

---

5-28-2012

## Hemiplegia in Men: A Case Study

Zenobia C.Y. Chan

*The Hong Kong Polytechnic University, zenobia.chan@polyu.edu.hk*

Gary C.T. Wong

*Caritas Rehabilitation Service, gary\_wongct@hotmail.com*

Follow this and additional works at: <https://nsuworks.nova.edu/tqr>



Part of the [Quantitative, Qualitative, Comparative, and Historical Methodologies Commons](#), and the [Social Statistics Commons](#)

---

### Recommended APA Citation

Chan, Z. C., & Wong, G. C. (2012). Hemiplegia in Men: A Case Study. *The Qualitative Report*, 17(22), 1-17. <https://doi.org/10.46743/2160-3715/2012.1766>

This Article is brought to you for free and open access by the The Qualitative Report at NSUWorks. It has been accepted for inclusion in The Qualitative Report by an authorized administrator of NSUWorks. For more information, please contact [nsuworks@nova.edu](mailto:nsuworks@nova.edu).

---



**Qualitative Research Graduate Certificate**  
*Indulge in Culture*  
Exclusively Online • 18 Credits  
**LEARN MORE**

NSU  
NOVA SOUTHEASTERN  
UNIVERSITY

NOVA SOUTHEASTERN

## Hemiplegia in Men: A Case Study

### Abstract

Hemiplegia, or paralysis of one side of the body, is caused by injury or illness (for example, a stroke), and leads to other disabilities. People with hemiplegia are limited physically in their daily activities. This limitation affects their social well-being and thus can lead to depression. This paper provides a comprehensive literature review on hemiplegia in men. A single case study of a man with hemiplegia living in Hong Kong is also presented here. A critical discussion of the signs and symptoms of “male-type” depression and humanising attitudes towards men with hemiplegia follows. Critical areas in rehabilitation, social support, and developing partnerships are also highlighted. This paper intends to facilitate better understanding by health and social care providers of the needs of men with hemiplegia. Implications for clinical practice and research are likewise addressed. Further studies using multiple case studies are recommended to ensure a comprehensive understanding of hemiplegia in men.

### Keywords

Hemiplegia, Case study, Men’s Health, Paralysis

### Creative Commons License



This work is licensed under a [Creative Commons Attribution-NonCommercial-Share Alike 4.0 License](https://creativecommons.org/licenses/by-nc-sa/4.0/).

## **Hemiplegia in Men: A Case Study**

Zenobia C.Y. Chan

The Hong Kong Polytechnic University, Hong Kong

Gary C.T. Wong

Caritas Rehabilitation Service, Hong Kong

---

*Hemiplegia, or paralysis of one side of the body, is caused by injury or illness (for example, a stroke), and leads to other disabilities. People with hemiplegia are limited physically in their daily activities. This limitation affects their social well-being and thus can lead to depression. This paper provides a comprehensive literature review on hemiplegia in men. A single case study of a man with hemiplegia living in Hong Kong is also presented here. A critical discussion of the signs and symptoms of “male-type” depression and humanising attitudes towards men with hemiplegia follows. Critical areas in rehabilitation, social support, and developing partnerships are also highlighted. This paper intends to facilitate better understanding by health and social care providers of the needs of men with hemiplegia. Implications for clinical practice and research are likewise addressed. Further studies using multiple case studies are recommended to ensure a comprehensive understanding of hemiplegia in men. Keywords: Hemiplegia, Case study, Men’s Health, Paralysis*

---

There are more than 600,000 people with disabilities worldwide (World Health Organization, 2007), and hemiplegia is one of the more common disabling conditions. It is defined as the paralysis of one side of the body (Pedretti, Smith, & Pendleton, 2001). It is caused by disease or injury to the opposite hemisphere of the brain. People with hemiplegia often display difficulties in mobility, cardiopulmonary function, and sensory functioning (Savinelli, Timm, & Montgomery, 1978). These difficulties affect their activities in daily living and thus have a negative impact on the quality of their life (Kong & Yang, 2006; Pedretti et al., 2001).

Conservative therapy for people with hemiplegia involves medical and surgical treatments. These aim to prevent complications from injuries such as cardiac diseases and pneumonia. Physiotherapy, occupational therapy, and speech therapy are also common treatments used to improve physical functions and maximise daily living and communication skills (Pedretti et al., 2001; Sunnerhagen, 2006).

Having disabilities, people may face difficulties in their daily lives, such as dependence on others in self-care and work. They may feel angry, depressed, and guilty when facing these challenges (The Royal College of Psychiatrists, 2007). This may be particularly true with men, on whom the image of masculinity is projected, including the attributes of power, control, strength, independence, and dominance (Tager, Good, & Morrison, 2006). This image may hinder men from expressing their difficulties in dealing with their disabilities. This problem is even more serious in traditional Chinese culture, where men are encouraged to take up all responsibilities, rather than to share their needs and feelings with others (Tam, Chan, Lam, & Lam, 2003). Note, however, that previous

research shows that the efficacy of hemiplegia treatments was not gender-determined (Chen, Mu, & Li, 2006); no significant gender difference was noted in hemiplegia treatments. As a result, healthcare professionals may not be aware of male patients' concerns in the rehabilitation process.

In this paper, a single case study is adopted to discern and evaluate the needs and difficulties of a man with hemiplegia. Alternative treatment approaches, with a focus on psychosocial needs, have been proposed to assist exploring his potential, and to motivate him to undergo healthcare treatment. A comprehensive literature review about hemiplegia and men with disabilities, a case study detailing the challenges of a typical man with hemiplegia, the implications of the study on healthcare practice, and the study limitations are discussed below.

