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# Commentaire

## Plaidoyer pour une « anti-préparation » consciente à la maternité

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Au Québec, l'une des principales conséquences liées à la médicalisation de la maternité s'exprime par l'instauration d'un dispositif ciblant le continuum de la grossesse jusqu'aux premières années de vie de l'enfant. Les cours prénataux dédiés aux parents comptent parmi les éléments directeurs, et disciplinaires, de ce dispositif. Comme le rapporte l'historienne Andrée Rivard (1), c'est précisément par la promotion de son programme d'éducation à la santé que le ministère des Affaires sociales du Québec dans les années 70 visait à convaincre les femmes et leur partenaire que ce sont les spécialistes investis en santé qui détiennent les « bonnes » connaissances, habiletés et compétences pour prendre en charge leur grossesse, leur accouchement, leur (non)allaitement et les premières années de vie de leur enfant. Initialement développés par les centres locaux de services communautaires (CLSC), ces cours gratuits ciblaient la population générale. Toutefois, les influences patriarcales et capitalistes ont contribué à l'instauration d'une véritable économie de la maternité. D'un côté, les sociétés capitalistes ont favorisé la transformation de ces savoirs en une marchandise, créant ainsi des industries autour de la maternité et de l'éducation parentale. À cette marchandisation des savoirs se greffe également un commerce matériel lucratif (p. ex. tabliers d'allaitement, livres sur la « bonne » maternité, suces, chauffe-lingettes et tire-lait). De l'autre, le patriarcat a influencé cette dynamique en renforçant les normes genrées associées à la maternité et, dans une plus faible mesure, à la parentalité. Cela s'exprime notamment par les attentes sociales envers les mères afin qu'elles consomment et utilisent ces savoirs-marchandises. De fait, aujourd'hui, les mères sont sollicitées par une multitude de programmes d'éducation à la santé, souvent payants, orientés précisément sur la maternité. Alors qu'auparavant ces programmes initiaux ciblaient principalement la grossesse (p. ex. alimentation, tabagisme), l'accouchement (p. ex. gestion de la douleur, physiologie de l'accouchement) et l'allaitement (p. ex. positions d'allaitement), les femmes sont actuellement confrontées à une commercialisation des savoirs entourant plus largement les premières années de vie de l'enfant (p. ex. diversification alimentaire menée par l'enfant, hygiène du sommeil, apprentissage à la propreté, développement du langage, optimisation des capacités motrices, éveil à lecture). Cette évolution est d'autant plus critique dans les dernières années avec la popularité du marketing d'influence sur les réseaux sociaux entourant la maternité (#momlife) qui renforce à son tour les normes genrées durant les premières années de vie de l'enfant, notamment en consolidant le besoin de consommation de savoirs-produits chez les mères (2).

Or, bien que cette commercialisation des savoirs semble répondre à des besoins d'apprentissage partagés par les mères elles-mêmes, force est de constater qu'elle peut également amplifier les pressions exercées sur ces dernières afin qu'elles consomment davantage de connaissances, de produits et de services liés à la maternité, souvent sans considérer pleinement leurs besoins individuels ainsi que les contextes culturels et sociaux dans lesquels elles évoluent. Cette performance de la maternité intensive (3) s'exerce en outre dans un contexte androcentrique où les femmes ont internalisé des rôles sociaux construits les contraignant parfois à chercher et à acheter ces connaissances pour répondre aux diktats établis en ce sens. Dans ce contexte, les mères sont parfois appelées et encouragées à ne pas faire confiance à leurs forces intrinsèques, voire à s'en méfier, et ainsi à normaliser ces formes d'assujettissement aux autorités tant scientifiques et professionnelles que commerciales. En plus d'exacerber les inégalités de genre, cette commercialisation peut aussi générer des inégalités socio-économiques en créant un marché où le savoir devient une marchandise accessible à celles qui ont des ressources financières suffisantes, perpétuant ainsi de nombreuses injustices et disparités à l'égard de l'accès à cette forme de consommation. Ce constat est particulièrement préoccupant en 2024, considérant la crise inflationniste actuelle touchant les familles (4). En effet, devant l'augmentation constante des factures d'épicerie et des loyers, de nombreuses femmes se retrouvent soumises à une pression accrue en devant composer avec les injonctions liées à cette performance de la maternité intensive, tout en répondant aux besoins essentiels de leur famille.

Paradoxalement, alors que la circulation de ces savoirs généralement médicalisés s'accélère, nous observons par la même occasion des statistiques préoccupantes au sujet de la santé mentale des mères (5). Il y a donc lieu de réfléchir à l'impact que peuvent générer ces préparations à la maternité sur la santé mentale et le bien-être des mères. Occupant les positions privilégiées de doctorantes et de mères, notre regard critique sur cette problématique nous amène à proposer une « anti-préparation » à la maternité en ce sens où les femmes devraient être appelées à déconstruire les croyances contraignantes entourant la maternité plutôt qu'à cumuler de nouvelles connaissances parfois contradictoires, souvent inutiles, et particulièrement anxiogènes. Cette « anti-préparation » ne constitue pas un appel à l'ignorance, mais elle encourage à pondérer la consommation de connaissances, dans la mesure où de telles connaissances sont génératrices de croyances qui effritent et surtout invisibilisent les forces intrinsèques des femmes. Bien que certaines informations entourant la maternité soient essentielles à connaitre, il nous semble nécessaire qu'une attention plus soutenue soit consacrée à l'autonomisation des mères ainsi qu'à la remise en question des normes dominantes qui, finalement, ne les servent pas toujours en première instance. Autrement dit, ce plaidoyer vise à ébranler la fonction autoritaire des savoirs médicalisés imbriqués aux normes capitalistes et patriarcales de la maternité vis-à-vis les forces intrinsèques des mères. En somme, par cet argumentaire, nous souhaitons ainsi promouvoir une approche non pas inclusive à cette commercialisation de la maternité, mais plutôt anti-oppressive en légitimant de façon conjointe les forces intrinsèques des mères et leurs croyances facilitantes qu'elles soient médicalisées ou tacites.

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# Commentary

## A call for conscious “anti-preparation” to motherhood

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In Quebec, one of the main consequences of the medicalization of motherhood is the introduction of an apparatus targeting the continuum from pregnancy to the child’s first years of life. Prenatal classes for parents are one of the key elements of this apparatus. According to historian Andrée Rivard (1), it was precisely through the promotion of its health education program in the 1970s that the then Ministry of Social Affairs aimed to convince women and their partners that health professionals held the “right” knowledge, skills and competencies to manage their pregnancy, childbirth, breastfeeding (or lack thereof) and their child’s first years of life. Initially developed by local community service centers (CLSCs), these free classes targeted the general population. However, patriarchal and capitalist influences have contributed to the establishment of a veritable economy of motherhood. On the one hand, capitalist societies have encouraged the transformation of this knowledge into a commodity, creating industries around motherhood and parenting education. Alongside this commercialization of knowledge is a lucrative material trade (e.g. breastfeeding aprons, books on “good” motherhood, pacifiers, wipe warmers and breast pumps). On the other hand, patriarchy has influenced this dynamic by reinforcing gendered norms associated with motherhood and, to a lesser extent, parenthood. This is especially reflected in the social expectations placed on mothers to consume and use these commodities. Indeed, these days, mothers are solicited by a multitude of health education programs, often for a fee, specifically devoted to motherhood. Whereas in the past, these initial programs focused primarily on pregnancy (e.g., diet, smoking), childbirth (e.g., pain management, physiology of childbirth) and breastfeeding (e.g., breastfeeding positions), women are now confronted with a broader commercialization of knowledge surrounding the first years of a child’s life (e.g., child-led dietary diversification, sleep hygiene, toilet training, language development, motor skills optimization, awakening to reading). This evolution has become especially critical in recent years with the popularity of influencer marketing on social media (#momlife), which reinforces gendered norms during the first years of a child's life, notably by increasing mothers' need to consume product and knowledge (2).

While this commercialization of knowledge seems to address learning needs identified by mothers themselves, it can also amplify the pressures put on them to consume more motherhood-related knowledge, products and services, often without fully considering their individual needs and the cultural and social contexts in which they evolve. This performance of intensive motherhood (3) also takes place in an androcentric context, where women have internalized socially constructed roles, sometimes forcing them to seek out and purchase this knowledge to meet established diktats. In this context, mothers can be called upon and encouraged not to trust their own intrinsic strengths, or to even distrust them, thereby normalizing these forms of subjugation to both scientific and professional as well as commercial authorities. Besides exacerbating gender inequalities, this commercialization can also generate socio-economic inequalities by creating a market where knowledge becomes a commodity accessible to those with sufficient financial resources, thereby perpetuating numerous injustices and disparities in terms of access to this form of consumption. This is particularly worrying in 2024, given the current inflationary crisis affecting families (4). Faced with ever-increasing grocery bills and rents, many women find themselves under increased pressure to cope with the injunctions of intensive performance of motherhood, while at the same time meeting their family's essential needs.

Paradoxically, at a time of accelerating circulation of this generally medicalized knowledge, we are also seeing worrying statistics regarding mothers' mental health (5). We therefore need to examine the impact that preparation for motherhood can have on mothers' mental health and well-being. Our privileged position as doctoral students and mothers allows for a critical look at this issue that leads us to propose a form of "anti-preparation" to motherhood, in the sense that women should be called upon to deconstruct the constraining beliefs surrounding motherhood rather than accumulate new knowledge that is sometimes contradictory, often useless, and particularly anxiety-provoking. This is not a call to ignorance, but it does encourage us to temper our consumption of knowledge that can generate beliefs that erode and, above all, invisibilize women's intrinsic strengths. While some of information surrounding motherhood is essential to know, we suggest that more attention must be devoted to empowering mothers and challenging dominant norms that ultimately don't always serve them. In short, this plea seeks to challenge the authoritarian function of medicalized knowledge embedded in capitalist and patriarchal norms of motherhood, which work to minimize the intrinsic strengths of mothers. Our intention is not to promote an inclusive view that rests on the commercialization of motherhood, but rather an anti-oppressive approach that legitimizes both the intrinsic strengths of mothers and their facilitating beliefs, whether medicalized or tacit.

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# 1

## Abstract

The theory of procedural justice, derived from social psychology, is employed in numerous fields of study concerned with the quality of interactions involving individuals in positions of authority. Although this theory is increasingly cited for its potential to promote approaches aimed at mitigating the effects of psychiatric coercion and better respecting individuals' rights, empirical literature provides limited insights into how procedural justice could be translated into practice. It is important, therefore, to examine the theoretical and practical implications of such an orientation. Based on a critical analysis of existing literature, this article will discuss the potential contributions and limitations of procedural justice applied in the field of mental health and psychiatric nursing. Procedural justice has limitations regarding solutions for human rights violations in psychiatry. It nonetheless allows a focus on the quality of interactions with individuals in coercive contexts, in addition to considering the social and identity-related implications of psychiatric coercion.

Key Words Coercion, Mental Health, Nursing, Procedural Justice, Psychiatry

# Does mental health practice benefit from procedural justice theory? A critical analysis on the opportunities and pitfalls of procedural justice to address coercion and human rights issues in psychiatry

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## Introduction

A paradigm shift in the field of mental health has been advocated for several years now. There is a call to move towards mental health care that focuses on support and respect for human rights, while moving away from biomedical and risk management models that contribute to justifying the use of coercion (1). This call for change aligns with an international effort to reduce the presence of coercion in mental health care (1). This objective can be challenging since, to this day, no general definition of psychiatric coercion exists, highlighting the complexity of this phenomenon. Most of the literature on the subject focuses on formal coercion (seclusion, restraint, involuntary hospitalization), which is regulated by legislation, or informal coercion, which refers to different pressures exerted on individuals by healthcare professionals to accept treatment (2, 3). However, coercion can also manifest in mundane yet humiliating and dehumanizing actions that are frequently excluded from writings on the subject, such as the lack of choice for hospitalized individuals regarding what they can wear, when they can eat, use the phone or go to bed (4, 5, 6, 7). It could then be argued that psychiatric coercion requires further exploration to fully understand its magnitude and subtlety, starting with the perspective of those who experience it. Thus, perceived coercion, which refers to the subjective experience of coercion (8), is a concept that has emerged and allowed considering other elements contributing to the negative experiences or feelings during mental health hospitalization, regardless of the presence or absence of formal coercion.

The initial studies on perceived coercion highlighted that the legal status of individuals during their hospitalization was not correlated with their experience of coercion; instead, it was their perception of the fairness of the process that was important (9, 10). This concept refers to procedural justice theory, which focuses on the qualitative aspects of social interactions and processes involving authority (11). Several subsequent studies confirmed these results by finding an inversely proportional relationship between the degree of procedural justice and the level of perceived coercion among individuals with mental health problems (9, 12, 13, 14, 15, 16). In the context of hospitalization, procedural justice is highly influenced by the quality of interactions with different figures of authority, including healthcare professionals (12). According to procedural justice theory, these interactions should be respectful, allow individuals to express themselves freely, and instill a sense of trust (17). Because nurses working in mental health are intimately involved in the care of hospitalized individuals on a daily basis and since interacting with the person is at the core of the nursing profession, procedural justice is frequently cited in the mental health and psychiatric nursing literature for its presumed potential to mitigate the consequences of coercion (12, 18, 19, 20, 21). While some authors suggest practical recommendations for the application of procedural justice (22, 23), very few writings report studies that have tested or explored the clinical relevance of this theory to address the challenges of human rights violations in psychiatry. Indeed, procedural justice has been predominantly used in the field of law enforcement, where police training has shown promising results such as a decrease in arrests and crimes, as well as a decrease in the public's perception of police as harassing or using force in an abusive manner (24). Although some parallels can be drawn with mental health nursing practice, the lack of studies on the subject raises questions about the existing enthusiasm towards this theory, in a context where the use of psychiatric coercion is increasing without evidence of its effectiveness and despite its detrimental effects on the individuals involved (25, 26, 27, 28). Therefore, the purpose of this article is to present a critical analysis on the potential contributions and limitations of procedural justice in the context of psychiatric care, while proposing strategies aimed at improving the experience of hospitalization by considering the relational aspects related to both care and coercion, as well as acknowledging and supporting the exercise of patients' rights. To do so, a brief historical overview of procedural justice theory is presented, followed by an in-depth exploration of its key principles, highlighting their relevance to nursing practice. To illustrate the possible contribution of procedural justice, a discussion of the strengths and limitations of this theory is provided, drawing parallels with psychiatric and mental health nursing theories.

## Method

A critical analysis based on a narrative review of the literature on procedural justice in a psychiatric context was conducted. Initially, to present the theory of procedural justice and its central principles, the original works of key authors associated with this theory were consulted (n = 12). Subsequently, a search strategy was developed in collaboration with a librarian, centered around the concepts of procedural justice and psychiatry, and a search was conducted across the following databases: CINAHL, MEDLINE, WEB of SCIENCE, PsycINFO, Criminal Justice Abstracts, and Social Sciences Abstracts. The included literature fell within the domain of psychiatric care and addressed the concept of procedural justice. Literature specifically focused on mental health courts was excluded. After initial selection, reference lists of included articles were reviewed to identify any other relevant literature. As a result, 19 articles were retained. To provide a comprehensive critical analysis that encompassed both the central principles of procedural justice and psychiatric care, additional pertinent literature was consulted on topics such as stigma and power relations.

The analysis of the literature was inspired by a pragmatic constructivist perspective of knowledge development. Pragmatic constructivism is a philosophy of knowledge characterized by its epistemological stance that asserts that only human experience is knowable (29, 30). The development of knowledge occurs through the construction of representations aimed at making sense of the phenomena we experience as humans (29). These representations, which allow us to understand the world we live in, are built upon the individual's experience of the lived phenomenon (29). Furthermore, pragmatic constructivism distinguishes itself by the absence of foundational ontological assumptions. Without denying the possibility of the existence of reality, this philosophy chooses not to make claims about the existence of a world independent of the human mind, as it considers that humans can only acquire knowledge based on their experience (30, 31). Thus, external reality is not a consideration within this stance, which posits the existence of a multitude of human experiences (31). The pragmatic nature of this philosophical posture manifests in the functionality expected from the elaborated representations, meaning that they must enable action and help navigate the world in a viable manner (32). Therefore, this paper discusses the strengths and limitations of procedural justice in constructing fairer and more pragmatic representations of psychiatric coercion, and consequently, the role that nurses can play in reducing its presence among individuals receiving psychiatric care.

## State of Knowledge

### Procedural justice: Brief history and theoretical models

The theory of procedural justice emerged in the 1970s in a field of social psychology focusing on the study of justice (33). Research in this field, aiming to understand relationships with authority, had previously been based on the idea that individuals evaluate their social experiences, relationships, and institutions based on the outcomes they receive (11). It was in the work of Thibaut and Walker (33) that the term "procedural justice" was first used. Situating their research in the context of legal dispute resolution, these authors postulated, in a then-counterintuitive manner, that the fairness of the process leading to a decision (the outcome) is as important to individuals as the outcome itself (33). Two main streams of thought are associated with this theory, providing both different and complementary explanations for understanding this social phenomenon. Thus, the literature encompasses instrumental models and relational models of procedural justice.

#### *Instrumental models*

Instrumental models of procedural justice are built on the presumption that individuals evaluate the fairness of the process based on the likelihood that it will lead to a favorable outcome (34). These models examine procedural justice from the perspective of control distribution: having control (33) or a voice (35) in the process increases the individual's perception of being able to influence the outcome in their favor. Thibaut and Walker (33) specifically focus on two components of control: process control and outcome control. The main finding from their work helps us understand that even if a decision is made by a third party (e.g., a judge), the perception of having control over the process, such as having the opportunity to present evidence, is an important determinant of the individual's perception of justice and, consequently, how they accept the outcome.

