APORIA

LA REVUE EN SCIENCES INFIRMIÈRES • THE NURSING JOURNAL

2018 Volume 10, Numéro 2/ Volume 10, Issue 2. ISSN: 1918-1345

Sommaire/Content

2018: Vol.10, Numéro 2/Vol.10, Issue 2

Éditorial/Editorial

Afin de souligner ses 10 ans d'existence, Aporia consacrera ses deux éditions de 2019 à des numéros spéciaux issus de deux conférences survenues en 2018. Chacune de ces conférences rassemblait des chercheurs, des cliniciens, des éducateurs, des étudiants, des militants et des décideurs autour de sujets d'actualité à l'intersection des champs de la santé et des domaines connexes tels que le droit, l'éthique et la philosophie politique.

Le premier numéro, qui paraîtra à l'hiver 2019, rassemblera des articles soumis par des participants au Forum sur l'état des droits en santé mentale au Québec qui s'est tenu les 10 et 11 mai 2018 à Gatineau, Québec, sous le thème Regards critiques et nouvelles pratiques (http://www.droitsaccesforum.net/). Ces articles présenteront différents angles de réflexions et d'analyses des enjeux relatifs à l'intersection du droit et de la santé mentale, et de l'impact de ces enjeux sur les personnes aux prises avec des problèmes de santé mentale. Ces enjeux concernent par exemple l'équité dans les soins, la justice, la participation citoyenne et des paradigmes alternatifs permettant de repenser la prise en charge des problèmes liés à la santé mentale. Comme tous les articles publiés dans Aporia, ces articles auront été révisés par les pairs. Les articles de ce numéro seront en français.

Le deuxième numéro, qui paraîtra à l'été 2019, présentera des articles reflétant différentes présentations qui ont eu lieu lors de la 7ème édition de la In Sickness & In Health International Conference du 7 au 9 juin 2018 à Sydney, en Australie (https://isihconference.com/isih-2018/). Les conférenciers ont abordé des enjeux complexes liés aux technologies dans les soins de santé, la gestion des corps, l'influence d'idéologies (néolibérales notamment) dans la structuration des services de santé, les nouveaux visages des discours de risque en santé, la marginalisation de certaines personnes et les disparités qui en résultent, les dynamiques de pouvoir qui sous-tendent les pratiques soignantes, ainsi que les impératifs multiples qui gouvernent les processus de production des connaissances en santé. Ces articles, en anglais, seront aussi révisés par les pairs.

La publication régulière reprendra dès l'hiver 2020.

In order to highlight its 10 years of existence, Aporia will dedicate the 2019 editions to special issues from two conferences that took place in 2018. Each of these conferences brought together researchers, clinicians, educators, students, advocates and decision makers around current issues at the juncture of health et related domains such as law, ethics and political philosophy.

The first issue will be published in the winter of 2019 and it will consist of articles submitted by participants of the Forum on the state of mental health rights in Quebec which was held May 10-11 2018 in Gatineau, Québec, under the theme Critical views and new practices (http://www.droitsaccesforum.net/). These papers will present different lines of thought and analysis to tackle issues arising at the intersection of law and mental health, and their impacts on persons struggling with a mental health issue. These issues include for example equity in care, justice, citizen participation, and alternative paradigms that can help us rethink the management of mental health issues. As with all other articles published in Aporia, these papers will be peer-reviewed. The papers in this issue will be in French.

Published in the summer of 2019, the second issue will showcase conferences papers presented at the 7th edition of the In Sickness & In Health International Conference which took place June 7-9 2018 in Sydney, Australia (https://isihconference.com/isih-2018/). Speakers addressed complex issues related to technologies in health care, the governing of bodies, ideological influences (e.g. neoliberalism) on the structuration of health services, the new forms of health risk discourses, the marginalization of certain individuals and the resulting health disparities, power dynamics underpinning care practices, as well as the multiple imperatives that govern knowledge production in health care. These papers, which will be in English, will also be peer-reviewed.

Regular publication will resume in the winter of 2020.

Amelie Perron, RN, PhD
Associate Professor
University of Ottawa
Receiving Editor, APORIA

1

Abstract
This paper presents findings from a qualitative case study that explored long term integration of internationally educated nurses in an Ontario healthcare facility. Using critical social theory as the philosophical underpinnings for this research, we selected the case based on the hospital's history of employing and supporting internationally educated professionals. Data sources included: documents review, twenty-eight interviews, socio-demographic survey and five focus groups involving IENs and other stakeholders. An overarching theme points to a 'two-way' notion of workplace integration whereby efforts are required on the part of the employer as well as the IENs. An in-depth analysis of the data reveals sub-processes of two-way integration: respecting diversity and difference, adopting inclusive practices and striving to achieve equity. Challenges in achieving two-way integration are discussed. Implications for nursing leaders to tap into IENs' diverse talents for the benefit of their local healthcare systems are highlighted.

Keywords equity, internationally educated nurses, inclusive practices, two-way integration, workplace integration

Unpacking "two-way" workplace integration of internationally educated nurses

ZUBEIDA RAMJI, JOSEPHINE ETOWA & ISABELLE ST-PIERRE

Introduction

For over a decade now, internationally educated nurses (IENs) as a specific segment of the nursing workforce have emerged as a focus for research. Most of this research examines the experiences, challenges and supports for IENs as they migrate to their new country context, navigate through processes of credentials assessments and registration, find meaningful employment and transition into nursing workplaces.[1-6] The nursing literature appears one-sided as it only emphasizes what is required for IENs to adjust to the host environment.[7] While the term "workplace integration" is frequently used about IENs, a definition is not provided.[8] In addition, literature on the experience of IENs over their long-term, post-transition phase[9-11] is scarce. The ways in which the organizational context influences IENs' integration in the workplace has not been a clear research focus.[7,9]

This research addresses the gaps by focusing on the experiences, achievements and contributions of IENs who are beyond transition and have been nursing in Canada for an average of eleven years. Early adaptation efforts towards a successful transition phase are critical in ensuring that IENs have grasped the differences in the role and scope in their nursing practice and are meeting the employer's probationary requirements.[6] However, the longer-term focus is necessary to understand IENs' ongoing satisfaction, progress and retention within the workplace and nursing profession.[12,13] This research's emphasis on the organizational context explores workplace integration as a 'two-way' process in nursing and generates insights for how

employers can effectively facilitate workplace integration of IENs.

Purpose

This paper is based on a study that aimed at understanding workplace integration from perspectives of both IENs and other stakeholders. The research was guided by concepts borrowed from social sciences about societal integration of immigrants and refugees, observations about healthcare employers' approaches to organization-wide efforts to support IENs, and the authors' own experiences.

This paper explores the overarching theme of workplace integration of IENs as a 'two-way' process and outcome. The notion of two-way integration is unpacked to outline three sub-processes: (1) Respecting diversity and difference, (2) Adopting inclusive practices and (3) Striving to achieve equity. The various levels of commitment and efforts required by the IENs as well as the employer organization to facilitate integration are highlighted, along with discussion of the major challenges encountered. The paper situates these findings within existing literature while highlighting implications for nursing and healthcare.

Theoretical Perspectives

Critical social theory (CST) provides relevant philosophical underpinnings for this research on workplace integration of IENs. While works of various theorists and thought leaders were considered, Lukes'[14] three dimensions or faces of power was found to be especially relevant in terms of how oppression and power imbalances impact not only IENs but also the structures and systems that make up their workplace organizations.

Lukes' first dimension or overt face of power is the pluralists' perspective about the way decisions are made: "A has power over B to the extent that he can get B to do something that B would not otherwise do".[15 p5] In this dimension the focus is on who participates, who gains and who loses, and who prevails in decision-making.[14-16] The assumption is that the decision-making process is open to everyone or virtually any organized group who cares about the issues at hand.[14-16] Since the process is considered open, leaders are assumed to be speaking on behalf of a group and so non-participation or inaction is not seen as a problem but is taken to reflect consensus.[14-16] With respect to marginalized groups, in this dimension, the possibility of power relations is not considered but instead non–participants are blamed or thought of as apathetic or incompetent.[14-16] Strategies to correct this situation try to "educate" or change the non-participants, still with the assumption that power constraints will not pose any barriers to participation.[14-16]

The second dimension or covert face of power excludes certain participants and issues altogether. This dimension creates bias by establishing what is important and what is unimportant. Organizations or groups take advantage of certain kinds of conflict and actively suppress others, so that issues are prevented from arising in the first place.[14-16)] The focus is not to prevail in a struggle, but to predetermine the agenda of the struggle itself.[14-16] This dimension does not consider how power intervenes in the issue-raising process and that fear and vulnerability might explain non-participation by marginalized groups.[14-16]

The third dimension or latent face of power was developed by Lukes[14] as follows: "A exercises power over B by getting her to do what he does not want to do, but he also exercises power over her by influencing, shaping or determining her very wants".[15 p12] In other words, the powerful group prevents the marginalized from effectively raising issues which also impacts their conception of the issues altogether.[14-17] This dimension is the hardest of all to identify because people influenced by this latent power find it difficult to discover its very existence.[14-17]

A CST perspective informed by theorists such as Lukes[14] ensures that organizations are taking on their share of responsibility to shift power and dismantle barriers, by questioning and analyzing all structures and practices. Various studies about racism in nursing have carried out analyses of how organizational policies and structures embedded with dominant white norms and values have been problematic for Black[18,19] and immigrant nurses.[20] A similar critical analysis appears to be absent in the body of literature about IENs. This research adds such critical analysis of power and its potential effects on IENs in the workplace.

Methodology

This qualitative research used an instrumental case study approach as described by Stake,[21] whereby the case organization facilitates the understanding of the phenomenon of interest. St. Michael's Hospital (SMH) in Toronto, Canada, with a track record of supporting IENs[22] was selected as the case allowing a critical examination of how integration of IENs unfolds through organizational initiatives. Data collection took place between October 2014 and March 2015 after obtaining approval from the research ethics boards of SMH and University of Ottawa. The sample of 28

participants was diverse with respect to age range, gender, country of origin and nursing education, ethno-racial heritage, immigration status and number of years and types of nursing or other professional work experiences. Fifty percent were IENs and the rest of the participants included peers/mentors (18%), managers/directors (21%) and senior leaders (11%). Participants were accessed through recruitment strategies such as presentations at meetings, information letters and posters. Purposeful sampling was carried out first, followed by snowballing technique to ensure diversity of IENs and others in the sample.

Four forms of data collection were used: semi-structured interviews; socio-demographic survey; focus groups and review of organizational documents such as strategic plans, project reports, health equity plans/reports, in order to understand the context of the stated commitment to supports for IENs. At the focus groups, a presentation of preliminary analysis preceded the discussion and had the added purpose of serving as a form of member checking and involving participants in shaping study recommendations. Informed consent was obtained from each participant. At the organizational level, permission was obtained from senior representatives about identification of the study site during and/or after completion of the research. Privacy and confidentiality was maintained by giving participants the option of being interviewed at an accessible offsite location away from their area of work; alpha-numeric code numbers were used to identify participants; interview notes, demographic profile and consent forms were separated from the data files and all electronic data files and storage devices were password protected. In reporting out the findings, quotes were selected carefully so as not to inadvertently identify the participants.

Thematic analysis was carried out in various stages. At a preliminary level, data analysis occurred simultaneously with data collection; it was inductive and iterative. Inductive coding of the data did not start with a pre-established list of codes but instead the codes emerged from the data.[23] After analyzing perspectives of each individual participant (within subcase analysis), the data was then re-sorted using NVivo 10 according to four stakeholder groups that make up the sample (i.e. between sub-unit analysis - of IENs, peers/mentors, managers/directors and senior managers). This was followed by analysis of IENs across each of the sub-units, namely: peers/mentors, managers/directors and senior managers - to identify areas of convergence and divergence.[21]

Finding: Two-way Integration of IENs

The overarching finding in this case study is that workplace integration of IENs occurs through a two-way process, requiring efforts from both the IEN and organization. Two-way integration has been categorized into three main sub-processes; (1) Respecting diversity and difference, (2) Adopting inclusive practices, and (3). Striving to achieve equity. Key messages conveyed in each of the sub-processes overlap but there are varying emphases in terms of ongoing changes and efforts required on the parts of the IEN and the workplace organization.

Respecting diversity and difference.

Respecting diversity and difference is demonstrated by IENs and the workplace organization in the way the needs of an increasingly diverse patient base are addressed. For example, the organization values how the diverse backgrounds of IENs help address patient diversity, but also acknowledges that IENs might experience various challenges in their transition from their former practice environments. IENs recognize and accept the responsibility of adapting to the numerous differences in nurses' role in Canada, along with grasping complexities of working with diverse patients and colleagues.

To adapt and make the transition into their new practice environment, IENs must invest time and resources to learn about nursing in Canada. When integrated, IENs are confident in their understanding of how the legal and professional frameworks that govern the role of the nurse are different from those in the other jurisdictions where they practiced. The context of being immersed in inter-professional teams and specifically their level of professional autonomy with regards to their interaction with physicians, is a major adjustment for most IENs. The differences in the role and scope of nurses' practices are described by an IEN:

> [Nurses] have a lot more autonomy and they're expected to …like we'll get the doctors asking us, well, what do you think? …they trust you as a professional to make decisions …your scope of practice is actually bigger here … (participant I001)

Aside from learning cultural nuances of behaviours of their diverse patients, colleagues and team members, many IENs have had the added challenge of mastering 'Canadian' English: "When I was new, they said I don't speak English well. They questioned my skills. As if they don't trust me…" (participant I017). This can be a major hurdle for many IENs, even those who perceived themselves as having come to Canada with adequate English language skills. This is further reinforced by a manager who said:

> …it is one thing to be able to speak English but it's another thing to get your point across in a way that's clear and that doesn't, you know, perpetuate stereotypes of an internationally educated person being not so educated (participant L005).

Once the IEN is integrated, s/he is seen to be 'fitting in' with the team and is valued by co-workers. The place of where s/he obtained the basic nursing education is not relevant anymore. One manager states: "The IENs that I work with, if I didn't know that they [had] practiced elsewhere or they got trained in a foreign country…now, I wouldn't know" (participant M004). Overall, the IEN has a greater sense of belonging when integrated. A manager explains how fellow colleagues in the workplace environment need to be open and willing to embrace IENs:

> And again, that's a two-way street. So the people who are within the hospital have to be ready and willing to accept someone who…may be on a learning curve in terms of culture and linguistics and practices and Canadian nursing practice (participant L005).

At the organizational level, a strong commitment to patients is evident in explicit statements of values and beliefs about respect for diversity and difference. There is recognition that having a workforce reflective of the ethno-racial and linguistic diversity within the patient population is important to improve access to services and supports. Workforce diversity is a priority according to this IEN:

> It's the values of St. Mike's…we work with the very marginalized population, very diverse and very challenging. And to do the best job, you have to have [a] diverse workforce. And what's a better way than to have diversity in your nurses (participant I027).

The diversity within the workforce reinforces the sense of belonging. This is described by IENs as a key factor in how the context enables workplace integration:

> We're really like a multicultural unit…I like it, because again, it's like we learn things from each other and you know, it's great because we've got a nurse who speaks Mandarin, one who speaks Cantonese, one speaks Vietnamese, one speaks Korean… three of them speak Portuguese. So it's great, we have people who can help each other out and like it's really quite fun (participant I001).

Managers emphasize the need to help IENs adapt to the new practice environment and become 'Canadian nurses'. Concern is shown for ensuring that there is equality of treatment for IENs.

This first sub-process of two-way integration focused on respecting diversity and difference, stems from the employer's commitment to its increasingly diverse patient base. IENs are a valuable resource for diversifying the nursing workforce and for reducing language or cultural barriers for patients and families. IENs have gone through an intense period of learning and relearning to adapt to Canadian nursing practice and to fit into their workplace. However, there are challenges when despite the growing diversity in the workforce, the policies and procedures are based on the assumptions and beliefs of the dominant group. This leads us to the next section where two-way integration is explained as a process focused on adopting inclusive practices.

Adopting inclusive practices

This sub-process of two-way integration emphasizes the workplace's commitment to an active stance in addressing exclusion experienced by anyone who, because of their differences, may be at risk of marginalization. Building on the context of a highly diverse workforce, systematic approaches to creating inclusive policies and practices can change the experience of staff, patients and the broader community. At the individual level, IENs become sensitized, accept the need to change their outlook and embrace inclusive practices themselves.

SMH, the case organization, has incorporated its commitment to creating and sustaining an inclusive organization in its mission, values and strategic plan. This commitment is enacted through various initiatives. A senior manager explains how the right to being different is embedded in the inclusive workplace culture:

> We have a culture…that is very open and inclusive to patients, if you like… that is very acceptant of different ways of talking and different ways of being. There's a non-judgmental sort of approach to care. Almost in the extreme …people behaving in ways that are totally objectionable and we still are welcoming and open. So if you can do that with patients, you can do that with each other, right…People are looking out for you as opposed to… judging you (participant L024).

Specific roles such as the Diversity and Special Projects Coordinator or more recently, the Director of Mission and Values have been in place to promote SMH's values of respect and inclusion of all peoples. An annual awards program which celebrates staff who have excelled at demonstrating the organization's mission and values, creates deliberate hype within the workplace to reinforce this priority. Additionally, the corporate orientation program for all new staff dedicates time for training about diversity, inclusion and equity.

Being aware of cultural differences and accepting diverse value systems are described by this senior manager as part of the integration process for IENs at SMH:

> I remember from my days, [when I was] responsible for the obstetrics unit and we had lots of nurses who were very judgmental towards some of our street folks. Particularly, street workers who were in for some reason usually of a pregnancy, delivery or whatever… the manager had to be very sensitive about the fact that this is different than from the Philippines and

> there are different norms and values and expectations (participant L025).

Immersion within such a workplace context over the long term has transformative effects on IENs as noted by this IEN:

> Back home, we seldom work with different [diverse] people...but then [once] you have integrated, you don't look that they're different…you're not racist… you respect that regardless of their backgrounds… cultural or sexual orientation, religious background… talking about St. Mike's, because we have diverse people here (participant I017).

The exposure to co-workers and patients of diverse backgrounds allows the integrated IEN to re-evaluate her/his own values/beliefs. One IEN explains:

> When you're an IEN, you come from somewhere, you come with several different cultures and values that you want to integrate with…some you will drop by the side, some you will redefine, and some you will refine. You know, it's all part of the integration (participant I012).

Aside from valuing diversity and differences that IENs bring to the workforce, senior level champions recognize need for inclusive practices that facilitate their integration. A strategic management approach whereby the priority is championed is discussed by this leader:

> Strategically and philosophically as a leader, I have to see the value of our IENs to our organization and to our healthcare system. So, if I don't see that, I'm not going to really invest any time or energy in that. So that's why I see my role as an executive leader to make sure that my other executive colleagues understand this is our commitment and support it and also that I'm working with directors and managers (participant L018).