## **Literature Review**

### **Men with Hemiplegia**

More than 600 million people worldwide live with various disabilities that are caused by chronic diseases, injuries, violence, and aging (World Health Organization, 2007). Hemiplegia is one of the more common disabilities, and may be caused by neurological problems like stroke and brain injury (Pedretti et al., 2001). Men with hemiplegia may have difficulties in self-care, home management, community integration, vocational skills, and leisure skills (Phipps & Richardson, 2007). Their vocational and sexual lives are also seriously affected (Marini, 2001). Comprehensive rehabilitation programs, such as physiotherapy, occupational therapy, speech therapy, and dietary and nursing care programs, are essential to facilitate independence in daily living in men with hemiplegia.

The culturally-dominant notions associated with masculinity may influence health practices (Gough, 2006). Men also tend to adopt an unhealthy diet (Wardle et al., 2004), take risks, and take up sports in terms of masculine attributes rather than for health benefits (Messner, 1992). These negative health practices may increase the risk of sustaining injuries and disabilities like hemiplegia (Good et al., 2008).

### **Depression in Men with Hemiplegia**

Men with hemiplegia display locomotion difficulties, speech deficits, and seizures, which lower their sense of self-esteem (Adamson, 2003; Pearson, Carr, & Halliwell, 1985; Tam, 1995; Tam et al., 2003). Consequently, both their physical appearance and fitness are affected, which in turn influence their self-image and psychological well-being (Tager et al., 2006). Academic, work, social, as well as romantic relationships are also affected (Gibbs, 2007; King, Shultz, Steel, Gilpin, & Cathers, 1993). Previous research also showed that men with disabilities are viewed as helpless, incapable, and inferior (Lyons, 1991; Marini, 2001). They experience being marginalised and stigmatised in society (Gerssick & Miller, 1997). This reduces their chances of reaching their potential as they go about their daily lives, and subsequently affects their quality of life.

Social support, especially from spouses, is one of the primary factors that aids men in coping with their illness and disability (Good et al., 2008; Gray, Fitch, Phillips,

Labrecque, & Fergus, 2000; Keitel, Zevon, Rounds, Petrelli, & Karakousis, 1990). Social support is also one of the factors that facilitates recovery from disability (Maunsell, Brisson, Deschenes, 1995). However, men hesitate to acknowledge their difficulties in front of women in order to obtain social support (Gray et al., 2000; Gibbs, 2007), and this contributes to higher levels of distress. Without sufficient support, men may adopt avoidance strategies, such as sleeping more than usual, alcohol consumption, and hiding their feelings from others (Gough, 2006; Heim, Valach, & Schaffner, 1997; World Health Organization, 2002).

### **Therapy for Men with Hemiplegia**

Conservative treatments like physiotherapy, occupational therapy, and speech therapy are common for men with hemiplegia. Studies have documented the effectiveness of therapeutic activities in improving the functions of people with hemiplegia (Pedretti et al., 2001; Saunders, Greig, Yong, & Mead, 2004; Savinelli et al., 1978). Concerning the gender factor, research has reported no significant differences in gender on treatment outcomes (Chen et al., 2006; Gokkaya, Aras, Yesilteps, & Koseoglu, 2006). Special concerns of men in receiving treatment are usually disregarded. In a previous study, the finding was that extra attention on receiving treatment is essential for men, as masculinity-related factors may prove detrimental to their recovery from disabilities (Good et al., 2006). Previous studies also consistently indicate that men are less likely to recognize their health problems (Courtenay, 2001; U.S. Department of Health and Human Services, 1998). This inattention may lead to delays in receiving treatment and thus may lower treatment effectiveness.

Psychosocial therapy is essential in assisting men to cope with hemiplegia. It can relieve the emotional disturbances and challenges involved during the adjustment period. It can equip men in learning how to cope with disabilities. As has been observed, men with hemiplegia are comfortable in an atmosphere where they can feel accepted, their viewpoints recognised, and their feelings validated through the process.

### **Counselling for Men with Hemiplegia**

Men with hemiplegia often display depression and refuse communication. Counselling has been found to reduce depressive moods and facilitate communication (Courtenay, 2001). Therefore, in communicating with men with hemiplegia, ambivalence should be viewed as normal in the initial stage of therapy. Confrontation and argumentation with them should be avoided (Miller & Rollnick, 2002). Becoming more empathic during counselling, remaining calm and not criticizing throughout the process are important. This approach could help them recognise the support they need to facilitate improvements in their situation.

Rehabilitation counselling is also common in psychosocial adjustment for men with hemiplegia (Don, 1996; Morse & Fife, 1998; Wong, Lee, & Lau, 2006). This method emphasises optimisation of personal capabilities to develop effective coping strategies and to accept their disabilities. A non-directive counselling approach also allows patients to take an active role in exploring their particular concerns (Don, 1996). This approach is also flexible and conducive to establishing rapport.

An extensive review of the literature reveals that patients are more likely to receive counselling and education from clinicians than to undergo physical examination (U.S. Preventive Services Task Force, 1996). This implies that extra attention is required, which is an important success factor in communicating with men with hemiplegia. There are also particular topics that may upset men with hemiplegia, and as such, sensitivity is imperative. Avoiding anticipatory anxiety and discomfort in communications is also important (Marini, 1992).

Men with depression are less likely to seek healthcare services, and tend to withdraw from others more (Courtenay, 2001). Seeking help is viewed as undermining a man's sense of independence. Humanising attitudes in communications, with reinforcement on men's health-seeking behaviours, may help them to adhere to therapy and thus enhance treatment compliance (Mercherbaum & Turk, 1987).