Leventhal (36) builds upon the work of Thibaut and Walker (33) by studying procedural justice in the context of resource allocation. According to Leventhal, the perception of justice is a determining factor in potentially all types of social processes or social interactions in which a person is involved on a daily basis, whether in personal, professional, or societal relationships (37). Thus, Leventhal's theoretical writings have recognized the relevance of this theory for other social contexts beyond legal contexts (11). The contribution of his model lies primarily in its six procedural rules, which explain how individuals form judgments about the justice of their experiences. These rules, which are discussed further in this paper, are consistency, lack of bias, reliability of information, correctability, representativeness, and ethics (36, 37).

#### *Relational models*

While instrumental models consider that individuals are only interested in the individual benefit they can gain from their involvement in the process that concerns them, relational models offer an identity-based explanation of procedural justice (11, 38). Lind and Tyler (11) build upon the original writings on procedural justice by postulating that procedures are not only interesting for the outcome they produce for the individual but also for the information they provide about their social status. Procedural justice is thus positioned as exerting an influence on the individual's social identity in relation to authority and, therefore, on their perception of self and self-worth (11). Their studies lead Lind and Tyler (11) to present three relational criteria: respect, trust, and neutrality. These authors eventually conclude that procedural justice cannot only be understood and explained in an instrumental or relational manner, and that the integration of these two approaches is necessary for the study of the psychology of procedural justice (11, 34). Thus, four central principles, derived from both instrumental and relational models, are now used in most writings on procedural justice.

### The four central principles of procedural justice: What pertinence for mental health nursing practice?

In this section of the paper, an in-depth exploration of the principles of procedural justice will demonstrate the potential of this theory for understanding the relational aspects surrounding psychiatric coercion. Each principle is presented based on the original writings of procedural justice, then contextualized to mental health nursing according to the available literature on the subject and our own interpretation of how the principles might translate into clinical practice.

#### *Voice*

**To be heard and recognized**: The principle of voice refers to the ability to explain one's situation and point of view to individuals in positions of authority (11). Thibaut and Walker (33) and Leventhal (36) consider the principle of voice important as it allows individuals to promote their own interests in the situation, by attempting to influence the decision concerning them in a favorable manner. With their relational models, Lind and Tyler (11) presented the principle of voice as having an effect on the perception of justice by individuals who, when given the opportunity to present information regarding their situation, perceive themselves as valued members of the group (11, 34). The fact that an individual's opinion is valued and considered worthy of being heard allows them to perceive the process more favorably, regardless of the outcome (11). Individuals living with mental health problems continue to be a particularly marginalized, stigmatized, voiceless, and invisible group in the social, healthcare, and research spheres (5, 39). According to Tyler and Lind (38), the quality of interaction with individuals in positions of authority is crucial in shaping their interpretation of their social status within the group. Thus, treating individuals with dignity while respecting their rights and opinions increases their perception of positive social status (38). Studies on procedural justice in the context of mental health have reported that having a voice is essential for hospitalized individuals and that the disregard for their perspectives leads to significant distress (12, 40). By incorporating this principle, nurses could not only alleviate the distress of the individual but also promote a sense of inclusion while reinforcing their self-esteem. However, the authentic implementation of this principle is challenging.

**Misuse and censorship:** Lind, Kanfer and Earley (34) address the risk of the deceptive use of voice, whereby a person is encouraged to speak up even though the authority has no intention of genuinely considering their point of view. This approach actually amplifies the objective injustice of the process, as the authority uses the principle of voice to advance its own interests (34). A study on the unfolding of mental health review board hearings in Canada revealed that procedural justice was used as a way to give the illusion to the patients that their voices were being heard, while what was said was very rarely taken into consideration (41). In the field of mental health, although the principles of autonomy and reciprocity are often highlighted in the literature, paternalism remains predominant in practice (42). Central to the paternalistic perspective, the principle of beneficence encourages action in the best interest of the person while perpetuating the prioritization of professional expertise at the expense of the person's experiential knowledge (42). Furthermore, a direct link can be made between coercion in mental health and the deceptive use of voice, as it is not uncommon to hear that greater involvement of the person makes the experience of coercion more acceptable and even therapeutic (21, 23). The principle of voice, therefore, calls for a reevaluation of nursing practice in mental health and a repositioning of the nurse in a perspective of reciprocity with hospitalized individuals. Merely listening to the person is no longer sufficient; interactions must strive for both objective justice (genuine involvement of the person and their perspective) and subjective justice (as experienced by the person). In this regard, several studies on procedural justice and perceived coercion associate the principle of voice with that of validation, explaining that it is not only important to provide sufficient opportunities for the person to express themselves but also to seriously consider what they say (19, 20, 43).

Although more focused on the instrumental benefit of procedural justice, Leventhal's model warns about a particularly interesting aspect of the principle of voice ("representation" in his model), namely censorship. According to this author, censorship, which can occur at any phase of the process or interaction, refers to the restriction of the flow of information, resulting in an underrepresentation of the actual quantity of information and opinion available (36). This information restriction occurs both during the reception of information (receiving the person's point of view) and the dissemination of information (providing information to the person about their situation) and will result in a decreased perception of justice (36). In psychiatric care, access to information and involvement in decisions remain an important issue, especially for individuals presenting with severe symptoms (7). However, it has been shown that even in the presence of psychotic symptoms, individuals are capable of distinguishing behaviors that enhance procedural justice (44). This highlights the importance for the nurse to ensure a flow of information that represents the reality of the person's situation, by sharing all relevant information (legal, medical) and by taking their opinion into account. The provision of information by the nurse should be improved, for example, by regularly assessing the person's information needs and adapting the timing and mode of information transmission (45). Furthermore, nurses should ensure that each person has access to essential information that will not only allow them to be informed about their rights but also to exercise them according to their situation and will.

### *Respect*

The principle of respect focuses on the ability of authority to treat individuals with politeness, dignity, and respect for their rights (38, 46). According to Tyler and Lind (38), the interpersonal quality of treatment offered to individuals by those in positions of authority is essential. In the literature on procedural justice, an often-cited example is that of the police mistreating a minority group, which reflects their low social status and lack of protection (17). A parallel can certainly be drawn with individuals living with a mental health problem, who are themselves marginalized.

Indeed, the stereotypes and prejudices held towards individuals living with a mental health problem result in their stigmatization within society and mental health services (47, 48). Link and Phelan (49) provide a social conceptualization of stigma, stating that it occurs when human differences are noticed, and individuals are categorized as being separate from the rest of society, resulting in a loss of status. According to the theory of procedural justice, concern for social status leads individuals in contact with a form of authority to seek signs that allow them to assess whether they are being treated with dignity and respect for their person and rights (38). The omnipresence of coercion in mental health certainly hinders a positive assessment of the respect offered during hospitalization. Indeed, the stigmatization of individuals living with a mental health problem results in discriminatory attitudes among healthcare professionals, which are reflected, among other things, in the use of coercion (48). In the field of mental health, elements related to respect are even more essential, as it is recognized that individuals who have been hospitalized often emerge from this experience with a sense of fear and even trauma, and subsequently choose to avoid using healthcare services in the future (27, 50). When individuals feel a lack of dignity and respect for their rights, it may communicate to them that their social status is inferior to the rest of society. One strategy for nursing practice may be elucidated by Leventhal's (1980) writings, which discuss "ethicality" as a procedural rule that pays particular attention to the values of the person involved in the procedure. According to this author, the perception of justice will be diminished if procedures are not aligned with the person's moral standards and values (36). For example, Leventhal (1980) explains that the use of deceptive and privacy-invasive observation methods may be considered unjust if a person believes them to be fundamentally wrong (36). Translated to the context of mental health hospitalization, this indicates that one way for the nurses to act with respect would be to ensure knowledge and consideration of the person's values while limiting the use of tactics that may impede their autonomy and privacy. Seemingly mundane methods, such as constant observation and arbitrary house rules, are regular occurrences in inpatient units and can be much more dehumanizing for some individuals than even the use of formal coercive measures (4, 5). Finally, it is important to note that the principle of respect pertains not only to interactions between individuals, but also to the structural elements inherent in the organization of work within inpatient units, which are often guided by a risk management culture (51) rather than a desire to uphold individuals' rights. The interactions between the individual and the environment in which they navigate during their hospitalization can also become dehumanizing if they do not promote a sense of respect for the individual and their rights.

### *Trust*

Trust is a principle that refers to the intention of authority as perceived by the individual involved in the interaction (17). Kindness and the desire to treat the person in a fair and ethical manner are essential elements for the individual in their relationship with authority (17, 38). According to the theory of procedural justice, the idea that the person may have long-term contact with authority is an important aspect to consider (17, 38). This implies that the quality of interactions is even more important as it allows the individual to predict the kind of treatment and behavior they can expect in the future when in contact with the same authority or a similar authority (17, 38). In the field of mental health, it can be considered that the nature of interactions between the individual and healthcare professionals is crucial not only for the quality of their current experience but also for implications for their future treatment. Interactions devoid of benevolence and justice can have an unsettling effect on the hospitalized person regarding their future interactions. As mentioned earlier, individuals who have experienced difficult and fear-filled mental health hospitalization tend to avoid healthcare services (50). Nurses, being in close relationship with the person, play a crucial role in determining the quality of the long-term relationship between the person and mental health services.

In early studies examining the role of coercion during mental health admission, the interpretation of others' motives towards the individual emerged as one of the key themes explaining perceived coercion (40, 52). Specifically, the impression that the other (e.g., nurse) is involved in the process with an appropriate level of concern for the individual had a significant influence on the perception of experiencing coercive behaviors (52). Trust, being a central aspect of the therapeutic relationship, makes these results unsurprising and confirms the importance of the nurse's role in reducing perceived coercion. However, the presence of coercion threatens trust within the relationship (22). Considering the ubiquity of coercion in mental health practices, establishing a genuine sense of trust can prove to be challenging. According to the theory of procedural justice, it is primarily the intentionality guiding the authority's actions that will determine the trust felt by the individual (17). It is about the individual believing that the authority shares the same fundamental values and will act to protect their interests (53). As mentioned earlier, the stigmatization of individuals living with a mental health problem makes them feel like a separate group, not part of the "rest of society." Believing that the dominant system represented by healthcare services shares their fundamental values and acts in their best interest becomes difficult for the individual, especially when safety is stated to be a predominant value in care units (51). Indeed, the need and obligation to ensure the safety of everyone and the fear of danger (real or perceived) in inpatient units can certainly impede the feeling of trust between the nurse and the hospitalized person. Demonstrating that the nurse has intentions guided by justice, benevolence, and ethics in a context where the individual is faced with imposed choices, rules, and treatments represents a particularly complex challenge. Furthermore, De Cremer and Tyler (54) examined the effects of trust in authority on the perception of procedural justice. They found that the presence of information indicating whether the authority was trustworthy modulated the perception of procedural justice and, consequently, the individual's cooperation (54). Considering the negative image associated with mental health hospitalization, the principle of trust calls for more than the individual actions of nurses; it requires a cultural and paradigm shift to portray psychiatry as being focused on respecting human rights.

### *Neutrality*

**The absence of prejudice.** The principle of neutrality focuses on the authority's ability to make the decision-making process unbiased in the eyes of the person involved (17). Individuals question whether they are being treated fairly compared to others within the same group (17, 55). According to Tyler and Lind (38), concerns related to the principle of neutrality are primarily linked to the belief of being discriminated against by the authority due to prejudice. This implies that the person "is somehow less worthy than those who receive more favored treatment, and this implication has extremely powerful consequences for feelings of self-worth" (38). This concept is particularly important to consider as several writings testify to prejudices, negative attitudes, and beliefs held by nurses towards individuals living with mental health problems (56, 57, 58). Increasing the perceived neutrality during a person's hospitalization would, therefore, begin with reducing prejudices held towards them. In the field of mental health, it is intriguing to observe that negative attitudes manifest through elements directly related to the central concepts of procedural justice. For example, there is often mention of the exclusion of the person from the decision-making process and their lack of access to all relevant information (58). Thus, the concept of neutrality, applied to mental health nursing practice, appears to be partly realized through the concrete application of other concepts of procedural justice (voice, respect, trust).

Furthermore, a suggestion offered by Tyler and Lind (38) is to ensure that decisions are based on facts rather than prejudiced opinions. In this regard, Leventhal (36) mentions the absence of bias, which means withdrawing any personal interest and avoiding blindly submitting to narrow prejudices. This author also presents a rule of consistency by explaining that procedures should be similar for everyone (36). Although this may be conceivable in a legal process, nursing practice, on the contrary, aims to recognize the individuality of the person and incorporate this conception into care. The rule of consistency becomes more interesting as it helps explain a factor contributing to the lack of respect for the rights of individuals in mental health and the associated experience of coercion. Indeed, house rules of inpatient units are consistently applied by nursing staff (i.e., similarly from one person to another), even though their implementation is not always justified by logic nor therapeutic reasons, and they encourage the perpetuation of dehumanizing practices (4, 51). Consistency should, therefore, lie in the application of interventions that promote education, access to information, and time spent engaging with the person to hear and consider their opinion.

**The absence of finality.** Paradoxically, the desire to be heard coexists with the fear of the consequences associated with disclosing sensitive information. Individuals living with mental health problems may fear that sharing their distress or symptoms will have an impact on their hospitalization, as they perceive professionals as having power over their treatment and care planning (59). The procedural rule of correctability presented by Leventhal (36) emphasizes the importance of opportunities for decisions to be reversed at different stages of the process. Neutrality, combined with the principle of voice, would enable the nurse to ensure that the individual frequently has the opportunity to share their perspective on their situation and the changes they wish to make, without the fear of reprisals. It is crucial that a person experiencing mental health hospitalization does not feel trapped in a situation where choices made regarding their health and lifestyle are irreversible.

In summary, the four principles of procedural justice allow for the development of representations of the phenomenon of coercion by positioning individuals living with mental health problems as having a need for social and identity recognition. Thus, relying on these representations, nurses could incorporate different aspects of procedural justice into their role with the aim of reducing coercion and enhancing the recognition and support for the person's rights. For example, a repositioning towards the person appears necessary, adopting a perspective of reciprocity and avoiding the constant, blind, and arbitrary application of rules. Additionally, special attention to bidirectional sharing of information with the person and its authentic use seem to be critical elements in promoting a sense of justice. Furthermore, considering the analysis of the four principles, the nurse cannot be considered the sole actor in integrating these principles within the mental health care system. Indeed, systemic changes are not only necessary in psychiatric care to improve the treatment of individuals involved and reduce the use of coercion but also to allow nurses to fulfill their role without being solely responsible for managing the unrealistic expectations of a failing system, that is, to decrease coercion and its harmful effects without risking safety issues. The implication of procedural justice for nursing, both in terms of clinical practice, their role and responsibility, is further elaborated in the discussion.

### Procedural justice to reduce perceived coercion: current application in nursing research

The association between procedural justice and perceived coercion has been reported in numerous studies, some of which have concluded that strategies and interventions aimed at reducing psychiatric coercion should incorporate the principles of procedural justice (12, 20, 43). It is surprising, however, that very few studies appear to have focused on its application in practice.

Two Norwegian studies from the same project (Breakthrough project psychiatry) were found. First, Sørgaard's study (2004) presents the results of an intervention based on procedural justice and aimed at reducing levels of perceived coercion within a psychiatric intensive care unit. The intervention involved formulating a treatment plan in partnership with the hospitalized person, followed by regular meetings to assess progress and renegotiate the plan as needed (60). In addition to representing the foundation of what should be done in care settings, this intervention was based on a reductionist interpretation of procedural justice as simply involving the person in decision-making regarding their treatment. It is not surprising, then, that the intervention did not significantly reduce levels of perceived coercion. The author of this study found that the use of patronizing communication from healthcare professionals was associated with higher levels of perceived coercion, suggesting that the form of interaction may be more important than simply involving the person in their treatment plan. Next, the study by Johnsen et al. (45) presents the evaluation of an intervention aimed at improving the transmission of information to individuals visiting a psychiatric emergency department. Nurses were required to provide individuals with a brochure containing legal information, information about the unit's functioning, and procedures to file a complaint. By emphasizing the importance of promoting the right to information, this intervention increased participants' satisfaction with the information received and improved their legal knowledge. The majority of participants reported perceiving coercion during their hospitalization, but the intervention did not significantly reduce it.

These two Norwegian studies attempted to incorporate elements related to procedural justice (primarily the principle of voice), but limited its application to very specific aspects, namely the treatment plan and written information transmission. Procedural justice involves a set of principles aimed at increasing the person's sense of justice through the recognition of their identity value within an interaction where there is an imbalance of power. To achieve this, it becomes clear that interventions developed to reduce coercion should also include human rights approaches, where the support offered to the person in exercising their rights is paramount.

Furthermore, these authors, like several others in the reviewed literature, rely on writings from studies on coercion in mental health rather than the original writings on procedural justice (9). Thus, the representation of the aspects of social psychology associated with this theory seems questionable in the reviewed studies. In this regard, a measurement scale for perceived coercion and procedural justice (MacArthur Admission Experience Survey) was created by Lidz et al. (9) and is currently used and cited as a reference in several studies on perceived coercion (15, 16, 61). However, little information exists on how this scale was developed to accurately represent the central principles of procedural justice and be applicable to the mental health context. Moreover, it has been subject to criticism, including its failure to consider the individual's lived and unique experience, its excessive simplification, and its limited context to the moment of admission to mental health care (5, 62). In short, empirical literature provides limited insights into how procedural justice could be translated into practice.

