APORIA

LA REVUE EN SCIENCES INFIRMIÈRES • THE NURSING JOURNAL

2014: Volume 6, Numéro 1/Volume 6, Issue 1. ISSN: 1918-1345

Sommaire/Content

2014: Vol.6, Numéro 1/Vol.6, Issue 1

Éditorial/Editorial

What does the bold and courageous verdict of homicide mean in the coroner's inquest into the death of Ashley Smith? Who is responsible for her death? And what good would it do to reopen criminal proceedings for the three front-line staff and one correctional manager originally charged in the case?

These individuals are merely agents of an aggressive order, "necessary" and arguably "proportional" to the demands of a diffuse and coordinated violent apparatus (dispositif). How else are we to understand the video evidence presented at the inquest, much of it resonant with Hollywood depictions of counter-insurgency tactics in the war on terror? Doing justice to Smith becomes surreal, impossible in the face of a faceless, anonymous system. Ethically and juridically we enter a grey zone: nobody is responsible, agents were just following orders.

If we look at our federal correctional system, it appears that we are at war with those who are most vulnerable among us—those who have a mental illness, our youth, the poor, Aboriginal peoples. And while we can expect high rhetoric from government officials, much hollow talk of "victims' rights," Ashley Smith is not and cannot be a victim in their eyes: she is collateral damage in a war being waged in our correctional facilities and in our communities.

Since Smith's death, the federal Conservatives have passed omnibus bills that have imposed harsher sentences on young offenders and the unconstitutional use of mandatory minimums, which have increased our prison population to an all-time high, disproportionately affecting Aboriginal peoples and persons requiring mental health care. Concerning the use of force, physical and/or chemical restraints, and solitary confinement, Bill C-10 changed the wording of the law from the use of "least restrictive measures" to what is deemed "necessary and proportionate."

While the principle of "least restrictive measures" was based on a response to an individual in particular circumstances, the shift in language ushers in a dangerously subjective and open-ended culture of corrections. "Necessary" for what? "Proportionate" to what? And according to whom? Will necessity and proportionality vacillate if the facility is over-crowded and under-staffed? At what point does a therapeutic approach cross over into management techniques, economic efficiencies, or torture, called for and justified by the system itself? The case of Ashley Smith demonstrates that we have crossed this line.

Stuart J. Murray, PhD
Associate Professor
Canada Research Chair in Rhetoric & Ethics
Carleton University

Dave Holmes, RN, PhD
Professor
University Research Chair in Forensic Nursing
University of Ottawa

1

Abstract
Over the last twenty years, ethics has been expanding in health care and chaplains comprise one of the key groups that provide ethics consultation services in the German arena of psychiatry. Like all professional actors in the practical arena, chaplains perform their role. Performance happens in relation to others who occupy positions that allow more or less exercise of power. This architecture of relational positioning and territory constitutes the social space. The question is, whether ethics in psychiatry can overcome the determination of positioning within the social space, and if yes: what is the scope of ethics? This article investigates into the role of chaplaincy as ethical agents (in Germany) on the basis of theoretical and empirical studies over the last 10 years. The meaning of social space in the field of psychiatry is explored by taking Pierre Bourdieu's work into account. For illustration, a case study is given.

Key words chaplaincy, ethics, psychiatry, social space

If Ethics in Psychiatry is the Answer - What was the Question?[1] Exploring Social Space and the Role of Clinical Chaplaincy

HELEN KOHLEN

Introduction

> How am I able to follow a rule? If this is not a question about causes, then it is about the justification for my following a rule in the way I do.
>
> If I have exhausted the justification I have reached bedrock, and my spade is turned. Then I am inclined to say: This is simply what I do.[2]

It is a fact that people in their everyday lives and in real space and time generally do not practice the kind of reflection that Wittgenstein points to in his philosophical investigations.[2] People learn social rules in order to successfully perform their roles in a given social order; they are not raised to resist these rules or question this order. According to Pierre Bourdieu,[3] social rules have not really changed over time, but the same ones continue to persist. In his work on Masculine Domination, he is surprised that people more or less accept the rules governing social order and thus reproduce it and relationships of power over and over again.[3] He explains that,

> …the established order, with its relations of domination, its rights and prerogatives, privileges and injustices, ultimately perpetuates itself so easily, apart from a few historical accidents, and […] the most intolerable conditions of existence can so often be perceived as acceptable and even natural".[3p1]

Bourdieu's sociology (1980, 1982, 1997, 2001) is not based on prefabricated assumptions about the social world, but on his observations of how individual members of a society find their place and position and how these positions relate to each other.[3-6] Therefore a social topology is necessary. On the one hand it consists of a place (topos) where a

single human being, a collective actor, or an institution is located as an absolute position within the social world: A is situated in field X in the position Y. It is a powerless position. On the other hand, social topology determines relational place within a social order or organization. The place of A is characterized by its proximity to B, C, and D and its distance to K, L, and M, which hold dominant positions in the field. For Bourdieu, relational localization is crucial since it describes the position that A holds and from which A perceives the field. To illustrate this kind of social topology, according to Bourdieu, one should depict the social world as a multidimensional space which originates from the process of mutual positioning. While physical space is marked by the fact that things are put in order of co-existence, social space is defined by the distinctions of positions.[5] To put it more generally: distinctions and exclusions determine mutual positioning.

This reproduction of an established order accounts, I think, for the hierarchical organization of hospitals, including the psychiatric clinic, to this day. Despite some maneuvering on ethics within the clinical setting over the last 20 years in order allow space for all actors involved in patient care, social rules that determine the hierarchical organization of these institutions continue to persist. Social positions of professional actors are relational and constitute the social space that directs who can exercise more or less power, who can define patient behaviour, and whether or not ethical questions count as something relevant.

Applied ethics in healthcare has been growing as an interdisciplinary enterprise since the 1960s, and in Europe, the field has expanded greatly over the last 15 years.[7] The demand for ethics in healthcare goes back to the bioethics movement in the US, which adopted the tone of the social movements of the 1960s and 1970s with their emphasis on autonomy and rights. The patients' rights movement reflected an increasing distrust of medical authority and was critical of the paternalism that was deeply entrenched within medical encounters.[8] Ethicists are now called upon to serve as expert consultants in numerous legal political, educational, industrial, and health care areas.

Not surprisingly, psychiatric practice has become the focus of growing ethical interest since it has become increasingly understood that psychiatric diagnoses are closely connected to cultural understandings of how people should behave. A diagnosis affects whether or not a particular behaviour is accepted as an individual character trait or is perceived as a deviant psychiatric disorder. Since psychiatric practices basically aim to change people's behaviour--to train "normal" behaviour--they demand the right to intervene into a patient's personality. Questions about patient autonomy and patient needs, as defined by patients themselves or someone in the role of advocate, have been stimulated by an ethical perspective.

An increase in ethical concerns has brought philosophers and theologians, as (bio)-ethics experts, to the health care arena. Chaplains comprise one of the key groups that provide ethics consultation services in the hospital.[9,10] This article will focus on chaplaincy in an attempt to understand the meaning of ethics in psychiatric practice. The questions raised include: what kind of role does clinical chaplaincy play in the hospital arena and what effect does an ethical perspective have on the positions that chaplains occupy (or re-occupy).

This first part of the article that follows will provide an explanation of the concept of social space and the hospital chaplain's position in relation to other professional groups. Part two will provide an overview of the different understandings of the role of chaplaincy. In it I will draw on anthropological and sociological studies,[11-14] but will also include theological discussions.[15,16] Although chaplains have a key role to play in clinical ethics, the literature on their actual practice is rare, especially in psychiatry. Part three will present a case story illustrating the reach of the chaplain's ethical role in practice, and its relational position and its importance in the social space of clinical psychiatry. Although this case study is not representative of all ethical work in clinical psychiatry, it serves to illuminate research on the role of clinical chaplains, especially with regard to their ethical role in psychiatry. Above all, it offers a detailed account on relational positioning and the power of medical definitions. To end, I will critically reflect on the concept of social space and how ethics can (or cannot) provide answers to conflicts in psychiatric practices.