### **The Situation in Hong Kong**

Hong Kong is a competitive living and working environment, where men with hemiplegia are at a disadvantage at work. The unemployment rate of people with disabilities is 50% (Hong Kong Council of Social Service, 2007), dramatically higher than the 4.2% rate among people without disabilities (Census and Statistics Department, 2007). Besides work, men with hemiplegia are less competitive in their academic and social lives. As masculinity is emphasised in traditional Chinese culture, failure in work and failure to provide a "wealthy life" for one's family may have a negative impact on self-esteem, causing depression in men. Research also shows that people with physical disabilities have lower self-confidence (Tam et al., 2003).

In Chinese culture, men believe that in the face of difficulties, they can get better without any help. Men are also less likely to disclose their problems to others, including to healthcare professionals (Wong et al., 2006). This may hinder men with hemiplegia from receiving appropriate therapy.

### **Knowledge Gaps**

There have been several studies done to evaluate the needs of men with hemiplegia. A study conducted by Lease, Cohen, and Dahleck (2007) indicated social perceptions of the disability where the perceived severity of disability could significantly predict interpersonal competency relations among men with disabilities. However, the focus of their study was sexual rehabilitation, thus the many other needs of men with hemiplegia may not have been discussed thoroughly.

Schopp et al. (2007) investigated the impact of masculine role variables on treatment outcomes in men with disabilities. The study showed that some traditional masculine concepts, such as the ability to control strong emotions, could be adaptive in the rehabilitation process, while other characteristics like dominant interpersonal traits may be a barrier to effective rehabilitation. However, because their study was based on a quantitative approach, the documented experience among men with hemiplegia may have been limited.

Although numerous counselling and psychological interventions for men have been recommended in the last two decades, limited psychosocial techniques have been

emphasised for healthcare professionals working with men in healthcare settings (Courtenay, 2000, 2001; Sutkin & Good, 1987). This paper aims to fill the knowledge gap by using a single case study approach to express the needs of one man with hemiplegia in the process of rehabilitation.

### **Researcher Context**

Zenobia C. Y. Chan is an assistant professor in nursing and she educates at the undergraduate and master level at The Hong Kong Polytechnic University. Her research interests include communication in nursing, qualitative research methods in health care, and multidisciplinary research on topics such as the family, education, and spirituality. She wishes to contribute to the healthcare system by empowering patients and their families, providing context-based care plans, and launching culturally-sensitive health initiatives.

Gary C. T. Wong is an occupational therapist providing rehabilitation service to clients with disabilities. He uses rehabilitation counseling techniques to empower clients throughout the rehabilitation process. Through the contact with clients in daily practice, he realizes the importance of understanding the needs of men with hemiplegia in order to tailor the rehabilitation program for them.

## **Methods**

### **Study Design**

A single case study approach was adopted. The case provided in-depth information about his needs. Since there is a gap in the understanding of how men with hemiplegia experience rehabilitation counselling, qualitative research is useful to explore the phenomenon that is little understood. It may also explore the thoughts, perceptions, and feelings of the participant. Readers also are invited to enter into and experience the world of the participant (Hipsky, 2006; Yin, 1993).

### **Selection of Participant**

The case was selected from the workplace of the researcher, which is one of the largest social service agencies providing rehabilitation services for people with hemiplegia in Hong Kong. The researcher provided rehabilitation counseling service to the participant. The researcher used criterion sampling. The participant was selected based on certain criteria: paralysis at one side of the body, changes of lifestyles after the onset of illness, or disabilities and low motivation to participate rehabilitation programs. This ensured relevant, complete, and sufficient amount of information obtained. Since this was an exploratory type of study, and it aimed at describing experiences, a non-probability sampling strategy was utilized.

## **Data Collection and Analysis**

A semi-structured interview was conducted by the researcher. The session lasted 60 minutes. The whole interview was videotaped and transcribed. The researcher performed a content analysis of the transcriptions to analyze the data. It consists of examining categorizing, tabulating, or otherwise recombining the evidence to address the initial propositions of a study (Polit & Beck, 2004; Yin, 1994). As a first step, the researcher reviewed the data to identify relevant parts. The researcher then developed primary categories by marking all the relevant parts and linking them into significant socio-psychological themes (Philaretou & Allen, 2006). The data were then fitted into the categories. Descriptive paragraphs about the categories were written, and relationships between the categories were explored (Ausband, 2006; Hipsky, 2006; Morse & Field, 1995; Philaretou & Allen, 2006; Polit & Beck, 2004). Pairwise comparisons between categories and responses from the participants were done to ensure that the “voice” of the participant was included and that data saturation was achieved (Onwuegbuzie & Leech, 2007). When categories were linked, the researcher went back to the original data to search for any missing data to ensure that all information was analysed. The interview was in Cantonese; only the most insightful segments were translated into English.

## **Ethical considerations**

Before data collection, written consent explaining the aims and nature of the study was given to the participant. Also, the researcher informed the participant there was no risk in participation of the study. He was informed of refusing to participate at any time of the study, by not attending the interview. This also guaranteed anonymity (Polit & Beck, 2004). Since the context of the setting did not require third-party approval, only one written consent form from the researcher was obtained. To protect personal data of the participant, he was assured that his information was only exposed to the researcher, and his personal information would not be given to any third parties. Also, the information would be destroyed after the study. Contact phone number and email address of the researcher were given to the participant, and he was welcome to contact the researcher if he had a question. The participant joined the study voluntarily. The participant agreed to join the study by signing the consent letter prepared by the researcher.