Leaders understand that the 'one size fits all' approach to workplace integration does not work. Nurse managers' encouraging and supportive style which recognizes the skills and expertise that IENs are bringing, is seen to be critical to their successful integration. A manager explains:

> I need to buddy you up with somebody, who is the best person, who am I going to buddy you up with regards to making you succeed and making you feel comfortable and making you shine or blossom or open up and we see the true potential of what you can provide (participant L003).

In this research, two policy areas were highlighted as affecting IENs differently than perhaps many of their peers: dealing with intolerant and racist behaviours and the use of one's mother tongue (other than English) in the workplace.

The effects of intolerant and racist behaviours of patients and/or their family members is described by this IEN:

> They look at your skin, they say, oh, I don't want to be treated by a brown skinned or a black skinned nurse. I want to be treated by [a]"Canadian", [implying] a white skinned…It's really [difficult], sometimes you feel disrespected (participant I013).

SMH has given priority and invested resources towards organization-wide implementation of best practice guidelines in order that all affected individuals, bystander colleagues and managers respond appropriately to intolerance or racism. The importance of consistent application of the protocols is described by this IEN:

> Sometimes they [patients/families] really use some bad words to us…but luckily we have other staff, they help us to talk to the patient...or take over from us… the manager comes and gets involved and talks to the patient… (participant I021).

The issue of staff members' use of their mother tongue (other than English) emerged as another policy area requiring a more balanced view. Managers recognize the value of a diverse staff team, including the camaraderie between IENs and other nurses who are of a similar heritage. At the same time, there is a firm policy that English is the language of the workplace to ensure inclusion of the entire team. A manager states:

> The expectation is that you speak English…so when you are practicing, when you're away from the unit, people are free to speak their mother tongue but when you're in a work environment and you're in a team, the expectation is that you're speaking English because that is the common language that everybody speaks (participant L009).

When it comes to caring for patients and families from backgrounds like their own, IENs are seen to have a direct benefit on how clinical assessments and/or treatments are facilitated, resulting in shorter lengths of stay, lower costs in terms of physician time and interpretation services. Managers/directors agree that lack of formal acknowledgment of the value of IENs' multi-lingual skills is a contradiction and source of tension, which should be addressed by restating related policies. The cumulative effects of a responsive and inclusive context result in the integrated IEN feeling more at ease and comfortable about her/his cultural identity. One IEN explains:

> So in my mind being really well integrated means you are able to accept the culture of this country and of the workplace but you're also able to own your own culture that you brought with yourself. (participant I027)

Central to this second sub-process of two-way integration is the leadership's commitment to creating and sustaining an inclusive environment. This commitment is based on the belief that people have a right to be different and that

the organization has a responsibility to adjust its policies and practices to reflect inclusion. While there are several challenges to overcome, organizational level changes in policies and practices in turn impact the workplace culture and the behaviours of individuals within, including the IENs themselves.

Striving to achieve equity

This third sub-process of two-way integration amplifies genuine openness and willingness to accept IENs as valuable contributors of knowledge and expertise. Having a grasp on the concept of equity, the employer organization recognizes the need to go beyond adopting inclusionary practices – that is, further than simply improving IENs' access to existing supports. Differential approaches, which are creative and responsive, are developed so that IENs may achieve equitable outcomes in terms of their professional growth. At the level of the IENs, such a context enables them to embrace the opportunities to progress on their leadership journey, albeit there many obstacles left to overcome.

This understanding of two-way integration shifts the focus from how IENs adapt or fit in to what IENs bring. Instead of being thought of as an 'IEN', colleagues think of her/him as any other 'Canadian nurse'. Furthermore, a critical dimension to this third sub-process is the potential for IENs to influence practices based on the expertise they bring from having nursed internationally in other healthcare systems. This manager explains the shift in attention to the IENs' international experience: "For me, what's important is that they reach a point where… they become professionals with international experience as opposed to internationally educated professionals" (participant L005). Most IENs have worked in at least one country, if not in a few different countries before practicing in Canada. Some participants in this research acknowledge benefits of learning from IENs who have worked in other jurisdictions where healthcare systems are technologically more advanced, as well as from developing countries where IENs have had to nurse creatively with very limited resources. The net effect of how the diversity of experiences and talents of IENs enrich the organizational culture is described by this leader:

> We think about the IENs fitting into the organization. But the true benefits of the internationally educated nurse, is not then just being a warm body and fitting into the organization but also what they bring to the organization, what they bring to patient care from the very fact that they are internationally educated and how they contribute and make our culture, not our culture in terms of Caucasian but I mean, our culture in terms of the organization, better (participant L026).

This valuing of IENs is aligned with SMH's core priority of delivering quality patient care. Its commitment to health equity is a core value and goal for its patients. Through its Centre for Research on Inner City Health, SMH has contributed to the growing body of evidence showing that marginalized people have the greatest health care needs, poorer access to services and the worst health outcomes. Staff and management collaborate in community initiatives with emphases on social determinants of health and issues of equity and access. One manager clearly articulates what equity means:

> Equity is more than just treating everyone equally. In fact, it means doing more for some groups, because they start from a position of inequity in the first place...to bolster their position, you have to do more. (participant L025)

It is appreciated that concepts of health and illness are culturally defined, and that role of family, faith, spirituality, lifestyle including diet and exercise, may have varying interpretations and impacts on health outcomes. IENs' roles as cultural interpreters and knowledge brokers are acknowledged as important for colleagues to learn from and as part of becoming culturally competent in caring for diverse patients/families. This senior manager explains how IENs can help expose their colleagues to different ways of thinking about health and illness, and how the prevailing Canadian way may be limiting:

> I think our IENs help us to be empathetic that there are other ways, not just the Canadian way of looking at treatment and…death, and even care of the body after, all of these things… I think, when I talk to IENs about these things, I become very sensitive to the fact that what you know is just what you know, it doesn't mean it's right. (participant L018)

By acknowledging that staff are part of the broader community, SMH focuses on addressing inequities within the workforce as well. Managers are open to differential supports for IENs as required, including mentoring, extended and/or tailored orientation programs. One peer/mentor provides the following example of differential support for a newly hired IEN:

> We had a nurse from India…She was hired for one of the critical care units but they [her unit managers] …sent her to our floor for a month, just to get her baseline, you know, just to get familiar with… Canadian nursing…They sent her to get trained on our floor for a month, which is general internal medicine, you get everybody there…So to me, that is great. You know, you just don't hire them [IENs] and then make them work in the critical care area…So that made the nurse feel very comfortable…when she was done a month… (participant M004)

Encouragement from frontline managers is seen as vital for IENs to get involved on various committees or task groups. This peer/mentor explains how the managers' role is more than just making information available:

> Well, they're posting what opportunity is there…and so everyone has equal opportunity to apply for that position. [But] the leadership encourages nurses to get involved…makes them [IENs] feel …they can do the job…being approached. And then saying, "you would be good for this role...There is a position, or we have a committee, we are forming a committee, and would you like to be involved...?" (participant P002)

The workplace's commitment to IENs achieving equity has an important effect on their growth. Career development is an important area at SMH, and they expect their managers to encourage IENs as much as their other staff to seek growth opportunities. An IEN states:

> I stayed with St. Michael's because there's been ongoing support for my growth, if I chose to do that. It's a matter of my personal choice but it would be difficult if I wanted to do something and I'm not given an opportunity. That for me would be a problem. (participant I027)

Aside from supports for professional development, various opportunities to influence the workplace and practice are available at SMH. IENs provide leadership in roles such as team leader, preceptor, mentor, educator, advanced practitioner, member on unit level or hospital wide committees and projects, as well as externally with professional associations and labour union. One IEN describes her leadership:

> I'm a senior staff, others look up to me, like if there's an issue that needs to be addressed and they ask me [about] any recommendation or they need my help… I've been alternate for the last like five years as a charge nurse, unit leader…supervising the staff. (participant I015)

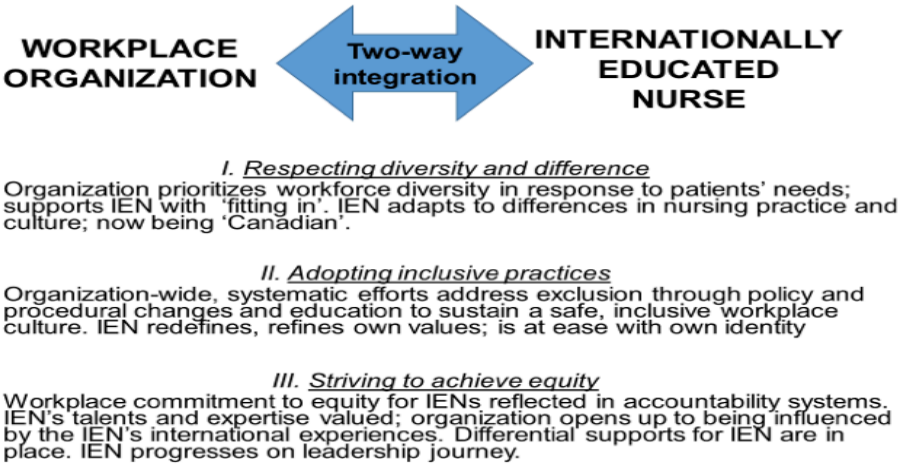
Another IEN speaks of how her graduate level research resulted in the adoption of new clinical protocols: "So I got that changed, I was a change agent in that...now it's routine…" (participant I012). The leadership's commitment to IENs' achieving their professional goals and aspirations extends beyond the confines of the workplace organization. A senior leader explains:

> If a nurse wants to start in a general area and move to critical care, they can do that at St. Michael's. If they want to work in the community, they can do that. And so I look at integration beyond St. Michael's, I sometimes will actually even encourage them [IENs] to go to another organization that has programs and services that are aligned with their true passion and vision. So integration means at the end of the day, that people get up and go to work where they feel they can maximize their full potential (participant L018).

Senior leadership is consciously behaving in ways that are strategic and systemic, striving for IENs to achieve equity at the wider system level. One senior leader states:

> It's not just "okay, now they're here and they're fully working, and my job is done". It's now how do they contribute back to the cause of IENs…as a leader you have to understand the national frame, the provincial frame and see that this is…just part of your job...I've always looked for opportunities…(participant L018)

This third sub-process of two-way integration emphasizes the employer's recognition of the talents and expertise that IENs bring. In addition to their diverse ethno-racial backgrounds and life experiences, IENs' international nursing experiences from other healthcare systems are also valued. Given that many IENs are in potential positions of inequity, there is a proactive approach to providing differential supports for participation in various roles and development of their full leadership potential. Although there are challenges, the organization's capacity to apply the concept of equity to IENs' integration is enhanced by its fundamental commitment to health equity for its diverse patients and community. Figure 1 summarizes the three sub-processes of the two-way integration.



Discussion

Workplace integration of IENs as a two-way process and outcome is new to nursing.[13,24] However, within the social sciences, notions of two-way integration of immigrants and refugees into their host communities have been part of the discourse for some time now. Definitions in immigrant and refugee studies describe integration as a mutual, two-way process between the new home or host society and the newcomers.[25-27] In Canada, the 1971 Multicultural Act and the federal Charter of Rights and Freedoms has provided the framework for the Integration Program which has the intent of encouraging a process of mutual accommodation and adjustment by both newcomers and the larger society.[28] Ley[29] explains that 'integration' attempts to signify a break with assimilation, particularly in a Canadian context where the federal policy "institutionalizes not only respect for difference but also the rights of being different".[p7] Despite the policy and dialogue, there is concern that program investments have been primarily focused on initial stages of adaptation and in promoting interactions among newcomers rather than with established immigrants or those born in Canada.[27,30]

Given this backdrop, the case organization, SMH, is indeed exemplary in its efforts to create a workplace environment where two-way integration of IENs is discussed and demonstrated in multiple ways. Perhaps being situated in the heart of Canada's most ethno-racially diverse city makes it easier since issues of equity, diversity and inclusion are 'in your face' and inertia is not an option. Despite its successes, SMH has experienced several challenges which are also identified by other studies. These tensions are discussed next and include: respecting diversity but conforming; increasing inclusion broadly at the risk of reinforcing marginalization for "others" and striving for equity but not being accountable.

Respecting diversity but conforming

Within the context of the first sub-process of respecting diversity and difference, various examples of difficulties related to workplace culture and communication skills of IENs were provided by participants. One significant challenge that IENs face is learning to communicate in Canadian English, especially the appropriate use of idioms, jargon, slang and acronyms. This has been widely documented in the literature.[3,31] Workplace culture and communication challenges remind IENs of their foreignness and lack of belonging, which often increase their sense of vulnerability. Difference based on ethno-racial backgrounds has been the subject of several studies on racism in nursing.[18,19,32-41] In a study of China-educated nurses practicing in Australia, negative meanings such as incompetence were ascribed to difference.[41] Etowa, et al.[19] found that Black nurses in Nova Scotia reacted to such experiences with a strong sense of insecurity and isolation. According to Etowa et al.'s[19] "theory of surviving on the margins"(p177), intense efforts on the part of IENs trying to adapt to become "Canadian" are appeasing strategies. These are in direct response to highly pressurized experiences and the strong desire to ensure they are liked by those are in the "centre" or who have more power.

At the level of the workplace, Allen[42] explains that sometimes the focus on diversity is primarily one of "add colour and stir".[p66] It is simply implied that a bunch of "other" people need to be taken into the mainstream organization.[42] Within such a context, Lukes'[14] overt dimension of power may be at play where processes are 'open' to everyone but there is little or no regard for IENs requiring any differential supports to integrate in the workplace. Although the organizational priority of workforce diversity is impressive, if policies and practices are left as neutral, they maintain the privilege of those who have traditionally held power and can have adverse impacts on individuals who are different from the dominant group.[43,44] This leads us to the sub-process of adopting inclusive practices where there are potential challenges as well.

Increasing inclusion broadly at the risk of reinforcing marginalization for "others"

Inclusion refers to the systemic nature of an organization, and to achieve it, workplaces must create policies and practices that recognize more than one view and that signal importance of learning from differences.[43] Healthcare organizations are faced with multiple and competing priorities. Sustaining inclusive practices requires thoughtful and measured efforts; gaining buy-in from all levels of leadership across large organizations can be an issue. When an inclusive definition of diversity, in which all differences (e.g. gender, age, race, socio-economic status, sexual orientation, abilities, etc.) is used to appeal to a broad audience, the dialogue related to race is not made explicit. This may be equated to Lukes'[14] covert face of power whereby leaving race 'off the agenda' results in continued marginalization and other painful experiences for racialized individuals.[45] Thus, there is a risk that organizational inclusion is in disguise whereby IENs, or other peoples 'of difference' are invited in, but are the only ones made to change and not the workplace.

Inclusive organizational environments are conducive to

encouraging self-reflection, self-determination and critical analysis at the individual staff level.[46-48] To be inclusive, it is recognized that needs for resources within the organization may vary among people, at various times and according to capabilities.[43] Additionally, a safe climate to ask critical questions that reveal decision-making mechanisms for how 'rules' in the form of policies, written and unwritten, have come about and how they affect different groups should be cultivated continuously within an inclusive framework.[49] In this sense the organization is open to continuous improvements to existing structures or systems that may be creating social closure or are exclusionary for specific groups.[50]

Striving for equity but not being accountable

There are multiple challenges in realizing the third sub-process of two-way integration of striving to achieve equity. At the core of these challenges is likely Lukes' (14) latent face of power, the most difficult for the IEN to identify as her/his very wants have been influenced. Firstly, as many experts in immigrant and refugee studies have stated, commitment to equity without accountability is inadequate.[43,51] Well intentioned organizations often fail to put accountability mechanisms in place. Specific targets and measures, both quantitative and qualitative, are essential if organizations are serious about acting on their value of achieving equitable outcomes for IENs.[43,51] The lack of accountability systems can also suggest that the link between the priority of integration of IENs and the organization's core business of delivering quality care has not been clearly established. The resulting scenario is where IENs' successful integration experiences of progressing on their leadership journey are limited to anecdotes from certain pockets of the organization.

Another related challenge has to do with difficulties in understanding the concept of equity. To be equitable, workplace policies or systems must be considerate of the need for differential supports for diverse staff.[43] Without continuous education and dialogue, managers could remain unclear (and unconvinced) about the importance of differential approaches for supporting IENs. Managers can become preoccupied with how offering of differential supports to IENs may be favoritism to the extent that IENs themselves may also start to adopt this perspective and resist the necessary assistance.

Finally, the lack of comfort in self-promotion is further compounded by the preoccupation for the IENs to fit in and adapt to Canadian nursing practice. The intense pressures of practicing as 'Canadian nurses' leaves little or no disposable time or energy for IENs to be analytical about the relevance of their international experiences to their Canadian nursing practice. If structured mechanisms are not in place to draw out IENs' professional insights from international contexts, Canadian nursing practice get signalled as the "gold standard".[52] The resulting effect of Lukes'[14] latent face of power manifests here such that IENs may internalize that their practice is inferior and requires 'fixing'. IENs hold back or refrain from sharing and utilizing their international experiences in the solving of local nursing problems.

Implications

Given various challenges at the individual IEN and the organization levels, it is reasonable that facilitating workplace integration is a continuous work in progress. Based on the experiences of SMH and experts, the following insights are summarized to assist other organizations who are also striving for two-way integration of IENs:

- *Diversity alone does not bring about an inclusive culture.* Minors et al.[43] state that all the characteristics of an organization, from its structure, decision-making processes, communication vehicles, and even to its mission, are based on assumptions about individuals and groups that comprise the dominant norm.

- *Inclusive organizational cultures can exist without diversity within their workforce.*[53] However, it is argued that to maximize organizational achievement, both diversity and inclusion are essential.[53] With increasing diversity within the staff and patient populations, challenging of assumptions and establishing new ones is necessary to promote inclusive practices.[43]

- *Equity is a difficult concept to grasp* – both in terms of health equity for patients and workplace equity for IENs. Managers and staff need regular opportunities to practice applying the 'equity lens' when reviewing policies and procedures and in planning programs. Continuous reminders that not everybody starts from the same position are necessary. The perceptions of needing to treat everyone equally or having that as a goal, could in fact reinforce status quo and systemic barriers. Differential supports for IENs are not unreasonable to achieve equitable outcomes.

- *Measuring disparities and improvements are cornerstones of all equity strategies*. Establishing meaningful metrics, both quantitative and qualitative for different populations is key.[43,51,54] This is equally true of workplace equity for IENs, as it is of healthy equity of patients.

•*Striving to achieve equity is more than having respect for diversity and difference and for adopting inclusive practices*. Saloojee[44] describes equity as follows: "it extends beyond bringing the 'outsiders' in, or notions of the periphery versus the centre. It is about closing physical, social and economic distances separating people, rather than only about eliminating boundaries or barriers between us and them".(p.ix) Accountability measures and mechanisms are imperative.