Ethics in the hospital arena

In Germany, nearly every hospital over the last 15 years has developed an instrument to address ethical issues. Basing the Clinical Ethics Committees (CEC) on those established in the US has been the preferred method, since the American model is seen as adequate to deal with ethical training, case discussions, and policy making.[9]

Field studies of ethics in health care have demonstrated the practice of ethics in the hospital arena and how it has been shaped.[9,17] In the clinical setting, ethics deals mainly with questions of decision-making at the end of life. Ethical questions based on principles and with a focus on autonomy

frame these discussions while questions concerning social rules that might have caused the problems the first place are sidelined and dismissed. Studies reveal that structural issues like the hierarchical organisation of the hospital and questions of working conditions are marginalized. Finally, the question of who is or is not authorized to define an ethical problem is never tackled.[9,17]

As Chambliss remarks:

> Talk of 'ethical dilemmas' diverts attention from the structural condition that has produced the problem in the first place. This is naturally in the interest of the status quo and is relatively unthreatening to powerful interests within the hospital. This is why so many hospitals can readily accept an 'ethics committee' and its debates about ethical issues.[17p92-93]

Social space and the position of hospital chaplaincy

Although the notion of space is still neglected, space is considered a basic sociological concept.[18,19] Because the term social space does not tempt one to use metaphors or to assume that space is a purely geographical concept, it is preferable to use words such as territory or location. In Bourdieu's sense, space is not thought of merely as a "container" filled with things, substances, or separate individuals, but rather is itself constituted from the coexistence of and relationships among objects and people, which therefore determines their position relative to each other.[6,3]

When the concept of social space is transferred to the microcosm of the hospital, separate professional actors are positioned in particular ways both to one another as well as to patients and their families. This relative positioning also holds true for medical devices, especially in intensive care units. Each position is therefore determined or relationally defined by its relation to other positions. The position of the hospital chaplain is determined by his or her closeness to patients and their families as well as by the social proximity to the senior physician and the head nurse. The dominant position of hospital physicians has been determined by the relatively weaker positions of chaplains and nurses within this space.[5]

Relational analysis is useful to capture both the formation and the interactive determination of significant differences.[5] The relational position of hospital chaplains within the institutional social space influences clinical practice. Chaplains' responsibilities originate in this social space from mutual positioning, associated role ascriptions, and transfers of responsibility, as well as the withdrawal, relief, or revocation of these responsibilities. In sum, mutual position reference is the only way that separate individuals can be connected within social space. If social space therefore gains shape through a mutual determination of social position, what constitutes social positions?

The social norms that are bound to a social position affect the individual, emerging as behavioral expectations that cannot be withdrawn from without punishment.[5,6] Consequently, a directive exists to arrange each position--a kind of script determines the social role that has to be played. In the field of health and disease, and especially in a hospital setting, a physician's position is associated with an expectation to cure, while a caring role is attributed to other actors (nursing, social work, and hospital chaplaincy). While the curing role is associated with knowledge of technology, the so-called hard skills, the caring role often requires the use of "soft skills". Those with a stronger claim to the use of hard skills, however, enjoy higher prestige.[5] The position of surgeons, for example, is a higher status that that of physicians involved in geriatrics, for example, which is associated with both curing and caring roles. Because the caring role is so strongly attributed to both chaplains and nurses, they are thus seen to have a less prestigious status.

Perspectives on the role of clinical chaplaincy and the psychiatric field

To understand a chaplain's perspective on ethical conflicts requires both a historical perspective on and a current knowledge of practice.Chaplaincy has long been linked to the Christian church, and chaplains have been drawn from its priests and ministers.

> While the history of the terms chaplain and chaplaincy suggest that ordained clergy are attached to a chapel, such as a hospital chapel, in many settings the majority of healthcare chaplains are not ordained clergy.[20p10]

However, chaplaincy has been affected by new understandings of the relationships between spirituality and institutional religion.

The role of the chaplain in the modern-day hospital is diverse and challenging. Kevin Franz explains that in responding to the needs of individuals in the modern healthcare system, chaplaincy has brought a distinctive knowledge base and set of skills that are integral to understandings of care.[21] While physicians might limit their perspective on patients to physical findings of measurable data, chaplains look for

the person behind the symptoms of a disease, diagnosis, or therapy.

Chaplains as ambivalent figures

Nonetheless, in her ethnographic study, Norwood comes to the conclusion that the role of the chaplain is an ambivalent one.[13] Her observations of their everyday practices in modern-day hospitals reveal how chaplains negotiate both structural and ideological marginality. At times they embrace their connection to medicine and at other times they embrace their connection to religion and religious practices. For her "the result is an ambivalent chaplain who strategically embraces one or the other paradigm in order to survive".[13p1] The presence of marginalized practices is not unique but a regular occurrence within the hospital setting. And although a range of activities from the sacred to the profane situates chaplains somewhat precariously between competing paradigms of science and religion, the role is not without agency.[p3] As Norwood's study demonstrates, "the margins are active, dynamic, and contested grounds where agents negotiate for power and for place".[13p25]

Chaplains as translators and possible trouble-makers

Hospital chaplains work with patients primarily by talking and listening.[15p184] They seek to understand what it means to be a human confronted with a disease or imminent death, and what consequences personal relationships can have on dealing with that situation. Consequently, hospital chaplains often describe their job as a form of *translation work* between patients' lived-in worlds and their hospital worlds.[11] Although it is usually interpreters who work with words and translators with texts, chaplains use this metaphor to point out that for them, it is more about trying to comprehend the underlying nature of what patients really want to say when they speak (or do not speak) about something. Hospital chaplains do not view the meanings of statements and silences as being isolated from patients' backgrounds and lived experiences, but rather, they always endeavor to understand the context. Hille Haker is convinced that the most important part of a hospital chaplain's work consists of interpreting the stories that he or she hears.[15p185] Hospital chaplains thus have the capacity and resources to render their patients' social worlds accessible, and to understand and speak the language belonging to it.

While these authors agree that hospital chaplaincy fills a gap in patient care, they also contend that a chaplain's work is not a clearly defined service. In his sociological-empirical research project, Raymond de Vries studied the role of chaplaincy in healthcare, and in 2008, he and his co-authors drew attention to the fact that hospital chaplains should consider how best to translate the meaning and value of their work into a language that hospital administration could understand.[11] They pointed out that in order to be perceived as a profession, an occupational group has to define a clear boundary of its work.

Doris Nauer understands the role of chaplaincy as one of advocacy on behalf of patients who might otherwise be incapable of acting for themselves.[16p232] In her sociologically oriented concept of diaconal chaplaincy, hospital chaplains do not limit their activity to focusing solely on patients' needs and sufferings but also address problems patients might have with hospital staff and management. For her, authentic chaplaincy means that chaplains deal with the hospital system and its structures in a constructivist-critical way, intervening, for example, in cases of what they perceive as unfair—when people in powerful positions define patient behavior as abnormal without knowing the particular patient well while people in less powerful positions do not have a say about treatment despite their concrete knowledge of the patient. Nauer's claims are situated within the German context where chaplains working in the hospital are not necessarily paid by the hospital but by the church, and can thus work more independently.[16] This independence allows chaplains to shift into the field of (institutional) politics by claiming that they will not shy away from conflicts and questions regarding preexisting institutional hegemonic structures. However, by actively resisting the social rules of the hospital system, chaplains can be understood as "trouble-makers".