## **Trustworthiness**

Credibility and transferability were guaranteed to maintain trustworthiness in qualitative study (Polit & Beck, 2004; Morse & Field, 1995; Yin, 1994). To maintain credibility, the researcher had persistent observation on the repeated characteristics that were relevant to phenomena (Polit & Beck, 2004). The researchers were experienced practitioners and researchers in qualitative study. The researchers could self-critique, and obtain feedback from the team, then make changes accordingly throughout the study (Ausband, 2006).

As the interview was the unique data collection method in the study, it had the risk of including incorrect data analysis and researcher bias in analysis and reporting (Yin,

1994). To prevent this, preliminary data summaries were reviewed and discussed with a university professor specializing in rehabilitation counseling to offer alternative explanations and suggestions (Polit & Beck, 2004; Yin, 1994). Also, the data were given to the participant to comment on the interpretation.

## Results

The results of this qualitative study illustrate the changes of the participant as the result of hemiplegia. Positive aspects of the changes are the focus. Therefore, strengths and the social supports of the participant are explored in order to overcome the hemiplegia. During analysis of the interview, the themes were developed based on the questions: *What are the changes in the participant's lifestyle resulting from hemiplegia? What are the strengths of the participant?* These are categorised by the main themes.

### Background of the Participant

The patient, John (not his real name), is 21 years old and endured a stroke one year ago. Because of this, John developed right hemiplegia and now requires assistance from his mother in his daily activities. John currently lives with his family. Before hemiplegia, John was in high school. His academic performance was good, and his admission to a university after graduation was expected. However, as his physical and cognitive functions were affected by hemiplegia, he was unable to complete his high school studies.

John receives conservative stroke therapies. However, he has developed depression over the past 6 months. He refuses to perform treatment activities such as rehabilitation exercises. In the past few months, his motivation to join social activities has also declined.

As counselling is found to reduce depressive moods and facilitate communication (Courtenay, 2001), a counselling session is conducted. This aims to help John regain his interest in treatment and develop a rapport with John.

### Lifestyle Changes after Stroke

John expressed a sudden lifestyle change as the result of hemiplegia, from an active teenager to a passive patient. At that moment, he showed difficulties in accepting the changes.

Researcher: "What do you do every day?"

John: "...The usual...watching TV...listening to the radio..."

Researcher: "Is there any particular TV or radio program that you are interested in?"

John: "Nothing special, just have nothing else to do at home."

Researcher: "Do you have any other interests?"

John: "None now..."

Researcher: "How about in the past?"

A moment of silence (about 5-10 seconds) was observed at this point. John took this time to organise his thoughts, and he was encouraged him to express the feelings (Ira & David, 1999).

John: "I used to play basketball when I was still a student...I was in the school basketball team. But it is all different now..."

John then dropped his head, focusing on his affected limb. This body language indicated that he still had not accepted his disabilities.

Researcher: "You had an active youth in the past. You changed a lot after the onset..."

Before the onset, John was interested in basketball. However, he had given up the interest due to hemiplegia. It was known that John could not accept his disabilities and adapt to the lifestyle changes. John focused on his abilities in the past rather than the present residual strength. Also, he was not aware of the need to use the residual abilities to cultivate new hobbies.

### **John's Strengths**

Although John focused on his disabilities, his strengths were explored gradually as the interview proceeded. It was known that John was a good basketball player.

John: "I get many prizes in basketball competition. Also, I am one of the representatives of the district basketball team, which is hard to be selected..."

Researcher: "What do you think about playing basketball again now?"

John: "I have lost contact with all my teammates, and I don't think I can play as well as before..."

John spoke passively about his abilities, only focussing on his disabilities. He overlooked his strengths. Through sharing similar experiences, John began to realise that he still has strengths, and he could regain his interest again.

Researcher: "I have encountered some patients with physical limitations, but they are good sports players, they win many prizes."

John: "Really?"

Researcher: "But they all exert effort in training and participate in treatment activities."

As the rapport was gradually established, John was willing to be more expressive about his reasons for refusing treatment activities.

John: "I have participated in treatment activities for several months, but until now I still need a lot of assistance from my mother."

Researcher: "You require assistance, how?"

John: "My mother helps me in simple tasks, such as cooking food..."

Although John showed a marked improvement in daily activities by joining the treatment program, the changes were suppressed. The positive changes were emphasized to let John understand the importance of treatment program in improving his abilities. This acts as reinforcement for John's efforts.

Researcher: "How about your self-care?"

John: "Sure, I do it by myself!"

John said this in a confident voice. He was motivated when he talked about or found his strengths.

Researcher: "Do you still remember how you were just after the onset?"

John: "...Lying on the hospital bed all day... I required assistance in walking..."

Researcher: "How about now?"

John: "It is much better than last year."

Researcher: "Do you know what you have done to make such changes?"

John: "I don't know exactly...but I have treatment every day... and complete my home program after discharge..."

Researcher: "Yes, the key to improving your ability is actively participating in treatment activities. If you do not, I am sure you could not perform your self-care activities as well as you do now."

John was not aware of his changes since he joined the treatment program; this reduced his motivation to continue. During this interview, positive regard was shown, which meant expressing appreciation to John, providing support and acceptance, and recognising him as a unique and worthwhile person. Reacting to this, John felt more confident and willing to face the challenges in the rehabilitation process.

### **Social Support from Family**

John expressed that his mother has taken care of his daily activities since the onset of his disabilities, which became a core component in the rehabilitation process.

Researcher: "Could you tell me more about your mother?"

John: "She works in a restaurant as a cleaner. She works from 9 a.m. to 10 p.m. every day."

Researcher: "How can she help you in cooking food?"