## Discussion

### Theoretical contribution

Based on the analysis of the central principles of procedural justice presented earlier, several elements appear relevant and promising for supporting the development of nursing practices that consider the relational aspects involved in psychiatric coercion. Since procedural justice originates from a different discipline, namely social psychology, its relevance is examined by juxtaposing it with existing nursing theories. This discussion illustrates how procedural justice and nursing theories can be complementary and potentially fill their respective gaps.

#### *The recognition of power relations*

Nursing practice in mental health is inevitably linked to notions of control and power. The dominance of a paternalistic perspective focused on safety combined with the pervasive presence of coercion in clinical settings places nurses in a role that is difficult to reconcile with the values of the profession, which call for, among other things, respect for individual autonomy (4, 51). Nurses experience ethical tensions related to the use of coercion and have mixed perceptions of their role (4, 51, 63). Considering the complexity of this role and the desire to move towards rights-based approaches with the aim of reducing coercion, theory should provide an in-depth understanding of the issues involved in power relations.

Nursing theories, while useful in terms of the therapeutic relationship, can contribute to maintaining the imbalance within the relationship. Many nursing theories used in the field of mental health have been influenced by a humanistic perspective, which places the person's experience at the heart of care and encourages nurses to establish a therapeutic relationship to help the person identify their needs and assist in their development to reach their full potential (64). For example, Peplau (65), a pioneer in psychiatric nursing widely cited in the literature, created the theory of interpersonal relations, positioning interactions with the person as central to psychiatric nursing practice. The therapeutic relationship is presented as the core of the profession, with the nurse assisting the person in achieving health and well-being (65). Although the quality of the therapeutic relationship is beneficial to the person's mental health experience and their perception of coercion (16), Peplau's theory (1997) disregards the coercion surrounding mental health practices and the dehumanizing context of hospitalization. In this regard, criticisms associated with humanism highlight its inability to recognize the notions of power and domination involved in relationships (66). A humanistic approach even risks victimizing the person by presenting them as having existential freedom and therefore being responsible for their difficult situation (66). More recent theories inspired by humanism also convey discourses that, despite their benevolent intentions, do not allow for the recognition of the role played by the dominant system. For example, the intermediate theory of Recovery Alliance Theory (67) suggests that the person ("service user" in the article) is primarily responsible for their well-being and that the only way for them to exert any form of control is to accept that their health is the result of their own actions. The very use of the term "service user" to identify people living with mental health problems in this theory is problematic according to some authors with experiential survivor knowledge. Russo and Wallcraft (5) explain that this type of language in the context of coercion is inappropriate as it implies that coercion is one service option among others and that the person is free to choose and use it, which is obviously not the case. Mental health hospitalization is rather associated with a loss of control, autonomy, and choice (4, 68). Although several nursing theories are based on humanism and aspire to the development of nursing practices that consider the person in its entirety, it is important to emphasize that mental health nursing education and practice largely remains framed by the biomedical model of psychiatric medicine (69, 70).

By focusing on relationships with authority, the theory of procedural justice enables us to contemplate social interactions within the context of power relations (11). A theory like procedural justice can guide and support nurses towards a practice that recognizes the presence and consequences of coercion and implements concrete strategies to reduce it. The four central principles presented earlier demonstrate the potential application of this theory to psychiatric nursing practice. For instance, the importance of information flow is particularly interesting to consider, as nurses are expected to both receive and provide information to the person during hospitalization. Practices aimed at reducing coercion could draw inspiration from this aspect by, for example, implementing a mechanism for equitable access to information for each hospitalized person, where information is provided in various ways, personalized, and repeated. In this regard, Johnsen et al. (45) implemented a nursing intervention aimed at providing hospitalized individuals with verbal and written legal information about their rights. This intervention showed significant and lasting positive effects on participants' satisfaction with the information received during their hospitalization, their experience on the units, and their knowledge of their rights (45).

### *The social, structural and environmental context*

These nursing theories do not situate individuals living with mental health problems within a social context where they are considered part of a marginalized group. Instead, the person is often viewed as an individual with unique experiences and needs. While this approach is not inherently negative, it fails to fully capture the impact that the quality (or lack of) of interaction between the person and authority can have. The theory of procedural justice considers the sensitive nature associated with a person's social status and the impact that relationships with various authority figures can have on their self-perception and, eventually, on their identity and the way they will respond to their situation. The principle of respect addresses this aspect by calling on authorities to recognize the influence of their actions on marginalized groups (17). The repeated use of coercion in mental health sends a message that individuals living with mental health problems are part of a group requiring extreme measures, thereby insinuating their dangerousness and their difference from the rest of society (71).

The lack of recognition of the social representation of individuals living with mental health problems in nursing theories may stem from the fact that these theories place the person, their experience, and their immediate needs at the center of the interaction. In such theories, the emphasis remains on the person's problems, and nurses are called upon to solve them. Procedural justice, on the other hand, values the quality of interaction, which should primarily aim for justice. The principles of voice, respect, trust, and neutrality can thus guide interactions that are recognized in the literature as having a positive effect on the experience of hospitalization and the perception of coercion. However, it is important to note that certain aspects that should be valued in psychiatric nursing are not represented in the theory of procedural justice, such as self-advocacy or building on the strengths of the person.

Moreover, although procedural justice focuses on increasing the fairness of the process, it does not question what is being done or the procedures that are already in place. While it allows considering the individual in relation to their social status and the authority they face during mental health hospitalization, the theory of procedural justice, like many nursing theories, does not account for the structural elements contributing to psychiatric coercion. For example, institutional policies in healthcare facilities, such as locked units, contribute to power dynamics and thus promote the presence of coercion (6). A reflection on the commonly established practices in psychiatric settings, as well as on the environment with which hospitalized individuals interact, is necessary. On this subject, established practices, existing policies, the organization of care and services, and, more broadly, a system of social control legitimizing coercion contribute to placing a burden on nurses by making them responsible for reducing coercive practices (63). Considering that procedural justice seems limited in its ability to bring about systemic changes and instead has the potential to mitigate the negative experience associated with coercion, it is worth questioning whether this theory might not amplify the burden already placed on the individual nurse.

### *The quality of interactions and status quo*

Procedural justice theory invites us to rethink interactions in order to make social processes involving authority more just. It is said that adhering to the principles of procedural justice should increase a person's satisfaction with the outcome they receive, regardless of whether it is favorable to them or not (11). In an effort to reduce coercion, it is worth questioning whether this theory justifies the use of coercion in psychiatry by presuming that better interactions should make the experience of coercion more acceptable for the person. This rhetoric is present in many writings on procedural justice and coercion. Indeed, several authors provide recommendations for professionals working with involuntarily hospitalized individuals or those subjected to community treatment orders. For instance, some suggest that the use of more procedurally just behaviors could help reduce perceived coercion associated with community treatment orders (14), while others go as far as asserting that approaches based on procedural justice render the initiation of involuntary hospitalizations therapeutic (21). McKenna, Simpson and Coverdale (20) encourage professionals to apply the principles of voice and respect, even when individuals' preferences are "overridden". These same authors emphasize the importance for professionals to consider the "need to feel informed and involved in the decision-making processes" (20), without acknowledging that access to information and decision-making (consent) are rights rather than needs or preferences. Following these various examples, it becomes clear that procedural justice is a theory that, when appropriated by the psychiatric field, runs the risk of becoming another tool justifying the use of coercion under the guise of a more humane approach. Considering that coercive and dehumanizing practices are maintained (some even increasing) (25), strategies should aim for their reduction and pay particular attention to human rights violations that persist in psychiatric settings, which procedural justice appears limited in addressing. The principles of voice, respect, trust, and neutrality should therefore be considered for their ability to encourage socially just interactions, but also for the purpose of establishing a relationship with the individual. In this regard, it is worth considering whether nursing theories, which excel in exploring human relationships in the context of care, would be more relevant. The qualitative study by Larsen and Terkelsen (4), which examined the experience of coercion from the perspective of hospitalized individuals in locked units and the professionals working there, highlighted that having physical and emotional proximity to the person reduced the use of coercion. An interesting aspect of the Recovery Alliance Theory is that it emphasizes the importance of "everyday relationships" in reducing power inequality within the relationship, signifying that the person needs to feel that the nurse approaches them in a humane and friendly manner (67).

In summary, it is not about asserting that procedural justice theory is absolutely superior to other theories that have proven their relevance in guiding the interaction between the nurse and the person living with a mental health problem. The use of procedural justice theory rather calls for nuance, without denying the positive aspects arising from nursing theories that value the development of a therapeutic relationship based on the individuality of the person and their unique life experience. Recognizing the benefits associated with a nurse who seeks to understand the person's lived experience, their immediate desires, and their need for empowering human interaction is essential. Furthermore, the principles of procedural justice extend the reflection by considering the notions of power, control, and inherent justice in mental health nursing practice, which directly impact the perception of coercion.

## Conclusion

This work represents an analysis of the relevance of using procedural justice as a theoretical framework for the development of psychiatric nursing practice specifically aiming to reduce coercion and human rights violations. The theory of procedural justice highlights the importance of the quality of interactions among individuals, especially in contexts where the notion of power comes into play, as is the case in psychiatric care. The central principles could thus promote interactions that are more sensitive to issues of power, respect, trust, and self-identity, potentially making contacts with psychiatric services less negative for the individuals involved. In addition, applying the principles of procedural justice may help promote the exercise of certain rights, such as the right to being treated with dignity and having access to information. However, procedural justice is limited in its capacity to address other human rights that continue to be frequently violated in psychiatry, such as the rights to integrity, liberty, or informed consent. As demonstrated through the analysis of various writings on psychiatric coercion, procedural justice poses the risk of becoming another accessory to make the use of coercion more morally acceptable, without actually facilitating significant changes in commonly accepted dehumanizing practices and structures in mental healthcare services.

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# 2

## Résumé

Cette étude visait à analyser les dénonciations soumises par des membres du personnel infirmier via une plateforme développée par un syndicat en santé du Québec. Une analyse de contenu de 1118 formulaires nous a permis de saisir la nature des situations dénoncées, d'identifier des stratégies additionnelles de divulgations infirmières et de documenter les réponses administratives. Les dénonciations, issues majoritairement d'infirmiers(ères) autorisés(es) en milieux de soins hospitaliers et de soins de longue durée, concernaient principalement la lourdeur et l'instabilité des conditions de pratique. Le recours au formulaire s'inscrivait dans une démarche de dénonciation plus large motivée par la présence de risques pour les patients et le personnel ainsi qu'une détresse morale. Le recours au temps supplémentaire était la principale réponse administrative aux situations dénoncées. Notre étude suggère que la plateforme répondait partiellement aux besoins des infirmiers(ères) et présentait certaines limites liées à sa conception et à la nature des informations recueillies. Elle souligne également l'importance d'améliorer les canaux de dénonciation interne, indispensables à la résolution de situations problématiques et au maintien de soins sécuritaires.

Mots clés Dénonciation, Infirmières et infirmiers, Plates-formes électroniques, Soins infirmiers, Soins sécuritaires

# Dénonciation infirmière et plateformes électroniques: Une analyse de contenu du *Formulaire de soins sécuritaires* de la Fédération interprofessionnelle de la santé du Québec

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## Introduction

Les infirmiers(ères) sont surreprésentés(ées) dans les études portant sur la dénonciation dans les milieux de soins (1). Or, jusqu'à tout récemment, la dénonciation infirmière était peu abordée dans la littérature en sciences infirmières et elle était souvent considérée sous l'angle des pratiques professionnelles et individuelles (2). Très peu d'études abordent la dénonciation comme un phénomène complexe doté d'importantes composantes organisationnelles et de processus qui font appel à un vaste ensemble de stratégies (p. ex., individuelles et/ou collectives, formelles et/ou informelles, internes et/ou externes, etc.) (3-10). La dénonciation infirmière peut se faire à l'interne, c'est-à-dire au sein du milieu de soin et de l'établissement concerné, et/ou à l'externe, c'est-à-dire à l'extérieur de l'établissement et en utilisant des stratégies telles que la prise de parole dans les médias et/ou les réseaux sociaux, le signalement via des mécanismes prévus dans la loi (p. ex., Loi facilitant la divulgation d'actes répréhensibles à l'égard des organismes publics) ou le recours à des plateformes électroniques de dénonciation (3,4,6,8-10). De façon générale, la dénonciation infirmière concerne cinq types de situations impliquant : 1) des conditions de travail non sécuritaires, 2) des inquiétudes liées à la pratique infirmière comme le non-respect de politiques et procédures et des standards professionnels, 3) des comportements problématiques en milieu de travail, 4) des manquements aux soins et aux droits des patients, et 5) des enjeux de nature administrative, tel que la dissimulation de méfaits ou la gestion inefficace ou inappropriée du personnel (2). La dénonciation, qu'elle soit interne ou externe, comporte des risques et des conséquences à la fois personnelles et professionnelles (2,5,10-17). C'est pourquoi il est important de mieux comprendre la dénonciation infirmière, et surtout de s'intéresser aux stratégies de dénonciation auxquelles ont recours les infirmiers(ères). Ces stratégies sont intéressantes et importantes en soi, mais elles offrent aussi des pistes de réflexion et de solution importantes pour faciliter la dénonciation – et par voie de conséquence, mieux protéger le personnel infirmier et les patients.

Différentes stratégies s'offrent aux infirmiers(ères) qui souhaitent dénoncer. Au sein des milieux et établissements de soins, trois types de stratégies de dénonciation interne sont possibles (2). Premièrement, il est possible d'aviser ses supérieurs immédiats oralement et/ou par écrit. Selon la réponse hiérarchique, il est alors possible de répéter la démarche en ciblant des instances supérieures ou d'autres instances responsables de la santé et sécurité au travail et/ou du bien-être et de la protection des patients. Deuxièmement, il est possible de faire une démarche et une divulgation auprès de regroupements de travailleurs tels les syndicats. Ce type de stratégie peut comporter des éléments à la fois internes et externes selon la structure associative et les outils mis à la disposition du personnel infirmier (p. ex., plateforme électronique de dénonciation). Finalement, il est possible de recourir à des outils de dénonciation interne tels qu'un formulaire de déclaration d'incident/accident. À l'externe, les stratégies varient en fonction du type de divulgation (publique, privée, ou les deux). Des exemples de stratégies comportant une divulgation publique incluent la prise de parole dans les médias et les réseaux sociaux. D'autres stratégies, comme entreprendre une divulgation aux instances publiques chargées de protéger les patients (p. ex., le Protecteur du citoyen au Québec ou le Défenseur des droits en France), impliquent une divulgation interne aux organisations publiques, mais demeurent toutefois externe au milieu et à l'établissement de soins ainsi qu'au système de santé. Les plateformes de dénonciation électroniques sont relativement récentes en sciences infirmières et sont peu abordées dans la littérature et, de façon plus large, dans les études portant sur la dénonciation. Le présent article s'inscrit dans un programme de recherche visant, entre autre, à étudier les plateformes de dénonciation électroniques (6) et tout particulièrement, celles de la Fédération interprofessionnelle de la santé du Québec (FIQ), car elles sont novatrices et propices à l'étude d'outils de dénonciation et la dénonciation infirmière comme telle.

Au cours de la dernière décennie, deux plateformes de dénonciation ont été créées par la FIQ. La première plateforme, celle du « formulaire de soins sécuritaires », que nous abordons dans cet article, a été lancée en 2016 lors d'une campagne visant deux objectifs : 1) encourager le personnel infirmier, les inhalothérapeutes et les perfusionnistes à dénoncer leurs conditions de travail en signalant des situations où « leurs conditions de travail ne leur permettent pas d'offrir des soins de qualité, sécuritaires et humains, à chaque fois que cela se produit » et 2) permettre à la FIQ de mener « des interventions précises, auprès des directions d'établissements ou de toutes autres instances appropriées (…) ». (18, p.7). Le formulaire de soins sécuritaires pouvait être soumis de façon anonyme ou non et comportait quatre sections : 1) Information de suivi pour l'équipe syndicale (p. ex., quart de travail, titre d'emploi, centre d'activités, etc.), 2) Description de la situation problématique (p. ex., date, description narrative de la situation, actions entreprises, etc.), 3) Analyse de la situation (p. ex., indicateurs liés à la qualité des soins, nombre de patients à charge, recours au temps supplémentaire, etc.), 4) Imputabilité de la gestion (p. ex., gestionnaire informé(e), nom, solutions offertes, etc.). La seconde plateforme, celle lancée au début de la pandémie COVID-19 (Je dénonce!), avait des objectifs et une structure similaires. Elle a d'ailleurs fait l'objet d'une analyse (6) qui viendra nourrir la discussion des résultats de la présente étude. Nous nous intéressons tout particulièrement au formulaire de soins sécuritaires, car il s'agit, selon nous, d'une plateforme précurseure en ce qui concerne l'utilisation d'outils de dénonciation électroniques pour divulguer des situations entravant la qualité et sécurité des soins. Cette plateforme s'ajoutant aux autres outils à la disposition du personnel, nous étions également intéressés dans la manière dont elle s'articulait avec l'usage de ces autres outils dans les démarches de dénonciations couramment utilisés par le personnel infirmier. C'est pourquoi nous avons porté notre attention sur les deux premières années d'existence de la plateforme (2016-2018).