Chaplains as ethical authority figures

The same services and rituals found in the traditional religious role of chaplains are also performed in psychiatry, although since patients do not die in psychiatric facilities on a regular basis, chaplains there rarely address grief and end-of-life issues.[12] Mary Strachan Scriver (2006) states that "… ideally, a chaplain would hold ethical and emotional authority equal to the substantial power of doctors".[22p454] She believes that the chaplain's religious concerns should be directed towards "justice, protection, and the sustenance of hope for both doctors and patients".[22p454] Gwendolin Wanderer picked up this idea as a starting point for her research in the field of psychiatry, when she investigated the potential for chaplains to become ethical and emotional authority figures.[14] In her in-depth interviews with chaplains on

their working conditions in German psychiatric hospitals, she focussed on ethical issues and the roles that they considered crucial.[14p297] The interviews revealed that patients on psychiatric wards basically have a greater interest in talking to chaplains when compared with those on non-psychiatric wards.[14p299] Nearly all of the interviewees considered religious services--the traditional roles of chaplaincy in conducting worship, performing religious rituals, and leading prayer--to be very important.[p301] When psychiatric hospital chaplains were asked about their ethical role, however, they were rather ambivalent. While some clearly identified with the role of a patient's advocate or guardian, others were not convinced and would even deflect any kind of ethical responsibility for psychiatric patients. They described structural institutional problems to be of high relevance for their work, but felt unable to influence change. None of the chaplains considered writing letters to people in positions of management to be fruitful. They also considered their time spent in committees to be irrelevant in making the institution a better place for both staff and patients.[p303] When they were asked what they would immediately change in psychiatric hospitals if they could, nearly all of them said:

> … that in the treatment of the mentally ill [there is] too much focus on psychopharmacology … many illnesses or symptoms could be better healed in therapy including conversation and individual care for patients, which unfortunately seems to be reduced as a result of cuts in the public health services' budget. [14p303]

In the chaplains' experiences, physicians very rarely asked for consultation, rejecting the idea of teamwork.[p304] Most important to all chaplains was their ability to spend time with patients.[p306]

According to Wanderers' study, chaplains played only a marginal role as ethics consultants in psychiatric clinics. The interviews demonstrated that chaplains were very much aware of having to walk a fine line between criticizing members of the treatment team on the one hand, and being responsible to their mentally ill patients on the other. The findings from this study complement another investigation into the views of hospital directors on the importance of various roles in the clinical setting.[12] Here the research team discovered that the administrators accepted the chaplain as ethical consultant to some degree, but that social workers and physicians were less willing to see them in this role. And while the administrators identified patient safety to be a job for everyone, chaplains were not yet fully integrated into the team.[12p222-4]

Kevin Franz, in writing about the role of chaplaincy in psychiatry, argued that "the 'place' of the chaplain is one which takes its character not from the institution but from the task: the spiritual care offered both to individuals and to the institution, from a place which may be described as 'marginal' or 'counter-cultural'".[21p124] According to him, an important question to ask is: "As they seek to be regarded as fellow professionals by others, and as they are properly accountable within the structures of health service, do they become 'insiders', part of the establishment, distinct from the person they seek to accompany?"[21p126]

The case story of "Kabila's dogs in Germany"

This case study is taken from a collection of written narratives by chaplains who were participating in an advanced class (2009-2010) at the Goethe University of Frankfurt. All students in the class were asked to contribute a story based on their clinical experience as ethical consultants.[2][23] The following, slightly abbreviated story refers to one chaplain's experience in a psychiatric setting.[3][24]

Patient information

This situation takes place in a rural German hospital for mentally ill people. Around 5 p.m., Dr. Mitterer[4], the senior physician in general psychiatry, calls me on the emergency mobile phone. She explains that she is worried about a patient from South Africa. She tells me quickly that the patient, Mr. Lumbado, is a Catholic priest, is 55 years old, was born in Southwest Africa, and has been working for approximately 10 months as a chaplain in village A. She explains that from a medical point of view, it is totally unclear what is wrong with him. The previous night, under "dubious and unclear" circumstances, Father Lumbado was delivered by police, handcuffed, from the county hospital 30 km away. He was very distrustful and appeared strange: "Just moved the mattress from the bed to the ground just like that." Dr. Mitterer emphasizes that under orders from her boss, Father Lumbado was not to leave the hospital before the middle of the following week. When I ask why, Dr. Mitterer answers that "the previous night at the county hospital, the patient took off his clothes and barricaded himself in his room". For the sake of gaining his confidence, Dr. Mitterer asks me to establish contact with him as soon as possible. She herself was about to leave for an off-duty weekend.

Encountering the patient

I visit the ward to see Father Lumbado. In the ward office, medical director Professor Dr. Schön approaches me, confirms the senior physician's information and impressions,

and mentions that the patient might not be truly mentally ill because his diabetes is out of order. Nevertheless, according to Dr. Schön's impressions, the priest is scared and not oriented. Dr. Schön asks me to build up the patient's confidence and to try to make him stay voluntarily at least. I ask him whether Father Lumbado has spoken about suicide or acted aggressively. He answers that anything is possible, because he was violent with the police.

At this time, no contact information for the patient's family, friends, or colleagues is available. The conversation with the medical director ends with reference to the senior physician, Dr. Baier, who was Catholic himself, and was on duty and aware of the situation.

Father Lumbado is located in a single room. After greetings and introductions, the first contact between the priest and me, he remains silent. He is sitting on his bed, arms crossed, looking at me emptily. He rises, takes the mattress off the bed frame, puts it on the ground, sits down on it, and says with a firm voice, "Please leave and come back tomorrow." The atmosphere is frosty and oppressive and filled with distrust. I can clearly sense that any additional word might violate Father Lumbado's boundaries and his need for protection. I understand that any additional attempt to communicate would be neither helpful nor reasonable at this time. I promise to visit him again but he answers only with a nod to my "goodbye".

Inwardly, this short first encounter with Father Lumbado bothered me a lot. His name isn't shown in the patient register where it should be. The whole situation seems suspicious, and I wonder: What does it mean to each of us in this psychiatric context when we are both "pastoral colleagues"-- with him in the role of a patient and me as a professional chaplain and ethics consultant? Is he willing to have contact with me at all? What has to be considered about his cultural origins? Are there political issues to be considered? Is he afraid of the German system?

Saturday afternoon, the nurse describes an obvious improvement in Father Lumbado's condition compared to the early morning. She describes his mood as relaxed and easygoing. She states: "Father Lumbado is talkative, funny, interested in a variety of topics, speaking German fluently. However, he stayed awake all night and refuses food and drinks only very little." I also am aware that this poses a medical problem for his diabetes. Any sedatives he strictly refuses. However, his condition deteriorated approximately one hour ago. He does not want to leave his room anymore. The senior physician, Dr. Baier, is notified--hoping for clarification and improvement with my help.

As I enter the room, Father Lumbado claps his hands, telling me that in his home country, friends are greeted that way. He calls me a friend because I am visiting him on a Saturday. His eyes shine, he smiles. His bed is messy, crumpled papers are scattered throughout the room. He offers me a chair, asks whether I have got time since he desperately needs to talk to me. He starts the conversation by telling me that we are both full-time Christians. He explains his observations about parallels: similar oppressive mechanisms of the male church against women, devaluation of women and black people. He talks about the war between rebel groups in his home country, about grave human rights violations, about using systematic violence against women as a weapon of war. The tempo and volume of his speech increases. He talks about rage and experiences of powerlessness. He doesn't accept my inquiries, gives testy replies, and requests that I should listen quietly. He continually tells me: "My soul is screaming! They came to get me--brought me here in handcuffs. Kabila's dogs in Germany, too. With drugs you beat me--but to no avail. Jesus is the victor!" He repeats these sentences with a fading voice.

Senior physician Dr. Baier enters the scene. Right away, Father Lumbado asks me to leave and to administer Communion on Sunday. Later, I meet Dr. Baier in the ward office. He intends to transfer the patient to a secure ward because he won't take tranquillizers (diazepam). He doesn't comment on the nurse's observation that, in the early morning, Father Lumbado was in better general condition. He also doesn't respond to me when I point out that he has suffered terror in his home country, and that his state of excitement could stem from a re-traumatization by the night time police operation he had to suffer. Dr. Baier interprets Father Lumbado's statements in the context of a psychosis. He emphasizes that it is imperative that the patient take medications.