•*Benefits of two-way integration are beyond IENs*. They extend to patients and families as well as various segments of the workforce, including Canadian educated and racialized nurses and other groups of internationally educated professionals. To prevent regression because of downsizing or budget cuts, a business case for IEN integration is required, with close alignment to the organization's core priority of delivering quality care.[55] Like in the business/trade sectors, nursing and healthcare leaders should recognize that as immigrants, IENs can be catalysts for innovation and new connections.[56] In this valuing context opportunities are cultivated for IENs to influence and shape nursing practice.[7]

Limitations

This research is a qualitative, instrumental case study involving a single organization within a specific community context. There are no expectations of replicating this study as this is a foundational work exploring the concept of workplace integration of IENs. However, it is conceivable that this study may lead to a program of research with multiple sites. The use of SMH as an exceptional case may be a limitation especially if one is interested in a deeper understanding of how social closure operates to exclude IENs from organizational processes. A thick description of the organizational context is provided so that the interested readers can reach a conclusion about transferability to other similar situations.

Conclusion

Recognizing that the notion of workplace integration of IENs is a two-way process requiring efforts at both the individual IEN and the organization levels is the unique contribution of this research. The one-sidedness of IEN integration found in the nursing literature to date is problematic as it places the burden of responsibility solely on the IEN. This research highlights that organizational efforts to facilitate IEN integration have the potential for broader benefits with respect to quality care for patients and their families, as well as positive changes for other groups of staff who may also be in positions of inequity. The case study approach and the selection of an exemplar organization have made it possible to gather rich insights about how two-way integration is experienced and explained by participants in multiple ways. While some will quell at the emerging ideas, it is our hope that nursing leaders will be incited to reflect and assess approaches to workplace integration of IENs within their organizations. Thoughtful and deliberate action by everyone will maximize the talents and experiences that IENs bring for the benefit of their patients and communities.

References

1.Freeman M, Baumann A, Fisher A, Blythe J, Akhtar-Danesh N. Case study methodology in nurse migration research: An integrative review. Applied Nsg Research 2012; 25: 222-228.

2.Newton S, Pillay J, Higginbottom G. The migration and transitioning experiences of internationally educated nurses: A global perspective. Journal of Nursing Management 2012; 20(4): 534-550. doi: 10.1111/j.1365-2834.2011.01222.x; 10.1111/j.1365-2834.2011.01222.x

3.Xu Y. Transition as a salient area of inquiry in healthcare: Asian nurses working in western countries. Home Health Care Management & Practice 2007; 19(6): 485-487. doi:10.1177/1084822307304249

4.Zizzo K., Xu Y. Post-hire transitional programs for international nurses: A systematic review. The Journal of Continuing Education in Nursing 2009; 40(2): 57-64.

5.Tilley C. Support for internationally educated nurses transitioning into practice: An integrative literature review 2007; Unpublished manuscript. Victoria, B.C: School of Nursing, University of Victoria.

6.Primeau M, Champagne F, Lavoie-Tremblay M. Foreign-Trained Nurses' Experiences and Socioprofessional Integration Best Practices – An Integrative Literature Review. The Health Care Manager 2014; 35 (3): 245-253.

7.Raghuram P. Interrogating the language of integration: the case of internationally recruited nurses. Journal of Clinical Nursing 2007; doi:10.1111/j.1365.2702.2007. 02097.x

8.Ramji Z, Etowa J. Current perspectives on integration of internationally educated nurses into the healthcare workforce. Humanities and Social Sciences Review 2014; CD ROM:ISSN: 2165-6258: 03 (03):225-233

9.Adams E, Kennedy A. Positive practice environments - Key considerations for the development of a framework to support the integration of international Nurses 2006; Geneva:

International Centre on Nurse Migration.

10.Canadian Health Human Resources Network (CHHRN). Knowledge synthesis – internationally educated health professionals: A review of the Canadian literature 2013; Ottawa: CHHRN.

11.Covell CL, Neiterman E, Bourgeault I. A scoping review of the literature on internationally educated nurses in Canada: Mapping a research agenda. Canadian Journal of Nursing Research 2014; 46(3): 26-45.

12.Salma J, Kathleen MH, Ogilvie L. Career advancement and educational opportunities: Experiences and perceptions of internationally educated nurses. Canadian Journal of Nursing Leadership 2012; 25(3): 56-69.

13.Ramji Z, Etowa J. Workplace integration: Key considerations for internationally educated nurses and employers. Administrative Sciences 2018; 1-18. doi:10.3390/admsci8010002.

14.Lukes S. Power: A radical view. New York: Palgrave MacMillan, 2005.

15.Gaventa J. Power and powerlessness - quiescence and rebellion in an Appalachian valley. Urbana: University of Illinois Press, 1980.

16.Sadan E. Empowerment and Community Planning: Theory and Practice of People-Focused Social Solutions. Tel Aviv: Hakibbutz Hameuchad Publishers [in Hebrew, translated to English by Richard Flantz], 1997.

17.Freire P. Pedagogy of the Oppressed. New York, NY: Herder & Herder, 1971.

18.Das Gupta T. Real nurses and others – Racism in nursing. Nova Scotia: Fernwood Publishing, 2009.

19.Etowa J, Sethi S, Thompson-Isherwood R. The substantive theory of surviving on the margin of a profession. Nursing Science Quarterly, 2009 22(2): 174-181.

20.Hagey R, Choudhry U, Guruge S, Turrittin J, Collins E, Lee R. Immigrant nurses' experience of racism. Journal of Nursing Scholarship, 2001; 33(4):389-394.

21.Stake RE. The art of case study research. Thousand Oakes, CA: SAGE Publications, 1995.

22.St. Michael's Hospital. 2010 Health Equity Refresh Report – Quality Healthcare for All – Prepared for the Toronto Central Local Health Integration Network. Toronto, ON: St. Michael's Hospital, 2010.

23.Braun V, Clarke V. Using Thematic Analysis in Psychology. Qualitative Research in Psychology, 2006; 3(1):79-89.

24.St-Pierre I, Covell CL, Primeau M, Kilpatrick K, Ndengeyingoma A, Tchouaket E. Factors that Support the Integration and Retention of Internationally Educated Nurses in the Canadian Healthcare Systems. Ottawa: Health Canada, 2015.

25.Hyndman J. Research summary on resettled refugee integration in Canada. Toronto, ON: Centre for Refugee Studies, York University, 2011. Retrieved from http://www.unhcr.ca/resources/4e4b77842.pdf

26.UNHCR. Executive committee conclusion on local integration 2005, No. 104 (LVI). Retrieved from http://www.unhcr.org/4357a91b2.html

27.Wong W, Poisson Y. From immigration to participation: A report on promising practices in integration. Ottawa, ON: The Public Policy Forum, 2008. Retrieved from http://www.hippycanada.ca/downloads/Immigration.pdf

28.Citizenship & Immigration Canada. Annual Report, 2013. Retrieved from http://www.cic.gc.ca/english/resources/publications/annual-report-2013/section4.asp#a3

29.Ley D. Post-Multiculturalism? Working Paper No. 05-18. Research on Immigration and Integration in the Metropolis. Vancouver: Vancouver Centre of Excellence, 2005.

30.Omidvar R, Richmond T. Immigrant settlement and social inclusion in Canada. Toronto, ON: The Laidlaw Foundation, 2003. Retrieved from www.laidlawfdn.org/working-paper-series-social-inclusion

31.Blythe J, Baumann A, Rheaume A, McIntosh K. Nurse migration to Canada: Pathways and pitfalls of workforce integration. Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society / Transcultural Nursing Society, 2009; 20(2): 202-210. doi:10.1177/1043659608330349

32.Allan H. Mentoring overseas nurses: Barriers to effective and non-discriminatory mentoring practices. Nursing Ethics, 2010; 17(5): 603-613. doi:10.1177/0969733010368747

33.Batnitzky A, McDowell L. Migration, nursing, institutional discrimination and emotional/affective labour: Ethnicity and labour stratification in the UK National Health Service. Social & Cultural Geography, 2011;12(2): 181-201. doi:10.1080/14649365.2011.545142

34.Dicicco-Bloom, B. The racial and gendered experiences of immigrant nurses from Kerala, India. Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing

Society / Transcultural Nursing Society,2004, 15(1), 26-33. doi:10.1177/1043659603260029

35.Hawthorne L. The globalisation of the nursing workforce: Barriers confronting overseas qualified nurses in Australia. Nursing Inquiry, 2001, 8, 213–229.

36.Kawi J, Xu Y. Facilitators and barriers to adjustment of international nurses: An integrative review. International Nursing Review, 2009, 56(2), 174-183. doi: 10.1111/j.1466-7657.2008. 00705.x

37.Magnusdottir H. Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse. International Nursing Review, 2005, 52, 263–269.

38.Mapedzahama V, Rudge T, West S, Perron A. Black nurse in white space? Rethinking the in/visibility of race within the Australian nursing workplace. Nursing Inquiry, 2012,19, 153–164.

39.Pizer CM, Collard AF, James SM, Bonaparte BH. Nurses' job satisfaction: Are there differences between foreign and US-educated nurses? Image--the Journal of Nursing Scholarship, 1992, 24(4), 301-306.

40.Turrittin J, Hagey R, Guruge S, Collins E, Mitchell M. The experiences of professional nurses who have migrated to Canada: cosmopolitan citizenship or democratic racism? International Journal of Nursing Studies, 2002, 39, 655–667

41.Zhou Y, Windsor C, Theobald K, Coyer F. The concept of difference and the experience of china-educated nurses working in Australia: A symbolic interactionist exploration. International Journal of Nursing Studies, 2011, 48(11), 1420-1428. doi: 10.1016/j.ijnurstu.2011.05.003

42.Allen DG. Whiteness and difference in Nursing. Nursing Philosophy, 2006, 7, 65-78.

43.Minors A. Creating anti-Racist organizations. The university to poly-versity series on anti-oppression organization change. Toronto: Arnold Minors & Associates. 2015.

44.Saloojee A. Social inclusion, anti-racism and democratic citizenship. Toronto: The Laidlaw Foundation. 2003.

45.Kersten A. Diversity management. Journal of Organizational Change Management, 2000, 13(3), 235-248. doi: 10.1108/09534810010330887

46.Getty GA.The journey between western and indigenous research paradigms. J Transcultural Nsg, 2010, 21(1), 5-14.

47.Manias E, Street A. Possibilities for critical social theory and Foucault's work: A toolbox approach. Nursing Inquiry, 2000, 7(1), 50-60.

48.Roberts S. Oppressed group behavior: implications for nursing. Advances in Nursing Science, 1983, 21-30.

49.Nussbaum M. Women's capabilities and social justice. Journal of Human Development, 2005, 1(2), 219-247. doi:10.1080/14649880020008749

50.Roscigno V, Mong S, Byron R Tester G. Age discrimination, social closure and employment. Social Forces, 2007, 86(1), 313-334.

51.Galabuzi G. Employment equity as "felt fairness": The challenge of building an inclusive labour market. Canadian Diversity, 2012, 9(1), 22-28.

52.Etowa J, Debs-Ivall S, Conners E. Engaging with racism: An opportunity to advance nursing practice. The International Journal of Health, Wellness, and Society, 2015, 5(2), 1-13.

53.Bormann T, Woods S. A framework for building inclusive organizations. New York: The Workplace Diversity Network, Cornell University. 1999. Retrieved from www.ilr.cornell.edu/wdn/upload/paper2.pdf

54.Toronto Central Local Health Integration Network (TCLHIN). Toronto Central LHIN stakeholder consultation report. Toronto: Toronto Central LHIN. 2011.

55.Turner T. Diversity 2020:12 Upcoming equity, diversity and inclusion trends and issues. Toronto: Turner Consulting Group Inc. 2014.

56.Parkouda M. The immigrant advantage: Leveraging immigrants for innovation and competitiveness. Presented at Canadian Immigration Conference 2014: Enhancing Canada's Immigration System—from Invitation to Integration. Toronto, ON: The Conference Board of Canada.2014.

Acknowledgements

Financial support for this postdoctoral research was obtained through the University of Ottawa's Faculty of Graduate and Postdoctoral Studies and the Nursing Leadership Network of Ontario. The authors would also like to express thanks to Ms. Betsy Kappel, Dr. Ivy Bourgeault, and Dr. Rani Srivastava. Their generous and constructive feedback has been critical in developing the concepts and ideas contained in this paper.

To contact the authors:
Zubeida Ramji, RN, PhD
Z. Ramji Associates Inc.,
141 Sandyhook Square,
Toronto, Ontario, M1W 3N6;
Canada
email: zramj091@uottawa.ca

2

Abstract
This paper explores cultural identity within General (Adult) and Psychiatric (Mental Health) nursing as reflected in healthcare literature; illustrating how significant cultural differences associated with the history of the disciplines, representation of their fields of practice, professional knowledge, power, status, gender and employment rights affect interdisciplinary communication and working relationships. Applying Social Identity Theory (SIT), it argues that psychiatric nursing is a low status group compared to general nursing and highlights actions, congruent with SIT, which can be regarded as attempts to enhance the status of this discipline; so far with very limited success.

Keywords culture, identity, nursing, social, theory

Cultural differences in General and Psychiatric Nurses: A critical analysis using Social Identity Theory

PHIL COLEMAN

Introduction

A quarter of the United Kingdom (UK) population now experience a mental health problem during their life.[1] Some mental health problems have specific biological causes or physical symptoms and every physical health problem has a psychological dimension. Moreover, many individuals experience physical disturbances for which no identifiable biological cause can be found.[2] In the UK, nursing care for adults with physical and mental health problems is provided by two practitioner groups who hold distinct qualifications located on separate parts of the Nursing and Midwifery Council (NMC) register. General (or Adult) nurses primarily offer physical healthcare, whilst Psychiatric (or Mental Health) nurses largely address an individual's psychological health problems.[3]

Although both disciplines have a history of formal training from the late nineteenth century, their origins are very different. The establishment of modern general nursing is commonly attributed to mid/late nineteenth century pioneers such as Florence Nightingale and Ethel Bedford-Fenwick introducing improved standards of hygiene, discipline and hospital organisation.[4,5] In contrast, psychiatric nursing developed from the late eighteenth/early nineteenth century 'moral treatment' movement within the asylums, led by reformers such as Phillippe Pinel and William Tuke.[6,7] Indeed, general and psychiatric nurse training was entirely separate until the early 1980s[8] and although UK nurse education is now based on generic and specialism-specific competences[9] 'often those who focus on physical health have little professional exposure to people with mental ill-health and vice versa'.[10, p20]

Arguably, the cultural identity of nursing is evident in its 'values, visions, norms, nomenclature, systems, symbols, beliefs, and habits'[11, p242] and this identity affects the way nurses interact with one another, different professional groups, those receiving care and other stakeholders. Although not without its critics, Social Identity Theory (SIT), developed by Tajfel and Turner four decades ago, has been described as 'one of social psychology's pre-eminent theoretical perspectives'.[12, p745] This theory suggests social identity emerges from 'people's identification with the groups and social categories to which they belong'.[13, p282] Each social category into which an individual either falls or feels an association provides a definition of who this individual is in terms of the defining characteristics of this category.[14]

SIT suggests social identification initially involves forming 'a reflexive knowledge of group membership' and then developing 'an emotional attachment or specific disposition to this belonging' [15,p.25]. Categorization and a drive for self-enhancement affect an individual's beliefs about relations between their own 'ingroup' and identified 'outgroups'; accentuating the perceived similarities between the individual and other ingroup members and their differences to outgroup members [16]. Although such beliefs may not reflect reality, they still affect 'the specific behaviours that group members adopt in the pursuit of self-enhancement'.[14, p260]

Whilst 'little research has been conducted into the development of the professional identity of nurses',[17, p165] written records provide one method by which to understand a professional culture.[18] Applying SIT principles and as an attempt to stimulate further discussion/debate on the topic, this paper explores cultural identity within general and psychiatric nursing as reflected in healthcare literature, illustrating how differences associated with the history of the disciplines, representation of their fields of practice, professional knowledge, status, gender and employment rights currently affect practitioner interaction and working relationships in the UK. Academic Search Complete, BioMed Central, CINAHL with Full Text, the Directory of Open Access Journals, Emerald Premier, Internurse, OvidSP Journals, Pub-Med, Sage Journals Online, Taylor & Francis Journals Online, several online UK 'broad-sheet' newspapers and healthcare websites were employed within the literature search. Key search terms and interdisciplinary differences were derived from professional discussions with academic colleagues involved in the delivery of general and psychiatric pre-registration nursing programmes and assertions within the paper driven by the extent of literature discovered to support them.

Origins of the disciplines

SIT proposes that individuals seek to acquire and maintain a positive, secure social identity[19] and enhance their self-esteem by making favourable comparisons between the social group to which they belong and other different relevant outgroups[12]; a process known as 'social comparison'.[20] Such comparison often lead outgroups to be reductively characterised by members of the ingroup, leading to stereotyping and prejudice.[15]

The positivist biomedical model of illness, which is based on the principles of biological abnormality, diagnosis, treatment and cure has dominated healthcare for over a century[21,22] and much general nursing practice is still based on this model.[23,24] Sellman[5, p130] argues that Florence Nightingale's approach to nursing was founded on the nineteenth century social more that individuals should display 'conformity with the orders of those with purported greater knowledge'. Physicians are deemed the experts in a biomedical approach to healthcare and so within this model the nurse's role is to accurately carry out medical directives, most of which focus on the physical needs of the patient.[25,26] In physical healthcare medicine therefore dominates nursing;[27,28] an assertion supported by the results of several research studies. Casanova et al.[29] suggested physicians often regard nurses as an extension of their role, whilst Manias and Street[30, p445] found general nurses reported 'a sense of marginalization during their encounters with doctors'. General nurses interviewed by Tang et al.[31] displayed poor professional identities; regarding themselves as subordinates to physicians in ward rounds. It is argued that technical advances, in which 'the nurses' act of care may be reduced to the pressing of buttons and the monitoring of digital symbols' [32,p.253], have led blurred the distinction between medical and general nursing activities. 'Nurses are increasingly taking on doctors' roles' and undertaking clinical tasks such as 'endoscopy, minor surgery, and anaesthesia'[33, p337] and specialist nurse practitioner roles involve prescribing medication, examining patients, diagnosing illnesses, and providing treatment in much the same way as physicians.[34]

Despite the influence of biological psychiatry and psychopharmacology, psychiatric nursing is described as 'less well rooted in the biomedical tradition than general nursing',[35, p129] and considered to have 'distinct attributes, which are at odds with a positivist and reductionist paradigm'; an approach which may dismiss individual needs in favour of categorising and medicalising patient experience.[36, p371] In contrast to general nursing, psychiatric nursing is founded more on a bio-psycho-

social model of intervention;[37,38] perhaps because the biomedical model has failed to provide a physical cause, or consistently effective medical treatments, for many mental health problems.[39,40] Medicine is therefore less dominant in mental health and provision based on a more collaborative model of multidisciplinary team (MDT) working,[41,42] involving clinical psychologists, occupational therapists, social workers, art therapists, psychiatric nurses as well as psychiatrists.[43] Research suggests that all these disciplines make a significant contribution to the MDT,[44] that their combined expertise delivers a more holistic and comprehensive mental health service[41] and that working relationships between psychiatrists and psychiatric nurses are stronger and more positive than those between physicians and general nurses.[45]

Stereotyping, status, and stigma

The impact of differing theoretical foundations underpinning the practice of nurses within both disciplines may account for various reported phenomena that reinforce outgroup stereotypes. General nurses are commonly portrayed as the doctor's helper[46] or handmaiden,[26,28] displaying 'an obsession with physical care' and perceiving the care recipient as a diagnosis rather than a human being.[25, p46] Sercu et al.[47, p311] explored the reasons Belgian psychiatric nurses gave for entering the discipline and their responses reflected some of these general nursing stereotypes:

> 'In general hospitals it's the doctor who decides and you will carry it out in practice'.
>
> 'General nursing is very technical. The contact with the people [service users] is medicalized, and because of the efficiency policy you have a lot of short, often too short, hospitalizations, which means that people are approached in a less human way [than in mental health nursing]. It makes it impossible to encounter the person as a human being'.
>
> 'I worked for three years in a general hospital and I wasn't happy. The contact with service users was different, everything had to go fast and the people were numbers. Individuals became their disorder, they didn't know service users' names.'.

