is the case of professions understood as an extension of informal care in a given field, such as nursing or education, where there may be devaluation of the care itself). In fact, Couto, Silva, Schraiber, Gomes and Figueiredo (2011) report that health professionals can adopt different behaviors towards men and women based on stereotypes. In this sense, since traditional gender roles shape social relations, which are perpetuated by beliefs and values socially transmitted though not always perceived, we can also think that patients might behave differently when cared for by female or male nurses (CIG, 2012). This may condition the access of male students to areas of care with more feminized representations such as sexual and reproductive health. Nevertheless, Renaud (2010) states that the intersubjective encounter conditioned by gender has no impact in the professional competence or quality of care as men and women may

display the same ethics, although phenomenally different.

Gender relations are also historically issues of power (Scott, 1995) and although gender equality is a fundamental value of the European Union, enshrined in the various European Treaties, we still witness strong inequalities in access, promotion and maintenance of male's health (Prazeres, 2009); in some professions the expectations still seem to be gender-based. With regards to healthcare, gender issues arise in Portugal in 2009 linked to sexual and reproductive health, historically a dimension of women's care. In this sense, introducing the gender perspective in this area of care is also a way to promote gender equality.

Several Equality Plans have already identified the gender perspective as a priority within health policies extended to all areas of society. However adequate skills and tools are required, and the concept of gender mainstreaming, acknowledged as the set of measures and strategies that promote gender equality (Perista & Silva, 2005). In Portugal, the 5th National Plan for Gender Equality, Citizenship and Non-Discrimination (2014-2017), approved by Council of Ministers Resolution No. 103/2013, defines gender equality as referring to the rights and freedoms of men and women with a view to equal opportunities, participation and recognition in the various spheres of life (public and private). When it concerns to sexual and reproductive health services, despite some changes, the accessibility of men to care is hindered by concrete physical barriers (lack of adequate spaces, bathrooms, eating places, own circuits, written information addressed to them). This may also influence students' perceptions of how they are accepted as male students by clients and clinical supervisors, in a much feminized care area. Ensuring equal opportunities, implies creating similar opportunities for students, male and female, analyzing how health services are organized according to gender, and understand how male students emotionally perceive these genderized experiences, and how they manage the emotions that stem from eventual gender stereotypes likely to influence their learning in this area of practice.

2.4 Gender and Emotional Competence

Nursing training, especially in a practice setting, should not be confined to the technical and scientific process, but also emphasize the student's personal development by the generating role that he has in all competences, especially those of a relational nature (Rabiais, 2010). That is, it is not possible to separate cognitive, social, affective and emotional dimensions when clarifying the factors that underlie the Nursing Care learning development. In addition to the other dimensions, the emotional dimension is essential not only for nursing practice but also for the student who often seeks success in a turbulent tangle of experiences, thoughts, and emotions that he needs to learn how to manage. To analyze the care process as a relational process impregnated with emotions and feelings (Diogo, 2015), becomes an attractive horizon because the emotional experience is omnipresent in each act of caring. The emotional labour is inherent to professional performance, which justifies the awareness of using those in the relationship with the clients, making it important to understand how nurses should seek and develop the human feeling experience as an instrument of care (Diogo, 2006). Emotions give meaning and guide

the nurse's actions by being explicitly intentional in their care (Diogo, 2015).

Regarding emotional competence, some authors point out that there are no gender-specific differences; nevertheless, they alert that different management strategies for emotions may be used depending on whether they are male or female (Erickson & Ritter, 2001). Kumar (2014), in her study on Emotional Labour, Emotions and Gender Management—who sought to analyze the emotional management of nurses from a gender perspective—concluded that there are no significant differences in the strategies adopted by participants concerning emotional management (repression or emotional disguise or seeking external support). Regarding the analysis of participants' perspectives on gender issues (for example gender effects and stereotypes) revealed that they are clearly felt. In this study it is also reported that women are better prepared for emotional management than men, and there is evidence of occupational segregation in certain professions, as previously mentioned by Taylor and Tyler (2000). On the other hand, Cottingham, Johnson, and Erickson (2017) in their study with nurses in the USA, conclude that there are differences, not only in emotional management but also in job satisfaction. The results indicate that gender seems to moderate the work of emotional management, which is associated in the case of men with its social "greater status". Getting less emotionally involved is less affected by negative emotions, and even when they get involved they are less likely to cover up these emotions which contributes to greater job satisfaction.