A discussion arises concerning the patient's anxieties regarding his past experiences of violence and his current experiences at the clinic. For Dr. Baier, pharmacological treatment has priority. He emphasizes that it is he alone who is fully responsible for the patient's well-being. He overlooks the fact that I do not share his diagnosis of delusion and that ethical questions have to be raised before coming to a quick medical solution. For the first time since my collaboration with Dr. Baier, I fully realize the different ways of thinking, feeling, and reasoning of the two professions we are in.

Refusal of medication and its consequences

In the private ward office, the nurse informs me that Father Lumbado, after consultation with Dr. Baier and at the behest of the physician on duty, has been transferred to the secure ward. The reasons mentioned were: barricading himself in his room, refusal of any medication or food, and loud praying.

On the secure ward, the nurse in charge informs me that things escalated during the morning. Father Lumbado again refused taking any psychotropic medication. Moreover, he rejected any offer to talk. It was noticed that he was less dismissive of female staff. Nursing staff decided that Mrs. Ruffing should be his primary nurse.

Mrs. Ruffing accompanies me to his room. Father Lumbado sits on his blanket, fixating on ties hanging from his bed. When opening the door, he says aloud, "Stop, no further!" When seeing me behind Mrs. Ruffing, he calls out, "Finally, finally. I won't survive this. Are you bringing Communion?" Nurse Ruffing leaves the room, saying to call her in case anything happens. The priest starts reciting prayers in Latin and French as well as in a presumably African language, all very low-voiced and quickly. I remain silent, then recite the Our Father in Latin and hand him the Communion Plate. No eye contact on his part, not a word, nothing. After receiving Communion, he says the Magnificat in Latin aloud again, followed by a determined, "Jesus lives--so do I!" He intones a Hallelujah, claps his hands, establishes eye contact, gives thanks, addresses me by my name, and with a tired look approaches me. He emphasizes how thankful he is for my coming as well as for the Communion. He also says that he will be able to feel himself again and that no one can bring him to his knees.

Eventually we begin to talk. He talks delightedly of his church's Sunday services "with African charm". He also tells of the rivalry between Dean Altmeyer and him, of racist devaluations he is also encountering with senior physician Baier, although he refuses my request to explain. He is afraid that he'd have to bear the cost, and besides, he is not willing to stay here for long. Communion has given him the strength to tear it all down, the whole ward. I tell him that I am worried about him and the other patients. He points out that he would not harm a fly. His mood ranges from being intimidated and scared, to being boastful and aggressive. He asks me whether I knew what it meant to live as a black person among white people. He talks about "black theology", the meaning of oppression and resistance. He declares that his forefathers would protect him, and states that we Europeans have no idea about the African faith in Christ. However, women might understand.

The keyword "woman" makes him pause in his monologue. He asks me about my family situation and mentions his nephew living 150 km away. I offer to telephone his nephew about his stay at the clinic, and he gives me his number. He calms down, and the fear and aggression wear off. He lies down on his bed, saying that he feels better, assuring me that I could leave and shouldn't worry. With the promise to visit him again the next day, I say goodbye.

In the office, I meet Dr. Baier, who has requested to see a judge to begin the procedures to involuntarily confine the patient and start compulsory treatment. According to his assessment, the patient is suffering from absurd racist delusions and needs medication instantly. My pointing out the ethical aspects that work against justifying his decision is ignored by him and we become involved in a controversial discussion concerning religious mania and the experience of faith in other contexts. A medical emergency call for Dr. Baier abruptly ends the conversation.

In the late afternoon, the primary nurse informs me that Father Lumbado's condition has deteriorated. By the time I arrive, Dr. Baier and six nurses are in the office. Dr. Baier states that Father Lumbado is in an extreme state of excitement, needing a sedative shot right away. He has been refusing everything, blares out threats, wanting only to talk to me. Dr. Baier advises against this. Based on this morning's experiences, I suggest visiting him to see if I can make some kind of connection and get him calmed down. Dr. Baier agrees, but points out that he and the crisis intervention team don't have all the time in the world.

As I enter, Father Lumbado is alone in his room. He seems anxious, threatening to set the ward on fire. We discuss the situation and he states clearly that he refuses psychotropic drugs. He is not ill, not psychotic; rather, he feels homeless and all alone. He describes his situation as "deracination". His aggression turns into sadness, he has tears in his eyes. Then he talks about his mother and siblings, asks about his nephew whom I have not yet been able to reach. The situation is noticeably becoming more relaxed.

Twenty minutes later, Dr. Baier, holding a syringe and accompanied by four nurses, enters the room. Father Lumbado starts shivering. I ask Dr. Baier for an ethical counseling session. He agrees, and we leave the room. I inform Dr. Baier about the course of events during this most recent contact, referring to my experiences in relaxing Father Lombado and to the opportunities that his good relationship with his nephew might provide. I also point out that his ability to express

himself clearly is important from an ethical perspective. Finally, I request more time to continue a peaceful dialogue to prevent violence. The term violence causes vigorous outrage in Dr. Baier, who refers to his medical obligation to act, saying that the patient does not understand his disease and that he has to be cooperative. After all, in his condition, according to Dr. Baier, he is unable to make autonomous decisions. Thus, there is a need for action. He emphasizes that the "fixation team" had been waiting for more than 35 minutes already. I try to explain my point of view and my ethical concerns from a chaplain's perspective. I question the time pressure for the decision on treatment since Father Lumbado is not in any life-threatening condition. I mention the patient's state of excitement that would be reinforced by medical intervention. I explain that from an ethical point of view, a violent medical intervention denies the patient's right of self-determination and discretionary competence. Dr. Baier disagrees, explaining that poor discretionary competence is a symptom of the patient's disease. He does not offer a verified diagnosis. Although I notice the contradictions to an ethical manoeuvre, I do not inquire any more and try to make sure that the nurses' perspectives are considered.

Dr. Baier refuses any assessment by nursing staff, especially by the primary nurse. He leaves unanswered the question of what the medical consequences would be of not administering the injection. He tells us that he now has to do his job as a doctor and ends the discussion. He asks me to leave the patient alone for the rest of the day. He leaves the office, briefly speaks to the nurses, and two accompany him to the patient's room. "Too bad. Here comes another trauma for the patient", Mrs. Ruffing, the primary nurse, comments on the scene. I feel impotent, furious, and exhausted.

Asking for an ethical case review

On the following day I asked for an interdisciplinary team meeting to suggest an ethical reflection on what had happened and what could have happened differently. Professor Schön explains that Dr. Baier did not have any other choice in his actions. I receive no response to my request for an ethical reflection on the situation. When I finally contact Father Lumbado's nephew, he tells me that his uncle has had traumatic war experiences and that he has been feeling upset for a long time.

Interpretation of the case story

In this section I take a closer look at the conflicts, how they are defined and by whom, and of the kinds of responses they elicited. In so doing, I will shed light on the role of the chaplain and the place she (re-)occupies.

At the very beginning, the female hospital chaplain in this story notices that the psychiatric hospital is located in a rural area. Patients who are immigrants, however, are rarely treated in rural German hospitals.

Patient information: Missing context and trust-building as an order

Via an emergency mobile phone, the senior physician in the general psychiatric department passed on the little information known about Father Lumbado to the chaplain. He does not, however, provide any background context. And although it is later admitted that the patient's fear may be attributable to his diabetic condition, and that he might not indeed be mentally ill, this lead is not pursued and an appropriate diagnosis of exclusion is not made.

The physician ordered the chaplain to get in contact with the patient straight away, specifically charging her to initiate measures to build the patient's confidence. The doctor wanted to ensure that the priest remained voluntarily, which would allow him to avoid a holding order. Confidence building is expected to be a readily available service provided by hospital chaplains, delegated because no one else is available.