Nurses working outside general nursing are often described in equally critical terms; being regarded as not 'real'[48,49] or 'proper'[50] nurses and inferior to colleagues in general nursing.[51] Specifically, psychiatric nurses have been portrayed as having a primarily custodial job[52] founded on little more than common sense[53] and regarded as lazy; avoiding hard work and instead chatting to patients.[54] Furthermore, Sabella and Fay-Hiller[51, p3] report overhearing general nurses 'telling other non-mental health nurses that mental health nurses are crazy'. Clearly, such negative stereotypes may adversely affect the nature of interactions between members of both disciplines.

The tensions between general and psychiatric nurses which originate from different theoretical perspectives underpinning their practice are perhaps greatest where their roles intersect; most notably when individuals require specialist physical and mental healthcare, since it may be these occasions when nurses display greatest variation in their values, perceptions and subsequent practice. For example, research suggests people failing to ensure appropriate nutritional intake or comply with dietary advice are perceived by general nurses as refusing to control their eating disorder, despite being able to do so [55], and are therefore considered difficult patients for whom it is not satisfying to care.[56]

Similarly, studies indicate those receiving treatment following deliberate self-harm are often perceived negatively by general nurses;[57] being regarded as manipulative,[58] attention-seeking and wasting staff time.[59] Research also suggests individuals with health problems arising from substance misuse are considered by general nurses to be responsible for their own ill-health, lacking self-control[60,61] and being 'an annoyance within general health care provision'.[62, p39] Perhaps the tendency for psychiatric nurses to consider the potential psycho-social origins of these problems explains why discussion with general nursing colleagues on appropriate care planning may be difficult.

General nursing has a higher status than psychiatric nursing within healthcare. Consistently underfunded,[63] mental health has long been described as a 'Cinderella service' and the 'poor relation' to physical healthcare;[64,65] whilst mental illness continues to be stigmatised.[38,47] Indeed, research exploring how general nurses in Brazil perceived having psychiatric care beds in a general hospital clearly illustrates such stigmatisation.[66, p4-5] Comments regarding individuals admitted for mental healthcare within the hospital included the following:

> 'I am afraid of them'
>
> 'I really can't feel empathy with them'
>
> 'They scare me, especially when everyone is asleep. I am afraid of physical assault'
>
> 'I feel uncomfortable with their presence here, particularly because it is very close to the maternity'

Similarly, second year general nursing students in Finland had 'prejudices and negative attitudes towards mental illnesses and psychiatric settings'.[67, p622] Via 'courtesy stigma', or stigma by association, mental health practitioners

may also be negatively perceived within and beyond the health services.[68,69] In Canada, the public were found to regard psychiatric nurses as evil and corrupt;[70] whilst research regarding the way psychiatric nurses were portrayed in international films between 1942 and 2005 identified ten archetypes, almost all negative; namely 'mother, sex kitten, mean spinster, hardened working-class man, bull dyke, Nazi custodian, kindly companion, mincing queen, brutal rapist and unquestioning obedient servant'.[71, p341] It seems improbable that such negative representations do not adversely affect the perception of psychiatric nursing held by both general and psychiatric nurses and interaction between such practitioners.

According to SIT a low status group member can reacquire positive social identity, an action called 'social change',[20] by various means. One technique is to make more flattering comparisons to the subordinate group.[19] Although literature apparently designed to deliberately demean general nursing and thereby heighten the standing of psychiatric nursing is reassuringly rare, one example appears to be a paper by an academic and psychiatric nurse regarding pre-registration nursing programmes. Clarke[72, p39] argued that although psychiatric nursing students are 'susceptible to the types and levels of debate that are appropriate to a university' and the breadth and depth of their programmes necessitates university-based study, many students on general nursing programmes 'crave more input on anatomy and physiology', fail to appreciate the importance of psychosocial studies and have 'anxieties about entering the workplace with limited knowledge about the medical tasks that await them'. Moreover, the academic claimed that general nursing students 'seek descriptive curricula, watered down versions of medicine, and they generally resent being denied this' [p.40], their programmes should last only two years and that their professional training be 'completely separate from mental health and other branches of nursing'.[p41]

Unsurprisingly, this paper triggered a heated debate in the nursing press, but no retraction or apology from the author. Indeed, his argument was developed in a subsequent book[73] where he describes the 'phenomenon of adult students coming to me tears streaming down their cheeks, clutching failed assignments titled: 'Critically assess the therapeutic properties of transactional analysis' and exclaiming 'But I came here to be a nurse!'[p176] and asserted that general nursing students should have a curriculum 'fitted around a two year – non-university – programme which gives them the professional equipment to work competently in medical settings'.[p180] Although these publications only capture the views of one psychiatric nurse it seems reasonable to assume that general nurses aware of them may believe they reflect a wider body of opinion within psychiatric nursing and thereby influence impression formation and subsequent interactions with members of this discipline.

Moral and ethical reasoning

In the UK, psychiatric nurses have legal powers which, under clearly defined circumstances, permit them to deprive an individual of their liberty and those receiving mental healthcare may be subject to detention and treatment against their will. The psychiatric nurse's 'moral duty to ensure safety'[74, p848] whilst optimising individual freedom[75] has therefore been emphasised. Indeed, it is suggested psychiatric nurses require a detailed appreciation of wider legal issues associated with providing treatment and care as well as a multidimensional understanding of moral and ethical reasoning to achieve this goal.[36,76]

Such reasoning is perhaps most evident in psychiatric nurse perceptions of lifestyle behaviours. For example, although smoking has been described as a habit which nurses should actively discourage,[77] research suggests that psychiatric nurses have more liberal attitudes to smoking than other healthcare practitioners,[78] believe it is an individual's right to smoke, are cautious about imposing their own values on smokers, 'mindful of the power imbalance in their relationship with patients' and base decisions about smoking on the ethical principles of autonomy, beneficence and non-maleficence.[79, p113] Inevitably, different views held by general and psychiatric nurses on emotive topics such as lifestyle behaviours that may have adverse physical consequences may reinforce inter-disciplinary negative stereotypes and impair discussions regarding care provision involving nurses from both groups.

Language and role redefinition

SIT suggests members of an inferior group may enhance their social identity by highlighting new, distinctive or positive dimensions about the group.[20] Arguably, by developing a distinctive set of concepts and vocabulary to describe their work, psychiatric nurses are adopting this strategy to raise their status. The term 'patient' is traditionally used to describe the person whom a physician treats[80] and implies a subservient and passive role for the individual,[81,82] which is considered incompatible with contemporary psychiatric nursing. Although still commonly used within the wider health services, this word is now employed less frequently in psychiatric nursing literature, where the individual is more

often referred to as a 'service user'.[37,47,83,84]

Nursing is a predominantly female occupation [4,85], but psychiatric nursing has always had a more balanced gender composition.[86] Recent data suggests that whilst only 10% of general nurses are male,[87] this figure rises to more than 38% in psychiatric nursing.[88] In response to the feminised nature of nurse training [89] and female-oriented descriptions of nursing care [90] there appears to be growing use of more gender-neutral psychiatric nursing terminology, with phrases such as 'nurturing', 'compassion' and 'sympathy'[5,86,87,91] being replaced by 'empowerment', 'facilitation' and 'empathy'.[36,84,92]

Furthermore, psychiatric nurses now emphasise distinctive features determining their practice, including holism, the therapeutic relationship, person-centred approach and therapeutic use of self[38,93,94] and sometimes even occupy roles from which the term 'nurse' itself is absent.[37] Whilst employing different language to describe psychiatric nursing interventions may increase the discipline's distinctiveness and possibly even help raise its status, it may also be divisive; increasing interactional misunderstandings between general and psychiatric nurses and raising suspicions about professional motives and conflicting values.

Members of a subordinate ingroup may seek to downplay less desirable aspects associated with their group[19] or reinterpret them in positive ways.[20] Arguably there is evidence of both activities within psychiatric nursing literature. The discipline's history includes many disturbing, unpleasant or uncomfortable features and there remains an ongoing tension between the psychiatric nurse's duties in respect of care and control.[95] In recent decades, however, some psychiatric nursing academics have sought to re-evaluate the discipline's history. For example, O'Brien[6] argues that, albeit in a rudimentary form, the importance of a therapeutic relationship was recognised in some asylums, poor asylum care was commonly the result of institutional overcrowding and even in the early part of the nineteenth century more enlightened asylum workers believed restraint was more likely to cause mental disturbance than prevent it.

Nurse retention and turnover

SIT proposes that members of an inferior group may enhance their self-esteem by leaving this group.[19] The NMC[96] reports that 27% more nurses are now leaving the professional register in the UK than joining it, but staff shortages in psychiatric are almost 42% higher than for general nursing.[1] Between 2014 and 2017 there was a 6.2% reduction in the total number of psychiatric nurses practising in England;[97] a situation partly attributed to these staff feeling overworked, undervalued and poorly paid.[98,99] Moreover, high staff turnover affects nursing morale and productivity; creating a less desirable working environment for those remaining[100] and thereby encouraging more staff to leave. Clearly, high psychiatric nursing workforce turnover may suggest, congruent with SIT, that some psychiatric nurses are indeed leaving this discipline because of its inferior status. Such action, however, may worsen the discipline's low status and lead general nurses to be less inclined to perceive colleagues in psychiatric roles as their peers; thereby reinforcing power inequities between both groups.

Ironically, one initiative implemented to promote recruitment and retention of mental health staff in the UK National Health Service (NHS) may have increased the number of psychiatric nurses leaving practice. 'Mental Health Officer status', which mirrored existing schemes in some mental hospitals before the formation of the NHS in 1948, was designed to compensate professionals practising in the less attractive field of mental health and allows staff to retire with an occupational pension from 55 years. Although this status was closed to new NHS pension scheme entrants in 1995,[101] it continues to affect early retirement levels in psychiatric nursing and perceived discrimination in the employment rights of experienced general and psychiatric nurses may have further damaged the working relationship between members of both disciplines.

Challenging the status quo

According to SIT, members of a subordinate group may engage in activities which seek to overturn the existing hierarchy.[19] Arguably, the UK government's recent decision to address the historic funding imbalance between physical and mental healthcare by 2021, recruit 2,000 new psychiatric nurses, consultants and therapists whilst attempting to encourage some of the 30,000 psychiatric nurses no longer practising to return to the NHS [102] might suggest that campaigning by nurses and other mental health practitioners has contributed to this policy change and is therefore an example of such group behaviour. This initiative, however, could harm professional relationships between general and psychiatric nurses if members of the former group fear it will be achieved by Central Government reallocating already limited resources in physical healthcare to fund these improvements.

Inter-disciplinary & inter-professional education

SIT proposes one final strategy which members of an inferior group may employ to improve their position; namely to

'adopt those positive characteristics attributed to the high-status group, so increasing the likelihood of a merger with that group'.[20, p44] Indeed, this approach may be the most promising way to redefine group identity and reduce inter-group conflict.[12] The current pre-registration nurse education programmes for different nursing disciplines in the UK have been described as 'training nurses in silos'[10, p21] and inter-disciplinary and inter-professional education are therefore advocated as means to promote more integrated healthcare provision and strengthen working relationships between different practitioner groups.[2,41,107]

As a result, there have been calls for UK pre-registration nursing programmes to be fully integrated.[2,98] Recent NMC[106] draft proposals regarding the future of nurse education, however, have ignored such calls; instead retaining specific nursing branches and professional qualifications. This conservative response to serious recruitment and retention issues may have been influenced by awareness that fully integrated pre-registration nursing curricula introduced in Australasia and North America, in which psychiatric nursing became a post-graduate specialism, appears to have increased recruitment problems to the discipline on both continents.[37,75] Nyatanga[107, p175] claims that 'professional ethnocentrism derived from professional identity and socialisation' acts as a key barrier to inter-disciplinary learning and it appears there is indeed evidence to support this assertion. An important shortcoming of any integrated pre-registration educational structure for psychiatric nursing, however, may simply be that young people, not yet directly exposed to nursing culture but with a specific desire to become psychiatric nurses, are unwilling to complete three years of undergraduate study on a generic nursing course before being able to focus on their specific field of interest.[53]

Perhaps of equal if not greater concern is the suggestion that, in those nations where fully integrated pre-registration nursing programmes have been launched, psychiatric nursing has experienced 'a growing uncertainty about itself as a profession'.[108, p550] It seems most unlikely, at least for the foreseeable future, that the implementation of this approach to address the status inequity between general and psychiatric nursing in the UK and thereby strengthen working relationships between members of the disciplines will occur. If a more equitable status between general and psychiatric nursing is to be achieved, then this may instead require psychiatric nurses to take further action reflecting the principles of SIT. Such efforts might need to include more aggressive lobbying to acquire a stronger voice within healthcare leadership,[109] continuing to challenge the stigma of mental ill-health,[9,47] or even undertaking 'a complete rebranding of mental health nursing'.[69, p17]

Limitations

Despite the value of SIT as a conceptual framework to examine general and psychiatric nursing, several limitations of this theory have been highlighted. Whilst SIT has been frequently used to retrospectively explain intergroup activity it has been much less effective in predicting such behaviour [103] and research has not so far provided evidence of a strong correlation between individual self-esteem and the perceived status of their ingroup.[12] Moreover, SIT has been criticised for failing to clearly articulate the specific psychological and social factors involved in group processes.[14] Given the expectation that, to be deemed a robust and credible explanation, any scientific theory must be falsifiable, the ability of SIT to account for an extremely wide range of observed phenomena means that it fails to comply with this requirement.[104] It is even questionable whether individual beliefs, values and modes of communication can ever be solely attributed to individual identification with a social group.

Inevitably, this paper cannot capture all differences associated with the cultural identity of general and psychiatric nursing and is shaped by the perceptions of those involved in its development. Moreover, word limitations mean it has intentionally focused on areas of difference rather than aspects of similarity as an attempt to stimulate further discussion/debate on a topic which has received comparatively little attention to date.

Conclusion

In conclusion, healthcare literature suggests differences in cultural identity related to the origins of general and psychiatric nursing, representation of these fields of practice, professional knowledge, power, status, gender and employment rights may significantly affect interactions between members of the two disciplines; manifested in the contrasting approaches to the care which they deem appropriate for individuals, the emphasis given to different forms of care, arguments surrounding the most suitable professional training for practitioners, conflicting views on lifestyle behaviours and the use of different language to describe nursing interventions.

Indeed, it appears that, as members of a low status group, psychiatric nurses are managing this status inequity by

employing many, if not all, of the strategies identified within SIT. More than a century after both disciplines introduced formal training, however, it is questionable whether any of these actions have yet measurably enhanced the status of psychiatric nurses; except perhaps for those choosing to leave this discipline. Since healthcare funding is finite and NHS budgets in the UK often described as over-stretched, however, inter-disciplinary tension between general and psychiatric nursing is arguably both a predictable and an unavoidable consequence of the way UK healthcare is provided.

References

1.Public Health England. Facing the Facts, Shaping the Future. A draft health and care workforce strategy for England to 2027. London: Public Health England, 2017.

2.Naylor C, Das, P, Ross, S., Honeyman, M, Thompson, J. & Gilburt, H. Bringing togetherphysical and mental health. A new frontier for integrated care. London: The King's Fund, 2016.

3.Nursing & Midwifery Council Standards for pre-registration nursing education. London: Nursing & Midwifery Council, 2010.

4.Leishman J. Back to the future: making a case for including the history of mental health nursing in nurse education programmes, The International Journal of Psychiatric Nursing Research 2005; 10[3]:.1157-1164.

5.Sellman D. Values and Adult General Nursing. In Pattison S, Hannigan B, Pill R & Thomas H. [eds] Emerging Values in Health Care: The Challenge for Professionals. London: Jessica Kingsley Publishers. 2010; 129-143.

6.O'Brien A. The therapeutic relationship: historical development and contemporary significance, Journal of Psychiatric and Mental Health Nursing 200; 8: 129–137.

7.Hannigan B. Values and Mental Health Nursing, in Pattison S, Hannigan, B, Pill, R & Thomas, H. [eds] Emerging Values in Health Care: The Challenge for Professionals. London, Jessica Kingsley Publishers. 2010; 109-127.

8.Nolan P. The search for a professional identity continues. British Journal of Mental Health Nursing 2012; 1[3]: 145-148.

9.Schafer, T, Wood, S & Williams, S. A survey into student nurses' attitudes towards mental illness: Implications for nurse training, Nurse Education Today 2011; 31: 328–332.

10.Chesnaye P. Integrating mental and physical healthcare, Nursing Times 2016; 112[32], 20-23.

11.Yap T, Kennerly S & Flint E. Nursing culture assessment tool [NCAT]: Empirical validation for use in long-term care, International Journal of Nursing Sciences 2014; 1: 241-249.

12.Brown R. Social Identity Theory: past achievements, current problems and future challenges, European Journal of Social Psychology 2000; 30: 745-778.

13.Crocetti E, Avanzi, L, Haw, S, Fraccaroli . & Meeu, W. Personal and Social Facets of Job Identity: A Person-Centered Approach, Journal of Business Psychology 2014; 29: pp.281-300.

14.Hogg M, Terry D & White K. A Tale of Two Theories: A Critical Comparison of Identity Theory with Social Identity Theory. Social Psychology Quarterly 1995; 58[4]: 255-269.

15.Benwell B & Stokoe E. Discourse and Identity. Edinburgh: Edinburgh University Press, 2006.

16.Stets J & Burke P. Identity Theory and Social Identity Theory. Social Psychology Quarterly 2000; 63[3]: 224-237.