John: "She does this at night...and so she goes to sleep late at night..." (Patient speaking slowly and avoiding eye contact with the interviewer)

Researcher: "When does your mother wake up and go to bed?"

John: "She goes to bed at 1:00 a.m. and gets up at 6:00 a.m." Researcher: "Your mother is really hard-working...Don't you think?"

John: "..."

A moment of supportive silence indicated that John understood the hard work of his mother. Although John's mother has taken care of John since the onset of his disabilities, he has overlooked his mother's efforts. The interview let John recognise that his mother has always supported him. Also, John's mother acted as a role-model, demonstrating that he needed to work hard in the rehabilitation process.

### **Discussion**

The results of the case study show one man with hemiplegia displaying signs and symptoms of "male-type" depression, which are often ignored and left untreated (Pollack, 2001). These symptoms include increasing withdrawal from relationships, avoiding help from others, denying sadness, and making harsh self-criticism (American Psychiatric Association, 1994). Throughout the interview, sensitivity to man's pride must be observed. In the case of John, he did not willingly show any sign of weakness. Therefore, in counselling him, harsh self-criticism must be prevented to avoid further embarrassment (Pollack, 2001). The interview with John created a therapeutic environment, simultaneously allowing the patient to save face while denying his dependence on healthcare professionals.

The case of John revealed how he typically tends to control his emotions and to be stoic at times (Harris, 1995). John rigidly adheres to this masculine identity and tends not to disclose his vulnerabilities. This was why he refused to describe his difficulties in his daily living.

The first step to promoting health for this man with hemiplegia is to humanise the situation. Humanising means validating or normalising one's health problems and concerns (Courtenay, 2001). The first step was to convey that his feelings and experiences were understandable or legitimate. This strategy can seriously undermine the "male identity" (Charmaz, 1995). Humanising communications can also assist him in overcoming his difficulties in expressing discouragement and fear in front of others (Courtenay, 2001).

Highlighting the patients' strengths also fosters motivation and treatment compliance. Commenting on men's strengths before evaluating how they feel may reduce embarrassment and allow them to express their emotions freely (Rappaport, 1984). To recall John's case, his successes in school and in self-care were highlighted in the interview; this encouraged him to be an active participant again in his own health care (Courtenay, 2001).

The problem-solving approach we adopted to empower John so he could express his difficulties. This can concretely alleviate his fears (Marini, 2001). For example, John's experience in joining treatment activities in the acute phase of hemiplegia was shared. This allowed him to understand the effectiveness of therapy on his functional improvement.

John often demonstrates difficulties in communicating, especially in identifying and describing their feelings. Communication that is focused primarily on exploring and expressing emotions is likely to make him feel frustrated and uncomfortable (Mahalik, 2001; Rubin, 1983). The words "feel" and "depressed" were avoided in communication. Focusing on thoughts may feel more natural for men who conform to traditional gender roles. Traditional adolescent gender roles were shared with John, like being a competent

sports player and student. This might have helped him to express his thoughts; for example, his hope to be engaged in sports again.

Men are thought to value independence, autonomy, and self-sufficiency (Courtenay, 2001; Marini, 2001). Therefore, they have significantly less extensive social networks. Involving friends and family for social support is also essential to improve the clinician-patient relationship and clinical outcomes (Delbanco, 1992). In John's case, the involvement of his mother in the early stage of therapy provides him with continuous social support.

Besides family, healthcare providers may also be an important source of support for men, especially unmarried men (Courtenay, 2001). Research indicates that men respond positively to efforts at follow-up contact (U.S. Preventive Services Task Force, 1996). In John's case, follow-up interviews and telephone follow-ups were planned to provide him with ongoing support.

Previous studies found that self-disclosure by male clinicians could make male patients feel safer in exploring issues of disease and disability (Courtenay, 2001; Mercherbaum & Tunk, 1987). Self-disclosure could establish a basis of similarity and promote trust. This may lead to increased treatment adherence and to an increased sense of competence and self-efficacy. Similarly, in the case of John, a partnership approach was established between him and the interviewer. Health care became a shared responsibility for the healthcare professional and for John. A previous study also found that men may value partnership and friendship through working on tasks or activities together (Courtenay, 2001).

In some cases, men have relatively little experience with the healthcare system. Thus, healthcare professionals are advised to use clear, simple, and direct words in promoting health for men with disabilities (Make, 1994; U.S. Preventive Services Task Force, 1996). In addition, men are generally less comfortable receiving information than giving it (Tannen, 1990). In the case study presented, the interviewer provided opportunities for John to elaborate on his knowledge of his health condition, and then followed this up by providing supplementary information.

Male patients are more likely to adhere to treatment when they have a sense of control over their disabilities (O'Brien, Petrie, & Raeburn, 1992). Thus, John must be made to feel that healthcare professionals recognize him as an individual (Rappaport, 1984).

### **Limitations**

This single case study explored how the participant felt about his disabilities. However, the transferability of results is questionable. Furthermore, as John was invited by convenience sample, his needs are not likely to represent all the needs of men with hemiplegia. Purposive sampling is recommended to invite participants with atypical experience. In addition, multiple case studies are preferred to obtain the views of participants until data saturation is reached and a comprehensive understanding of the needs of men with hemiplegia achieved. Also, member checking could be done by inviting participants to review the results, or employing a research team to conduct the review. This could improve the integrity of the study (Yin, 1994).