## Objectifs de l'étude

Notre étude avait pour but de décrire les caractéristiques des infirmiers(ères) ayant dénoncé par le biais du formulaire de soins sécuritaires, de comprendre la nature des situations dénoncées, de documenter les autres stratégies de dénonciation utilisées par les infirmiers(ères) mises en évidence dans le formulaire et d'explorer les réponses administratives, ainsi que leurs justifications. Ce faisant, notre étude visait à mieux comprendre la dénonciation infirmière électronique en étudiant le formulaire de soins sécuritaires comme plateforme de dénonciation électronique.

## Méthodes

Pour répondre aux objectifs de l'étude, nous avons fait appel à une analyse de contenu avec méthodes mixtes (19-21). À partir du corpus de formulaires de dénonciation (n=4868 formulaires soumis entre 2016 et 2018) compilé dans une base de données anonymisées, nous avons retiré les formulaires incomplets (n=390) et utilisé une méthode d'échantillonnage aléatoire systématique pour sélectionner 25% des formulaires. Une fois ce processus complété, une première vérification de l'échantillon (n=1122) a été effectuée pour confirmer que les formulaires avaient bel et bien été soumis par un(e) infirmier(ère). Au final, notre échantillon comptait 1118 formulaires.

### Collecte des données

À partir de la base de données contenant le corpus des formulaires de dénonciation en format tableau, nous avons extrait les données des formulaires sélectionnés pour l'analyse en préservant leur structure originale. En préparation pour l'analyse, certaines colonnes ont été éliminées, car elles ne contenaient pas d'informations utiles à l'analyse (p.ex., langue, nombre de patients à charge au moment de la dénonciation, nombre de patients à charge normalement) et des colonnes ont été ajoutées afin de faciliter l'organisation des données (p. ex., ajout d'une colonne pour chaque indicateur coché caractérisant les situations dénoncées). Le formulaire de dénonciation contenait des questions fermées (p. ex., boîtes à cocher) et ouvertes (p. ex., boîtes de texte). Les données contenues dans la base de données étaient donc mixtes, reflétant ainsi les données quantifiables recueillies par le biais des boîtes à cocher et les données narratives écrites par les infirmiers(ères) directement dans le formulaire en ligne. Les données narratives contenaient plus d'information, pour mieux comprendre les situations dénoncées, ainsi que les stratégies de dénonciation utilisées et les réponses administratives.

### Analyse des données

Compte tenu de la taille de l'échantillon et du volume de données à analyser, nous avons développé une grille d'analyse en deux étapes. En premier lieu, quinze formulaires ont été utilisés pour organiser la grille et évaluer son efficacité et son utilité. La grille a ensuite été testée de nouveau en utilisant quinze autres formulaires. Une fois la grille finalisée, les analyses (quantitative et qualitative) ont été complétées.

Les données quantitatives ont fait l'objet d'une analyse statistique descriptive permettant de mettre en lumière les distributions de fréquences au sein de l'échantillon et de mieux comprendre les caractéristiques des infirmiers(ères) qui dénoncent, les situations dénoncées, les stratégies de dénonciation utilisées et les réponses administratives rencontrées. Les données narratives ont fait l'objet d'une analyse de contenu à la fois déductive et inductive (22). Pour la portion déductive, nous avons fait appel aux catégories existantes dans le formulaire pour nommer ce que décrivaient les infirmiers(ères) dans leurs données narratives. Par exemple, si une infirmière décrivait une situation rejoignant des indicateurs non cochés dans le formulaire, nous ajoutions ces indicateurs manuellement. Pour la portion inductive, nous avons utilisé trois types d'approches. Si les données narratives faisaient état de situations, de stratégies et/ou de réponses administratives récurrentes qui n'étaient pas reflétées dans la structure originale du formulaire de dénonciation, nous avons manuellement ajouté ces catégories. Les catégories existantes dans le formulaire étant assez limitées, cette stratégie s'est avérée utile et révélatrice de certaines lacunes que nous aborderons dans le cadre de la discussion. Les données narratives ont aussi été codées à l'aide de mots-clés permettant de mieux comprendre la nature des situations dénoncées et les raisons motivant les infirmiers(ères) à dénoncer. Finalement, les thèmes les plus récurrents ont été notés afin de pouvoir identifier des pistes de réflexion quant aux enjeux se dégageant des données. Nous estimons que la saturation de la portion inductive a été atteinte après l'analyse de 465 formulaires.

## Résultats

Nos résultats s'articulent autour de quatre catégories qui répondent aux objectifs de cette étude. La première catégorie décrit les caractéristiques des infirmiers(ères) qui dénoncent. La deuxième résume les situations dénoncées ainsi que les thèmes les plus fréquemment abordés dans la portion narrative du formulaire. La troisième aborde les stratégies de dénonciation utilisées et témoigne d'un éventail assez large de stratégies dont plusieurs n'étaient pas abordées dans le formulaire. Finalement, la dernière catégorie fait état des réponses administratives et de leurs justifications.

### Caractéristiques des infirmier(ères) ayant dénoncé

Les caractéristiques des infirmiers(ères) dont les formulaires faisaient partie de l'échantillon sont présentées dans le Tableau 1. Près de la moitié (n=554, 49,6%) des infirmiers(ères) ayant dénoncé sur la plateforme exerçaient leurs fonctions sur le quart de jour. Plus de la moitié pratiquaient en tant qu'infirmier(ère) (n=612, 54,7%) et un peu plus du quart (n=289, 25,8%) en tant qu'infirmier(ère) auxiliaire. Les infirmiers(ères) cliniciens(ennes), quant à eux(elles), constituaient près de 20% (n=209) de l'échantillon. Les assistants(es) du supérieur immédiat (n=234, 20,9%) représentaient le plus grand nombre de dénonciations

Tableau 1: Caractéristiques des infirmiers(ères) ayant dénoncé (n = 1118)

| | | n | % |
|---|---|---|---|
| Quarts de travail | Jour | 554 | 49,6 |
| | Soir | 362 | 32,4 |
| | Nuit | 202 | 18,1 |
| Titres | Candidat(e) à l'exercice de la profession infirmière | 8 | 0,7 |
| | Infirmier(ère) auxiliaire | 289 | 25,8 |
| | Infirmier(ère) – *diplôme d'études collégiales* | 612 | 54,7 |
| | Infirmier(ère) clinicien(ne) - *baccalauréat* | 209 | 18,7 |
| Postes | Assistant(e) du (de la) supérieur(e) immédiat(e) | 234 | 20,9 |
| | Chef(fe) d'équipe | 87 | 7,8 |
| | Assistant(e) chef(fe) d'équipe | 5 | 0,4 |
| | Conseiller(ère) en soins infirmiers | 1 | 0,1 |
| | Non spécifié | 790 | 70,8 |
| Régions | Bas-Saint-Laurent | 69 | 6,2 |
| | Saguenay-Lac-Saint-Jean | 53 | 4,7 |
| | Capitale-Nationale | 129 | 11,5 |
| | Mauricie et Centre-du-Québec | 62 | 5,5 |
| | Estrie | 102 | 9,1 |
| | Montréal | 105 | 9,4 |
| | Outaouais | 15 | 1,3 |
| | Abitibi-Témiscamingue | 33 | 3,0 |
| | Côte-Nord | 18 | 1,6 |
| | Nord-du-Québec | 2 | 0,2 |
| | Gaspésie-Îles-de-la-Madeleine | 9 | 0,8 |
| | Chaudière-Appalaches | 29 | 2,6 |
| | Laval | 4 | 0,4 |
| | Lanaudière | 8 | 0,7 |
| | Laurentides | 214 | 19,1 |
| | Montérégie | 266 | 23,8 |
| Secteurs | Soins hospitaliers (incluant les soins critiques) | 479 | 42,8 |
| | Soins de longue durée | 353 | 31,6 |
| | Soins dans la communauté | 86 | 7,7 |
| | Soins ambulatoires | 83 | 7,7 |
| | Soins de santé mentale | 77 | 6,9 |
| | Soins en milieu de réadaptation | 27 | 2,4 |
| | Soins au bloc opératoire | 13 | 1,2 |

rapportées selon le poste. Toutefois, la majeure partie de l'échantillon n'a pas spécifié de poste (n=790, 70,8%), ce qui nous empêche de connaître les répartitions définitives selon le poste des auteurs des formulaires dans notre corpus de données.

Les données par région démontrent que près du quart des formulaires provenaient d'infirmiers(ères) travaillant dans des établissements de santé en Montérégie (n=266, 23,8%), suivi par les régions des Laurentides (n=214, 19,1%), de la Capitale nationale (n=129, 11.5%), de l'Estrie (n=102, 9.1%) et de Montréal (n=105, 9.4%). Les autres régions cumulaient chacune moins de 100 formulaires. Les régions du Nord-du-Québec (0,2%), de la Gaspésie-Îles-de-la-Madeleine (0,8%), de Laval (0,4%) et de Lanaudière (0,7%) représentaient respectivement moins de 1% de l'échantillon. Plusieurs facteurs peuvent expliquer pourquoi certaines régions étaient plus ou moins représentées. Nous proposons une hypothèse dans la discussion.

Les dénonciations concernaient principalement les soins en milieux hospitaliers (n=429, 42,8%), incluant les soins critiques À eux seuls, les soins critiques (p. ex., urgences et soins intensifs) représentaient environ le tiers (31%) des dénonciations infirmières en milieux hospitaliers. Les dénonciations concernant les milieux de soins de longue durée représentaient quant à elles le tiers de l'échantillon (n=353, 31,6%).

### Caractéristiques des situations dénoncées

Le formulaire de dénonciation proposait dix indicateurs (voir Tableau 2) à cocher déjà prédéterminés ainsi qu'un indicateur « autre » permettant d'ajouter un contenu narratif. Les répondants pouvaient choisir un ou plusieurs indicateurs, et ce, sans limite de choix. Ce faisant, la majorité des infirmiers(ères) avaient coché plus d'un indicateur dans leur soumission. Les deux tiers des dénonciations concernaient les besoins en soins et/ou la lourdeur des patients (n=737, 66%). Les autres indicateurs les plus fréquemment cochés concernaient des situations où les infirmiers(ères) n'avaient pas pu prendre leur repas ou pause (n=510, 45,6%) et rapportaient la lourdeur de leur tâche administrative (n=472, 42,2%). Plus du tiers des dénonciations indiquaient, respectivement, une équipe de travail instable (n=421, 37,7%) et une incapacité à effectuer les soins requis (n=431, 38,6%).

La combinaison d'indicateurs la plus fréquemment observée lors de l'analyse était celle de la lourdeur des patients combinée à la lourdeur de la tâche administrative, ainsi que temps de repas ou pause non pris. Finalement, nous avons noté que l'indicateur concernant l'incapacité à administrer les soins requis comportait certaines nuances, car le fait de ne pas cocher cet indicateur était associé à l'indicateur de ne pas avoir pris son repas ou sa pause. En d'autres mots, les soins requis étaient complétés non pas parce que les infirmiers(ères) étaient en mesure de compléter les soins requis pendant leur quart de travail normal, mais plutôt, car ils(elles) utilisaient leur temps de repas ou de pause pour le faire.

Bien que les indicateurs, inclus dans le formulaire, permettaient de décrire certains facteurs contribuant aux situations dénoncées, ils ne permettaient toutefois pas de comprendre en profondeur ces situations et les raisons motivant les infirmiers(ères) à se tourner vers le formulaire. L'analyse des données narratives nous a donc permis d'aller au-delà des facteurs et d'identifier trois principaux thèmes qui mettent en lumière la nature des situations dénoncées : 1) la présence d'un ou de plusieurs risque(s) pour le patient et/ou le personnel, 2) les conséquences de la situation pour le patient et/ou le personnel, et 3) l'urgence de dénoncer découlant d'une détresse morale importante.

Les données narratives nous ont permis de comprendre, par exemple, que les infirmiers(ères) ne se servaient pas du formulaire de soins sécuritaires pour dénoncer la lourdeur des patients. Ce qui était dénoncé, avant tout, était le(s) risque(s) associé(s) à cette lourdeur ainsi que les conséquences pour le patient et/ou le personnel. De façon générale, et ce peu importe l'indicateur choisi, les risques rapportés étaient ceux liés à l'intégrité physique et psychologique du personnel ainsi que ceux concernant la qualité des soins, la santé et la sécurité des patients.

Les exemples de risque(s) d'atteinte à l'intégrité physique pour le personnel concernaient principalement des situations impliquant du matériel défectueux, des aires physiques inadéquates et du manque de personnel augmentant les risques de blessures physiques. Ce type de situations était fréquemment rapporté dans certains secteurs, notamment en

Tableau 2: Caractéristiques des situations dénoncées (n = 1118)

| | | n | % |
|---|---|---|---|
| Indicateurs | 1 - Besoins en soins/lourdeur des patients | 737 | 66,0 |
| | 2 - Lourdeur de la tâche administrative | 472 | 42,2 |
| | 3 - Équipe de travail instable | 421 | 37,7 |
| | 4 - Substitution | 213 | 19,1 |
| | 5 - Formation/orientation inadéquate | 162 | 14,5 |
| | 6 - Équipement/matériel inadéquat/insuffisant | 156 | 14,1 |
| | 7 - Lieux physiques inadéquats/déplacements | 119 | 10,6 |
| | 8 - Repas/pause n'ont pas été pris | 510 | 45,6 |
| | 9 - Incapacité à effectuer soins requis | 431 | 38,6 |
| | 10 - Ajouts de lits (débordement) | 84 | 7,5 |

santé mentale, en soins critiques et dans les soins de longue durée.

> « […] De plus, le frein de plusieurs civières est défectueux. Ce qui a pour conséquence que, lors de la mobilisation des patients, la civière bouge, augmentant le risque de blessure pour les professionnels en soins et les [préposés aux bénéficiaires]. » (Formulaire #33).

Les situations soulevant des risques à l'intégrité psychologique du personnel concernaient principalement l'épuisement associé au temps supplémentaire obligatoire et l'augmentation chronique du ratio infirmière-patient. L'extrait ci-dessous démontre bien les risques pour l'intégrité psychologique :

> « La liste de rappel m'a forcé à faire un quart de travail en temps supplémentaire (8h de soir + 8h de nuit). Je suis restée éveillée pendant plus de 24 heures, ce qui a compromis ma capacité à fournir des soins sécuritaires et adéquats, à cause de la fatigue physique et psychologique. » (traduction de l'anglais, Formulaire #47).

Une portion importante des formulaires faisait référence directement à un ou plusieurs risque(s) inhérents à la qualité des soins, la santé et la sécurité des usagers. Le risque le plus souvent rapporté était le manque de personnel nécessaire pour assurer une surveillance clinique sécuritaire. La surveillance clinique des patients présentant un trouble cardiaque qui nécessite une télémétrie, des patients sous dialyse, et des patients instables, en sont quelques exemples. Les autres risques les plus souvent cités concernaient du matériel manquant, comme des électrodes de défibrillation, de l'équipement défectueux, tel que des climatiseurs non fonctionnels lors de canicules ou des lieux physiques inadéquats entravant la surveillance clinique nécessaire. Le manque d'expérience et de formation mettant à risque la sécurité des patients, des délais dans l'évaluation et la réalisation de certaines tâches cliniques et l'interruption fréquente lors de la préparation des médicaments, augmentant les risques d'erreurs, faisaient également partie des risques rapportés.

> « Suite au déménagement de la pédiatrie, le nombre de chambres a été réduit. On a donc été contraint de placer un bébé de 4 jours dans une chambre de débordement de la maternité. Le bébé était sous mes soins, mais la chambre qu'il occupait était isolée de la pédiatrie par des portes et de plus, lorsque les parents utilisaient la cloche d'appel, celle-ci ne sonnait pas en pédiatrie, mais seulement en maternité. » (Formulaire #20).

Plusieurs situations rapportées comportaient aussi des conséquences réelles pour les infirmiers(ères) qui dénonçaient. Parmi les conséquences rapportées, on retrouvait l'expérience d'émotions négatives face à la situation dénoncée, tel que la peur de perdre son permis de pratique professionnel, la colère face aux injustices vécues et l'anxiété ressentie face aux dilemmes éthiques. Des effets négatifs sur la vie familiale et une perturbation des relations entre collègues, comme des conflits entre les équipes œuvrant sur différents quarts et une ambiance de travail négative, étaient aussi rapportés. De plus, à diverses occasions, l'objet de la dénonciation visait des conséquences directes, pour l'intégrité physique et mentale des infirmiers(ères). La violence verbale, les menaces et les agressions physiques étaient des conséquences rapportées à plusieurs reprises. L'extrait suivant, décrivant une situation en soins de longue durée où se trouvait une équipe de travail instable (indicateur 3) et une formation/orientation inadéquate (indicateur 5), illustre les conséquences physiques décrites dans la portion narrative des formulaires:

> « Altercation avec un patient agressif: fracture de l'annulaire gauche et trois autres employées blessées (deux infirmières auxiliaires et un préposé aux bénéficiaires). » (Formulaire #1951).

Ce sont cependant les conséquences vécues par les patients qui semblaient motiver le plus les infirmiers(ères) à dénoncer. Des soins non faits, des chutes ou des blessures, des erreurs de médicaments, des complications médicales évitables et des émotions négatives vécues par les patients étaient rapportés. Un autre formulaire décrivant une situation en soins de longue durée où on dénotait l'absence du/de la gestionnaire offre un aperçu de la gravité des conséquences décrites dans les formulaires.