17.Willetts G & Clarke D. Constructing nurses' professional identity through social identity theory. International Journal of Nursing Practice 2014; 20: 164–169.

18.Williams A & Sibbald B. Changing roles and identities in primary health care: exploring a culture of uncertainty. Journal of Advanced Nursing 1999; 29[3]: 737-745.

19.Hornsey M. Social Identity Theory and Self-categorization Theory: A Historical Review. Social and Personality Psychology Compass 2008; 2[1]: 204–222.

20.Skevington S. Intergroup relations and nursing. European Journal of Social Psychology 1981; 11: 43-59.

21.Wade D & Halligan P. Do biomedical models of illness make for good healthcare systems? British Medical Journal 2004; 329: 1398-1401.

22.Hemingway S. The future of mental health nursing education in the United Kingdom: Reflections on the Australian and New Zealand experience. Journal of Psychiatric and Mental Health Nursing 2016; 23[5]: 331-337.

23.Gould B. Role of reflective group discussions in the development of nursing skills. Mental Health Practice 2011; 14[8]: 32-33.

24.Mazzotta C. Biomedical approaches to care and their influence on point of care nurses: a scoping review. Journal of Nursing Education and Practice 2016; 6[8]: 93-101.

25.Pearson A, Vaughan, B & FitzGerald, M. Nursing Models for Practice. Third Edition. Edinburgh: Butterworth Heinemann 2005.

26.Matziou V, Vlahioti E, Perdikaris, P, Matziou T, Magapanou E & Petsios, K. Physician and nursing perceptions concerning interprofessional communication and collaboration. Journal of Interprofessional Care 2014; 28[6]: 526–533.

27.Domino E. Nurses Are What Nurses Do- Are You Where You Want to Be? Archives of Research in Nursing Journal 2005; 81[1]: 187-201.

28.Summer S & Summer H. The image of nursing: The handmaiden, Nursing Times, 7th October. 2010. Available from: https://www.nursingtimes.net/roles/nurse-managers/the-image-of-nursing-the-handmaiden/5020163.article. Accessed 25 March 2018.

29.Casanova J, Dorpat D, Hendricks B, Theis, L. & Wiesman S. Nurse-Physician work relations and role expectations. Journal of Nursing Administration 2007: 37[2]: 68-70.

30.Manias E & Street A. Nurse-doctor interactions during critical care ward rounds. Journal of Clinical Nursing 2001; 10: 442-450.

31.Tang C, Zhou W & Chan S. Interprofessional collaboration between junior doctors and nurses in the general ward setting: A qualitative exploratory study. Journal of Nursing Management 2018; 26: 11–18.

32.Stickley T & Freshwater D. The art of loving and the therapeutic relationship. Nursing Inquiry 2002; 9[4]: 250–256.

33.Coombes R. Dr Nurse will see you now. British Medical Journal 2008; 337: 660-662.

34.Nurse.org Nurse Practitioner. 2018. Available from: https://nurse.org/resources/nurse-practitioner/ Accessed 2 April 2018.

35.Norman I. Models of Mental Health Nursing Education: Findings from a Case Study in Tilley S [ed.] Psychiatric and Mental Health Nursing: The Field of Knowledge. Oxford: Blackwell Science, 2005, 129-149.

36.Hewitt J. Redressing the balance in mental health nursing education: Arguments for a values-based approach. International Journal of Mental Health Nursing 2009; 18: 368–379.

37.Hurley J & Lakeman R. Becoming a Psychiatric/Mental Health Nurse in the UK: A Qualitative Study Exploring Processes of Identity Formation. Issues in Mental Health Nursing 2011; 32[12]: 745-751.

38.Townsend M. Psychiatric Mental Health Nursing: Concepts of Care in Evidence-Based Practice, 8th Edition. Philadelphia: F. A. Davis Company 2015.

39.Katschnig H. Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. World Psychiatry 2010; 9: 21-28.

40.Grant A. Demedicalising misery: Welcoming the human paradigm in mental health nurse education. Nurse Education Today 2015; 35: e50–e53.

41.McAllister M, Statham D, Oprescu F, Schmidt T, Boulter C, Taylor, P, McMillan J, Jackson S & Raith L. Mental health interprofessional education for health professions students: bridging the gaps. The Journal of Mental Health Training, Education and Practice 2014; 9[1]: 35-45.

42.McCrae N, Askey-Jones S & Laker C. Merely a stepping stone? Professional identity and career prospects following postgraduate mental health nurse training. Journal of Psychiatric and Mental Health Nursing 2014; 21: 767–773.

43.Health Education England. Mental Health Nurse. 2018. Available from: https://www.healthcareers.nhs.uk/explore-roles/nursing/roles-nursing/mental-health-nurse. Accessed 2 April 2018.

44.Barker P & Walker L. Nurses' perceptions of multidisciplinary teamwork in acute psychiatric settings. Journal of Psychiatric and Mental Health Nursing 2000; 7: 539-546.

45.Roche M & Duffield C. A Comparison of the Nursing Practice Environment in Mental Health and Medical-Surgical Settings. Journal of Nursing Scholarship 2010; 42[2]: 195–206.

46.Ballou K & Landreneau K. The Authoritarian Reign in American Health Care. Policy, Politics, & Nursing Practice 2010; 11[1]: 71–79.

47.Sercu C, Ayala R & Bracke P. How does stigma influence mental health nursing identities? An ethnographic study of the meaning of stigma for nursing role identities in two Belgian Psychiatric Hospitals. International Journal of Nursing Studies 2015; 52: 307–316.

48.Vishakha V. Does everyone think learning disability nurses are not real nurses? Nursing Times, 15th July. 2013. Available from: https://www.nursingtimes.net/students/does-everyone-think-learning-disability-nurses-are-not-real-nurses/5060871.article. Accessed 2 April 2018.

49.Shepley J. OR & Psych Nurses are not "real" nurses… judging our own. 17th August. 2016. Available from: https://nurseneedscoffeestat.org/2016/08/17/or-psych-nurses-are-not-real-nursesjudging-our-own/. Accessed 2 April 2018.

50.Ramsay D. "What is an LD nurse, what do you do… Oh, so not a proper nurse?". 2015. Available from: https://www.mencap.org.uk/blog/what-ld-nurse-what-do-you-do-oh-so-not-proper-nurse. Accessed 25 March 2018.

51.Sabella D & Fay-Hiller T. Challenges in mental health nursing: current opinion. Nursing: Research and Reviews 2014; 4: 1-6.

52.Nolan P & Hooper B. Revisiting mental health nursing in the 1960s. Journal of Mental Health 2000; 9[6]: 563-573.

53.Holmes C. Guest editorial. Journal of Psychiatric and Mental Health Nursing 2001; 8: 379–381.

54.Hitchen L. Why is mental health nursing unpopular? Nursing Times 2008; 104[23]: 16-17.

55.Seah X, Tham X, Kamaruzaman, N & Yobas P. Knowledge, Attitudes and Challenges of Healthcare Professionals Managing People with Eating Disorders: A Literature Review. Archives of Psychiatric Nursing 2017; 31: 125–136.

56.Carter N, Webb C, Findlay S, Grant C & Blyderveen S. The Integration of a Specialized Eating Disorders Nurse on a General Inpatient Pediatric Unit. Journal of Pediatric Nursing 2012; 27: 549–556.

57.Cleaver K. Attitudes of emergency care staff towards young people who self-harm: A scoping review. International Emergency Nursing 2014; 22: 52–61.

58.Friedman T, Newton C, Coggan C, Hooley S, Patel R, Pickard M. & Mitchell A. Predictors of A&E staff attitudes to self-harm patients who use self-laceration: Influence of previous training and experience. Journal of Psychosomatic Research 2006; 60: 273– 277.

59.Conlon M & O'Tuathail C. Measuring emergency department nurses' attitudes towards deliberate self-harm using the Self-Harm Antipathy Scale. International Emergency Nursing. 2012; 20: 3– 13.

60.Brener L, Von Hippel W, Kippax S & Preacher K. The Role of Physician and Nurse Attitudes in the Health Care of Injecting Drug Users. Substance Use & Misuse 2010; 45: 1007–1018.

61.Chang Y & Yang M. Nurses' Attitudes toward clients with substance use problems, Perspectives in Psychiatric Care 2013; 49: 94–102.

62.Harling M, Overy C, Beckham G, Denby R, Goddard S, O'Connor C, Piotrowski E, Prout T & Tully D. Addressing negative attitudes toward substance use in nursing: A peer led approach in nurse education. Drugs and Alcohol Today 2006: 6[2]: 38-41.

63.Happell B. Let the buyer beware! Loss of professional identity in mental health nursing. International Journal of Mental Health Nursing 2014; 23[2]: 99–100.

64.Marti, P. A Strong Patient Advocate. Kai Tiaki Nursing New Zealand 2012; 18[8]: 27.

65.Johnson S. What are your experiences of mental health care? The Guardian 6th September. 2017. Available from: https://www.theguardian.com/healthcare-network/2017/sep/06/experiences-mental-health-care-nhs. Accessed 25 March 2018.

66.Moll M, Silva L, Magalhaes H & Ventura C. Nursing Professionals and Psychiatric Admission in General Hospital: Perceptions and Professional Training. Cogitare Enfermagem 2017; 22[2]: 1-7.

67.Koskinen L, Mikkonen I & Jokinen P. Learning from the world of mental health care: nursing students' narratives. Journal of Psychiatric and Mental Health Nursing 2011; 18: 622–628.

68.Morgan N. In the shadow of Nurse Ratched. Crosscurrents - Journal of Addiction & Mental Health, 2010; 13[3]: 14-15.

69.Heyman I. Challenging misconceptions about mental health nursing. Nursing Times 2012; 108[28]: 16-17.

70.Ng S, Kessler L, Srivastava R, Dusek J, Duncan D, Tansey M & Jeffs L. Growing prac-tice specialists in mental health: addressing stigma and recruitment with a nursing residency programme. Nursing Leadership 2010; 23: 101-112.

71.De Carlo K. Ogres and Angels in the madhouse. Mental health nursing identities in film. International Journal of Mental Health Nursing 2007; 16[5]: 338-348.

72.Clarke L. Nurse education in the university setting. Nursing Standard 2004; 18[24]: 39-41.

73.Clarke L. Reading Mental Health Nursing: Education, Research, Ethnicity and Power. Edinburgh: Churchill Livingstone 2008.

74.Holyoake D. I spy with my little eye something beginning with O: looking at what the myth of 'doing the observations' means in mental health nursing culture. Journal of Psychiatric and Mental Health Nursing 2013; 20: 840–850.

75.Hazelton M, Rossiter R, Sinclair E & Morrall P. Encounters with the 'dark side': New graduate nurses' experiences in a mental health service. Health Sociology Review 2011; 20[2]: 172–186.

76.Terry L. The nurse's role and the NMC Code of Professional Conduct in the use of Section 58 powers. Mental Health Practice 2003; 7[3]: 22-25.

77.Berkelmans A, Burton D, Page K & Worrall-Carter L. Registered Nurses' smoking behaviours and their attitudes to personal cessation. Journal of Advanced Nursing 2011; 67[7]: 1580–1590.

78.Dickens G, Stubbs J & Haw C. Smoking and mental health nurses: a survey of clinical staff in a psychiatric hospital. Journal of Psychiatric and Mental Health Nursing 2004; 11: 445–451.

79.Lawn S & Condon J. Psychiatric nurses' ethical stance on cigarette smoking by patients: Determinants and dilemmas in their role in supporting cessation. International Journal of Mental Health Nursing 2006; 15: 111–118.

80.Ritchie C, Hayes D & Ames D. Patient or client? The opinions of people attending a psychiatric clinic. Psychiatric Bulletin 2000; 24: 447-450.

81.Hehir B. What's in a name? Quite a lot, actually. Nursing Standard 2012; 26[47]: 26.

82.Saito D, Zoboli E, Schveitzer M & Maeda S. User, client or patient? Which term is more frequently used by nursing students? Text & Context Nursing Journal 2013, 22[1]: 175-183.

83.McDougall T & Brimblecombe N. Turning values into action, Mental Health Practice 2006; 9[8]: 10-12

84.Health Education England. Personal characteristics and skills required [mental health nursing]. 2018. Available from: https://www.healthcareers.nhs.uk/explore-roles/nursing/roles-nursing/mental-health-nurse/personal-characteristics-and-skills-required-mental-health-nursing. Accessed 2 April 2018.

85.Holyoake D. Male identity in mental health nursing. Nursing Standard 2002; 16[48]: 33-37.

86.Hollup O. The impact of gender, culture, and sexuality on Mauritian nursing: Nursing as a non-gendered occupational identity or masculine field? Qualitative study. International Journal of Nursing Studies 2014: 51: 752–760.

87.Ross D. Challenges for Men in a Female Dominated Environment. Links to Health & Social Care 2017; 2[1]: 4 -20.

88.Health Education England. NHS Hospital and Community Health Services [HCHS]: Qualified mental health nurses in England by Ethnicity and Gender as at 30 September 2015. 2015. Available from: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwjF39XGytDZAhWJL1AKHQbXC1AQFghBMAI&url=http%3A%2F%2Fcontent.digital.nhs.uk%2Fmedia%2F19550%2FQualified-nursing-staff-and-support-staff-by-ethnicity-gender-level-HEE-region-and-AfC-band---Sept-2015%2Fxls%2FQualified_nursing_staff_and_support_staff_by_ethnicity__gender__level__HEE_region_and_AfC_band_- . Accessed 25 March 2018.

89.Boschma G, Yonge O & Mychajlunow L. Gender and professional identity in psychiatric nursing practice in Alberta, Canada, 1930–75. Nursing Inquiry 2005; 12[4]: 243–255.

90.Crawford P, Brown B & Majomi P. Professional identity in community mental health nursing: A thematic analysis. International Journal of Nursing Studies 2008; 45: 1055–1063.

91.McSherry W, Bloomfield S, Thompson R, Nixon V, Birch C, Griffiths N, Fisher S & Boughey A. A cross-sectional analysis of the factors that shape adult nursing students' values, attitudes and perceptions of compassionate care. Journal of Research in Nursing 2017; 22[1–2]: 25–39.

92.Price T & McAllister M. Narratives of mental health nursing in the emergency department. TEXT 2017; Special Issue 38: 1-8.

93.Chambers W. Integrating values into the mental health nursing curriculum. British Journal of Mental Health Nursing 2012; 1[4]: 256-259.

94.Freshwater D, Cahill J & Essen C. Discourses of collaborative failure: identity, role and discourse in an interdisciplinary world. Nursing Inquiry 2014; 21[1]: 59–68.

95.Royal College of Nursing. History of mental health nursing. 2015. Available from: http://psychiatrict.rcnlearning.org.uk/. Accessed 3 March 2018.

96.Nursing & Midwifery Council. The NMC Register. 30th September 2017. London: Nursing & Midwifery Council, 2017.

97.Royal College of Nursing. The UK nursing labour market review 2017. London: Royal College of Nursing, 2017.

98.House of Commons Health Committee. The nursing

workforce. Second Report of Session 2017–19, London: House of Commons, 2018.

99.Royal College of Nursing. Left to chance: the health and care nursing workforce supply in England. London: Royal College of Nursing, 2018.

100.Health Education England. Growing Nursing Numbers. Literature review on nurses leaving the NHS, London: Health Education England, 2014.

101.NHS Business Services Authority. NHS Pensions - Mental Health Officer status [1995 Section only]. [Online]. Available from: https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Mental%20Health%20Officer%20status%20factsheet-20160202-%28V6%29_0.pdf. 2016 Accessed 5 April 2018.

102.Bodkin H. Government promises an extra 21,000 NHS mental health staff, The Telegraph, 31st July. 2017. Available at: https://www.telegraph.co.uk/news/2017/07/30/government-promises-extra-21000-nhs-mental-health-staff/ Accessed 25 March 2018.

103.Korte R. A review of social identity theory with implications for training and develop-ment, Journal of European Industrial Training, 2007; 31[3]: 166-180.

104.Hogg M & Williams K. From I to we: Social identity and the collective self. Group Dy-namics: Theory, Research, and Practice 2000: 81–97.

105.McLeod K & Simpson A. Exploring the value of mental health nurses working in primary care in England: A qualitative study. Journal of Psychiatric and Mental Health Nursing 2017; 24: 397-395.

106.Nursing & Midwifery Council. Requirements for Pre-Registration Nursing Education Programmes. Draft for Consultation. London: Nursing & Midwifery Council, 2017.

107.Nyatanga L. Professional ethnocentrism and shared learning. Nurse Education Today 1998; 18: 175-177.

108.Molloy L, Lakeman R & Walker K. More Satisfying Than Factory Work: An Analysis of Mental Health Nursing Using a Print Media Archive. Issues in Mental Health Nursing 2016; 37: 550–555.

109.Brinkman A. Developing a collaborative purpose. Kai Tiaki Nursing New Zealand 2016; 22[8]: 32.

To contact the author:

Phil Coleman
Staff Tutor/Senior Lecturer
The Open University
School of Health, Wellbeing & Social Care, Faculty of Wellbeing, Education & Language Studies
Walton Hall, Milton Keynes. MK7 6AA.
United Kingdom
email: phil.coleman@open.ac.uk

3

Résumé
Le présent article consiste en une recension narrative des connaissances produites sur l'expérience des hommes de leur propre infertilité, afin de mieux cerner cet objet de recherche et d'identifier d'éventuelles avenues à explorer. Une recherche documentaire effectuée dans les bases de données CINAHL, MEDLINE, PsycArticles, et SCOPUS a permis d'identifier, au terme d'un tri en plusieurs étapes, 15 articles pour fins d'analyse. Cinq thèmes ont émergé : la masculinité menacée, la paternité problématisée, l'agentivité déniée/revendiquée, le rapport au corps et l'expérience émotionnelle de l'infertilité. Ces résultats permettent de dégager de nouvelles avenues de recherche ou d'interventions cliniques. D'une part, une meilleure problématisation du concept d'infertilité dans laquelle il est examiné comme un processus social et temporel aux ramifications conjugales, familiales et sociales et d'autre part une approche plus holistique de l'infertilité qui prend en compte l'ensemble des composantes du vécu des hommes.

Mots-clés expérience psychosociale, infertilité masculine, masculinité, recension narrative systématique

L'expérience psychosociale des hommes de leur infertilité : une recension narrative systématique

ISABEL CÔTÉ, FRANCINE DE MONTIGNY & SABRINA ZEGHICHE

Introduction

Le problème de l'infertilité touche 15 % des couples dans les pays développés et 25 % des couples dans les pays en voie de développement; 1 couple sur 4 ou 6 peut donc rencontrer des difficultés à concevoir.[1] On estime qu'environ 30 % des cas sont attribuables à des facteurs masculins, 30 % à des facteurs féminins et 30 % à une combinaison des deux. Environ 8 % des cas demeurent inexpliqués.[2]

Définie comme l'impossibilité de concevoir un enfant en dépit de rapports sexuels réguliers sur une période de 12 mois,[3] l'infertilité est reconnue comme un enjeu de santé publique par l'Organisation mondiale de la Santé (3), qui a établi des lignes directrices invitant le personnel médical à aller au-delà des diagnostics et des interventions cliniques et à porter une attention particulière aux aspects psychologiques liés aux problèmes de fertilité afin d'œuvrer pour l'amélioration de la qualité de vie des couples infertiles.