Currently, emotional involvement is a concept closely related to nursing care, characterized by nurses' sensitivity to the client's emotional needs (Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006). The same authors emphasize that the nurse, as an element who cares and is close to clients, absorbs their suffering experience. Despite not being able to be away from this fact, it plays an important role in relieving suffering through interventions that depend on the way stands emotionally (focused on himself or on the client). It is in the daily care of the different clinical contexts that the nursing student comes in contact with the clients, establishing a relationship that determines the mobilization of their emotions, which can be a source of discomfort. Specifically, in end-of-life client care, students reveal an increased need for emotional support (Terry & Carroll, 2008; Diogo, Rodrigues, Sousa et al., 2017). These experiences generate powerlessness in the way the student sees its performance, touched by the difficult management of their emotions, often mirrored in feelings of abandonment and guilt (Terry & Carroll, 2008). The revelation of these feelings highlights the importance of supervising nurses for the student as emotional support elements in emotionally intense situations (Terry & Carroll, 2008) to enhance emotional competence (Diogo, Rodrigues, Sousa et al., 2017).

According to Xavier (2013) the construct of "emotional competence" is not consensual and there is no clear definition of what it entails and defines. But it seems consensual that it is based on emotional intelligence, which is in line with Goleman (2010). Xavier (2013) also points out that the construct emotional competence includes various processes, giving rise to a variety of consequences, as well as allow us to understand, express and properly regulate the emotional phenomena. For the nursing researcher, the development of emotional competence occurs throughout life, with training and nurses'

emotional education acting as a preponderant role in optimizing its development.

3. Statement of Problem

3.1 Description of Research Problem and Questions

Gender stereotypes impacts on the development of male's emotional competence and influence sexual and reproductive health care. This problem is accentuated by male student's difficulties in access to sexual and reproductive health care and their restricted participation in sexual and reproductive health learning activities.

Considering the purpose of this research project—to explore the emotions experienced by male students in a nursing practice setting in the sexual and reproductive health area—we intend to answer the following questions:

- What are male students' emotional experiences?
- What are the feelings triggered by the restrictions on nursing care related to gender stereotypes?
- How they perceive these experiences? Do they review and incorporate the practice of care in the context of sexual and reproductive health?
- What emotional management strategies do they use and how do they promote the development of emotional competence that positively influences care in the area of sexual and reproductive health?

It is indeed important to answer the previous questions, which can shape the Caring experience, since the teaching-learning process can be influenced by the affective-emotional dimension.

3.2 Study Objectives

For the development of this project the following objectives were established:

- Understand the emotional experience of students of bachelor's degree in nursing in clinical teaching in the 3rd and 4th year in sexual and reproductive health.
- Analyze the gender stereotypes that influence students' emotional experience in the sexual and reproductive health area.
- Identify the emotional management strategies mobilized by the male students in the sexual and reproductive health area.

4. Method

4.1 Research Design Overview

Qualitative approach, descriptive and exploratory. This project is structured in two phases:

- In the first phase, 18 learning journals written between 2009 and 2017 by male students in clinical teaching, in the area of sexual and reproductive health, will be analyzed.
- In the second phase, a Workshop will be held with clinical supervisor nurses, in which the participants will be trained to include the gender perspective in clinical teaching, analyzing with them the results of the work performed in the first phase of this project. This Workshop will also allow the collection of contributions by the participating nurses (in the form of possible strategies identified by

them) through a focus group.

The data analysis will be performed according to the conventional content analysis technique (Hsieh & Shannon, 2005) in which the coding of categories derives directly from the text data through a predominantly inductive reasoning, and using the Software Nvivo 10 for organization and extraction the data relevant to the study.

4.2 Study Participants

Eighteen male students in years 4 of the Nursing Degree, in the scope of clinical teaching of sexual and reproductive health, and twelve nurse's supervisors in the same clinical setting.

4.3 Participant Recruitment

In compliance with the ethical principles in research, in April 2017 authorization was requested to the presidency and ethics committee of the Nursing School for the use of the content extracted from the learning journals written by the male students. The authorization was granted upon contact with them to obtain written informed consent. The participating nurses will give their consent during the Workshop. Throughout the entire investigation process the confidentiality of the collected data will be guaranteed by eliminating the names of students and nurses, assigning an identification code, to which only the researchers of the educational institution will have access.