### **Implications of Men's Health Practice**

Men with hemiplegia have varied needs. However, many of them are unable to express these needs openly, while women, in general, are willing to express their feelings in front of others. In this situation, women are at an advantage in a healthcare setting: their needs are possibly better addressed since they are able to express themselves more freely (Gibbs, 2007; Wong et al., 2006). Men with disabilities need to be understood in the context of the difficulties they encounter in their daily activities, including work and leisure. This single case study may act as an initial step in exploring the needs of men with hemiplegia. It is also essential for health care professionals to assist men with hemiplegia so that they can learn to adjust to their situation, while evaluating the patients' strengths throughout the rehabilitation process.

Similarly, in the case of John, he needs to re-connect with his identity and his strength. As male patients receive healthcare services, they need to be helped to regain their self-respect, dignity, and confidence (Widang & Fridlund, 2003). Throughout the rehabilitation process, male patients need to participate fully so that they know when they need assistance the most, and so that they can be helped in making decisions and in managing their day-to-day activities (Widang & Fridlund, 2003). It is essential for healthcare professionals to establish partnerships with male patients in order to empower them, because if patients continue to feel powerless, the risk of their illness worsening increases (Wallerstein, 1992). Recognising that the learning patterns and conversational styles of men are different from those of women (Golombok & Fivvish, 1994) may prove useful. It is imperative that health care professionals understand the gender differences in their interventions with men to help enhance the effectiveness of the therapy being applied.

In John's interview, he struggled with the loss of independence in his daily functions, having to comply with treatment rules, and being a passive recipient of certain services. He was also struggling with financial matters and his future employability (Marini, 2001). These manifestations may also mean that in general, men with hemiplegia struggle with the same challenges. Addressing these challenges in health care could enable men with hemiplegia to develop a sense of control over their daily lives.

John experienced a sense of helplessness, as he required the assistance of others in his daily life. In the process, he had abandoned his previous interests. To cite an observation from a previous study, there is an almost intolerable boredom owing to the loss of a previous active lifestyle (Marini, 2001). If recreational activities are not incorporated into routine healthcare treatment, men may lose the motivation to participate (Marini, 2001). Thus, healthcare professionals should consider the values and interests of their clients, and incorporate these elements in the healthcare programs.

Some anti-social responses like avoidance and isolating oneself from others are also found in John. Healthcare practitioners can help patients to explore their concerns, and to recognise and appreciate their own individuality (Marini, 2001). In John's case, his strength and interests were identified, and he was given reassurance. This enabled him to identify his uniqueness, despite his disabilities.

Individual case study methodology could provide new insights in counselling practice (Chan, 2007). Using this approach, one can understand the values of each patient (Cunningham, 1998). Each patient has his own stories, and his needs are unique. In this

case, John's history and family background were explored.

This single case study explored the need of a man in the rehabilitation process. Further studies using various communication strategies for this particular population would be a valuable contribution to understanding the emotions of men with hemiplegia. Men may also have different needs at different life stages (Smith, 2006). Discerning the values and concerns of men with disabilities at different life stages is important in developing a comprehensive rehabilitation plan for them.

## References

- Adamson, A. (2003). Self-image, adolescence, and disability. *The American Journal of Occupational Therapy*, 57(5), 578-581.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Ausband, L. (2006). Qualitative research and quilting: Advice for novice researchers. *The Qualitative Report*, 11(4), 764-770. Retrieved from <http://www.nova.edu/ssss/QR/QR11-4/ausband.pdf>
- Census and Statistics Department. (2007). *Hong Kong statistics-labour*. Retrieved from [http://www.censtatd.gov.hk/hong\\_kong\\_statistics/statistics\\_by\\_subject/index.jsp?subjectID=2&charsetID=2&displayMode=T](http://www.censtatd.gov.hk/hong_kong_statistics/statistics_by_subject/index.jsp?subjectID=2&charsetID=2&displayMode=T)
- Chan, C. Y. Z. (2007). The grandfather-grandson relationship in Hong Kong. *International Journal of Men's Health*, 6(2), 115-126.
- Chen, L., Mu, R., & Li, J. (2006). Analysis on relative factors of influencing limb functional recovery in the patient with hemiplegia. *Zhongguo Zhenjiu*, 26(11), 778-780.
- Charmaz, K. (1995). Identity dilemmas of chronically ill men. In D. Sabo & D. F. Gordon (Eds.), *Men's health and illness: Gender, power and the body* (pp. 261-291). Thousand Oaks, CA: Sage.
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50, 1385-1401.
- Courtenay, W. H. (2001). Counseling men in medical settings: The six-point HEALTH plan. In G. R. Brooks & G. E. Good (Eds.), *The new handbook of psychotherapy and counseling with men* (pp. 59-91). San Francisco, CA: Jossey-Bass.
- Cunningham, R. (1998). Counselling someone with severe aphasia: An explorative case study. *Disability and Rehabilitation*, 20(9), 346-354.
- Delbanco, T. L. (1992). Enriching the doctor-patient relationship by inviting the patient's perspective. *American College of Physicians*, 116(5), 414-418.
- Don, A. B. (1996). *Counselling skills for health professionals*. South Melbourne: Macmillan Education Australia.
- Gerssich, T. J., & Miller, A. S. (1997). Gender identities at the crossroads of masculinity and physical disability. In M. Gergen & S. Davis (Eds.), *Toward a new psychology of gender* (pp. 455-475). New York, NY: Routledge.
- Gibbs, L. (2007). Identifying work as a barrier to men's access to chronic illness (arthritis) self-management programs. *International Journal of Men's Health*, 6(2), 143-155.