Depuis la fin des années 1990, davantage d'études replacent l'infertilité dans son contexte social, au-delà du contexte purement clinique, bien que celui-ci demeure prépondérant. De fait, l'infertilité est désormais examinée comme une construction sociale, et plus seulement comme une condition médicale aux conséquences psychologiques. Comme l'expliquent Greil, Slauson-Blevins[4] : « Infertility is best understood as a socially constructed process whereby individuals come to define their ability to have children as a problem, to define the nature of that problem and to construct an appropriate course of action ». La composante subjective dans la définition de l'infertilité est davantage soulignée, au lieu de s'en tenir uniquement

à l'étiquette objective du diagnostic médical. On observe ainsi une plus grande proportion de recherches qualitatives permettant de mieux cerner l'expérience des personnes infertiles dans un contexte socioculturel donné, et d'obtenir des données différentes de celles auxquelles donnent lieu les recherches quantitatives;[4] lesquelles sont plus axées sur la quantification des aspects émotionnels grâce à des mesures de bien-être ou de détresse, avec un intérêt particulier pour la comparaison entre les scores des hommes et des femmes.[5]

La recherche sur l'expérience des hommes de l'infertilité est, toutefois, considérée comme une des lacunes à combler dans ce domaine,[4] puisque les études sur l'infertilité ont ciblé majoritairement l'expérience des femmes.[6] De plus, certaines études ayant porté sur l'expérience des hommes présentent des failles méthodologiques. Plusieurs chercheurs soulignent la tendance à s'intéresser à l'expérience des hommes à travers le prisme de leurs conjointes, soit en les interrogeant directement sur l'expérience de leur mari, soit en menant des entrevues de couples, où l'homme peut être amené à moduler son discours en présence de sa conjointe pour se conformer au rôle de soutien qu'il s'attribue.[5-8]

Le présent article propose ainsi, au moyen d'une revue narrative systématique, de faire un état des lieux des connaissances produites sur l'expérience des hommes de leur propre infertilité, afin de mieux cerner cet objet de recherche et d'identifier d'éventuelles avenues à explorer.

Objectif de recherche

Rappelons tout d'abord qu'une revue narrative vise une compréhension qualitative d'un objet – en l'occurrence l'expérience de l'infertilité masculine – et se distingue, en ce sens, d'une revue systématique qui cherche plutôt à tester des hypothèses à partir des preuves publiées sur l'objet en question, basée sur un protocole visant à réduire les risques de biais.[9] Ainsi, plus précisément, la présente revue narrative systématique s'intéresse à l'expérience des hommes infertiles vue comme un phénomène psychosocial, c'est-à-dire comme phénomène indissociable des enjeux sociaux qui le façonnent et de ses répercussions sur le plan psychologique. On entend par là, l'expérience subjective des hommes de leur infertilité, que ce soit sur le plan social ou émotionnel, à savoir la représentation, le vécu, le ressenti des hommes de leur infertilité, ainsi que les reconfigurations que l'infertilité entraîne par rapport aux définitions de la masculinité et de la paternité par exemple. Si la présente revue aborde la question de l'expérience émotionnelle des hommes infertiles, elle se distingue néanmoins de celle effectuée par Hanna and Gough[5] par le choix méthodologique sur lequel elle repose, à savoir que seules les études empiriques ont été retenues et parmi celles-ci, seules les recherches portant sur le point de vue des hommes concernés ont été incluses (excluant les études portant sur le point de vue de la conjointe ou encore celles portant sur les deux partenaires).

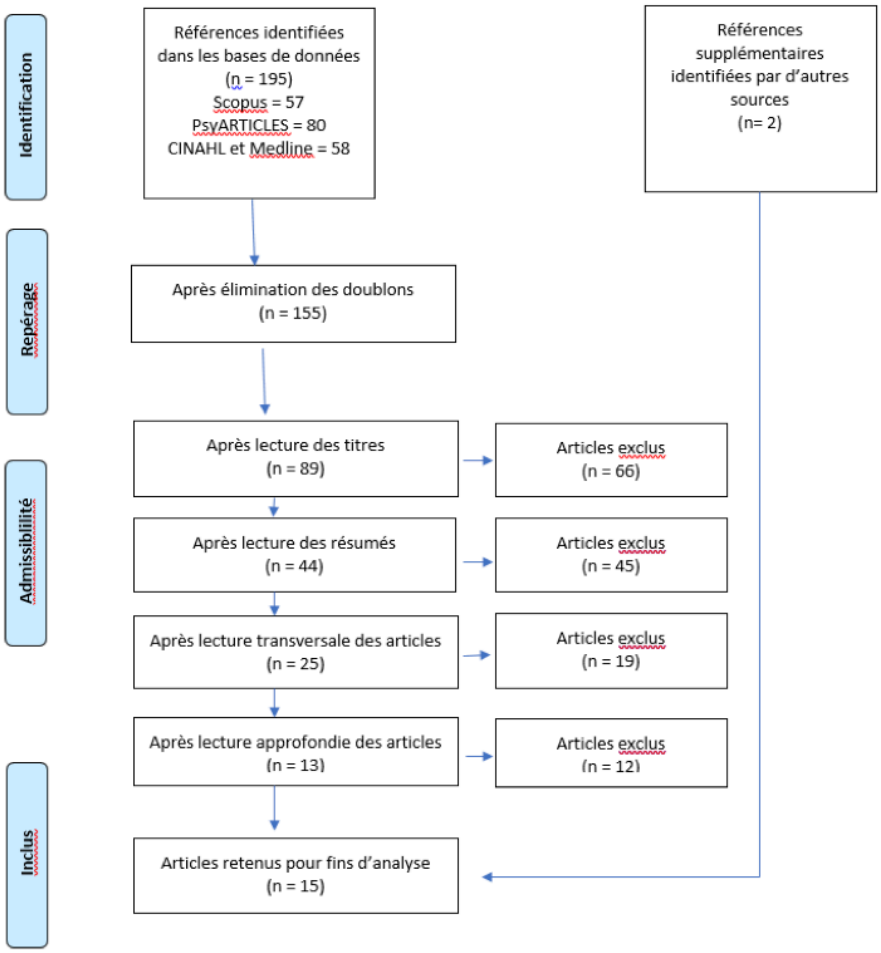
Méthodologie

Une recherche documentaire a été effectuée entre les mois de mai 2017 et juillet 2017, dans les quatre bases de données suivantes : CINAHL, MEDLINE, PsycArticles, et SCOPUS. Les bases de données ont été choisies en fonction de leur pertinence par rapport au sujet, à savoir un sujet qui recouvre à la fois les disciplines des sciences de la santé et des sciences sociales. Les mots clés utilisés étaient Man OR men OR male AND Infertility OR infertile AND experience et la période publication ciblée, de 2006 à 2017. Il est communément admis que le contexte socioculturel façonne l'expérience vécue de l'infertilité,[4] que ce soit par rapport à l'accessibilité des technologies reproductives qui ont un impact sur les perceptions et les réactions à l'infertilité (10) ou par rapport aux représentations sociales vis-à-vis de l'absence volontaire ou involontaire d'enfant.[11] Le regard sur la paternité ainsi que les conditions d'accès à la paternité dépendent également du contexte socioculturel.[12] En ciblant les dix dernières années, on s'est assuré de circonscrire un contexte socioculturel le plus homogène possible. Les langues retenues étaient le français, l'anglais et l'espagnol (langues maîtrisées par les auteures du présent article). Enfin, seuls les articles revus par les pairs ont été retenus.

Une recherche séparée dans les deux bases de données SCOPUS et PsycArticles et une recherche conjointe dans EBSCO pour les deux bases de données CINAHL et MEDLINE ont donné les résultats préliminaires suivants : Scopus (n = 57), PsycArticles (n = 80), CINAHL et MEDLINE (n = 58). Au total, 195 articles ont été trouvés à l'issue de cette recherche préliminaire. Une fois tous les articles versés dans un logiciel de gestion des références (EndNote), les doublons ont été éliminés pour un résultat total de 155 articles (cf. figure 1).

La lecture des titres des articles a permis d'élaborer un premier filtre, au terme duquel les articles considérés comme non pertinents ont pu être éliminés. Ainsi, les titres ne rendant pas compte de la question de l'infertilité, s'intéressant uniquement à l'expérience des femmes ou au point de vue des professionnels de la santé, ou encore, indiquant un traitement médical de l'infertilité ont été éliminés. Ce premier filtre a réduit le nombre d'articles à 89.

La lecture des résumés a constitué un deuxième filtre, à



l'issue duquel, le nombre d'articles est passé de 89 à 44. Ainsi, les études suivantes ont été éliminées : celles ne portant pas principalement sur l'infertilité ou l'abordant de manière marginale, celles examinant l'infertilité féminine uniquement, ou encore celles adoptant un angle trop médical.

Après la lecture des résumés, une lecture transversale des articles a permis d'éclaircir certains points ne pouvant pas être connus à la lecture des résumés. Le nombre des articles est alors passé de 44 à 25. Ce troisième filtre a permis d'éliminer les articles s'intéressant à l'infertilité de manière générale sans distinction entre infertilité masculine et infertilité féminine, ceux faisant cette distinction dans la description de l'échantillon tout en les amalgamant dans la discussion des résultats, ceux s'intéressant à l'infertilité masculine d'un strict point de vue médical, et enfin, ceux s'intéressant au couple comme dyade sans que l'expérience singulière de l'homme ne soit abordée de manière distincte.

Enfin, une lecture approfondie des articles restants a permis d'établir un quatrième filtre, à l'issue duquel, seules les études qualitatives portant uniquement sur l'expérience des hommes de l'infertilité masculine ont été retenues. Ce choix a été motivé par un souci d'homogénéité des approches, l'expérience n'étant pas conceptualisée et analysée de la même manière selon que l'on s'y intéresse sous un angle quantitatif ou qualitatif. L'approche qualitative permet de mieux répondre à la question de recherche énoncée. Rappelons, par ailleurs, que l'expérience des hommes étant peu documentée, ou souvent amalgamée avec celle des femmes, cette recension porte uniquement sur l'expérience des hommes. Seules 13 études correspondaient aux critères retenus. Deux autres articles se sont ajoutés, tirés de références trouvées dans ces articles et qui, après une lecture minutieuse, se sont avéré tout à fait pertinents. Au total, 15 articles ont été donc retenus aux fins d'analyse. La liste complète des articles retenus se trouve dans le tableau 1 en annexe.

Table 1

Référence complète de l'article	**Discipline**	**Méthode, échantillon, pays**
Arya, S. T., & Dibb, B. (2016). The experience of infertility treatment : the male perspective. Human Fertility (Cambridge, England), 19(4), 242-248.	Psychologie	Analyse phénoménologique interprétative et entrevues d'environ 1 heure (24 items abordés dont le soutien offert et les interactions entre les participants et les professionnels de la santé), n = 15 hommes, Grande-Bretagne.
Bell, A. V. (2016). 'I don't consider a cup performance; I consider it a test': masculinity and the medicalisation of infertility. Sociology of Health and Illness, 38(5), 706-720.	Sociologie	Théorisation ancrée, entrevues en profondeur d'environ 90 minutes, n = 30 hommes ayant suivi un traitement (dont 20 directement impliqués dans le diagnostic d'infertilité et 10 indirectement (leur conjointe était infertile)), États-Unis.
Crawshaw, M. (2013). Male coping with cancer-fertility issues: putting the 'social' into biopsychosocial approaches. Reproductive Biomedicine Online, 27(3), 261-270.	Sciences sociales	Entrevues, n = 28 hommes (survivants d'un cancer, ayant par conséquent des problèmes de fertilité) dont 13 caucasiens et 15 sud-asiatiques, Grande-Bretagne.
Dooley, M., Nolan, A., & Sarma, K. M. (2011). The psychological impact of male factor infertility and fertility treatment on men: A qualitative study. Irish Journal of Psychology, 32(1-2), 14-24.	Psychologie clinique	Théorisation ancrée, entrevues en profondeur (entre 35 et 90 minutes) couvrant 5 thèmes (1.infertilité, 2. traitement, 3.relations, 4. image de soi, 5. soutien), n = 9 hommes infertiles (suivant un traitement) et sans enfants, Irlande.
Dwyer, A. A., Quinton, R., Pitteloud, N., & Morin, D. (2015). Psychosexual Development in Men with Congenital Hypogonadotropic Hypogonadism on Long-Term Treatment: A Mixed Methods Study. Sexual Medicine, 3(1), 32-41. doi: 10.1002/sm2.50	Endocrinoologie	Méthode mixte : volet quanti (quantifier la fréquence des problèmes psychosexuels) et volet quali (approfondir les infos contenus dans les questionnaires afin de mettre sur pied des modèles pour orienter les interventions des professionnels de la santé.) / Focus groups - questions : "What has been the most difficult part of living with CHH?" et "How has CHH affected your sex life and intimate relationships?", volet quali: n = 26 hommes et volet quanti : n = 101, Suisse.
Fahami, F., Quchani, S. H., Ehsanpour, S., & Boroujeni, A. Z. (2010). Lived experience of infertile men with male infertility cause. Iranian Journal of Nursing and Midwifery Research, 15(Suppl1), 265-271.	Sciences infirmières	Méthode phénoménologie descriptive, entrevues (45 à 60 minutes), n = 10 hommes infertiles, Iran.
Hadley, R., & Hanley, T. (2011). Involuntarily childless men and the desire for fatherhood. Journal of Reproductive and Infant Psychology, 29(1), 56 68.	Psychologie	Théorisation ancrée, entrevues individuelles, semi-structurées (entre 35 et 75 minutes) abordant les thèmes suivants : life-stage awareness of fatherhood; meaning of fatherhood; feelings surrounding fatherhood; past, present and future familial, close, and social relationships; advantages and disadvantages of childlessness; societal 'fit'; mental and physical health; and feelings of 'broodiness', n = 10 hommes (6 en couple, 4 célibataires), Grande-Bretagne.

Table 1

Référence complète de l'article	Discipline	Méthode, échantillon, pays
Hanna, E., & Gough, B. (2016). Emoting infertility online: A qualitative analysis of men's forum posts. Health:An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 20(4), 363-382.	Sciences sociales	Analyse thématique d'un forum de discussion réservé exclusivement aux hommes (13 fils de discussion, 415 posts, 20 utilisateurs), Grande-Bretagne.
Hanna, E., & Gough, B. (2017). Men's accounts of infertility within their intimate partner relationships: An analysis of online forum discussions. Journal of Reproductive and Infant Psychology, 35(2), 150-158.	Sciences sociales	Analyse thématique inductive d'un forum en ligne pour hommes seulement (415 posts, 20 utilisateurs), Grande-Bretagne.
Herrera, F. (2013). "Men always adopt": Infertility and reproduction from a male perspective. Journal of Family Issues, 34(8), 1059-1080.	Sociologie	Analyse narrative, entrevues semi-structurées (12 entrevues avec hommes exclusivement et 4 entrevues de couple), n = 16 hommes (7 ayant eu un enfant après FIV; 10 ayant adopté) sans égard à l'origine de l'infertilité, Chili.
Hinton, L., & Miller, T. (2013). Mapping men's anticipations and experiences in the reproductive realm: (in) fertility journeys. Reproductive BioMedicine Online, 27(3), 244-252.	Sciences de la santé	Étude sur l'infertilité : Entrevues individuelles : divisées en deux parties, 3 cas d'infertilité masculine, 3 cas d'infertilité féminine, 3 cas d'infertilité conjointe, et 2 cas d'infertilité inexpliquée. / n = 38 (dont 11 hommes, vivant avec ou sans enfants (recrutés et rencontrés entre 2007 et 2009)) / Étude sur la paternité : Étude longitudinale. Jusqu'à 4 rencontres. Entrevues individuelles à 7-8 mois prénatal, au moment de la grossesse, 6-12 semaines postnatal, 9-10 mois postnatal, et lorsque l'enfant atteint l'âge de 2 ans.
Johansson, M., Hellström, A.-L., & Berg, M. (2011). Severe male infertility after failed ICSI treatment-a phenomenological study of men's experiences. Reproductive Health, 8(1), 4-10.	Sciences de la santé	Questions ouvertes et exploratoires. / n = 17 hommes (sur deux ans), Grande-Bretagne. Méthode phénoménologique descriptive, entrevues (60 à 70 minutes) menées entre 2006 et 2007 et traitements entre 2004 et 2005, n = 8 hommes, Suède.
Malik, S. H., & Coulson, N. (2008). The male experience of infertility: A thematic analysis of an online infertility support group bulletin board. Journal of Reproductive and Infant Psychology, 26(1), 18-30.	Sciences sociales	Analyse thématique inductive entre janvier 2005 à juin 2006 d'un groupe de soutien en ligne (53 fils de discussion, 728 messages, 166 utilisateurs), Grande-Bretagne.
Parrott, F. R. (2014). 'At the hospital I learnt the truth': diagnosing male infertility in rural Malawi. Anthropology & Medicine, 21(2), 174-188.	Sciences sociales	Recherche menée entre 2011 et 2013 et entrevues en profondeur (3 par participant), n = 14 hommes (ainsi que leur partenaire – entrevues individuelles), Malawi.
Schick, M., Rösner, S., Toth, B., Strowitzki, T., & Wischmann, T. (2016). Exploring involuntary childlessness in men - a qualitative study assessing quality of life, role aspects and control beliefs in men's perception of the	Psychologie	Théorisation ancrée, entrevues semi-structurées (entre juillet septembre 2013) et entrevues individuelles (avec l'homme seul – d'une durée moyenne de 24 minutes – de 10 à 71 minutes), n = 13 hommes rencontrés (en cours ou sur le point de suivre un traitement contre l'infertilité), Allemagne.

Description des études recensées

Les études retenues ont été menées principalement en Europe, dont 7 en Grande-Bretagne,[13-19] une en Irlande,[20] une en Suisse,[21] une en Suède,[22] une en Allemagne (23), et seulement trois en dehors de l'Europe ; soit une aux États-Unis,[24] une en Iran,[25] une au Chili[7] et une au Malawi[26].

D'emblée, il faut préciser que les termes « expérience » et « infertilité » recouvrent des réalités très vastes, dont il est utile de préciser les contours. Dans les articles retenus, l'expérience renvoie aux interactions entre les participants et les professionnels de la santé,[15] au rapport des hommes avec les technologies en matière de reproduction (24), à leurs comportements,[13] à leur bien-être psychologique (20), à leur développement psychosexuel,[21] à la perception de leur place dans le processus reproductif,[7,14,17] à l'expression de leurs émotions,[27] aux conséquences sur leurs relations intimes,[16] et à leur relation conjugale et à leur vie sociale[26].