> « […] Les deux usagères étaient tombées. Une qui avait descendu la côte du stationnement avec son fauteuil roulant et était couchée sur le côté, la tête dans une mare de sang et l'autre usagère en haut de la côte, dont la jambe était ouverte. L'ambulance a été appelée, puisque l'infirmière croyait qu'elle s'était fracturé le cou. Les deux usagères ont été amenées au CH dans la même ambulance puisqu'il n'y en avait plus de disponible […] » (Formulaire #295)

Les risques importants et les conséquences directes motivaient les infirmiers(ères) à dénoncer, mais c'est plutôt la détresse morale ressentie qui contribuait au sentiment de devoir agir en dénonçant.

> « Lors d'une rencontre avec le coordonnateur de soir pour nous signaler que nous travaillerons durant le quart de nuit avec du personnel en moins, on se fait dire que ce n'est pas grave si on ne prend pas nos pauses puisqu'elles seront payées et que même si les

> prises de sang ne sont pas toutes faites, personne ne va mourir. D'y aller au plus urgent et pour le reste ce n'est pas grave. Où est l'humanité dans cette situation? Au nom de nos patients, svp, pouvons-nous les soigner sécuritairement et avec dignité (…) On a des fardeaux de tâches de fous avec 15-17 patients à charge pour [l'infirmier(ère)] et 1 [l'infirmier(ère)] auxiliaire en chirurgie orthopédique (…) On doit laisser des patients dans leur urine par manque de temps et faire les coins ronds pour s'en sortir. Clairement, on tente de tuer notre passion à petit feu et on se contrefout de l'humain derrière les chiffres et statistiques. » (Formulaire #1052)

Le formulaire de soins sécuritaires devenait ainsi un outil de dénonciation externe, s'inscrivant dans une démarche de dénonciation comptant plusieurs stratégies à la fois internes et externes. Nous abordons ces stratégies dans la prochaine section.

### Caractéristiques des stratégies de dénonciation

Le formulaire électronique comportait quatre stratégies de dénonciation pouvant être cochées qui figurent au haut du Tableau 3. Il s'agissait d'entreprendre une action collective (n=711, 63,6%), d'aviser le(la) gestionnaire (n=794, 71%), de constater l'absence du (de la) gestionnaire (n=254, 22,7%) et de remplir un rapport d'incident/accident (n=191, 17,1%) (voir Tableau 3). C'est d'ailleurs pourquoi ces quatre stratégies de dénonciation sont les plus représentées au sein de l'échantillon. L'absence du (de la) gestionnaire ne constitue pas une stratégie de dénonciation comme telle, mais cette catégorie permet de documenter un facteur organisationnel important qui influence le processus de dénonciation et les stratégies de dénonciation vers lesquelles se tournent les infirmiers(ères).

Au fil de l'analyse et de manière inductive, nous avons identifié d'autres stratégies de dénonciation. Par exemple, près de 20% des formulaires mentionnaient la stratégie d'aviser le (la) représentant(e) syndical. Parmi les autres stratégies mentionnées, nous notons trois types de catégories : 1) demander des ressources supplémentaires, 2) aviser d'autres instances et utiliser d'autres outils de dénonciation, et 3) revendiquer ses droits soit en réclamant les heures travaillées ou en refusant une demande dans un contexte de soins non sécuritaire. Finalement, il apparait intéressant de souligner qu'au sein de l'échantillon, le recours aux réseaux sociaux était, pour ainsi dire, inexistant contrairement au contexte de dénonciation infirmière des dernières années.

En plus des stratégies de dénonciation utilisées par les infirmiers(ères) qui n'étaient pas a priori inclus dans le formulaire de soins sécuritaires (voir Tableau 3), la portion narrative des formulaires nous a permis de poser trois constats par rapport à l'utilisation stratégique du formulaire.

Premièrement, bien que le formulaire eût pour but d'inciter les infirmiers(ères) à dénoncer toute « situation qui pose des risques pour la qualité et la sécurité des soins ou qui nuit à [leurs] conditions d'exercice » (tiré du formulaire), nous avons rapidement remarqué que le formulaire servait aussi à dénoncer des situations de nature chronique. En d'autres mots, le formulaire était utilisé pour dénoncer des situations vécues à répétition et non pas une situation unique, exceptionnelle ou anormale.

> « La situation problématique dont je veux vous faire part ne s'applique pas seulement sur un quart de travail, mais bien depuis quelques mois sur l'unité de médecine de jour. En effet, les soins administrés ne sont pas toujours adéquats pour plusieurs raisons: manque de personnel, le manque d'expérience, ainsi que la surcharge de travail […]. » (Formulaire #437).

Deuxièmement, le formulaire semblait aussi utilisé pour dénoncer de façon collective. Par exemple, nous avons constaté des similitudes dans plusieurs soumissions nous amenant à supposer que certaines infirmières s'étaient mobilisées « en bloc » pour soumettre des formulaires. Finalement, pour plusieurs, le recours au formulaire semblait représentait une tentative désespérée de se faire entendre par le syndicat et de sonner l'alarme après avoir eu recours à de nombreuses stratégies de dénonciation à la fois interne et externe (mais surtout interne) qui s'étaient avérées inefficaces. Les prochains extraits illustrent clairement ceci :

> « À la clinique d'hémato-oncologie, nous faisons 5 jours de travail en 3 jours, à cause des congés des fêtes. C'est l'enfer, conditions de travail difficiles et dangereuses. Trop de choses à faire et peu de temps pour le faire […] C'est malade et ça va nous rendre malades si ça continue ainsi. La FIQ où êtes-vous? J'espère que vous allez dénoncer cette situation! » (Formulaire #1388)

> « Ces derniers temps, on fonctionne quasiment tous les jours avec de l'effectif en moins […] comme je vous le dis ce n'est pas la première fois. C'est comme une tendance, soit il manque une préposée, soit il manque une infirmière, soit une infirmière auxiliaire. On te dit commence, on va t'envoyer quelqu'un, pour se ramasser à la fin de la journée sans personne. En fait il faut faire quelque chose, on est épuisé physiquement et psychologiquement, on est épié, surveillé, on a aucun soutien cela ne peut pas continuer comme ça, SVP FAITE QUELQUE CHOSE! » (Formulaire # 1886).

Tableau 3: Caractéristiques des stratégies de dénonciation, outre le formulaire (n = 1118)

| | | n | % |
|---|---|---|---|
| Stratégies | **Stratégies proposées dans les boîtes à cocher** | | |
| | Entreprendre une action collective | 711 | 63,6 |
| | Aviser le(la) gestionnaire | 794 | 71,0 |
| | Absence du(de la) gestionnaire absente | 254 | 22,7 |
| | Remplir un rapport d'incident/accident | 191 | 17,1 |
| | Aucune | 2 | 0,2 |
| | **Stratégies identifiées de façon inductive** | | |
| | Informer le(la) représentant(e) syndical et/ou le syndicat | 190 | 17,0 |
| | Réclamer les heures travaillées | 64 | 5,7 |
| | Demander du personnel supplémentaire | 34 | 3,0 |
| | Aviser le patient et/ou la famille | 28 | 2,5 |
| | Aviser le(la) médecin et/ou le(la) pharmacien(enne) | 19 | 1,7 |
| | Remplir formulaire de situation dangereuse | 11 | 1,0 |
| | Faire un rapport aux collègues (p.ex., fin de quart) | 9 | 0,8 |
| | Aviser le comité de soins | 8 | 0,7 |
| | Ventiler auprès de collègues, amis, proches | 8 | 0,7 |
| | Refuser ou résister | 7 | 0,6 |
| | Aviser la santé et sécurité au travail | 4 | 0,4 |
| | Afficher sur les réseaux sociaux | 1 | 0,1 |

### Caractéristiques des réponses administratives

Les boîtes à cocher spécifiques aux réponses administratives étaient plutôt limitées. Parmi les trois options proposées qui figurent au haut du Tableau 4, la réponse administrative la plus rapportée était le recours au temps supplémentaire (n=538, 48,1%). Il nous est toutefois impossible de déterminer s'il s'agissait de temps supplémentaire volontaire ou obligatoire (TSO). Toutefois, en se tournant vers les données narratives, on comprend rapidement que cette distinction est souvent difficile à faire et que le recours au temps supplémentaire (obligatoire ou fortement suggéré) est une pratique courante, tel que l'explique cet infirmier(ère) :

> « Une tonne de temps supplémentaire (TS) affecte l'urgence de [nom de l'hôpital], dont plusieurs obligatoires ou fortement suggérés par les supérieurs. Ce sont les mêmes personnes qui doivent faire tous les TS puisque nous avons eu une grande quantité de [candidats(es) à la profession]. Ce qui est une aberration, on se rappelle ici qu'on est pris en otage par notre employeur puisque lui-même n'est pas capable de gérer efficacement ses ressources. Souvent on vient qu'à nous demander si on veut rester en TS (…) la plupart des gens du quart en cours sont épuisés puisque nous avons un roulement presque incroyable de TS, des infirmières qui font 16h, 8 à 10 fois par quinzaine ... ça existe encore aujourd'hui. Nous avons de graves manques d'effectifs, l'employeur place dans des zones demandant une expertise avancée des nouveaux qui ne connaissant pas la routine et qui n'ont pas du tout l'expertise nécessaire aux soins sécuritaires et de qualité aux patients (…) » (Formulaire #573).

Près du tiers des répondants ont également souligné que le manque de personnel avait été comblé par le remplacement d'une absence (n=365, 32,6%). Or, il est impossible pour nous de déterminer si ce remplacement impliquait du temps supplémentaire, voire du TSO. Finalement, le recours à une agence de placement infirmier (n=131, 11,7%) était rapporté dans plus de 10% de l'échantillon. Au fil de l'analyse, il est apparu nécessaire de créer deux nouvelles options et de documenter des réponses administratives n'apparaissant pas dans les choix. Ainsi, nous avons relevé qu'invalider la dénonciation était une réponse administrative décrite dans près de 15% des formulaires (n=164). La collaboration, quant à elle, se limitait à 1% des formulaires (n=12).

Le formulaire offrait aussi des options pour décrire les justifications accompagnant les réponses administratives. En d'autres mots, les raisons mentionnées par les gestionnaires pour justifier leur réponse. Toutes les options figurant dans le Tableau 4 faisaient partie du formulaire original. Les trois raisons les plus fréquemment mentionnées étaient: 1) le surcroît de personnel demandé, mais non obtenu (n=428, 38,3%), 2) la réorganisation ou les coupures (n=209, 18,7%), et 3) les contraintes budgétaires (n=152, 13,6%). Il est à noter que 20% des formulaires (n=221) indiquaient qu'aucune raison ne

Tableau 4: Caractéristiques des réponses administratives et raisons données (n = 1118)

| | | n | % |
|---|---|---|---|
| Réponse(s) administrative(s) | **Réponses proposées dans les boîtes à cocher** | | |
| | Recours au temps supplémentaire | 538 | 48,1 |
| | Absence remplacée | 365 | 32,6 |
| | Recours à une agence de placement infirmier | 131 | 11,7 |
| | **Réponses identifiées de façon inductive** | | |
| | Invalider la dénonciation | 164 | 14,7 |
| | Collaborer pour trouver une solution | 12 | 1,1 |
| | Aucune | 12 | 1,1 |
| Raison(s) donnée(s) | Surcroît de personnel demandé, mais non obtenu | 428 | 38,3 |
| | Réorganisation et/ou coupure | 209 | 18,7 |
| | Contraintes budgétaires | 152 | 13,6 |
| | Urgence ou surcroît imprévus des besoins des patients | 138 | 12,3 |
| | Autre : attente livraison (p.ex., matériel/équipement) | 1 | 0,1 |
| | Aucune | 221 | 19,8 |

leur avait été donnée pour justifier la réponse administrative.

En plus des trois réponses identifiées dans les boîtes à cocher (recours au temps supplémentaire, absence remplacée, recours à une agence de placement), trois autres réponses administratives ont émergé lors du processus d'analyse inductif des données narratives (invalider, collaborer, aucune). La réponse représentant la proportion la plus importante était l'invalidation de la dénonciation, de la situation dénoncée ou de la personne dénonçant. L'invalidation se caractérisait principalement par une personne en position d'autorité (p. ex., gestionnaire) niant ou ignorant les situations rapportées et/ou discréditant, humiliant et/ou intimidant la personne ayant dénoncé et/ou en refusant de mettre en place les solutions proposées par la personne même ou le personnel infirmier de façon plus large. L'extrait démontre bien cette invalidation ainsi que les démarches entreprises pour dénoncer une situation dangereuse:

> « Le lundi [date], alors que nous étions en plan de contingence due au congé férié, nous avons eu en hémodialyse un patient des soins intensifs sous moniteur alors que c'est interdit sur notre unité de travail. Nous sommes considérés comme une unité de clinique externe avec des patients stables, sinon ils doivent être transférés à [nom de la ville], pour être dialysé. Il nous a été amené malgré que le coordonnateur eût été mis au fait de la situation. La personne à qui le patient était attitré ne lisait pas les moniteurs cardiaques et les médecins, le coordonnateur et le personnel des soins intensifs ont été avisé de cette situation. Qu'est-ce que nous aurions pu faire de plus pour protéger le patient et avoir la meilleure qualité des soins? » (Formulaire #563).

Face à cette invalidation, nous avons noté que les infirmiers(ères) se tournaient souvent vers d'autres stratégies de dénonciation, tel que rapporté précédemment. Ce qui n'était cependant pas reflété dans le formulaire et qui est apparu dans l'analyse des données narratives, était le recours à d'autres stratégies pour pallier aux situations dénoncées. À défaut d'obtenir la(les) réponse(s) administrative(s) satisfaisante(s), les infirmiers(ères) mettaient donc eux(elles)-mêmes en place des stratégies permettant de pallier le manque de personnel ou diminuer les risques et conséquences pour les patients. Nous avons ainsi identifié plusieurs passages décrivant des stratégies comme appeler soi-même des collègues de travail pour remplacer une absence et/ou réorganiser les soins de manière à réaliser les tâches ou les soins prioritaires et/ou faire du travail non-rémunéré. Ces stratégies avaient pour but de combler urgemment un manque de réponse administrative ou de prendre en charge une situation face à laquelle les réponses administratives s'étaient avérées insuffisantes et/ou inadéquates – et ce, dans le but de réduire les risques et conséquences pour les patients.

> « Grand surplus de travail sur le département […] deux transferts urgents [à faire] et personnel infirmier

> nécessaire introuvable. Le système central de recherche de personnel [de mon hôpital est] insatisfaisant en cas d'urgence. Obligation, par moi-même, d'appeler une infirmière directement chez elle pour réussir à trouver une infirmière nécessaire immédiatement. […] » (Formulaire #1156).

## Discussion

Nos résultats brossent un portrait d'un échantillon de dénonciations réalisé par le biais du formulaire de soins sécuritaires entre 2016 et 2018. En créant cet échantillon, notre objectif n'était pas de générer des résultats représentatifs de toutes les dénonciations, mais plutôt de se servir d'un corpus de données pour décrire les caractéristiques des infirmiers(ères) qui dénoncent, comprendre la nature des situations dénoncées, documenter les autres stratégies de dénonciation utilisées par les infirmiers(ères) (outre le formulaire) et explorer les réponses administratives ainsi que leurs justifications. L'analyse nous a permis de constater que les formulaires inclus dans notre échantillon avaient été soumis majoritairement par des infirmiers(ères) autorisés(es), exerçant de jour dans des milieux de soins hospitaliers et de soins de longue durée. Bien avant la pandémie de COVID-19, les dénonciations issues des milieux de soins de longue durée étaient déjà importantes. Représentant plus du tiers de notre échantillon, les formulaires dénonçant des soins non sécuritaires en soins de longue durée soulèvent des questionnements importants quant aux milieux de soins et outils disponibles dans ces milieux pour dénoncer. Plusieurs des infirmiers(ères) ayant dénoncé publiquement les conditions insalubres et non sécuritaires dans les centres d'hébergement de soins de longue durée (CHSLD) pendant la pandémie de COVID-19 ont d'ailleurs souligné l'absence de mécanismes internes pour signaler des situations non sécuritaires et de structure administrative permettant une intervention rapide en cas de problèmes de dotations, d'équipement manquant, etc. (3,4). Pour ce qui est de la représentativité des régions, il est difficile de tirer des conclusions. Le formulaire de soins sécuritaires faisait partie d'une campagne de la FIQ et avait pour but de recueillir des données pouvant être utiles au travail de cette organisation syndicale. Ainsi, il se peut que certains milieux et certains établissements se soient mobilisés plus que d'autres. Il se peut aussi que l'utilisation du formulaire pour faire des dénonciations « en bloc » ait eu pour effet d'augmenter le nombre de dénonciations faites dans une région plutôt qu'une autre.

Les situations les plus fréquemment dénoncées au sein de notre échantillon concernaient la lourdeur (p. ex., lourdeur des patients et lourdeur de la tâche administrative), l'instabilité (p. ex., instabilité des équipes de soins et manque d'expérience ou de formation du personnel), les conditions de travail (p. ex., repas et pauses non-pris) et les manquements aux soins (p. ex., soins requis non-effectués). Les risques et les conséquences, à la fois pour les patients et le personnel infirmier, engendrés par ces situations, et la détresse morale qui en résulte étaient des moteurs importants dans la décision de remplir un formulaire de soins sécuritaires. Or, le formulaire s'inscrivait dans une démarche de dénonciation plus large comptant plusieurs stratégies comme en témoignent nos résultats. Le formulaire servait aussi à dénoncer des situations de nature chronique, à dénoncer collectivement et à sonner l'alarme auprès de la FIQ. Le recours au temps supplémentaire était la principale réponse administrative aux situations décrites dans les formulaires analysés, réponse justifiée par le manquement de personnel (p. ex., dotation déficiente ou perte de personnel). Tel que présenté dans les résultats, il nous est toutefois impossible de départager le temps supplémentaire du temps supplémentaire obligatoire (TSO) au sein du corpus. Cette stratégie fortement dénoncée à l'époque du formulaire de soins sécuritaires a continué à être mobilisée au sein des différents milieux de soins, au point de faire l'objet d'une plainte à l'Organisation internationale du Travail – plainte mise de l'avant par le FIQ en février 2022. Finalement, nous avons aussi relevé que l'invalidation était une réponse administrative fréquente et que face à la non-résolution des situations dénoncées, les infirmiers(ères) en venaient à passer eux(elles)-même à l'action pour réduire les risques et conséquences pour les patients en comblant le manque de personnel ou réorganisant les soins.