- Gokkaya, N. K. O., Aras, M., Yesilteps, E., & Koseoglu, F. (2006). Reflex sympathetic dystrophy in hemiplegia. *International Journal of Rehabilitation Research*, 29(4), 275-279.
- Golombok, S., & Fivvsh, R. (1994). *Gender development*. Cambridge, MA: Cambridge University Press.
- Good, G. E., Schoop, L. H., Thomason, D., Hathaway, S. L., Mazyrek, M. O., & Sanford-Martens, T. C. (2008). Men with serious injuries: Relations among masculinity, age and alcohol use. *Rehabilitation Psychology*, 53(1), 39-45.
- Good, G. E., Schoop, L. H., Thomason, D., Hathaway, S. L., Sanford-Martens, T. C., Mazyrek, M. O., & Mintz, L. B. (2006). Masculine roles and rehabilitation outcomes among men recovering from serious injuries. *Psychology of Men & Masculinity*, 7(3), 165-176.
- Gough, B. (2006). Try to be healthy, but don't forgo your masculinity: Deconstructing men's health discourse in the media. *Social Science & Medicine*, 63, 2476-2488.
- Gray, R. E., Fitch, M., Phillips, C., Labrecque, M., & Fergus, K. (2000). Managing the impact of illness: The experiences of men with prostate cancer and their spouses. *Journal of Health Psychology*, 5(4), 531-548.
- Harris, I. M. (1995). *Messages men hear: Constructing masculinities*. Bristol, PA: Taylor & Francis.
- Heim, E., Valach, L., & Schaffner, L. (1997). Coping and psychosocial adaptation: Longitudinal effects over time and stages in breast cancer. *Psychomatic Medicine*, 59, 408-418.
- Hipsky, S. (2006). The pre-conceptual map methodology: Development and application. *The Qualitative Report*, 11(4), 719-728. Retrieved from <http://www.nova.edu/ssss/QR/QR11-4/hipsky.pdf>
- Hong Kong Council of Social Service. (2007). *Rehabilitation services*. Retrieved from [http://www.hkcss.org.hk/rh/employ\\_manual.htm](http://www.hkcss.org.hk/rh/employ_manual.htm)
- Ira, D. W., & David, M. G. (1999). *The process of counseling and psychotherapy: Matters of skill*. Pacific Grove, CA: Brooks/Cole.
- Keitel, M. A., Zevon, M. A., Rounds, J. B., Petrelli, N. J., & Karakousis, C. (1990). Spouse adjustment to cancer surgery: Distress and coping responses. *Journal of Surgical Oncology*, 43, 148-153.
- King, G. A., Shultz, I. Z., Steel, K., Gilpin, M., & Cathers, T. (1993). Self-evaluation and self-image of adolescents with physical disabilities. *The American Journal of Occupational Therapy*, 47, 132-140.
- Kong, K. H., & Yang, S. Y. (2006). Health-related quality of life among chronic stroke survivors attending a rehabilitation clinic. *Singapore Medical Journal*, 47(3), 213-218.
- Lease, S. H., Cohen, J. E., & Dahleck, T. D. (2007). Body and sexual esteem as mediators of the physical disability-interpersonal competencies relation. *Rehabilitation Psychology*, 52(4), 399-408.
- Lyons, M. (1991). Enabling or disabling? Students' attitudes toward persons with disabilities. *American Journal of Occupational Therapy*, 45(4), 311-316.
- Mahalik, J. R. (2001). Cognitive therapy for men. In G. R. Brooks & G. E. Good (Eds.), *The new handbook of psychotherapy and counselling with men* (Vol. 2, pp. 544-564). San Francisco, CA: Jossey-Bass.

- Marini, I. D. (1992). The use of humor in counseling as a social skill for disabled patients. *Journal of Applied Rehabilitation Counseling, 23*(3), 30-36.
- Marini, I. D. (2001). Issues of males with physical disabilities in rehabilitation settings. In G. R. Brooks & G. E. Good (Eds.), *The new handbook of psychotherapy and counselling with men* (Vol. 1, pp. 185-206). San Francisco, CA: Jossey-Bass.
- Make, B. (1994). Collaborative self-management strategies for patients with respiratory disease. *Respiratory Care, 39* (5), 566-579.
- Maunsell, E., Brisson, J., & Deschenes, L. (1995). Social support and survival among women with breast cancer. *Cancer, 76*(4), 631-637.
- Mercherbaum, D., & Turk, D. C. (1987). *Facilitating treatment adherence: A practitioner's guidebook*. New York, NY: Plenum.
- Messner, M. (1992). *Power at play: Sports and the problem of masculinity*. Boston, MA: Beacon.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York, NY: Guilford.
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.
- Morse, S. R., & Fife, B. (1998). Coping with a partner's cancer: Adjustment at four stages of the illness trajectory. *Oncology Nursing Forum, 25*, 751-760.
- O'Brien, M. K., Petrie, K., & Raeburn, J. (1992). Adherence to medication regimes: Updating a complex medical issue. *Medical Care Research, 49*(4), 435-454.
- Pearson, L., Carr, J., & Halliwell, M. (1985). The self-image of adolescents with spina bifida. *Zeitschrift für Kinderchirurgie, 40*(Suppl. I), 27-30.
- Pedretti, L. W., Smith, J. A., & Pendleton, H. M. (2001). Cerebral vascular accident. In L. W. Pedretti & M. B. Early (Eds.), *Occupational therapy: Practice skills for physical dysfunction* (5<sup>th</sup> ed., pp. 785-806). St. Louis, MO: Mosby.
- Phipps, S., & Richardson, P. (2007). Occupational therapy outcomes for patients with traumatic brain injury and stroke using the Canadian Occupational Performance Measure. *The American Journal of Occupational Therapy, 61*(3), 328-334.
- Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods* (6th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Pollack, W. S. (2001). "Masked men": New psychoanalytically oriented treatment models for adults and young adult men. In G. R. Brooks & G. E. Good (Eds.), *The new handbook of psychotherapy and counselling with men* (Vol. 2, pp. 527-543). Thousand Oaks, CA: Sage.
- Rappaport, B. M. (1984). Family planning: Helping men ask for help. In J. M. Swanson & K. A. Forrest (Eds.), *Men's reproductive health* (pp. 245-259). New York, NY: Springer.
- Rubin, L. B. (1983). *Intimate strangers*. New York, NY: Harper & Row.
- Saunders, D. H., Greig, C. A., Young, A., & Mead, G. E. (2004). Physical fitness training for stroke patients. *Cochrane Database of Systematic Reviews, 1*, 1-41.
- Savinelli, R., Timm, M., & Montgomery, J. (1978). Therapy evaluation and management of patients with hemiplegia. *Clinical Orthopaedics and Related Research, 131*, 15-29.
- Smith, E. J. (2006). The strength-based counselling model. *The Counseling Psychologist, 34*(1), 13-79.