Les causes de l'infertilité diffèrent d'une étude à l'autre et ne sont pas toujours précisées. Ainsi, dans une étude, il s'agit d'infertilité découlant d'un cancer,[13] dans une autre, d'hypogonadisme hypogonadotrope (CHH),[21] et dans la troisième, d'azoospermie obstructive[22]. En revanche, d'autres auteurs utilisent le vocable générique d'infertilité[16,18,27] ou de male factor infertility[20]. La question de la temporalité distingue également les études en question. Différents moments de l'expérience de l'infertilité ont retenu l'attention des chercheurs soit, au moment des essais de conception[13,14], à l'annonce du diagnostic,[23,26] au moment du traitement,[20,23] ou encore à la période post-traitement[7,22].

Pour ce qui est des approches employées, on en relève principalement deux ; soit la phénoménologie interprétative[15,22,25] et la théorisation ancrée.[14,20,23,24] À part les trois études qui avaient pour matériau d'analyse les messages sur des forums en ligne,[16,18,27] toutes optent pour la méthode des entrevues, sauf l'étude de Dwyer, Quinton[21] qui recourt aux groupes focus. Enfin, il s'agit d'études ayant de faibles échantillons, soit de 8[22] à 30 hommes[24].

Méthode d'analyse

Les études retenues ont fait l'objet d'une analyse thématique telle que décrite par Braun and Clarke.[28] Tout d'abord, les données sur l'expérience des hommes infertiles ont été lues minutieusement afin d'identifier des codes. Ces codes ont été rassemblés en différentes catégories thématiques et les données appartenant à chaque catégorie thématique ont ensuite été colligées. Enfin, les données ont été systématiquement réexaminées pour s'assurer qu'un titre et une définition claire soient attribués pour chaque catégorie thématique afin qu'elles correspondent aux données codées.

Il est fortement recommandé d'expliciter le cadre théorique guidant une analyse thématique, puisque chaque cadre possède ses propres présupposés et postures paradigmatiques. Ainsi, l'analyse thématique réalisée dans cette revue narrative s'est appuyée sur un cadre qui s'intéresse à la perspective subjective des hommes concernés, à savoir le sens qu'ils donnent à cette expérience, de même qu'à la façon dont le contexte social participe à la structuration de cette subjectivité. C'est ce que Braun and Clarke[28] qualifient de cadre contextualiste.

Résultats et discussion

L'analyse thématique, tel qu'explicitée précemment, a permis de dégager cinq thèmes, à partir des données recueillies dans les études recensées et indépendamment des catégories thématiques utilisées par les auteurs de ces études. Les thèmes dégagés sont : la masculinité menacée, la paternité problématisée, l'agentivité déniée/revendiquée, le rapport au corps et l'expérience émotionnelle de l'infertilité. Ces cinq thèmes sont évidemment inter-reliés : la masculinité englobe la paternité; par conséquent, si l'infertilité menace la masculinité, elle menace également la paternité et pousse les hommes qui en souffrent à la problématiser (la repenser, la redéfinir ou y renoncer). Cette masculinité menacée affecte à son tour l'agentivité des hommes en contexte d'infertilité, qui se retrouvent privés de leur rôle d'acteur dans un processus dont ils se sentent exclus, marginalisés. Ils ne parviennent, pour certains d'entre eux, à se réapproprier cette agentivité qu'au moyen de stratégies bien précises. Par ailleurs, la masculinité se répercute également sur le corps et le rapport conflictuel que l'on peut entretenir avec ce corps « défaillant». Enfin, tout cela a un impact sur l'expérience émotionnelle des hommes infertiles, qui doivent composer avec un éventail d'émotions négatives, qui vont de la tristesse aux idées suicidaires. Chaque thème sera ci-après abordé.

La masculinité menacée

La définition hégémonique de la masculinité est étroitement liée à l'expérience de l'infertilité masculine, car elle prescrit une forme idéalisée et fixe de la masculinité, où celle-ci est biologique, dominante et forte.[29] Ainsi, la masculinité est associée aux concepts de puissance (sexuelle), de capacité

reproductive et de stoïcisme. Cette définition, se muant en norme sociale de par son caractère hégémonique, se répercute sur plusieurs plans : le rapport au corps (sexué ou sexuel), le rapport à la paternité et les rôles de genre.

L'infertilité est perçue alors comme un défaut (au sens de manque) de masculinité, puisqu'elle remet en question la fonction des organes sexuels, la « qualité » du sperme – souvent de façon erronée – , la puissance sexuelle, et la capacité à devenir père.[13,20] L'homme infertile se voit alors atteint dans son identité sexuelle puisque sa vie sexuelle est perçue comme déficiente, de même que ses organes sexuels et ses spermatozoïdes,[13,22] dans son identité de genre puisque l'infertilité l'empêche de se sentir complètement homme,[15] et dans un pan de son identité sociale puisque sa capacité à assumer le rôle social de père biologique est remise en question.[15,17,22]

Étant donné que l'infertilité vient menacer les fondements de la définition hégémonique de la masculinité, elle entraîne un regard social qui peut être assez dur et peu flatteur sur les hommes qui en souffrent. Ainsi, plusieurs études ont fait état de la stigmatisation, qu'elle soit réelle ou perçue, qui accompagne l'infertilité masculine.[13,15,18,20,25,26]

Par ailleurs, si les hommes sont atteints dans leur identité masculine en raison de l'infertilité, il reste qu'on attend d'eux qu'ils se conforment aux injonctions de stoïcisme associées à la masculinité. Autrement dit, leur statut d'hommes les contraint à se montrer forts et comprendre les impacts de leur infertilité sur le désir d'enfant de leur conjointe, nonobstant la façon dont ils vivent eux-mêmes cette expérience,[17,18,22] et ce, parfois au prix de leur propre bien-être émotionnel[18]. Dooley, Nolan[20] précisent toutefois que tous les hommes n'adhèrent pas aux définitions hégémoniques de la masculinité et que leur degré d'adhésion est étroitement lié à la manière dont ils endossent ce rôle d'homme stoïque. Ainsi, plus un homme s'aligne sur les notions hégémoniques de la masculinité, plus il est enclin à faire bonne figure face à l'adversité, moins il va verbaliser ses émotions et plus il va se sentir contraint d'être stoïque pour soutenir sa conjointe. Cette injonction au stoïcisme et au rôle de soutien alimente le sentiment de marginalisation et de manque d'agentivité dont il sera question plus loin.

Si la plupart des études s'accordent pour établir un lien entre infertilité et masculinité menacée, certaines apportent quelques nuances intéressantes. Ainsi, Crawshaw[13] énonce quatre facteurs qui peuvent moduler ce lien. Le premier concerne le contexte de l'infertilité. L'auteur explique que l'infertilité qui survient à la suite d'un cancer ne menace pas la masculinité de la même façon que d'autres types d'infertilité. En effet, le statut de survivant dont bénéficient les hommes ayant souffert d'un cancer vient tempérer la menace à la masculinité. Le deuxième concerne les croyances culturelles ou religieuses qui peuvent donner à l'infertilité un sens autre, qui n'implique pas forcément une masculinité perçue comme déficiente, telle, par exemple, la volonté divine. Le troisième concerne les facteurs socio-économiques qui, selon l'auteur, façonnent davantage les définitions hégémoniques de la masculinité que l'infertilité. Autrement dit, la masculinité se définirait davantage à l'aune de la capacité de l'homme à subvenir aux besoins de son foyer qu'à sa capacité reproductive. Enfin, la question de la temporalité est aussi déterminante dans le lien perçu entre infertilité et masculinité. Ainsi, la période de transition entre l'enfance et l'âge adulte étant une période de construction identitaire, notamment sexuelle, si le diagnostic d'infertilité survient à ce moment-là, l'équation entre infertilité et masculinité déficiente s'imprimera davantage qu'à d'autres moments de la vie.

Seule l'étude de Bell[24] prend le contre-pied du lien établi entre infertilité et masculinité menacée. L'auteur explique ainsi qu'en construisant l'infertilité comme une condition médicale, le problème reproductif est placé hors de la sphère de contrôle de l'homme, et ne reflète désormais plus sa force ou sa masculinité. Par ailleurs, comme les hommes sont, objectivement, exclus du processus reproductif puisque les femmes sont au centre du traitement de l'infertilité, cela leur permet de se distancier de l'identité d'hommes infertiles. Ils endossent plutôt le rôle de soutien, ce qui présente l'avantage de renforcer leur masculinité. Enfin, les traitements s'étant banalisés et la demande d'aide de la part des hommes s'étant normalisée, cela amène à éliminer le sentiment de honte relié à l'infertilité masculine. En somme, selon Bell,[24] la médicalisation du processus reproductif contribue à faire advenir (achieve) ou renforcer la masculinité des hommes infertiles, plutôt qu'à la fragiliser, dans un contexte féminisé de reproduction. L'effet de légitimation du processus médical réifie la maladie et la sépare du champ de la sexualité. Les hommes ne perçoivent donc pas leur infertilité comme étant négative, ni comme une menace à leur masculinité.

La paternité problématisée

Comme mentionné précédemment, l'infertilité masculine est étroitement liée à la capacité reproductive et la possibilité d'assumer son rôle de père, que subsume l'identité masculine. La plupart des études expliquent comment l'infertilité masculine complexifie le rapport des hommes à

la paternité. Ainsi, Arya and Dibb[15] rapportent l'attitude dominante de défiance qu'ont les hommes infertiles par rapport aux méthodes alternatives en matière de paternité. L'adoption ou le don de sperme apparaissent comme des options peu enthousiasmantes en raison de la nature du lien filial qu'elles impliquent. En effet, celui-ci n'étant pas biologique, le rôle paternel s'en voit profondément affecté pour la plupart des hommes infertiles. Par ailleurs, les options alternatives à la paternité biologique sont peu populaires en raison de la stigmatisation sociale réelle ou perçue qui y est attachée. Crawshaw[13] explique, pour sa part, que c'est tout le rapport à la paternité qui est affecté, à savoir la capacité des hommes à s'engager dans des relations et à se projeter comme père, en plus de cette posture ambivalente face aux alternatives à la paternité biologique. Parrott (26) illustre la situation au Malawi des hommes infertiles, pour qui le diagnostic d'infertilité est une entaille à leur personne parce qu'il menace leur rôle de futurs pères.

En somme, la paternité peut difficilement être pensée autrement qu'en termes biologiques et l'infertilité représente justement une entrave à cette capacité reproductive biologique; elle est donc perçue comme un aveu d'échec de paternité et, par ricochet, de masculinité.

Hadley and Hanley[14] font par ailleurs une distinction utile entre ce qu'ils appellent la force émotive (qui désigne l'idéal de la paternité) et l'agentivité réelle (qui désigne l'intentionnalité sociale en matière de paternité). Pour ces auteurs, les hommes infertiles semblent mener une lutte entre ces deux pôles, de façons variables en fonction de leur trajectoire de vie; c'est dans la trentaine que les hommes sont les plus susceptibles de passer de la force émotive à l'agentivité réelle. Pour cette catégorie d'hommes, l'infertilité est perçue comme une véritable entrave à cette intentionnalité sociale. Ils doivent donc trouver des moyens d'ajuster et de réévaluer leurs croyances émotionnelles, psychologiques et sociales en la matière.

Ainsi, si l'infertilité masculine met de l'avant le sujet des options alternatives à la paternité biologique, elle pose également la question de la possibilité de vivre sans enfants, de renoncer tout bonnement à une éventuelle paternité.[13,23] Schick, Rösner[23] précisent à ce sujet que la confrontation à cette éventualité n'est pas vécue de la même façon selon que les hommes connaissent leur diagnostic depuis longtemps ou qu'ils viennent d'en prendre connaissance. Le temps qui s'écoule entre le moment de l'annonce du diagnostic et la confrontation à cette question influence son acceptation ou non. Toujours selon cette étude, les hommes qui connaissent depuis longtemps leur condition d'infertilité semblent plus en paix avec la perspective de mener une vie sans enfants. Ceux pour qui le diagnostic est récent font reposer la qualité de leur vie sur le fait d'avoir des enfants. Ils ont alors plus de mal à repenser leurs projets de vie.

En somme, que la paternité soit seulement un idéal ou une véritable intentionnalité sociale, que l'homme doive la postposer, la repenser ou y renoncer, il reste que la question ne peut être éludée une fois que le diagnostic d'infertilité masculine est connu. La paternité est d'ailleurs étroitement liée à la question de l'agentivité, troisième thème identifié dans cette revue narrative.

L'agentivité déniée/revendiquée

La plupart des études consultées mettent en relief ce concept d'agentivité en lien avec l'expérience de l'infertilité. Le plus souvent, il s'agit d'une agentivité déniée. Mais toutes les études ne l'examinent pas de la même façon. Dans certains cas, ce déni est propre au contexte de l'infertilité, pour d'autres, au contexte de la périnatalité, pour d'autres encore, il n'est ni définitif ni absolu.

En contexte d'infertilité, l'agentivité peut être déniée, car les hommes souffrent d'un manque de reconnaissance du corps médical, mais aussi de l'entourage, se sentent ignorés dans les échanges avec les professionnels de la santé ou encore, peu ou pas pris en compte dans le processus de traitement de l'infertilité.[15] En raison de la nature des traitements, les hommes peuvent se sentir réduits à un rôle fonctionnel, celui de donneur de sperme, ou à un statut de spectateur passif.[13] L'expérience de l'infertilité pour les hommes est également une expérience marquée par un sentiment d'impuissance[16,17] lié à la fois au constat de l'infertilité, au processus médical qu'il entraîne, ainsi qu'au dénouement des traitements.[23]

Les hommes se sentent par conséquent marginalisés. Hanna and Gough[16] expliquent ce sentiment de marginalisation par l'emphase mise sur le corps des femmes. En d'autres termes, par le capital biologique dont bénéficient les femmes dans l'univers reproductif, elles sont perçues par les hommes comme étant les détentrices du pouvoir en contexte d'infertilité. Parce qu'ils ne jouissent pas d'une expérience corporelle directe des traitements contre l'infertilité, les homSmes affirment avoir moins d'agentivité que leurs partenaires. Ce manque de reconnaissance de leur statut d'agent actif dans le processus leur dénie également le droit de bénéficier de soutien. Ainsi, la biologie serait construite comme la clé qui déverrouille l'agentivité et le soutien en matière d'infertilité, et ce, au profit des femmes et au détriment des hommes.

Comme mentionné précédemment, pour certains, ce sentiment de marginalisation est spécifique au contexte d'infertilité. Ainsi, Herrera,[7] qui a examiné l'expérience des hommes éprouvant des difficultés à concevoir en comparant le processus de reproduction assistée et le processus d'adoption, affirme que les hommes qui ont suivi un parcours de reproduction assistée se perçoivent comme étant des acteurs secondaires et passifs. Au contraire, les hommes qui ont adopté un enfant se perçoivent comme des acteurs à part entière.

Hinton and Miller[17] affirment quant à eux que si le sentiment de marginalisation n'est pas propre au contexte d'infertilité, c'est parce qu'il s'étend au contexte périnatal dans sa globalité. Cela expliquerait pourquoi ce sentiment perdure chez les hommes infertiles qui attendent un enfant. En effet, comme l'expliquent ces auteurs, que ce soit dans le cadre de la médecine reproductive ou encore, dans les services de maternité, lors de l'accouchement, les intervenants médicaux s'occupent principalement du corps de la femme. C'est pourquoi les hommes infertiles comme les hommes fertiles décrivent leur rôle comme étant celui de soutien à leur partenaire, ce qui renforce leur sentiment d'être des observateurs passifs.

À l'inverse, Schick, Rösner[23] expliquent que certains hommes endossent ce rôle de soutien volontairement, et que cela leur procure au contraire un sentiment d'agentivité en prenant voix au chapitre et en assumant une certaine responsabilité dans le processus. De même, pour Johansson, Hellström,[22] le sentiment de marginalisation n'est pas immuable. S'il émerge à l'annonce du diagnostic d'azoospermie en raison de la « perte» de masculinité qu'il entraîne, il s'estompe lorsque les traitements portent leurs fruits et que les tests s'avèrent encourageants. En revanche persiste le sentiment de marginalisation qui relègue les hommes au rang de compagnons, plutôt que de partenaires à part entière.

Enfin, les hommes infertiles peuvent revendiquer ou se réapproprier cette agentivité déniée en adoptant certaines stratégies, notamment en se tournant vers les plateformes virtuelles, des espaces en ligne de partage d'informations et de soutien par et pour les hommes infertiles. Les études ont montré que les hommes qui recourent par exemple aux forums en ligne soulignent l'importance d'avoir comme interlocuteurs d'autres hommes qui ont vécu la même chose, et que le soutien émotionnel et pratique reçu via ces plateformes est précieux, car il comble le manque de soutien de leur entourage. Ces espaces revalorisent l'apport des hommes, leur redonnent de l'agentivité en leur permettant non seulement de s'entraider, mais aussi en libérant la parole et en ouvrant un espace d'expression qui leur est ailleurs inaccessible.[18,27] Recourir à d'autres espaces d'échanges apparaît ainsi comme une stratégie efficace pour contourner l'agentivité déniée en contexte d'infertilité, que ce soit en matière d'accès à l'information, de reconnaissance ou de soutien.

Après avoir abordé la question de l'agentivité, le quatrième thème identifié porte sur la question de l'expérience corporelle qui sous-tend l'infertilité masculine.

Le rapport conflictuel au corps

La question du rapport au corps est étroitement liée à la définition hégémonique de la masculinité. Elle renvoie également à la notion de marginalisation et de manque d'agentivité expliquée précédemment et amènera à examiner l'expérience émotionnelle des hommes infertiles. Autrement dit, ce thème sert de point de jonction entre les différents éléments abordés dans le cadre de l'expérience de l'infertilité masculine.

Pour ce qui est de la question du rapport au corps, il est utile de faire la distinction entre l'infertilité soupçonnée, l'infertilité avérée, et l'infertilité visible. Tant que l'infertilité est soupçonnée, elle peut être imputée à la femme étant donné le lien étroit déjà mentionné entre le processus reproductif et le corps des femmes. Comme l'explique Parrott[26], l'analyse du sperme constitue un mode distinct de compréhension de l'infertilité et de son origine. Une fois l'infertilité masculine avérée, on observe un rapport au corps qui peut être plus ou moins conflictuel. Crawshaw[13] affirme qu'une équation est faite entre fertilité et puissance (sexuelle) et qu'une imagerie de guerre est invoquée pour décrire un sperme de bonne qualité. Un sperme défaillant remet en cause la virilité de l'homme, sa force et sa puissance. Le corps devient à la fois un obstacle à cette virilité revendiquée et un moyen de la compenser. Ainsi, le corps peut être utilisé, via la performance sexuelle, pour compenser le spectre de l'infertilité en raison de l'amalgame fait entre sexualité et virilité.