En plus d'analyser les dénonciations réalisées par le biais du formulaire de soins non sécuritaires, nous souhaitions également analyser ce formulaire en tant que plateforme de dénonciation électronique. Le recours aux plateformes électroniques pour faciliter la dénonciation dans le secteur public est une pratique établie. Or, le recours aux plateformes électroniques, pour faciliter les dénonciations infirmières et compiler le contenu de ces dénonciations, représente une nouvelle pratique qui mérite d'être étudiée davantage (6). Notre analyse nous a permis de poser deux constats par rapport au formulaire de soins sécuritaires. Premièrement, nos résultats démontrent que la conception de ce formulaire (p. ex., choix de boîtes à cocher, langage utilisé, information recueillie, etc.) correspondait partiellement aux besoins des infirmiers(ères), aux situations dénoncées et aux stratégies administratives signalées. Par exemple, le formulaire reflétait une conceptualisation des situations à dénoncer comme étant exceptionnellement non-sécuritaires. En revanche, les formulaires analysés dressaient le portrait de milieux de soins qui sont a priori non-sécuritaires, contribuant à des situations chroniques à haut risque tant pour les patients, que pour le personnel infirmier. Ces résultats convergent avec ceux de Perron et ses collègues (6) suite à l'analyse de la deuxième plateforme de dénonciation développée par la FIQ pendant la première vague de la pandémie de COVID-19. Lors de la conception d'une plateforme de dénonciation électronique, il faut donc prendre en considération le contexte plus large dans lequel travaillent les infirmiers(ères) et développer des moyens de dénoncer des enjeux systémiques minant la qualité et la sécurité des soins pour l'ensemble des patients de même que des situations de soins non-sécuritaires impliquant un patient ou un groupe de patients en particulier.

Deuxièmement, nos résultats soulignent l'écart entre la simplification des options permettant d'amasser et de compiler les données de nature quantitative et la complexité des données de nature qualitative nécessitant un niveau d'analyse allant au-delà des fonctionnalités de la plateforme. En d'autres mots, le contenu narratif s'est avéré essentiel pour comprendre la nature des situations dénoncées, les stratégies de dénonciation utilisées, les réponses administratives, de même que la nature des risques et les conséquences associées aux milieux non-sécuritaires décrits par les infirmiers(ères). Sans ces données, permettant de contextualiser et nuancer, les résultats quantitatifs auraient été insuffisants pour comprendre ce qui était dénoncé, pourquoi et comment. Or, bien qu'il soit intéressant et important de concevoir une plateforme qui puisse permettre la collecte de données narratives, il importe aussi de s'assurer que ces données puissent être analysées et utilisées – une tâche qui s'est avérée laborieuse. De plus, il faut s'assurer de concevoir une plateforme assez complète et utile pour éviter que les infirmiers(ères) aient à soumettre leur dénonciation par écrit en utilisant les boîtes de texte. Cette approche soulève des enjeux éthiques, car elle peut créer des barrières à la dénonciation et des iniquités au sein de la profession (p. ex., qui est en mesure de prendre le temps de dénoncer et qui ne l'est pas). Nous avons également constaté au sein de l'échantillon que les infirmiers(ères) se tournent vers les boîtes de texte dans l'espoir d'être entendus et de recevoir de l'aide. Ces boîtes de texte doivent donc être accompagnées d'un dispositif permettant de consulter, analyser, et utiliser les données recueillies au sein d'un grand échantillon de formulaires. Finalement, nous avons constaté la très grande détresse des infirmiers(ères) dans la façon dont ils(elles) rédigeaient leur dénonciation, d'où l'importance de s'assurer qu'un suivi soit fait, concernant leur démarche et les détails fournis dans les boîtes de texte.

Les experts en matière de dénonciation s'entendent sur l'importance de doter le personnel soignant d'outils sûrs, intègres et efficaces afin de promouvoir, faciliter, recueillir et traiter efficacement les signalements d'employés témoins de situations à risque ou de méfaits, et que la protection de ceux et celles qui dénoncent doit constituer une priorité centrale dans la conception de tels outils (23). La diversité de ces outils quant au format est reconnue; toutefois, la conception d'un tel outil gagne à respecter les meilleures pratiques en matière de confidentialité et d'efficacité (24) et ainsi augmenter, d'une part, la probabilité que l'outil soit utilisé par un employé qui souhaite dénoncer et, d'autre part, que les situations dénoncées cessent. Selon Vandekerckhove et James (25), les dénonciations réussies sont celles qui, d'une part, ont permis un processus entièrement sécuritaire pour les personnes qui dénoncent et, d'autre part, ont mené à une résolution efficace des situations dénoncées. Comme mentionné en introduction, le formulaire de soins sécuritaires avait pour but d'encourager les infirmiers(ères) à dénoncer et de recueillir, de façon confidentielle, des informations pouvant servir à exercer des pressions sur les administrateurs du système de santé afin de rectifier des situations compromettant la qualité et la sécurité des soins. En tant qu'outil de dénonciation électronique, développé par une instance syndicale, le formulaire respectait le besoin de protéger ceux et celles qui dénoncent en maintenant leur anonymat et en les soustrayant aux risques, largement documentés, que peut entraîner la dénonciation interne ou externe lorsque celle-ci est faite publiquement (8,26).

En ce qui a trait au deuxième critère proposé par Vandekerckhove et James (25), à savoir l'efficacité de la dénonciation à résoudre les situations décrites par les infirmiers(ères), nos données ne nous permettent pas de statuer sur l'efficacité du formulaire à mener à des soins plus sécuritaires puisqu'il ne recense pas l'issue des interventions tentées par la FIQ auprès des milieux de soins. Il faut cependant noter que contrairement à d'autres plateformes de dénonciation électroniques utilisées dans le secteur public (p. ex., Protecteur du citoyen au Québec), le formulaire n'était pas rattaché à des mécanismes institutionnels formels et standardisés obligeant un suivi des signalements recueillis et la mise en œuvre de correctifs institutionnels. Les chercheurs sur la dénonciation considèrent que de tels mécanismes sont nécessaires pour assurer une prise en charge organisée et systématique des signalements, la transparence des processus de résolution et la confiance des utilisateurs des outils de dénonciation. En ce sens, notre réflexion fait écho aux observations de Perron et collègues (6), selon qui le fait qu'un outil ne soit pas rattaché à des processus systématisés de prise en charge, peut réduire la portée et l'efficacité des dénonciations, échouer dans les tentatives d'accroître l'imputabilité des milieux de soins, et ultimement décourager des infirmiers(ères) à en faire usage. Au-delà de cet aspect, il faut également noter que l'étude de Vandekerckhove et James (25), qui se penchait sur le degré d'efficacité des dénonciations réalisées par le biais d'instances syndicales, concluait que celles-ci s'avéraient plus sécuritaires pour les personnes qui dénoncent, mais moins efficaces pour mettre fin aux situations dénoncées. Notre analyse a d'ailleurs révélé plusieurs formulaires dans lesquels les infirmiers(ères) interpelaient directement la FIQ afin qu'elle intervienne dans les situations dénoncées, suggérant le fait que certains(es) s'inquiétaient de ne pas être entendus ou soutenus par la FIQ, et de dénoncer en vain. Cette inquiétude mérite d'être soulignée car nos résultats indiquent que près de 70% des infirmiers(ères) avaient initié une action collective en réponse à la situation dénoncée et près de 20% disaient avoir informé leur représentant(e) syndical et/ou le syndicat. Le recours au formulaire semblait donc répondre à un besoin de transmettre la dénonciation à un niveau supérieur dans la structure hiérarchique de la FIQ – suggérant possiblement une non-résolution des démarches entreprises auprès des instances syndicales locales.

À la lumière de notre étude, l'on peut se questionner sur l'utilité et l'avenir des plateformes de dénonciation telles que le formulaire de soins sécuritaires. Plusieurs chercheurs affirment que les syndicats jouent un rôle essentiel dans les processus de dénonciation, mais que les outils et les stratégies utilisées sont insuffisants, à eux seuls, pour transformer et renforcer les cultures et les pratiques organisationnelles, qui contribuent aux types de situations dénoncées dans le formulaire de soins sécuritaires (23, 25). Malgré le fait que le formulaire de soins sécuritaires avait pour but de créer une boucle de rétroaction, en recueillant des formulaires à l'externe pour ensuite intervenir à l'interne, auprès des organisations en santé, son efficacité demeure limitée. Pour assurer une dénonciation efficace, des outils et mécanismes internes sont nécessaires. Par exemple, Kenny et ses collègues (24) expliquent que la dénonciation dite « interne » devrait être assurée par des mécanismes combinés et croisés, qui permettent notamment le recueil sécuritaire des dénonciations, la mise en relation des situations dénoncées avec d'autres sources d'informations (p. ex., enquêtes, audits), de même que la disponibilité de canaux de communication, notamment auprès des personnes ayant dénoncées, au sujet de la prise en charge de la dénonciation et des résolutions mises en œuvre. Une telle approche permet des interventions plus efficaces, alliant à la fois la protection des personnes qui dénoncent et l'efficacité des démarches, vers une résolution organisationnelle plus productive et cohérente (24). Or, il est entendu qu'une telle approche ne peut être efficace à moins d'être utilisée au sein d'une culture organisationnelle qui reconnaît l'importance et l'utilité de la dénonciation, dans l'amélioration de la qualité et la sécurité des soins.

## Recommandations

Nous proposons quatre recommandations. Au plan conceptuel et théorique, nous croyons qu'il est important d'étudier les outils de dénonciation (incluant les plateformes électroniques) qui comporte à la fois une dimension interne et une dimension externe. Le formulaire de soins sécuritaires, comme outil de dénonciation et outil de travail d'une instance syndicale capable d'intervenir auprès d'instances en santé et d'établissements de soins, est un exemple intéressant qui remet en question la traditionnelle séparation entre dénonciation interne et externe. Le rôle des plateformes de dénonciation dans la transformation de dénonciations individuelles (p. ex., formulaire individuel) en dénonciation collective (p.ex., accumulation de centaines voire milliers de formulaires) mérite aussi d'être exploré davantage. Finalement, nous constatons l'importance de repenser ce que les infirmiers(ères) dénoncent, c'est-à-dire de proposer une conceptualisation plus élargie allant au-delà d'un patient ou d'une situation de soins à la manière d'un rapport d'incident. Dans le contexte actuel, nos résultats de recherche ainsi qu'une proportion majeure de cas de dénonciations infirmières recensés ou médiatisés montrent que les dénonciations portent sur des enjeux plus larges et complexes qui rendent les soins non-sécuritaires, notamment des pratiques et des cultures organisationnelles contre-productives, voire nocives, et des facteurs méso- et macro-systémiques (ex : réformes et restructurations intensives; roulement, absentéisme et perte de personnel qualifié; retrait de ressources; sous-financement de secteurs névralgiques tels que les soins de première ligne et les soins de longue durée; augmentation des demandes de productivité; champs professionnels rigides; lourdeur administrative; etc.). Nous notons l'importance de mener plus de recherche sur la dénonciation infirmière, les outils de dénonciation utilisés par les infirmiers(ères) (incluant les outils émergents comme les plateformes électroniques et les réseaux sociaux), et leur efficacité. Comme mentionné dans la discussion, la dénonciation interne doit aussi faire l'objet d'études en sciences infirmières. Des études de cas portant sur des milieux ayant développé des outils et mécanismes de dénonciation interne novateurs seraient particulièrement utiles. Enfin, le rôle, dans la dénonciation interne, des infirmiers(ères) gestionnaires de première ligne et intermédiaires occupant des postes hybrides (clinique et gestion) est aussi à explorer, ainsi que la manière dont le fait que ces personnes soient syndiquées ou non influence leur implication. Il s'agit d'un groupe dont les pratiques de dénonciation sont peu comprises. Enfin, nous avons identifié un besoin de développer un champ de pratique interdisciplinaire afin de mieux concevoir les plateformes électroniques, d'optimiser leurs fonctionnalités et leur utilité tout en diminuant les risques associés à la composante électronique, notamment le risque de cyberattaque ou d'atteinte à la confidentialité. En outre, nous ne pouvons passer sous silence l'importance d'offrir du soutien et des ressources (p. ex., consultation éthique) aux infirmiers(ères) qui dénoncent, car leur détresse était évidente dans les formulaires. Il ne fait aucun doute que faciliter la dénonciation est important, mais qu'offre-t-on en retour aux infirmiers(ères) qui dénoncent?

## Forces et limites

La présente étude comporte trois forces principales. Premièrement, elle s'appuie sur une analyse rigoureuse de plus de mille formulaires de dénonciation contenant des données riches et ayant été soumis par des infirmiers(ères). La taille de l'échantillon ainsi que la qualité des données représentent donc, selon nous, une force importante de notre étude. Deuxièmement, elle repose sur un devis à méthodes mixtes comportant une approche à la fois déductive et inductive. La décision d'inclure un volet qualitatif pour analyser les données narratives ainsi qu'une approche inductive pour aller au-delà des boîtes à cocher déjà incluses dans le formulaire constitue aussi une force importante. Troisièmement, l'étude vient combler un véritable vide du point de vue des savoirs infirmiers au regard de ce type de plateforme. À notre connaissance, il s'agit de la deuxième analyse seulement d'une plateforme électronique de dénonciation complétée en sciences infirmières au Canada et à l'échelle internationale, ce qui permet de faire une contribution importante à la compréhension du phénomène émergent de la dénonciation infirmière par le biais de plateformes électroniques et qui pourrait mener à des analyses comparatives intéressantes sur ce phénomène dans d'autres disciplines et/ou impliquant d'autres types de professionnels. Une limite qu'il importe de mentionner est la création de nouvelles catégories de façon inductive impliquant un processus interprétatif. Toutefois, nous croyons que le fait d'avoir complété ce processus par voie de consensus entre trois chercheurs minimise cette limite. Une autre considération est que notre étude couvre spécifiquement la période de 2016 à 2018. La définition de cette période n'est pas une limite en soi, mais il convient de rappeler qu'elle n'est pas représentative des différents contextes de dénonciation infirmière dans la province. En effet, le phénomène de la dénonciation infirmière a connu des tournants importants au Québec en raison notamment de vagues inédites de dénonciations cumulées en 2018 et 2019 au regard des conditions générales de travail, puis entre 2020 et 2022 dans le contexte des dérapages liés à la gestion de la pandémie à la COVID-19 (3,4,6). Nous ne prétendons donc pas à une généralisation de nos résultats au phénomène dans son ensemble.

## Conclusion

Cette étude nous a permis de décrire les caractéristiques des infirmiers(ères) ayant dénoncé par le biais du formulaire de soins sécuritaires, de comprendre la nature des situations dénoncées, de documenter les autres stratégies de dénonciation utilisées par les infirmiers(ères) (outre le formulaire) et d'explorer les réponses administratives ainsi que leurs justifications. Elle nous a aussi permis de mieux comprendre la dénonciation infirmière électronique en étudiant le formulaire de soins sécuritaire comme plateforme de dénonciation électronique. Malgré les limites de l'étude et l'évolution des pratiques relatives à la dénonciation au cours des cinq dernières années, les résultats contribuent à l'état des connaissances sur ce phénomène en soins infirmiers et la recherche spécifique aux plateformes de dénonciation électroniques. Ces plateformes sont nouvellement utilisées en sciences infirmières et leurs caractéristiques sont encore peu documentées tout comme leur usage et leurs impacts. Il importe de mener des travaux à la fois conceptuels (théoriques), empiriques, et pratiques (p. ex., technologiques) pour déterminer la place que devrait occuper ces plateformes en sciences infirmières et s'assurer que celles qui sont mises en place adhèrent aux meilleures pratiques afin de protéger les infirmiers(ères) qui dénoncent et faciliter une résolution des problématiques dénoncées. Les plateformes de dénonciation électroniques, qu'elles soient externes ou hybrides (externe et interne) semblent répondre à un besoin réel du personnel soignant, mais elles ne peuvent pas à elles seules pallier un manque de canaux internes permettant une dénonciation sécuritaire et efficace. Il est donc impératif de s'intéresser à la fois à créer des milieux où la dénonciation interne est possible et des outils pour dénoncer de façon externe lorsque nécessaire.

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## Abstract

This article presents partial results of a mixed methods study about consensual non-monogamists' perceptions of their parenting and sexual lifestyle, particularly those involving the transition to parenthood, intimacy and communication. Using The Expanding the Movement for Empowerment and Reproductive Justice Lens that was enhanced by Cowan and Cowan's Ecological Model of the Transition to Parenthood, six participants completed an online questionnaire and a semi-structured interview guide. Parenting consensual non-monogamists prioritise sexual intimacy over emotional intimacy, and communication is very important for them. The quantitative results support the qualitative ones: the participants had a higher level of parenting sense of competence, and the means for emotional and sexual intimacy were lower for primary partners than for secondary ones. Perinatal health care professionals including nurses need to know more about parenting consensual non-monogamists and their partner(s). More research is warranted with this particular group of parents, especially on their experiences of minority stress, resilience and taking a more intersectional research approach.