Encountering the patient: Interruptions, different behavior definitions and perspectives

On her first encounter with Father Lumbado, the chaplain realizes through his body language that he clearly rejects her, and as a result, she removes herself from the situation. Nonetheless, she is worried about his behavior and begins to reflect on his status as a priest and what it means to him --a male priest in a patient's role. She also begins to wonder what experiences could have led Father Lumbado to act the way he did and considers the possibility that he had to protect himself in his home country for political reasons. She also figures that he might feel threatened by the "German system". With all of these questions, she is searching for the context of his behavior as well as for the person behind the unsupported psychiatric diagnosis. When she returns the following day, the priest begins to think of her as a friend, and over the course of their meeting, she proves to be a patient and mindful listener, learning that the factors of gender and power play a role in his life.

For the physician, however, pharmacologic treatment had priority. Although the chaplain pointed out that Father Lumbado had suffered terror in his home country, and that his state of excitement could be interpreted as a re-

traumatization by the night time police operation, Dr Baier derided the hospital chaplain's attempts to explain the patient's delusions. Only then does the chaplain realize the differing perspectives between the medical practice of psychiatry and pastoral care, and she asks herself how best to communicate her thoughts that were in conflict with the psychiatrist's order.

Refusal of medication and consequences: Violence as an answer

Eventually, the nurse in charge explains that the priest has barricaded himself in his room, refusing to take any medication or food, praying loudly and threatening people, and the senior physician transfers him to the secure ward. Still, Father Lumbado refuses to take psychotropic medication, remains strictly unapproachable, and refuses offers of talks. It is observed that he is less wary with female nursing staff as well as with the female hospital chaplain, whom he thankfully welcomes. Although he briefly mentions the senior physician's racist devaluations, the chaplain believes that he does not mention details for fear of negative consequences. The patient's mood swings between fear and aggression but he begins to calm down when the subject of family issues and women comes up. The chaplain does not make any more attempts to reassert her observations with respect to the senior physician's therapeutic intentions.

In the meantime, the senior physician has organized an involuntary commitment and has requested a judge. He attributes Father Lumbado's behaviour to "absurd" racist delusions that require medical treatment. Although the patient adamantly refuses psychotropic drugs, a "team" uses force to immobilize him.

Asking for ethical case review: No comment

The hospital chaplain's request to hold a retrospective ethical case review is not taken seriously by the medical director and instead, she was told that there had been no alternative to the way that the physician had handled the case. As the dominant member of the social space in the hierarchical organization of the hospital, the psychiatrist holds on to his position. He thinks that he knows best how to handle the resistant behavior of the patient and does not question the use of physical force to break the patient's will. The chaplain, however, is more concerned with building trust through dialogue with the patient and attempting to understand how his behaviour is connected with his background history. The psychiatrist cannot see any positive outcomes to the chaplain's proposed plan of action and the institutional structure of the hospital allows him to hold on to his powerful position and to define what is right and wrong without giving space to the chaplain's perspective on the situation.

Summarizing analysis

Metaphorically speaking, the role of chaplain runs along a "side track" of the medical practice of psychiatry. In this case, the chaplain's translation work and conversations with the patient operate beside the physician's decisions--they are tolerated but not integrated. The chaplain views the decisions of the senior physician as a form of power of institutional authority--his orders had to be obeyed. The chaplain thus finds herself caught between the requirements of the psychiatric institution for a pharmacological solution to the situation, and her patient's wish to not take any drugs. This question motivates thinking about the power of psychiatry: the psychiatric diagnosis is perceived as the "truth" about the patient's state of health, and overrules the assessments made by the chaplain and the patient himself about his condition. As the chaplain put it, her perception of what the patient did or did not want, to what extent his self-determination had to be respected, and to what extent compliance with his wishes might have caused harm, had no room within the "institutional requirements" and "psychiatric professionalism".

No discussion about treatment among the parties involved took place beyond the "necessity" of administering the psychotropic drugs. A recognition of the dialogue between the patient and the chaplain, as well as her translation work, was not included in the therapeutic approach. Psychiatry reinforced its position as part of academic medicine, and the psychiatrist's pharmaceutical knowledge, even though used to treat unclearly diagnosed illness, was viewed as professionalism. There was no provision for another perspective or for an alternate method of treatment. The patient's anger at his situation was answered with force.

In the organization of psychiatric practice, team meetings that would allow members to enhance knowledge about patients by incorporating the differing perspectives of all the professionals involved do not exist. In this account, the chaplain's contribution to decisions about the patient remains irrelevant, even if it was heard, leading to feelings of powerlessness She eventually gives up, tacitly accepting what is perceived as an inferior social position dominated by physicians--and her expertise in ethics does not make any difference.

Final remarks

At the concrete level of interaction in psychiatric hospitals, the positions and different kinds of perspectives of the professional actors involved in the institution, like clinical chaplains and psychiatrists, are in powerful competition especially when the subject of ethics comes into play. In the case story presented here, the chaplain attempted to bring about alternatives to pharmacological treatment. The psychiatrist accepted the work of the chaplain to a certain extent, but did not integrate the perspectives of either her or the nurses into his medical decision-making.

Finally, the actors in the field re-occupy a certain social space to exercise power within the limits and the scope of their position. Chaplains, especially as ethics counsellors, have begun to address the problems noted in this paper by interdisciplinary manoeuvres in ethics. In this case study, however, we found no teamwork or joint decision-making processes in this psychiatric practice. The viewpoint of the chaplain may have been consulted, but her considerations on the problem had no impact on the outcome.

In light of my analysis I believe that questions of ethics can barely challenge a hierarchical hospital social structure that works to keep the status quo. Physicians practice according to the dominant medical model of diagnosis and treatment. The issue of ethics, with its focus on respect for autonomy, challenges this practice by illuminating and supporting the validity of individual actions and reactions. Thus, from a critical ethical perspective that considers issues of power and social space, psychiatry has not yet left room for the sick individual to be considered an agent capable of intentional action.

Notes

[1]I borrowed the idea of putting the title in this kind of question from Sarah Sexton (1999): If Cloning is the Answer, What was the Question? Sara Sexton.

[2]I thank the publisher (LIT) for the permission to reprint the case story.

[3]Translation from German into English by Irina Stivaktakis and Helen Kohlen.

[4]All names are fictitious and places have been abbreviated with letters.

References

1.Sexton S. If Cloning is the Answer, What was the Question? Power and Decision-Making in the Geneticisation of Health. International Women's University, Germany, Hannover, August-September, 2000.

2.Wittgenstein L. Philosophical Investigations. Oxford: Blackwell Publishing, 2009.

3.Bourdieu P. Masculine Domination. Cambridge: Polity Press, 2001.

4.Bourdieu P. The Logic of Practice. Stanford, California: Stanford University Press, 1980.

5.Bourdieu P. Die feinen Unterschiede. Frankfurt a. M.: Suhrkamp, 1982.

6.Bourdieu P. Die verborgenen Mechanismen der Macht. Hamburg: VSA Verlag, 1997.

7.Stevens TML. Bioethics in America. Origins and Cultural Politics. Baltimore: John Hopkins University Press, 2000.

8.Fox RC. More than Bioethics. Hastings Center Report 1996; November-December, 5-7.

9.Kohlen H. Conflicts of Care. Hospital Ethics Committees in the US and in Germany. Franfurt a. M: Campus, 2009.

10.O' Brien CF. Ethics Training for Professional Chaplains in the United States, in Medical Ethics in Health Care Chaplaincy. Essays, Moczynski HH, Bentele L (eds). Berlin: LIT, 2009; 13-31.

11.DeVries R, Berlinger, Cadge W. Lost in translation. The Chaplain's Role in Health Care,. Hastings Center Report 2008;38(6):23-27.

12.Flannelly KJ, et al. A National Survey of Hospital Directors' Views about the Importance of Various Chaplain Roles. Differences among Disciplines and Types of Hospitals. JPastoral Care Counselling 2006;60(3):213-24.

13.Norwood F. The Ambivalent Chaplain: Negotiating Structural and Ideological Difference on the Margins of Modern-Day Hospital Medicine. Medical Anthropology 2006;25(1):1-29.