Les choses se complexifient davantage lorsque l'infertilité est visible. C'est le cas des patients dont l'infertilité est survenue à la suite d'une amputation des organes sexuels lors d'un traitement anti-cancéreux. Dans ce cas, une équation se fait entre organes sexuels (amputés) et virilité (atteinte).[13] C'est le cas également des hommes qui souffrent de CHH. Ce trouble freinant le développement normal des organes génitaux laisse en effet une trace visible et écorne très

sérieusement l'image que les personnes en question ont de leur corps. Dwyer, Quinton (21) énoncent les différents ressentis de ces hommes : la peur d'être exposé au regard des autres, le besoin de se cacher son corps et sa nudité, la honte de son corps, les problèmes d'estime de soi liée à cette honte, la difficulté à envisager une quelconque intimité sexuelle, et la persistance des effets délétères sur l'image corporelle même longtemps après que le trouble ait été traité.

Ce rapport conflictuel au corps a des répercussions négatives sur l'expérience émotionnelle des hommes infertiles. C'est justement ce sujet qui sera abordé plus en profondeur ci-après.

L'expérience émotionnelle

L'expérience émotionnelle des hommes infertiles a longtemps été sous-estimée[4,5,30-35] en raison, entre autres, des biais de recherche que comportent les études qui se sont penchées sur l'expérience des hommes, tel que mentionné précédemment, mais aussi en raison du cadre des entrevues, moins propice à l'expressivité émotionnelle des hommes. Par ailleurs, souvent considérées comme des avancées biomédicales à saluer, les pratiques de PMA sont rarement examinées sous l'angle du « prix émotionnel » qu'elles entraînent chez les hommes infertiles.[36]

Dans les études retenues aux fins d'analyse, l'expérience des hommes est décrite comme étant chargée d'émotions et de réactions négatives comme la dépression, un sentiment d'isolement, et parfois même des idées suicidaires.[15] D'autres émotions ont été soulignées comme le choc, la tristesse, la culpabilité, l'espoir, ou encore des pensées d'autodénigrement comme le sentiment d'être anormal, inadéquat, ou de ne pas être un homme à part entière. On pourrait ajouter à cette longue liste d'autres émotions comme le déni, l'incrédulité, la solitude, la frustration,[25] la perte de repères, un sentiment d'exclusion (qui peut amener à des comportements à risque),[14] un sentiment de gêne ou d'humiliation[17] ou de honte,[26] de perte d'estime de soi[20].

À l'énumération des différentes émotions mentionnées par les hommes dans les études recensées, il apparaît évident que l'infertilité est une expérience dont la charge émotive est considérable pour les hommes qui la vivent. Contrairement à ce qu'affirme Bell[24], l'infertilité n'est en aucun cas une expérience banalisée par les hommes, et l'atteinte à la masculinité n'est en rien minimisée par le contexte médical. À part cet auteur, tous les autres font état d'une expérience douloureuse, à des degrés variés, sur le plan émotionnel. Ces études démontrent en outre que les hommes ressentent des émotions fortes et les expriment. Ce qui distingue ces émotions, ce n'est pas leur contenu, ni leur intensité, mais le contexte où elles peuvent s'exprimer librement..

Conclusion

Cette revue narrative de 15 articles a permis de faire un état des lieux des connaissances produites sur l'expérience des hommes de leur infertilité. Cinq thèmes interreliés ont été identifiés, soit la masculinité menacée, la paternité problématisée, l'agentivité déniée/revendiquée, le rapport au corps et l'expérience émotionnelle de l'infertilité. Cela dit, cette recension comporte certaines limites du fait, entre autres, du nombre d'études recensées, de la qualité variable des études et de la diversité des disciplines. Le nombre d'études recensées ne permet pas d'établir des conclusions dont on pourrait généraliser la portée. Par ailleurs, comme toute recension, celle-ci est tributaire de la qualité et de l'exhaustivité des données secondaires sur lesquelles elle se base. Certaines nuances n'ont pas pu être apportées en raison d'informations manquantes, comme les caractéristiques des hommes en question, le type d'infertilité, la temporalité dans l'expérience de l'infertilité. Enfin, la variété des disciplines est également un obstacle étant donné les spécificités disciplinaires en termes de problématisation, de théorisation et d'opérationnalisation. Toutefois, malgré ces limites, cette recension permet de dégager des constats, et d'identifier d'éventuelles avenues de recherche ou d'interventions cliniques. Ainsi, les thèmes dégagés offrent des pistes aux professionnels de la santé, tels les infirmières ou psychologues, qui souhaiteraient explorer les enjeux psychologiques de l'infertilité masculine auprès des hommes concernés.

Ainsi, il apparaît de ces analyses que la problématisation même du concept d'infertilité semble lacunaire. Tel que démontré par Greil, Slauson-Blevins (4), l'infertilité est une construction sociale. Il y a infertilité dès lors que la notion de parentalité comme rôle social entre en jeu. Autrement dit, l'infertilité renvoie à l'impossibilité d'un état souhaité et non à une symptomatologie médicale. Si ce point de vue est largement partagé en sciences sociales, l'angle clinique reste prépondérant dans l'examen de l'infertilité. Celle-ci est donc souvent perçue comme un état de fait, indépendant des enjeux sociaux qui le sous-tendent. Il est donc utile de rappeler le regard social qui la façonne. Par ailleurs, il est nécessaire de considérer la diversité des expériences d'infertilité, tous les cas d'infertilité ne se confondant pas. L'expérience de l'infertilité ne peut pas être vue comme

un bloc monolithique, un tout cohérent et indivisible. Qui plus est, elle doit être perçue, non comme un état (statique), mais comme un processus temporel, qui s'inscrit dans un mouvement davantage itératif que linéaire. Enfin, elle doit être considérée dans son inscription dans un parcours de vie, afin de saisir son influence sur la transition à la paternité qui peut ou non s'ensuivre, ainsi que sur les relations des pères avec leurs enfants, que ceux-ci soient nés avant, ou après l'expérience d'infertilité. Replacer l'infertilité masculine dans un contexte temporel plus large permet de mieux appréhender cette expérience.

L'infertilité étant une construction sociale, il importe aussi de s'intéresser à l'influence des normes sociales en matière de masculinité et de paternité sur l'expérience corporelle et émotionnelle des hommes infertiles. Ainsi, le rôle de l'éducation, des médias et des politiques de santé dans les représentations entourant les hommes et leur expérience de l'infertilité mérite d'être remis en question. Plus précisément, l'imbrication de la masculinité, de la paternité et de la sexualité dans ces représentations mériterait d'être davantage étudiée en lien avec l'expérience de l'infertilité des hommes.

Par ailleurs, il est essentiel de ne pas examiner cette expérience isolément, sans tenir compte des interinfluences entre les différentes dimensions du système social dans lequel elle s'inscrit. Il s'agit ici de considérer non seulement l'expérience de l'infertilité masculine au plan individuel, mais aussi d'en examiner les interinfluences systémiques. Autrement dit, il s'agit d'en interroger les ramifications sociales, familiales et conjugales. Ainsi, le regard du chercheur et du clinicien peut alors se poser sur les effets de l'infertilité masculine sur la relation conjugale ou sur les relations sociales. Ce n'est qu'ainsi qu'on pourra par exemple saisir l'enjeu de la marginalisation dont il a été question plus haut.

Il est aussi pertinent de se pencher sur le soutien social disponible ou souhaité par les hommes en contexte d'infertilité masculine. Il ne suffit pas de tenir pour acquis que le rôle de soutien endossé par l'homme soit le résultat d'un choix entièrement assumé et donc sans conséquence. Tel que discuté plus haut, les injonctions au stoïcisme relèvent d'une conception hégémonique de la masculinité, dont il est difficile de s'affranchir complètement; injonctions qui peuvent entraver l'espace d'expressivité des hommes et accentuer leur sentiment de marginalisation. Autrement dit, le fait qu'ils se présentent eux-mêmes comme source de soutien ne doit pas nous empêcher de les interroger sur leurs propres besoins en matière de soutien et d'être à l'écoute par rapport aux modalités de ce soutien. En particulier, les relations tissées avec les professionnels de la santé tout au long de cette expérience, de même que l'attention portée par ces intervenants sur les hommes et le couple, méritent d'être mieux comprises.

Enfin, alors que les interventions offertes par les professionnels de la santé portent la plupart du temps sur la réparation du corps défectueux, par les traitements offerts, l'analyse des écrits révèle que le rapport au corps n'est qu'une des composantes de l'expérience des hommes. C'est ainsi que la souffrance qui se loge dans la masculinité menacée, la paternité problématisée, l'agentivité reniée/revendiquée et l'expérience émotionnelle des hommes est peu prise en compte par ces professionnels. Ce n'est qu'au prix d'une approche holistique, qui considère l'ensemble de ces composantes que le vécu masculin de l'infertilité pourra être réellement compris et que les interventions dont ces hommes font l'objet pourront répondre à toute la complexité de cette expérience.

Références

1.World Health Organization. Prevalence of Infertility, Infecundity and Childlessness. 2016.

2.Practice Committee of the American Society of Reproductive Medicine. Effectiveness and treatment for unexplained infertility. Fertility And Sterility. 2006(86):S111-S4.

3.World Health Organization. Current practices and controversies in assisted reproduction. Report of a meeting on Medical, Ethical and Social Aspects of Assisted Reproduction. 2002:128.

4.Greil AL, Slauson-Blevins K, McQuillan J. The experience of infertility: a review of recent literature. Sociology of Health & Illness. 2010;32(1):140-62.

5.Hanna E, Gough B. Experiencing male infertility: A review of the qualitative research literature. SAGE Open. 2015;5(4).

6.Genesse D, Bécotte K, Brassard A, Purcell-Lévesque C, Péloquin K. L'expérience psychologique masculine et féminine de l'infertilité: Différences et similitudes. Revue canadienne de santé communautaire. sous presse.

7.Herrera F. "Men always adopt": Infertility and reproduction from a male perspective. Journal of Family Issues. 2013;34(8):1059-80.

8.Throsby K, Gill R. "It's Different for Men":Masculinity and IVF. Men and Masculinities. 2004;6(4):330-48.

9.Cook DA, West CP. Conducting systematic reviews in medical education: a stepwise approach. Medical Education. 2012;46(10):943-52.

10.Kirkman M, Rosenthal D. Representations of Reproductive Technology in Women's Narratives of Infertility. Women & Health. 1999;29(2):17-36.

11.Letherby G. Childless and Bereft?: Stereotypes and Realities in Relation to 'Voluntary' and 'Involuntary' Childlessness and Womanhood. Sociological Inquiry. 2002;72(1):7-20.

12.de Montigny F, Gervais C, Dubeau D. La place des pères en périnatalité : le programme québécois « Initiative Amis des pères au sein des familles ». Revue de médecine périnatale. 2017.

13.Crawshaw M. Male coping with cancer-fertility issues: putting the 'social' into biopsychosocial approaches. Reproductive Biomedicine Online. 2013;27(3):261-70.

14.Hadley R, Hanley T. Involuntarily childless men and the desire for fatherhood. Journal of Reproductive and Infant Psychology. 2011;29(1):56-68.

15.Arya ST, Dibb B. The experience of infertility treatment: the male perspective. Human Fertility (Cambridge, England). 2016;19(4):242-8.

16.Hanna E, Gough B. Men's accounts of infertility within their intimate partner relationships: An analysis of online forum discussions. Journal of Reproductive and Infant Psychology. 2017;35(2):150-8.

17.Hinton L, Miller T. Mapping men's anticipations and experiences in the reproductive realm: (in)fertility journeys. Reproductive BioMedicine Online. 2013;27(3):244-52.

18.Malik SH, Coulson N. The male experience of infertility: A thematic analysis of an online infertility support group bulletin board. Journal of Reproductive and Infant Psychology. 2008;26(1):18-30.

19.Hanna E, Gough B. Emoting infertility online: A qualitative analysis of men's forum posts. Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine. 2016;20(4):363-82.

20.Dooley M, Nolan A, Sarma KM. The psychological impact of male factor infertility and fertility treatment on men: A qualitative study. Irish Journal of Psychology. 2011;32(1-2):14-24.

21.Dwyer AA, Quinton R, Pitteloud N, Morin D. Psychosexual Development in Men with Congenital Hypogonadotropic Hypogonadism on Long-Term Treatment: A Mixed Methods Study. Sexual Medicine. 2015;3(1):32-41.

22.Johansson M, Hellström A-L, Berg M. Severe male infertility after failed ICSI treatment-a phenomenological study of men's experiences. Reproductive Health. 2011;8(1):4-10.

23.Schick M, Rösner S, Toth B, Strowitzki T, Wischmann T. Exploring involuntary childlessness in men - a qualitative study assessing quality of life, role aspects and control beliefs in men's perception of the fertility treatment process. Human Fertility (Cambridge, England). 2016;19(1):32-42.

24.Bell AV. 'I don't consider a cup performance; I consider it a test': masculinity and the medicalisation of infertility. Sociology of Health and Illness. 2016;38(5):706-20.

25.Fahami F, Quchani SH, Ehsanpour S, Boroujeni AZ. Lived experience of infertile men with male infertility cause. Iranian Journal of Nursing and Midwifery Research. 2010;15(Suppl1):265-71.

26.Parrott FR. 'At the hospital I learnt the truth': diagnosing male infertility in rural Malawi. Anthropology & Medicine. 2014;21(2):174-88.

27.Hanna E, Gough B. Emoting infertility online: A qualitative analysis of men's forum posts. Health:An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine. 2016;20(4):363-82.

28.Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006;3(2):77-101.

29.Connell R. Masculinities. 2nd ed. Berkeley, California: University of California Press; 2005. 324 p.

30.McCreight BS. A grief ignored: narratives of pregnancy loss from a male perspective. Sociology of Health & Illness. 2004;26(3):326-50.

31.Dolan A, Coe C. Men, masculine identities and childbirth. Sociology of Health & Illness. 2011(33):1019-34.

32.Webb RE, Daniluk JC. The end of the line: Infertile men's experiences of being unable to produce a child. Men and Masculinities. 1999(2):6-25.

33.Edelmann RJ, Connolly KJ. Gender differences in response to infertility and infertility investigations: Real or illusory. Br J Health Psychol 2000(5):365-75.

34.Péloquin K, Lafontaine M-F. What Are the Correlates of Infertility-Related Clinical Anxiety? A Literature Review and the Presentation of a Conceptual Model. Marriage & Family Review. 2010;46(8):580-620.

35.Péloquin K. Infertilité une réalité sociale et conjugale sur laquelle il faut se pencher Cahier recherche et pratique 2013;3(2):22-6.

36.Giami A. Le « glauque » ou la production de sperme

infertile. Ethnologie française. 2011;41(1):41-8.

Remerciements
Les auteurs tiennent à souligner la contribution financière de la Chaire de recherche du Canada sur la santé psychosociale des familles à la realisation de cette étude

Pour contacter les auteures:
Isabel Côté, PhD
Université du Québec en Outaouais
Département de travail social
283, boulevard Alexandre-Taché, pièce C-2322
Succursale Hull
Gatineau, Québec, J8X 3X7
Canada
courriel: isabel.cote@uqo.ca

Francine de Montigny, Inf., PhD
Université du Québec en Outaouais
Département du Québec en Outaouais

Sabrina Zeghiche, PhD(c)
Université d'Ottawa
Sociologie

APORIA
LA REVUE EN SCIENCES INFIRMIÈRES • THE NURSING JOURNAL

ABOUT APORIA

Aporia is a peer-reviewed, bilingual, and open access journal dedicated to scholarly debates in nursing and the health sciences. The journal is committed to a pluralistic view of science and to the blurring of boundaries between disciplines. Therefore the editorial team welcomes critical manuscripts in the fields of nursing and the health sciences that include critique of dominant discourses related to the evidence-based movement, best practice guidelines, knowledge translation, managerialism, nursing and health care practices, ethics, politics of health care and policies, technology, bioethics, biopedagogies, biopolitics etc. Research results in nursing and health-related disciplines are also welcome. *Aporia* encourages the use of various epistemologies, philosophies, theoretical perspectives and research methodologies. In the critical analyses of health-related matters, *Aporia* embraces a wide range of epistemologies, philosophies and theories including cultural studies, feminism(s), neo-marxism, post-structuralism, postcolonialism and queer studies.

While the public already pays to fund health research, it is inconceivable that the public should be required to pay yet again, to gain access to research results. Subscription to scientific journals can sometimes reach up to thousands of dollars that are paid directly from public funds. Aporia inscribes itself along the margins of this practice by allowing for a definite fracture to take place within the current trends in the field of scientific publication, which constitute the dominant model for the diffusion of knowledge. *Aporia* is, therefore, a free online journal. Following the footsteps of Deleuze and Guattari, the *Aporia* team firmly believes that freedom is only made possible in the margin; an autonomous space that is controversial, sometimes polemical and without censorship that does not sacrifice scientific and academic rigor. As such, the objective is to encourage access to scientific knowledge and to give the reader an opportunity to actively position himself/herself regarding the written words in order to give a plurality of meanings to the text.

Therefore, *Aporia* adheres to the following principles:

-Freedom of speech
-Critical pedagogy
-Recognition of local knowledge(s)
-Critique of dominant discourses.

SUBMISSION

Research manuscripts, theoretical and philosophical pieces must not exceed 7,000 words. Commentaries and responses related to published articles must not exceed 3,000 words. Manuscripts and the cover letter should be submitted to aporia@uottawa.ca.

Cover Letter

Papers are accepted for publication in the Journal on the understanding that the content has not been published or submitted for publication elsewhere. This must be stated in the cover letter, which should be sent with the manuscript. The cover letter must contain an acknowledgement that all authors have contributed significantly, and that all authors are in agreement with the content of the manuscript. When applicable, it should be stated that the protocol for the research project has been approved by a suitable and relevant Research Ethics Board. All investigations involving human subjects must include a statement that subjects provided informed consent and anonymity should be preserved. Authors should declare any financial support or relationships that may cause conflicts of interest.

Authorship Credit

Each author should have participated sufficiently in the work. Authorship creditsshould be based on substantial contributions to:

-conception and design, or analysis and interpretation of data;
-drafting the article or revising it critically for important
-intellectual content; and
-final approval of the version to be published.

Preparation of the Manuscript

Research manuscripts, theoretical and philosophical pieces must not exceed 7,000 words. Commentaries and responses related to published articles must not exceed 3,000 words. Submissions should be prepared in word-processing software using Arial 11. The text file should be double-spaced and set with top, bottom and side margins of 2.5cm or 1 inch.

For more information, please visit Aporia online at http://www.oa.uottawa.ca/journals/aporia/index.jsp?lang=.