Keywords Consensual non-monogamy, Transition to parenthood, Emotional intimacy, Sexual intimacy, Communication

# Parenting Consensual Non-Monogamists' Perceptions of Parenthood, Intimacy, and Communication

JACQUELINE AVANTHAY STRUS & VIOLA POLOMENO

## Introduction

Although perinatal health care providers including nurses encounter parenting consensual non-monogamists (PCNMs), there is a dearth of studies on consensual non-monogamy (CNM) in the context of parenthood (1-3). CNM is defined as an individual choosing to engage in a romantic and/or sexual activity with more than one partner, with all partners being aware of their involvement (4,5). The three main types of CNM are polyamory, swinging, and open relationships. While polyamory involves having multiple romantic, loving and/or sexual long-term non-exclusive relationships (1), swinging involves non-exclusive sexual relationships, especially for heterosexual couples (6). Open relationships are romantic, and accompanied by additional sexual connections (1).

The transition to parenthood is "the period starting with the decision to have a child or becoming pregnant and terminating when the child is 2 years old" (7, p. 36). Many changes are associated with this transition such as physical and sexual (7). However, the two most affected dimensions are intimacy and sexuality (8-10). In the initial postpartum period, there is more emphasis on the parenting role due to the demands of the newborn and the new mother's recovery (9). Couples appear to cope better when they can more quickly strike a balance between the roles of lover, partner, and parent (9).

Stigma towards CNM can lead to health inequities for parents such as an increase in sexually transmitted infections (STI's) (11), and may also affect their children's lives (12). This stigma may result in parents who participate in CNM non-disclosure during health care interactions (12). Yet, Pallotta-Chiarolli (12) indicates that there are benefits in raising children in polyfamilies: less strain in the division of labour and the care of the children; a greater sex-positive attitude; a stronger bond between parents and children; a better division of resources (financial, physical, emotional and others); polyparents having more time for themselves; and polychildren being exposed to more than one role model. This article presents partial findings from a larger study whose aim was to describe Manitoban consensual non-monogamists' perceptions of parenting and their sexual lifestyle. The partial findings featured in the article are in relation to the following research questions:

1) What are the perceptions of PCNMs in regard to their transition to parenthood, their emotional and sexual intimacy, and their communication? (QUAL)

2) What are the perceptions of PCNMs in regard to the Parenting Sense of Competence Scale and the emotional and sexual intimacy subscales of the Personal Assessment of Intimacy in Relationship Inventory? (quan)

3) What are the similarities and differences between the perceptions of PCNMs in regard to their transition to parenthood, their emotional and sexual intimacy, and their communication, and their perceptions in regard to the Parenting Sense of Competence Scale and the emotional and sexual intimacy subscales of the Personal Assessment of Intimacy in Relationship Inventory? (QUAL and quan)

## Conceptual Framework

The study's conceptual framework relies on The Expanding the Movement for Empowerment and Reproductive Justice (EMERJ) (13) lens, which is a concrete way of integrating the Reproductive Justice Framework in research, or more practically, when working with communities, such as PCNMs. This lens assists in identifying the challenges that people face in regard to their gender, bodies and sexuality (13). The family dimension within the EMERJ lens was enhanced by Cowan and Cowan's Ecological Model of the Transition to Parenthood (8). This ecological model encompasses the five central aspects of family life: each person's inner world; the relationship between parents and children; the relationship between the parents; the one between grandparents, parents and grandchildren; and lastly, the one between family members and the institutions outside of the family unit.

## Methods

A brief overview of the methodology is presented here as it was previously published by Avanthay Strus and Polomeno in 2021 (14).

**Research study type and design.** The original mixed-methods research study type used the triangulation design-convergence model (19), including "a single phase, (and) both types of data are given equal emphasis" (p. 84). In this case, "the two sets of results are converged during the interpretation, and the intent is to draw valid conclusions about a research problem" (p. 84). This design was chosen for two reasons: 1) it is time efficient as both the quantitative and qualitative data are collected simultaneously, and 2) both data sets are considered of equal importance (19).

**Population, sample and sample size.** The research population focused on individuals who were parents and consensual non-monogamists. Eight participants met the following inclusion criteria: 1) be 18 years old and more; 2) having been in a consensually non-monogamous relationship in the last two years; 3) having started to be consensually non-monogamous before or during the transition to parenthood; 4) be a primary parent for the child(ren); 5) the child must still be in their care and have always been so since birth; and 6) speak, read and write in English. The exclusion criterion involved individuals in an exclusive same-sex relationship. Only six of the original eight participants completed the online questionnaire and the interview; two withdrew for personal reasons.

The sample consisted of four female and two male participants, their ages ranged from 31 to 45 years (M = 37.67 years, SD = 6.37), and five participants identified as bisexual or pansexual and the other one as heterosexual. At the beginning of the transition to parenthood, one participant identified as polyamorous, one was in an open relationship, and four participants were swingers. At the time of data collection, two participants identified as swingers, while four of them were polyamorous. Four participants were married, one was common-law, and the last one was separated. Three participants had secondary partners at the time of data collection and three had secondary partners during the transition to parenthood. The number of children for each participant ranged from 1 to 3, with an average age of 10.63 years at the time of the interviews. Their incomes ranged from $19 000 to over $60 000. All participants were Canadian born.

**Data collection.** The qualitative data were collected using a semi-structured interview guide (3) containing 32 questions divided into four different sections: 1) the participants' perceptions of the transition to parenthood; 2) their sexual lifestyle; 3) the conciliation of their parenting role and their sexual lifestyle; and 4) their perceptions of health care professionals. This guide was developed incorporating the EMERJ lens (13) as well as Cowan and Cowan's Ecological Model (8). Only the first two sections of the interview guide are considered for this present article (findings from the fourth section are now published (14)). The interviews took between 1.5 and 2 hours to complete.

The quantitative data were collected using an online questionnaire that contained 24 questions regarding sociodemographic, relational, and parenting characteristics and included three research instruments (see Avanthay Strus (3)): the Parenting Sense of Competence Scale (PSCS) (16); the Personal Assessment of Intimacy in Relationship Inventory (PAIR) (only the emotional and sexual intimacy subscales were retained) (17); and the Parenting Role-Sexual Role Conciliation Scale (PRSRCS) which was created for this study (3). Data from the PSCS and the two PAIR Inventory subscales are considered for this article. The online questionnaire took the participants between 15 and 20 minutes to complete.

The PSCS (16) is a 16-item self-administered questionnaire (with 2 subscales: efficacy and satisfaction) using a 6 point-Likert scale, from 1 = "Strongly Disagree" to 6 = "Strongly Agree". The seven questions pertaining to the 'Efficacy' subscale focus on the parents' competence, capability levels and problem solving abilities. The nine questions that are part of the 'Satisfaction' subscale measure parents' anxiety, motivation and frustration. A total score is obtained by adding the values for each item, with a higher score indicating a more positive parenting experience. The PSCS has an internal consistency using Cronbach's alpha ranging from 0.75-0.88 for the subscales and for the total scale.

The PAIR (17) Inventory is a 36-item self-administered questionnaire that measures the perceived and expected levels of intimacy in a relationship. It contains five subscales representing five dimensions of intimacy: emotional, social, sexual, intellectual, and recreational. Only the emotional and sexual intimacy subscales were retained for this study. Each item is rated on a 5-point Likert scale, from 1 = "Strongly Disagree" to 5 = "Strongly Agree". The scores are obtained by adding up the values for each item, with a higher score indicating a higher level of intimacy. Perceived and expected levels of intimacy can also be compared using the mean score. If a discrepancy is found between the perceived and expected levels of intimacy in a certain subscale, then there are difficulties in that area; for example, less satisfaction with it. The Cronbach alpha reliability coefficients for the emotional and the sexual intimacy subscales are 0.75 and 0.77, respectively.

**Data analysis.** The qualitative data were analysed using the Schreier inductive method (18) to infer themes that came up during data analysis. This systematic approach to data analysis (18) used inductive and objective methods to infer these themes. This approach began by submersing in the data by repeatedly reading after the interviews were transcribed. General impressions and thoughts were noted following the general themes in the interview guide (Transition to Parenthood, Sexual Style/Sexuality, Conciliation of Roles, and Health Care Professionals). During the process, the two rounds of coding were first compared for consistency. This permitted the researcher to reorganize the coding frame to eliminate any inconsistencies and subcategories that could be interchangeable. Any inconsistencies that arose during the primary analysis were compared between co-researchers.

Descriptive statistics (15) were applied to all quantitative variables using Version 24 of SPSS Statistics (20). Following Creswell and Plano Clark's (19) triangulation design convergence model, both qualitative (primary data set) and quantitative (complimentary data set) data were collected at the same time and given equal emphasis (19). However, the qualitative data were first analysed, followed by the quantitative data. Once the data had been analysed, they were then converged during the interpretation phase. These comparisons could result in the data sets being congruent (similar) or divergent (dissimilar).

**Ethical considerations.** Ethics approval had been obtained from the first author's educational institution, where they were a master's student in nursing. Informed consent was obtained from each participant, while each was attributed a number (First Participant=P1, Second Participant=P2, etc.) to protect their identities. The participants chose the location and time for their interview.

## Results

The qualitative data analysis from the original study resulted in five themes: perceptions of the transition to parenthood; intimacy and communication during the transition to parenthood; relationship evolution and sexual style during the transition to parenthood; the conciliation of roles during the transition to parenthood; and the relationship with health care providers. Results from the first two themes (perceptions of the transition to parenthood; emotional and sexual intimacy and communication) are featured in this article (see Table 1). Results from the corresponding quantitative data are also presented.

### Perceptions of the transition to parenthood

The participants' perceptions regarding the transition to parenthood obtained from the interviews are divided into four phases: preconception, pregnancy, childbirth, and the first two years postpartum. The quantitative results from the PSCS are added here.

**Qualitative results.** During preconception, all of the participants in this study had conversations with their primary partners about having children. For four of them, this decision was a planned one. As P1 states: "It was the next logical step". Two others who did not prepare for pregnancy expressed concerns about the impact of schooling or a recent move.

Table 1: Results of Qualitative Data Analysis from the First Two Themes of the Original Study

| Themes | Categories | Subcategories |
|---|---|---|
| **Perceptions of Parenting Consensual Non-Monogamists Regarding their Transition to Parenthood** | Decision to become a parent | Conscious decision |
| | | Unplanned pregnancy |
| | Pregnancy | Positive reactions |
| | | Negative reactions |
| | | Health complications |
| | Childbirth | Uncomplicated |
| | | Complicated |
| | Birth to 2 years | Birth to one year |
| | | One year to 2 years of age |
| **Intimacy and Communication During the Transition to Parenthood** | Intimacy | Changes in emotional intimacy |
| | | Changes in sexual intimacy |
| | Communication | Changes in communication with the arrival of children |
| | | Impact of mental health on communication |

Regarding the second phase of pregnancy, the participants described this period as being positive or negative. Those who had planned their pregnancies seemed to be more prepared to take on the parenting role, and those who had support were better able to deal with this phase. However, some of them had developed complications (n=3) such as pregnancy loss, multiple gestation or physical difficulties related to previous health conditions, resulting in negative perceptions of pregnancy. Three participants who had high needs children prior to pregnancy also had more negative perceptions. Participants with negative perceptions (pregnancy complications or high needs children) expressed how these circumstances adversely affected intimacy and communication in their relationships: for example, P4 indicates, "I felt jealous of her partners…felt like a third wheel".

Concerning the third phase of childbirth, the four female participants either experienced uncomplicated labour and birth (n=2) or a complicated one (multiple gestation, perineal tearing, postpartum hemorrhage, n=2). For the participants who described the childbirth experience as being positive, they expressed it in the following ways: "…hard, beautiful, interesting fascinating, scary" (P2), and, "…instant love…I would do it million times over" (P4). The participants with a more complicated childbirth were more affected in the initial postpartum period. Some participants expressed experiencing post-traumatic stress associated with traumatic childbirth experiences. P4 expressed how her male partner had experienced trauma from being present at the birth: "No guy wants to see that". It took longer for one female identified participant to resume sexual activity with her male primary partner due to the trauma that this primary partner had witnessed during childbirth. Her male primary partner was quicker to resume sexual activity with their female secondary partner. Certain participants (P2) took longer to take on the role of parent due to childbirth-associated trauma.

For the last phase of birth to two years of age (of the child/children), the participants indicated that they required time to adjust to having children. Also, this adjustment varied between the men and women in the study: the women identified with the parenting role earlier than their male counterparts. P1 explained it this way, "When I became pregnant, I became a parent…I would say that once my daughter was born he became a parent". Certain participants who expressed concerns about having difficulty meeting their own needs during this period had to deal with a high needs child.

Five out of the six participants had high needs children for their first or third child. One participant expressed how the first three months were traumatic due to extreme sleep deprivation.

> "I would so that the first 3 months were extremely traumatic...She had severe colic and needed to be held constantly so the stress of the sleep deprivation for my wife and I was…um…almost unmanageable. We had support, but there wasn't a lot of support that could be given…" (P2).

Also, the father participants had to contend with sleep deprivation and providing for their families. At the same time, their female partners took time off due to parental leave to look after the children.

**Quantitative PSCS results.** The total score of the PSCS can range from 17 to 102, with a higher score indicating a parent's higher sense of competence. All of the participants' total scores for the PSCS were on the higher side, ranging from 74 to 90 (M = 84.00; SD = 6.85) (see Table 2). Female identified participants had a higher mean score (M = 85) than male identified participants (M = 77.5),

For the efficacy subscale, the only item that produced the lowest score was Item #7, 'Being a parent is manageable and any problems are easily solved'. Four participants scored 5 out of 6, while 2 others scored 3 out of 6. This would indicate that parenthood has challenges and that these problems are not easily solved. However, Item #17 ('Being a good parent is a reward in itself') had the highest number of participants (four out six) who scored 6 out of 6 ('Strongly agree').

For the satisfaction subscale, the items that produced the most frustration, thus affecting their parenting motivation, and lowered their level of satisfaction were: Item #3 ('I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot'), Item #4 ('I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated'), and Item #14 ('If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent'). On the other hand, the two items that were identified as producing high satisfaction were: Item #8 ('A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one'), and Item #16 ('Being a parent makes me tense and anxious').

The quantitative results from the PSCS can be compared with the previously mentioned qualitative ones. The PSCS results actually corroborate the results obtained from the qualitative data: for example, the fathers identified with their parenting role later in the process once their child was born or when their child was around a year of age. Their scores were lower than those of the mothers in the sample who identified as a parent during pregnancy.

## Emotional and sexual intimacy

The qualitative results for emotional and sexual intimacy obtained from the interview guide will first be presented, followed by the quantitative results derived from the PAIR Inventory.

**Qualitative results.** *Emotional intimacy.* Some participants reported an increase or a decrease in emotional intimacy, while there was no change for others. P6 shared how emotional intimacy continued to increase after the children's birth. This was attributed to the couple's need to present themselves as a 'united front' in the face of obstacles regarding their parenting challenges. Even if emotional intimacy had increased gradually over time, they did regain the prepregnancy level to when the child was a year of age. P6 shared the following:

> "…in terms of being able to see my spouse to become a parent and be ready for that role and just caregiver in general…and having him feel the baby move… particularly the second time around…just seeing that uh blossom in my spouse was was (a) special time for me" (P6).

For two others (P1 and P2), there was a decrease in emotional intimacy after the birth of their child, but it did increase again, with a return to a prepregnancy level when the child was slightly younger, at about 10 months of age.

> "There was definitely more intimacy before my daughter, and it's at this point though…in the intermediate time there was a…a…natural dip for a while, and it had taken a while to rebuild that. We are still rebuilding that, but I would say that we are most of the way towards where we were before she was born" (P2).

Table 2: Results from the Parenting Sense of Competence Scale (n=6)

| | Mean | Standard Deviation | Range |
|---|---|---|---|
| **Efficacy** | 41.33 | 2.77 | 8-48 |
| **Satisfaction** | 41.00 | 6.36 | 9-54 |

P3 and P4 did not notice a change in their emotional intimacy during the initial postpartum period.

*Sexual intimacy.* Concerning sexual intimacy, differences were noted between female and male participants and from one pregnancy to the next. Male participants indicated a change in their levels of sexual interest throughout the transition to parenthood. All participants waited for the new mother's physical healing before resuming sexual activity, especially with perineal tearing. One participant explained:

> "I feel like it (the tear) saved me for a little while of not having, giving me an excuse not to have sex and then the baby crying and then oh oh, baby's crying I would have to do this to, we started, I started cosleeping in my daughter's room and I'd say a big portion of that was uh…to kind of escape unwanted advances" (P1).

The female participants who breastfed (n=4) reported a decreased libido, while two participants also noted 'touch fatigue' related to breastfeeding. During sexual play, most participants did not include the breasts, while two did. The participants who had a breastfeeding partner made modifications to sexual positions to accommodate for this: 'female on top' and 'doggy style' were the preferred positions while limiting the 'missionary' position. For those identifying as female, changes in their appearance affected their desire for sexual intimacy. P3 stated, "I did not feel like myself afterwards or sexy, an object of desire".