14.Wanderer G. Ethics in Psychiatric Clinics Chaplaincy. A German Perspective, in Medical Ethics in Health Care Chaplaincy. Essays, edited by W. Moczynski, H. Haker and K. Bentele. Berlin: LIT, 2009;293-317.

15.Haker H. Narrative Ethics in Health Care Chaplaincy, in: Medical Ethics in Health Care Chaplaincy. Essays, edited by W. Moczynski, H. Haker and K. Bentele. Berlin: LIT, 2009; 143-73.

16.Nauer D. Seelsorge im Krankenhaus? Sorge um die Seele! Katholischer Krankenhausdienst 2009;8(8):225-34.

17.Chambliss DF. Beyond Caring. Hospitals, Nurses, and the Social Organisation of Ethics. Chicago, London: The University of Chicago Press, 1996.

18.Schäfers B, Kopp J. Grundbegriffe der Soziologie. Wiesbaden: VS Verlag für Sozialwissenschaften, 2006.

19.Löw M. Raumsoziologie. Frankfurt a. M.: Suhrkamp, 2001.

20.Reich WT. Introduction, in Medical Ethics in Health Care Chaplaincy. Essays, edited by W. Moczynski, H. Haker and K. Bentele. Berlin: LIT, 2009; 9-10.

21.Franz K. The chaplain, in Mental Health Ethics. The Human Context, edited by Ph. Barker. London and New York: Routledge, 2011; 124-31.

22.Scriver MSt. Reflections on CPE Experiences After two Decades. JPastoral Care Counselling 2006;60(5):445-54.

23.Bobbert M. (forthcoming). Gerechtigkeit und Parteilichkeit. Schnittstellen von Klinikseelsorge und Medizinethik. Berlin: LIT.

24.Anonymous Author (forthcoming). Kabila's Dogs in praised Germany, in Gerechtigkeit und Parteilichkeit. Schnittstellen von Klinikseelsorge und Medizinethik, edited by M. Bobbert. Berlin: LIT.

Contact Information for Author:
Helen Kohlen, Ph.D.
Philosophical-Theological University of Vallendar
Pallottistr. 3, 56179 Vallendar
Germany
Email: hkohlen@pthv.de

2

Résumé
Le recrutement de personnes appartenant à une population dite cachée comporte plusieurs défis méthodologiques. Or, peu d'ouvrages abordent la question. En raison notamment de la stigmatisation dont ils sont l'objet, les minorités sexuelles ainsi que les consommateurs de drogues font partie des populations « cachées ». Certaines populations cumulent plusieurs comportements socialement stigmatisés, ce qui complexifie leur recrutement. Le but de cet article est d'effectuer une analyse critique des écrits sur les principaux défis associés au recrutement auxquels sont confrontés les chercheurs qui s'intéressent aux minorités sexuelles, particulièrement à celles qui consomment des drogues. Nous avons effectué une recension des écrits sur les principales stratégies utilisées afin de faire face à ces défis et discutons de leur applicabilité à partir d'une expérience de recherche menée auprès d'hommes gais et bisexuels qui présentent une consommation problématique d'alcool et/ou de drogues. Plusieurs stratégies recensées peuvent s'appliquer à la recherche auprès d'autres populations cachées.

Mots clés consommation de drogues, défis méthodologiques, minorités sexuelles, recrutement

Recruter des minorités sexuelles qui consomment des drogues : survol critique des défis méthodologiques à partir d'une recension des écrits et d'une étude qualitative auprès d'hommes gais et bisexuels

JORGE FLORES-ARANDA, KARINE BERTRAND, & ÉLISE ROY

Introduction

Certains groupes de la population présentent un grand intérêt pour la recherche en santé mais ces derniers sont quelquefois difficiles à rejoindre. Le terme « caché » est parfois utilisé pour décrire ces groupes pour lesquels il n'existe pas de répertoire ou de recensement et qui sont souvent considérés minoritaires par rapport à la population dite « générale », en raison de caractéristiques ou comportements particuliers.[1] Les consommateurs de drogues,[2] les minorités sexuelles[3] ainsi que les minorités sexuelles qui consomment de drogues[4] font partie de ces populations.

L'orientation sexuelle n'étant que rarement prise en compte dans les enquêtes populationnelles, les minorités sexuelles (lesbiennes, gais, bisexuels, transgenres) sont difficilement identifiables.[5,6] Par ailleurs, les personnes qui dévoilent leur orientation sexuelle lors de ces enquêtes sont souvent celles ayant une identité homo/bisexuelle. [6] Les problèmes que vivent les minorités sexuelles sont par conséquent très souvent occultés et rarement approfondis. Quant aux grandes enquêtes populationnelles sur la consommation de drogues, celles-ci rejoignent rarement les minorités sexuelles, étant donné que l'orientation sexuelle n'est pas une variable à l'étude ou encore parce que les gens craignent de dévoiler leur orientation sexuelle.[4] Les enquêtes dites de deuxième génération, notamment dans des domaines comme celui de la recherche sur le VIH[7] pallient en partie à ce problème et depuis quelques années

des efforts considérables ont été réalisés pour rejoindre les populations dites cachées. Néanmoins, puisque le but de ces enquêtes est surtout de caractériser les populations dans un but de surveillance épidémiologique, plusieurs dimensions importantes relatives à la santé et les facteurs qui l'influencent, demeurent négligés.

Plusieurs auteurs utilisent des méthodes qualitatives et soutiennent que celles-ci sont appropriées lorsque l'on veut étudier, en profondeur et de façon itérative, certains comportements socialement considérés indésirables ou marginaux et pour lesquels des lacunes importantes en matière de connaissances scientifiques sont constatées.[3,6,9,10,8] Dans cette perspective, les travaux des chercheurs appartenant à la tradition de « l'école de Chicago », ont été parmi les pionniers dans l'utilisation de méthodes qualitatives, inspirées notamment de l'interactionnisme symbolique, dans des études sur la consommation de drogues.[11,12] Toutefois, les devis des recherches qualitatives impliquent souvent, par la réalisation d'entrevues ou des observations sur le terrain, la rencontre en personne des membres de la population cible, et cela peut constituer un frein au recrutement des participants. Cette difficulté peut s'expliquer en partie par le fait que ces méthodes présentent un niveau d'anonymat moins important comparativement à des entrevues téléphoniques ou à des sondages en ligne, par exemple.[13] En ce sens, les chercheurs rencontrent plusieurs difficultés associées au recrutement et les ouvrages abordant cette question sont peu nombreux.[13]

Ainsi, les objectifs de cet article sont : (1) Effectuer une analyse critique des écrits sur les principaux défis méthodologiques liés au recrutement des minorités sexuelles dans le cadre de recherches qualitatives, tout en examinant les enjeux spécifiques concernant la consommation de drogues; (2) Décrire les principales stratégies utilisées par les chercheurs pour faire face à ces défis; et (3) Discuter de l'applicabilité de certaines de ces stratégies dans le cadre d'une étude menée à Montréal auprès d'hommes gais et bisexuels qui présentent une consommation problématique d'alcool et/ou de drogues illicites.