5. Expected Results

The inclusion of the gender perspective in clinical teaching is an additional challenge for the area of sexual and reproductive health, since it is a traditionally female domain of care that has historically, socially and culturally excluded male as caregivers and as subjects of care. By having as target client's predominantly healthy people of reproductive age, to experience processes associated with sexuality, reproductive issues and family processes, requires an approach focused on the emotional and relational issues, but also gender sensitive. It is possible that male nursing students may feel "displaced" in a predominantly feminized environment, such as in the area of sexual and reproductive health, where they have to deal with eventual gender stereotypes, clients and clinical supervisors, often female, a wealth of feminized written and oral information, often conveyed in sexist and non-inclusive language. This task will be hindered if they have not been provided with gender-sensitive training during the academic teaching and are not guided by gender-aware persons, such as clinical supervision nurses.

Under these conditions, students' increased work (in relation to their female peers) is revealed by being able to deconstruct gender stereotypes, "filtering" their own representations and associated emotions about caring in this area and representations of clients and clinical supervisors. It is known that emotional competence promotes greater adaptive resilience capacity in the face of stressful situations. Understanding students' emotional experiences in clinical teaching of sexual and reproductive health, related to possible gender stereotypes and restrictions to care in this area, may facilitate the study of the phenomenon—gender stereotypes from the perspective of the male student, leading us to understand how emotion itself manages these genderized experiences, what sense it gives them and how it

incorporates them into learning in clinical teaching. On the other hand, the contribution of clinical nurse supervisors will be equally important for the co-construction of strategies to improve the students learning conditions and to promote more equitable educational experiences with regard to gender. By training these professionals to recognize and work on these stereotypes, we are helping students to promote a more holistic approach in nursing practice.

References

Aboim, S. (2007). Clivagens e continuidades de género face aos valores da vida familiar em Portugal e noutros países europeus. In K. Wall, & L. Amâncio (Eds.), *Família e género em Portugal e na Europa: atitudes sociais dos portugueses* (pp. 35-91). Lisboa: Imprensa de Ciências Sociais.

Amâncio, L. (1994). *Masculino e feminino: A construção social da diferença*. Porto: Afrontamento.

Amâncio, L. (2003). Ogénero no discurso das ciências sociais. *Análise Social*, *188*, 687-714.

Amâncio, L. (2004). *Aprender a ser homem: Construindo masculinidades*. Lisboa: Livros Horizonte.

CIG. (2012). *Guião de educação género e cidadania*. Lisboa: CIG.

Collière, M. (2000). *Promover a vida: Da prática das mulheres de virtude aos cuidados de enfermagem*. Lisboa: Lidel.

Cottingham, M., Johnson, A., & Erickson, R. (2017). "I Can Never Be Too Comfortable": Race, Gender, and Emotion at the Hospital Bedside. *Qualitative Health Research*, 1-14. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/29094641

Crespo, A., Ferreira, A., Couto, A., Cruz, I., & Joaquim, T. (2008). *Variações sobre sexo género*. Lisboa: Livros Horizonte.

DGS. (2008). *Saúde reprodutiva: Planeamento familiar*. Lisboa: DGS.

Diogo, P. (2006). *A vida emocional do enfermeiro: Uma perspectiva emotivo-vivencial da prática de cuidados*. Coimbra: Formasau.

Diogo, P. (2015). *Trabalho com as emoções em Enfermagem Pediátrica: Um processo de metamorfose da experiência emocional no ato de cuidar* (2nd ed.). Loures: Lusodidacta.

Diogo, P., Rodrigues, J., Sousa, O., Martins, H., & Fernandes, N. (2017). Desenvolvimento de competências emocionais do estudante de enfermagem em ensino clínico: A função de suporte do enfermeiro supervisor. In D. Paula (Ed.), *Investigar os Fenómenos Emocionais da Prática e da Formação em Enfermagem* (pp. 149-194). Loures: Lusodidacta.

Erickson, R., & Ritter, C. (2001). Emotional labor, burnout, inauthenticity: Does gender matter? *Social Psychology Quarterly*, *64*(2), 146-163. https://doi.org/10.2307/3090130

Faria, L., & Lima Santos, N. (2011). Questionário de competência emocional. In C. Machado, M. Gonçalves, L. Almeida, & M. Simões (Eds.), *Instrumentos e contextos de avaliação psicológica* (pp. 67-80). Coimbra: Almedina.

Giddens, A. (2008). *Sociologia* (6th ed.). Lisboa: Fundação Calouste Gulbenkian.

Goleman, D. (2010). *Inteligência Emocional* (13th ed.). Lisboa: Temas e Debates.