- Sunnerhagen, K. S. (2006). Circuit training in community-living “younger” men after stroke. *Journal of Stroke and Cerebrovascular Diseases, 16*(3), 122-129.
- Sutkin, L., & Good, G. (1987). Therapy with men in health-care settings. In M. Scher, M. Stevens, G. Good, & G. A. Eichenfield (Eds.), *Handbook of counseling and psychotherapy with men* (Vol. 1, pp. 372-387). Thousand Oaks, CA: Sage.
- Tager, D., Good, G. E., & Morrison, J. B. (2006). Our Bodies, Ourselves revisited: Male body image and psychological well-being. *International Journal of Men's Studies, 5*(3), 228-237.
- Tam, S. F. (1995). Relationship of self-concept and social desirability tendency of Hong Kong Chinese adults with physical disabilities. *Journal of Hong Kong Association of Occupational Therapists, 5*(1), 4-16.
- Tam, S. F., Chan, M. H., Lam, H. W., & Lam, L. H. (2003). Comparing the self-concepts of Hong Kong Chinese adults with visible and not visual physical disability. *The Journal of Psychology, 137*(4), 363-372.
- Tannen, D. (1990). *You just don't understand: Women and men in conversation*. New York, NY: Ballantine.
- The Royal College of Psychiatrists. (2007). *Coping with physical illness*. Retrieved from <http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/physicalillness/copingwithphysicalillness.aspx>
- U.S. Department of Health and Human Services. (1998). *Vital and health statistics: Current estimates from the National Health Interview Survey, 1995*. Hyattsville, MD: Author.
- U.S. Preventive Services Task Force. (1996). *Guide to clinical preventive services* (2nd ed.). Baltimore, MD: Williams & Wilkins.
- Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion, 6*, 197-205.
- Wardle, J., Hasse, A. M., Steptoe, A., Nillapum, M., Jonwutiwes, K., & Bellisle, F. (2004). Gender differences in food choice: The contribution of health beliefs and dieting. *Annals of Behavioural Medicine, 27*(2), 107-116.
- Widang, I., & Fridlund, B. (2003). Self-respect, dignity and confidence: Conceptions of integrity among male patients. *Journal of Advanced Nursing, 42*(1), 47-56.
- Wong, C. W., Lee W. K., & Lau, B. S. T. (2006). Are Chinese men less susceptible to anxiety and depression? A community-based cross-sectional survey from Hong Kong. *Journal of Men's Health and Gender, 3*(2), 152-159.
- World Health Organization. (2002). *Gender and mental health*. Retrieved from [http://www.who.int/gender/other\\_health/en/genderMH.pdf](http://www.who.int/gender/other_health/en/genderMH.pdf)
- World Health Organization. (2007). *Disability, including prevention, management and rehabilitation*. Retrieved from <http://www.who.int/nmh/a5817/en/>
- Yin, R. K. (1993). *Applications of case study research*. Newbury Park, CA: Sage.
- Yin, R. K. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage.

---

### Author Note

Zenobia C. Y. Chan is an assistant professor at the School of Nursing, The Hong Kong Polytechnic University. Zenobia loves writing for both its therapeutic and

communicative uses. She has written for a wide range of academic journals and has contributed to nine English books and four Chinese books. She has published papers related to nursing, family studies, counselling, mental health, medical education, social work, qualitative research, and poetry. Correspondence regarding this article can be addressed to: Zenobia C. Y. Chan RN, MA, MPH, PhD, School of Nursing, The Hong Kong Polytechnic University, Hung Hom, Hong Kong, China; Phone: 852-2766-6426; E-mail: [hszchan@inet.polyu.edu.hk](mailto:hszchan@inet.polyu.edu.hk)

Gary C.T. Wong is an occupational therapist, providing rehabilitation service for people with physical and intellectual disabilities including people with hemiplegia. Correspondence regarding this article can also be addressed to: Gary C.T. Wong at Units 101-111, On Pak House, Cheung On Estate, Tsing Yi, N.T. Hong Kong; Work telephone: 852-3106-0288; Email: [gary\\_wongct@hotmail.com](mailto:gary_wongct@hotmail.com)

Copyright 2012: Zenobia C. Y. Chan, Gary C.T. Wong, and Nova Southeastern University

#### Article Citation

Chan, Z. C. Y., & Wong, G. C. T. (2012). Hemiplegia in men: A case study. *The Qualitative Report*, 17(Art. 44), 1-17. Retrieved from <http://www.nova.edu/ssss/QR/QR17/chan.pdf>

---