Démarche méthodologique

Contexte du projet de recherche mené auprès d'hommes gais et bisexuels montréalais

Il s'agit d'une étude doctorale visant à répondre à la question suivante : Quels sont les liens entre les trajectoires addictives et le vécu homosexuel chez les hommes ayant des relations sexuelles avec d'autres hommes (HARSAH) et comment ces liens s'articulent-ils entre eux ? Par trajectoire addictive, nous entendons le parcours de consommation de substances psychoactives (SPA) menant à une consommation problématique du point de vue du participant. Pour ce qui est du vécu homosexuel, nous le définissons comme une trajectoire psychosociale et comportementale pouvant mener au développement de l'identité homo/bisexuelle. Cette définition s'inspire du cadre théorique sur les «Trajectoires du développement de l'orientation sexuelle» (*Life Course Development of Human Sexual Orientation*).[14]

Nous avons mené une étude qualitative descriptive reposant sur une perspective interactionniste symbolique. Les participants ont été recrutés en fonction des critères d'éligibilité suivants : se reconnaître comme gai ou bisexuel, avoir eu un ou des rapports sexuels avec un autre homme dans la dernière année, avoir une consommation problématique de SPA, être âgé de 18 ans et plus, s'exprimer en français, être né au Canada et résider dans la région métropolitaine de Montréal. La consommation problématique de SPA a été documentée via les questionnaires *Détection et évaluation du besoin d'aide* (DEBA) pour l'alcool et les drogues.[15] De plus, afin de compléter l'exploration du vécu homosexuel ainsi que de caractériser l'orientation sexuelle des participants, la grille sur l'orientation sexuelle de Klein a été utilisée.[16,17] Celle-ci mesure six dimensions de l'orientation sexuelles dans une perspective temporelle. Ceci s'appuie sur une compréhension de l'orientation sexuelle comme un concept multidimensionnel et dynamique.

Recension des écrits

Nous avons effectué une recension des écrits concernant les aspects liés au recrutement de la recherche auprès des minorités sexuelles en général, et plus spécifiquement auprès des minorités sexuelles qui consomment des drogues. Ainsi, nous avons consulté les principales banques de données utilisées dans différents domaines, soit la médecine, la sociologie, le travail social et la toxicomanie (CINAHL, FRANCIS, Medline, PASCAL, PsycINFO, PsyARTICLES, PsyCRITIQUES, PsyEXTRA, Psychology and Behavioral Sciences, SocINDEX, Social Work Abstracts). Nous avons consulté des articles révisés par les pairs et publiés en français ou anglais. Nous avons également procédé à la consultation des références citées dans les documents retenus. En raison des objectifs de cet article, nous avons examiné autant des articles de réflexion sur des aspects méthodologiques que des recherches empiriques ayant étudié, avec des méthodes qualitatives, ou ayant un volet qualitatif, la population et le comportement qui nous intéressaient.

Résultats

Cette section rapporte l'examen critique de la littérature que nous avons recensée. Cet état des connaissances nous a permis d'identifier certains constats relatifs au recrutement des minorités sexuelles, particulièrement celles qui consomment de drogues.

Les défis pour rejoindre les populations cibles et les stratégies pour y faire face

Bien définir la population cible

La définition et l'opérationnalisation des concepts à étudier constituent des étapes importantes de tout processus de recherche. Cependant, lorsque l'on travaille avec des groupes sociaux minoritaires, sur des questions relativement peu étudiées ou sur des comportements socialement stigmatisés, cette étape comporte un défi supplémentaire qui est celui de définir et d'opérationnaliser un concept sur lequel on ne connaît que très peu.[6] Pour ce qui est des minorités sexuelles, certains auteurs ont constaté que peu d'études définissent de la même façon ce qu'est l'orientation sexuelle[18,19] et plusieurs considèrent qu'il est important de tenir compte des différentes dimensions qui composent le concept d'orientation sexuelle (l'attirance, les comportements, les fantasmes), et ce, tout au long de la vie.[6,20] Toutefois, la définition opérationnelle de la variable orientation sexuelle varie d'une étude à l'autre, allant de l'autodéfinition,[3] au comportement sexuel[21,22] et aux aspects identitaires et comportementaux. [23] Ce constat est corroboré par une recension systématique des études ayant un échantillon probabiliste et portant sur la santé des personnes gaies, lesbiennes et bisexuelles (LGB). Les résultats de cette recension systématique montrent que l'orientation sexuelle est tantôt définie par l'auto-déclaration des participants, tantôt par le comportement ou les attirances sexuels rapportés.[19] En outre, dans certains cas, la façon dont l'orientation sexuelle est définie n'est pas mentionnée.[1,2,10,13] Il est intéressant de noter que parmi les études ne définissant pas cette variable, la majorité ne ciblait pas exclusivement de minorités sexuelles. Ceci rend difficile de connaître de façon précise la réalité des minorités sexuelles car, sans une définition opérationnelle, on ne sait pas de qui s'agit-il exactement.

Outre la définition opérationnelle de la variable orientation sexuelle, le choix d'un sous-groupe à l'intérieur des minorités sexuelles constitue un autre défi. En effet, essayer d'étudier les minorités sexuelles dans son ensemble peut se révéler une tâche extrêmement ardue. Bien qu'il existe des points communs entre les personnes lesbiennes, gaies, bisexuelles et transgenre, chaque sous-groupe présente des spécificités qui lui sont propres.[6] Ainsi, les chercheurs doivent tenir compte de ces différences et évaluer la pertinence d'inclure de façon large l'ensemble des minorités sexuelles ou de cibler l'une d'entre elles, en fonction de l'objectif de recherche.[6]

En ce qui a trait à l'opérationnalisation de la consommation problématique de substances chez les minorités sexuelles, particulièrement chez les hommes, on observe une situation similaire à celle décrite précédemment. En effet, rappelons que plusieurs études soutiennent que la consommation d'alcool et de drogues chez les HARSAH est plus élevée que celle observée chez les hommes de la population générale.[5,24-29] Toutefois, compte tenu des variations méthodologiques des études s'étant penchées sur la question (variations dans les échelles de mesure, techniques d'échantillonnage variées, différents niveaux de contrôle de variables confondantes, différentes définitions de ce qu'une consommation problématique, etc.), la gravité de la consommation de SPA chez les HARSAH (en termes de diagnostic d'abus et de dépendance) demeure un sujet mal documenté.[24,30] En outre, il est difficile d'établir des comparaisons entre la consommation de SPA chez les HARSAH et celle de la population générale puisque, comme il a été mentionné précédemment, peu d'enquêtes populationnelles portant sur la consommation de SPA ont comme variable l'orientation sexuelle.[5]

Identifier la population cible

Lorsqu'on veut étudier certains groupes populationnels minoritaires, et parfois marginalisés, la façon dont les personnes appartenant à ces groupes se perçoivent devrait être prise en compte. En ce sens, certains auteurs soutiennent que les personnes qui acceptent de participer à une étude auprès des minorités sexuelles sont généralement celles ayant développé une identité homosexuelle ou bisexuelle.[6] De plus, ces mêmes auteurs soulignent que les personnes qui sont prêtes à dévoiler leur orientation sexuelle ou leur comportement sexuel avec des personnes du même sexe ont également tendance à participer davantage à des études.[6]

Dans les cas des consommateurs de drogues, plusieurs d'entre eux, notamment ceux ayant une consommation perçue comme contrôlée, tendent à se différencier des autres consommateurs. Par exemple, une étude suédoise s'est penchée sur les représentations sociales concernant la consommation de drogues d'un groupe de consommateurs « socialement intégrés » (personnes ayant une occupation –travail/études-, ayant un domicile fixe, n'ayant pas des problèmes judiciaires en raison de leur consommation,

etc.). Ces personnes se percevaient différemment des autres consommateurs, accentuant ainsi la différence qu'ils voyaient avec les personnes qu'ils considéraient comme des consommateurs abusifs.[31] Dans ce sens, la stigmatisation dont l'usage de drogues et l'orientation sexuelle font l'objet peut compliquer davantage l'identification de la population cible.[1,2]

Les stratégies pour recruter la population cible

Les moyens que les chercheurs ont mis de l'avant pour faire face à la difficulté de rejoindre une population minoritaire reposent en grande partie sur des stratégies visant à développer une meilleure connaissance du milieu et de ses principaux acteurs. Ainsi, certains chercheurs travaillant auprès de minorités sexuelles et/ou des minorités sexuelles consommant des drogues ont recours aux groupes de discussion focalisés, aux entrevues avec des informateurs clefs ou à la cartographie de certains quartiers afin de déterminer quels seront les moyens de recrutement les plus appropriés.[10,2,32,1] La constitution d'équipes de professionnels recruteurs connaissant la population cible et visant à la rejoindre sur le terrain,[10,1,2] tout comme la collaboration avec des organismes travaillant directement auprès de la population (associations, services de santé, travailleurs de rue, etc.) constituent d'autres méthodes utilisées par les chercheurs.[3,1,20,32] En outre, la méthode boule de neige est également utilisée afin de rejoindre certains groupes populationnels.[3,1,10]