Hsieh, H., & Shannon, E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *9*, 1277-1288. https://doi.org/10.1177/1049732305276687

IPPF. (1999). *Carta dos direitos sexuais e reprodutivos*. Lisboa: Secretaria das ONG do Conselho Consultivo da CIG.

IPPF. (2008). *Declaração dos direitos sexuais*. Lisboa: Secretaria das ONG do Conselho Consultivo da CIG.

Kumar, P. (2014). *Trabalho Emocional, Gestão das Emoçõese e Género: Um enfoque nos profissionais dos serviços comerciais e da saúde*. Dissertação de Mestrado: Mestrado em Gestão de Recursos Humanos, Universidade do Minho: Escola de Economia e Gestão.

Louro, G. (2008). Género e sexualidade: Pedagogias contemporâneas. *Proposições*, *19*(2), 17-23. https://doi.org/10.1590/S0103-73072008000200003

Machin, R., Couto, M., Silva, G., Schraiber, L., Gomes, R., & Figueiredo, W. (2011). Concepções de género, masculinidade e cuidados de saúde: Estudo com profissionais de saúde da atenção primária. *Ciência e Saúde Colectiva*, *16*(1), 4503-4512. https://doi.org/10.1590/S1413-81232011001200023

Morse, J., Bottorff, J., Anderson, G., O'Brien, B., & Solberg, S. (2006). Beyond empathy: Expanding expressions of caring. *Journal of Advanced Nursing*, *1*, 75-90. https://doi.org/10.1111/j.1365-2648.2006.03677.x

Oliveira, M. (2016). O Cuidar e o género. *Atas do I Congresso Internacional em Saúde Materna*. Lisboa: ESEL.

Perista, H., & Silva, A. (2005). Impacto em função do género: Avaliação de medidas de política. Cadernos Condição Feminina. *Coleção Bem me Quer*, *10*.

Prazeres, V. (2009). *Género e Indicadores de Saúde*. Lisboa: CIG. Retrieved from https://www.cig.gov.pt/wp-content/uploads/2014/01/159_164_t3c_capF.pdf

Rabiais, I. (2010). Sensibilidade emocional dos estudantes de enfermagem na aprendizagem de cuidar. In A. Fernandes, Â. Santos, C. Barros, E. Guilherme, M. J. Martins, M. J. Miranda, & R. Vilela (Eds.), *Emoções em saúde—Contributos* (pp. 36-53). Fátima: Corrente Dinâmica.

Renaud, I. (2010). O cuidado em enfermagem. *Revista Pensar Enfermagem*, *14*(1), 2-8. Retrieved from http://pensarenfermagem.esel.pt/files/2010_14_1_2-8(2).pdf

Resolução do Conselho de Ministros N.º 103/2013 de 31 de dezembro. (2013). *V Plano Nacional para a igualdade de género, cidadania e não-discriminação 2014-2017, aprovado pela Resolução do Conselho de Ministros N.º 103/2013 de 31 de dezembro. Diário da República I Série, Nº 253 de 31 de dezembro de 2013*.

Scott, J. (1995). Género: Uma categoria útil de análise histórica. *Educação & Realidade: Gênero e Educação*, *20*(2), 71-99. Retrieved from https://edisciplinas.usp.br/pluginfile.php/185058/mod_resource/content/2/G%C3%AAnero-Joan%20Scott.pdf

Taylor, S., & Tyler, M. (2000). Emotional Labour and Sexual Difference in the Airline Industry. *Work, Employment & Society*, *14*(1), 77-95. https://doi.org/10.1177/09500170022118275

Terry, L., & Carrol, J. (2008). Dealing with death: First encounters for first-year nursing students. *British Journal of Nursing*, *17*(12). https://doi.org/10.12968/bjon.2008.17.12.30298

United Nations. (1995). *Report of the International Conference on Population and Development (Cairo)*. New York: United Nations.

Wall, K. (coord.), Cunha, V., Atalaia, S., Rodrigues, L., Correia, R., Correia, S., & Rosa, R. (2016). *Livro Branco: Homens e Igualdade de Género em Portugal*. Lisboa/CITE.

WHO. (2006). *Definig sexual health: Report of a technical consultation on sexual health*. Geneva: WHO.

Xavier, S. (2013). *Significar a competência emocional do enfermeiro na prestação de cuidados de conforto à pessoa em fim de vida* (Tese de doutoramento em Enfermagem). Retrieved from https://ulsd067222_td_Sandra_Xavier.pdf