The participants who were in open relationships or identified as swingers did not participate in CNM in the initial postpartum period, being limited by the physical changes due to childbirth. However, those in polyamorous relationships were more cognizant of their emotional and sexual intimacy. All participants mentioned that sexual activity during the first postnatal year was more 'vanilla' with less incorporation of BDSM practices. P2 shared the following: "short and quick right…not as tantric".

**Quantitative PAIR Inventory results.** All the participants completed the perceived emotional and sexual intimacy PAIR Inventory subscales for their primary partner, three of them for a secondary partner, however, none responded for a third partner.

*Emotional intimacy.* The perceived levels of emotional intimacy scores for the participants' primary partners (n=6) ranged from 24 to 92 (M = 69.00; SD = 30.61), while for the secondary partners (n=3), the score range was between 80 and 96 (M = 85.33; SD = 9.23) (see Table 3). Looking more closely at each of the items individually, only two items had a 67% agreement or disagreement (four out of six participants): strongly agreed for, 'My partner listens to me when I need someone to talk to' (Item #1), and strongly disagreed with, 'I often feel distant with my partner' (Item #13).

The mean for the perceived level of emotional intimacy for the primary partners (69.00) was lower than the mean for the perceived level of emotional intimacy for the secondary partners (85.33). Yet, most of the participants did score in the expected range of between 48 and 58 (17). The lower scores for the perceived level of emotional intimacy for two participants were corroborated with the qualitative results: these two participants had a decrease in emotional intimacy after the birth of their first child. All participants with secondary partners reported either a similar or higher perceived level of emotional intimacy for their secondary partners than for their primary partners during the transition to parenthood.

*Sexual intimacy.* The scores for the perceived level of sexual intimacy for the participants' primary partners (n=6) ranged

Table 3: Results for Perceived Level of Emotional and Sexual Intimacy (PAIR Inventory) (n=6)

| | Mean | Standard Deviation | Range |
|---|---|---|---|
| **Emotional Intimacy (Primary Partner)** | 69 | 30.61 | 0-96 |
| **Emotional Intimacy (Secondary Partner)** | 85.33 | 9.33 | 0-96 |
| **Sexual Intimacy (Primary Partner)** | 88.67 | 9.35 | 0-96 |
| **Sexual Intimacy (Secondary Partner)** | 88 | 4.00 | 0-96 |

from 68 to 92 (M = 86.67; SD = 9.35), while the scores ranged from 84 to 92 (M = 88.00; SD = 4.00) for the secondary partners (n=3) (see Table 3). Nevertheless, there was a greater range in the scores for the primary partners than for the secondary ones. When analysis was carried out for each item individually, there were two items that all participants were in disagreement with (100%): 'I hold back my sexual interest because my partner makes me feel uncomfortable' (Item #21), and 'My sexual partner seems disinterested in sex' (Item #33). Indeed, participants in this study scored above the reported average for the perceived level in sexual intimacy, for both their primary and secondary partners: in a non-clinical sample of 385 respondents (17), the average perceived level of sexual intimacy ranged between 48 and 58.

## Communication during the transition to parenthood

Only qualitative results are available for communication during the transition to parenthood. All participants recognized the importance of communication in maintaining their relationships: five participants noticed an overall change in their communication patterns during the first year of parenthood, and one did not.

Two participants noted improved communication, which was out of necessity: they were more open and honest with each other after having children. Their ability to come together allowed them to overcome obstacles they faced during parenthood.

> "…you really do need to be able to communicate, um… you have to be able to communicate your needs with respect to what the children need and, how you are going to meet those needs together as a team" (P6).

Two other participants (P1 and P2) noticed decreased communication and desire to express their wants and needs. They reported drifting apart and experiencing decreased intimacy stemming from perinatal losses while trying to conceive and having different opinions about childrearing practices. The added stress of postpartum depression and having a high-needs child are two other factors that contributed to their breakdown in communication. Emotional intimacy and communication ability gradually increased over time, returning to the prepregnancy level once their child was one year of age.

One participant (P3) noted increased intimacy and emotional connection due to better communication after the second child's birth. Still, communication decreased after the third child's birth due to having a high-needs child and mental health concerns.

Communication was likewise affected when the participants faced a mental health concern, which resulted in partners becoming closer or leading to a breakdown in communication. Five participants dealt with postpartum depression (PPD) in themselves or their partners. These concerns were compounded by having a 'high needs' child. Two participants were able to surmount this hurdle by working on rebuilding their communication, leading to an improvement in this part of their relationship. For the other three participants, mental health concerns (PPD or PPD with psychosis) led to a breakdown in communication. For P3, her mental health concerns ultimately led to a relationship breakdown with her partner. The breakdown occurred postnatally after the third child's birth, during which time her primary partner had an extra-conjugal affair. In hindsight, she understood why her partner left, "it wasn't his job to fix me, their dad leaving me made me take responsibility for my own mental health".

Participants emphasized how their ability to communicate their needs was due to their participation in CNM. P6 expressed the following:

> "…so is part of our, an integral part of our relationship as a couple…opened us to be able to communicate in a way that we did not do before (...) So we've had to develop that communication side uh more so because of the lifestyle that we live and as a result that has made us far more intimate uh and close in our relationship" (P6).

Once participants began to reengage in CNM after the birth of their children, the transition to parenthood combined with their experience with CNM allowed them to better read their partners' emotional needs during lifestyle events, and to gauge whether or not they were comfortable in various situations. They also made it a regular practice to do planned check-ins with each other to ensure that their partner's body language matched how they were feeling and to tell each other what they desired and needed.

## Discussion

The partial findings from this mixed methods study contribute to a newly emerging body of research that aims to understand the four phases of the transition to parenthood concerning CNM, as previous researchers (1,22) have focused only on childbirth or parenting. The discussion that ensues focuses on the participants' profile, their perceptions of the transition to parenthood, emotional and sexual intimacy, and communication within this context.

**Participants' profile.** The participants' profile is more varied than previously published studies (5,22,23) but aligns with more recent ones (22,37), having more diverse samples. Particular attention was paid to how the participants were recruited to try to overcome the "artifact effect of community-based strategies that have created an inaccurate reflection of people who engage in CNM" (25, p. 1). As the study's sample was located in Winnipeg, Manitoba, their characteristics may differ than those from other parts of Canada and even the United States (11,23,24,26). Overall, there appears to be a greater acceptance of sexual diversity in Canada and elsewhere, including the swinging culture (25).

**Transition to parenthood.** Regarding the transition to parenthood, the participants in the current study are similar to other parents who undergo this transition; however, the findings reveal that differences are present, particularly concerning their sexuality.

The decision to become a parent was a significant finding during the preconception phase, as all participants (100%) had had this talk. This finding was present in the study published by Arseneau and colleagues (1), referring to it as 'Deliberately Planning Families'. Given the nature of this study, it would be interesting to explore further the deliberate planning of families that most PCNMs appear to make. We wonder why consensual non-monogamists seem to put more effort into this decision. Indeed, the Society of Obstetrics and Gynecology of Canada reveals that only 50% of all pregnancies in Canada are planned (27).

During the second phase of pregnancy, the participants had positive and negative reactions to it. The participants expressed the importance of support during low- and high-risk pregnancy, which increased their positive response to pregnancy. Indeed, from a conjugal perspective, the findings from the present study reveal how such complications can bring partners closer to each other. On the other hand, opportunities for sexual intimacy were limited, so these participants were more aware of their feelings toward the primary partner and the importance of communication. Balzarini and collaborators (28) explain how polyamorous parents are more adept at communicating, thus support is more available. This warrants further consideration in the context of pregnancy for pregnant consensual non-monogamists.

The participants experienced positive and negative reactions during the third phase involving childbirth. Those with no complications had positive reactions to childbirth, while those with complications had negative ones. Childbirth complications impacted the women, their relationships, their attachment to their babies, and their postnatal sexuality. The female participants who had these complications had postnatal sexual difficulties. This warrants additional investigation as women who are consensual non-monogamists and experience childbirth complications may have more concerns about their postnatal sexuality, particularly the resumption of sexual activity. Notably, women with perineal tears and episiotomies found that their postnatal sexuality had been negatively affected, leading to a delay in the resumption of sexual activity (9). Another study finding was that participants who experienced birth trauma experienced post-traumatic stress disorder. Birth trauma's consequences are detrimental to conjugal relationships, sexual dysfunction, fear of childbirth, and difficulties with mother-infant relationships (9). These findings highlight the need for perinatal health nurses to assess the birthing parent and the relational partner(s), both research-wise and clinically.

In the last phase of parenting, two findings were unexpected: there was a higher prevalence (five out of six participants) of postpartum depression (PPD) and having special needs children (five out of six participants). As most participants had special needs children, this increased their likelihood of having PPD. The prevalence for these two conditions is higher than in the perinatal and parenting populations (29). Despite these challenges, all participants found ways of dealing with their situations and using strategies to reach a new level of adjustment. Jenks (23) posits that polyamorists and swingers are pushed to communicate and find new coping methods as no social norms exist. The polyamorous participants appear to have fared better, which could partially be explained by a greater distribution of resources between the parents. This is similar to the findings reported in the Pallota-Chiarolli study (12), wherein polyamorous parents were better able to reconcile their various roles (lover, partner, parent), had more time for themselves, and had less stress relating to household tasks and childrearing.

In regard to the PSCS, two aspects are noteworthy: first, the participants' scores for the PSCS were higher compared to previously published studies (16,30); and second, the female participants had higher scores than the men. For the first aspect, it appears that the participants' higher PSCS scores may be attributed to the support that they received, either with secondary partners or from others in their social network. This aspect warrants further investigation as to how this support occurs in the context of parenting consensual non-monogamy. For the second aspect, the female participants identified with the parenting role during their pregnancies, whereas the men did so when their children were about 12 months of age.

These findings are similar to those reported by Condon and colleagues (31), in which fathers integrated their parenting role later than the mothers. Also, fathers incorporate the parenting role more when they feel like better partners.

When comparing the qualitative results with the quantitative PSCS ones, the participants' parenting satisfaction was lower when they had PPD and/or a high-needs child. Ross and collaborators (32) found that plurisexual parents with greater levels of PPD attributed it to minority stress, decreased parenting self-efficacy, and lack of social support. Plurisexual individuals appear to be at significant risk of being excluded both by their heterosexual counterparts and sexual minority communities, which in turn, affects their mental health during the transition to parenthood (33).

**Emotional intimacy.** The study participants reported a decline in their emotional intimacy in the initial postpartum period, with a gradual return to it (9). Similarly, they were trying to find a way to integrate their parenting role with their other roles of lover and partner. This sample had additional stressors, as they had to deal not only with multiple gestation and multiple pregnancy losses, but also with PPD and/or having a high-needs child. Since the participants are PCNMs (3), they seem to be better able to recognize this emotional decline and reach out to their partners to rebuild their relationship. Although there was a dip in the participants' emotional intimacy after the birth of their children, as demonstrated by the qualitative results, the quantitative results indicate that the participants had a higher level of conjugal satisfaction.

The participants demonstrated a higher level of resilience, which could partially explain these findings. Additional resilience was established when there was the presence of a secondary partner. Resilience theories gather around two critical components: a significant threat or stressor and positive adaptation to the situation despite the threat or stressor (34). The transition to parenthood is considered stressful in itself, so any changes that the participants may have experienced in emotional intimacy with a return to a positive level, may be partially attributed to their resilience (3,35).

**Sexual intimacy.** The participants experienced physical discomfort during pregnancy and early postpartum (9). Even though some of them did experience birth trauma, which affected their capacity for intimacy, they did bounce back, demonstrating resilience (34). When looking more closely at the participants' scores in relation to perceived levels of sexual intimacy, their scores showed higher levels of sexual intimacy than previously published studies (17). As expected for most partners during the postnatal period, the potential decline would either appear not to have happened or could have happened but remained higher than the average.

When considering the qualitative and quantitative results together, PCNMs appear to be better prepared for the transition to parenthood, seem more aware of the sexual changes associated with this transition, and do not appear to experience the same period of non-sexuality (9). In the initial postpartum phase, it appears that PCNMs do not partake in the lifestyle because of the physical changes associated with childbirth and the decreased libido related to breastfeeding. Sexual activity during the first postnatal year was more vanilla, and participants decided to practice CNM and BDSM away from their home. Consensual non-monogamists have a higher level of sexual satisfaction, even during the transition to parenthood (22).

PCNMs in this study seem to place greater emphasis on sexual intimacy during the transition to parenthood. They have a greater ability to communicate their sexual desires and needs to their partner(s).

**Communication.** The participants used communication as a way to regain emotional and sexual intimacy and to strike a balance between the roles of lover, partner and parent. Changes and challenges with communication can be expected during the transition to parenthood as parents' roles change (8). Three dimensions are salient to the conciliation of roles during the transition to parenthood: role expectations, role enactment, and role negotiation (36). Communication is needed for all three dimensions. During this transition, most parents initially focus on their new role of parent to the detriment of their other roles of lover and partner (37). Because new parents usually prioritise the role of parent over those of lover and partner postnatally, there is often a decrease in emotional and sexual intimacy and communication (3,8). However, the findings from this present study suggest that PCNMs chronologically concentrate on the role of parent, followed by the role of lover and then, that of partner.

Although the study participants reported stress and disorganization after the first child's birth (8), their communication was still distinct in three ways. First, the participants recognized the importance of communication as they were more aware of their communication skills. Putting their advanced communication skills into practice empowered these parents to overcome the challenges faced with PPD and/or having a high-needs child. Second, these advanced communication skills could have stemmed directly from their 'lifestyle'. Individuals who uphold CNM need good communication in order to consult with each other before, during and after a CNM encounter, with a potential spillover effect for their parenting (3). Third, as part of the 'lifestyle', the participants had to do regular check-ins. Through this transparency, it appears that their desires and needs were easily identified, enabling them to not only share them with each other but also to support them. Consequently, these combined skills helped to better equip the participants in their roles of lover, partner, and parent, increase their satisfaction with their relationship and help them navigate more than one person as a partner and more than one relationship.

## Strengths and Limitations

This study contributes to the growing body of perinatal health nursing research that examines CNM associated with the four phases of the transition to parenthood: preconception, pregnancy, birthing and parenting. The breadth and depth of the data analyses were demonstrated through the comprehensive results obtained for this study. However, the goal of this study was not to generalise, but to gain a greater understanding and contextualization of the transition to parenthood for PCNMs. This greater understanding and contextualization were particularly meaningful, as they were supported by the application of the conceptual framework that relied on the EMERJ lens (13) and enhanced by Cowan and Cowan's Ecological Model (8).

## Implications for Nursing Education, Practice and Research

Although this study was exploratory and descriptive and did not seek to generalize, several recommendations and/or implications emerged from the findings for nursing education, practice, and research.

**Nursing education.** It is recommended that parenting CNM should be part of the undergraduate curriculum in perinatal health nursing for the theory and clinical practicum courses. The clinical practicum usually includes a learning laboratory, simulations, and placement in a healthcare facility. Students can become more aware of this particular group of parents, better understand their needs, and learn how to intervene clinically. Concretely speaking, content can be added to the theory and clinical practicum courses, including post-clinical conferences, that focuses on the four phases of the transition to parenthood, and on this particular group of parents' intimacy (emotional and sexuality) and communication. Training in human sexuality that includes parenting CNM can also be extended for continuing perinatal health nursing education through conferences, webinars, workshops, and podcasts (14).

**Nursing practice.** PCNMs may disclose their sexual lifestyle to perinatal health care providers including nurses who demonstrate support, empathy, and cultural safety. Cultural safety requires these providers to reflect on the structures in place that assumes heteromononormativity. It is recommended that frontline nurses and other HCPs integrate a cultural safety approach with this group of parents: these providers through educational sessions would learn to recognize their own assumptions about their clients based on sex, sexual orientation and sexual practices, age, gender, race, relationship status, ability, socioeconomic status, and other aspects (37).

The findings also suggest that PCNMs require a different clinical approach: the participants in this particular study were well-versed in the health risks involved with their lifestyle, and were more likely than their monogamous counterparts to deliberately plan their families, and to ask questions on how their lifestyle could influence the first phase of the transition to parenthood (decision to be a parent). Perinatal nurses would be better prepared and equipped to have more open communication and discussion with these clients and their partner(s), in order to talk about these health risks for themselves and their children (unborn and born), thereby increasing their knowledge, and consequently, their resilience. Acknowledging additional relational partners promotes a more family-centred approach to care for all concerned parties. It is therefore recommended that continuing education should be offered to perinatal health nurses, in order to raise their awareness of the growing diversity of families, including sexuality diversity families. With these changes, PCNMs will feel more encouraged to access perinatal health care services throughout the transition to parenthood, thus resulting in better perinatal health outcomes.

**Nursing research**. Further research is warranted with this particular group of parents by using bigger samples, replicating the study in other parts of Canada and in other languages such as French. The use of other conceptual frameworks such as intersectional theory is suggested for future studies as well as more participatory approaches, bringing the voices of PCNMs to the forefront (39).

## Conclusion

From the study findings, perinatal health nurses can better understand PCNMs, who are unique yet are just like other parents. Despite the challenges the participants faced regarding the four phases of the transition to parenthood and the adjustments in intimacy and communication, they managed to keep the connection in their relationships. It appears that this sexuality diversity group has an underlying resilience that helps them cope with parenthood and modify their sexual lifestyle. All perinatal health care professionals, including nurses, need to know that ‘family comes first’ for these parents.

## Ethical Permissions

Ethics approval was obtained from the University of Ottawa Research and Ethics Board in Ottawa, Canada (Ethics File Number H05-17-05). All study participants provided informed consent, and their anonymity was preserved.

## Conflict of Interest

The two authors do not have any conflict of interest to report.

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