La promotion d'une étude est une étape importante du processus de recherche car elle aura une influence sur la population qui sera rejointe et qui participera à l'étude. Ainsi, lorsque l'on effectue une étude auprès de populations cachées telles les minorités sexuelles ou les consommateurs de drogues, la diversification des lieux et des méthodes de promotion peut s'avérer cruciale.[20,10] Cet élément est d'autant plus important lorsque la population cible appartient à deux groupes minoritaires (par exemple, minorités sexuelles et consommateurs de drogues). En ce sens, plusieurs chercheurs ont recours à des méthodes de promotion telles que des affiches, des annonces dans les journaux, des dépliants ainsi que des annonces sur internet, qui constituent différentes façons de rejoindre la population ciblée.[3,2,1,10,32,13] Depuis quelques années, les chercheurs utilisent de plus en plus l'internet autant pour effectuer la promotion de leurs études que pour réaliser la collecte des données.[6] Sur ce point, certains chercheurs soulignent que, dans le cadre d'une étude auprès d'une population difficile à rejoindre ou sur un sujet sensible, tel que la consommation de drogues, la création d'une page web afin de publiciser l'étude permettra aux éventuels participants de bien comprendre le projet et ce que son éventuelle participation impliquerait. De plus, ces auteurs mentionnent que si la page web est rattachée à celle d'une université ou d'une autre institution crédible, cela favorisera la confiance des participants.[13]

Au-delà des moyens, l'utilisation des termes appropriés lors de la promotion d'une étude est cruciale. C'est un défi particulier dans le cas des populations cachées car le vocabulaire utilisé dans la communauté n'est pas nécessairement connu des chercheurs. La terminologie utilisée pour faire référence à l'orientation sexuelle a été identifiée comme étant un élément ayant une influence sur le taux de participation à une étude, notamment parmi les membres des minorités sexuelles appartenant aussi à une minorité ethnique.[20] Ainsi, plusieurs auteurs mentionnent différentes terminologies utilisées par des membres de minorités ethniques pour faire référence soit à l'orientation sexuelle, soit aux relations sexuelles et/ou affectives avec un partenaire de même sexe.[20] Par exemple, « *two spirit* » est un terme utilisé par plusieurs membres des Premières nations en Amérique du Nord pour faire référence aux personnes ayant des relations affectives et sexuelles avec un partenaire de même sexe ou dont l'identité de genre est fluide.[33] Également, l'expression « *down low* » est utilisée particulièrement par les hommes afro-américains pour faire référence aux hommes qui ont des rapports sexuels avec d'autres hommes. Cependant, cette expression a une connotation négative pour plusieurs de ces hommes.[22] Le contact avec des informateurs clés ou avec des organisations travaillant auprès de la population cible permettra aux chercheurs d'utiliser la terminologie adéquate.[20]

Les stratégies recensées dans cette section ont l'avantage de faciliter le recrutement mais peuvent occasionner que les participants présentent des caractéristiques trop homogènes ou qu'ils proviennent du même réseau social. Bien que plusieurs études qualitatives visent une population bien spécifique, plusieurs chercheurs diversifient leurs stratégies de recrutement et utilisent différents moyens de diffusion afin de rejoindre une variété de participants en fonction des objectifs poursuivis. En effet, le succès du recrutement d'un groupe difficile à rejoindre reposerait notamment sur la multiplicité des méthodes utilisées[32] ainsi que sur l'évaluation et l'ajustement constant des stratégies employées.[1,2,10] En outre, afin de favoriser la participation des populations difficiles à rejoindre, ou dans le cadre d'une étude sur un sujet sensible, plusieurs auteurs soulignent l'importance d'assurer l'anonymat des participants.[13,20]

La prise en compte d'autres statuts minoritaires

Certains chercheurs s'intéressent à des populations qui cumulent des statuts minoritaires. Toutefois, de nombreux chercheurs travaillant auprès des groupes appartenant à plusieurs catégories socialement stigmatisées tendent à étudier séparément chacun de ces aspects plutôt que de se pencher sur la façon dont ces statuts minoritaires s'inter-influencent.[34] En effet, les identités et les inégalités que ces statuts minoritaires peuvent produire son interdépendantes, créant ainsi un défi important en termes de collecte et d'analyse des données.[34] Pour ce qui est des minorités sexuelles qui consomment de drogues, plusieurs chercheurs considèrent que certaines dimensions associées au vécu homosexuel pourraient moduler la consommation de SPA, notamment : l'homophobie intériorisée (culpabilité, honte, refus en lien avec sa propre orientation sexuelle)[35] qui pourrait générer des problèmes de santé mentale;[36,37] la stigmatisation et l'homophobie sociale;[38,39] le processus de *coming out* et les difficultés associées à la parentalité ou au deuil de celle-ci.[38,40-42] Outre la consommation de substances, la santé des minorités sexuelles peut être affectée par le stress d'appartenir à un groupe social minoritaire (*minority stress*).[43] Ce concept est fondé sur la prémisse que dans une société hétérosexiste (vision du monde reconnaissant une plus grande valeur à l'hétérosexualité),[44] les personnes homosexuelles ont une propension à vivre un stress chronique.[43] Par ailleurs, lorsque l'on effectue des études auprès des minorités sexuelles, il est important de tenir compte de certains aprioris pouvant provenir d'éventuels biais hétérosexistes. Ainsi, il est suggéré le travail en équipe et la divulgation des aprioris afin d'éviter que ces éventuels biais teintent le processus de recherche.[45]

Plusieurs auteurs soutiennent que la présence importante d'alcool et de drogues dans certains espaces de socialisation[5,38,46] peut influencer la consommation des minorités sexuelles. Ainsi, lorsqu'on étudie des comportements socialement marginalisés, comme la consommation de drogues, chez les minorités sexuelles, il est pertinent de tenir compte des facteurs qui peuvent moduler ces comportements ainsi que des façons dont ces comportements s'inter-influencent. Par ailleurs, la connaissance de ces facteurs permettra la formulation d'une question de recherche claire, ce qui guidera d'une façon efficace les stratégies de recrutement à mettre en place. Ainsi, la rencontre avec des acteurs du milieu peut s'avérer nécessaire pour bien cerner la problématique à l'étude et ses principaux enjeux[3] ou pour cibler un sous-groupe populationnel particulier.[23]

Dans la littérature recensée, quelques auteurs, notamment ceux s'étant penchées sur des minorités sexuelles et des minorités ethniques tiennent compte des interactions entre l'orientation sexuelle et l'origine ethnoculturelle.[20,22,32-34] Notons toutefois que les interactions entre l'orientation sexuelle et la consommation sont davantage étudiées sous l'angle de comportements sexuels à risque.[5,25,47-52] Ainsi, les éventuels liens entre la consommation et le vécu homosexuel restent à explorer.

Discussion

En guise de discussion, nous aborderons l'applicabilité de certaines des stratégies recensées dans la littérature visant à rejoindre des minorités sexuelles en général, ou des minorités sexuelles qui consomment des drogues en particulier. Ces stratégies seront discutées en lien avec celles utilisées dans le cadre de notre étude menée à Montréal auprès d'hommes gais et bisexuels qui présentent une consommation problématique d'alcool et/ou de drogues illicites. Il est important de souligner que compte tenu de la nature inductive de notre projet de recherche, les stratégies employées, notamment en ce qui a trait au recrutement des participants, ont évolué en fonction des situations observées sur le terrain.

Sur la façon de définir la population cible

Dans le but de rejoindre la population que nous ciblions, il était important de définir et d'opérationnaliser les concepts à l'étude. De plus, puisqu'il serait méthodologiquement extrêmement ardu de se pencher sur l'ensemble des minorités sexuelles,[6] nous avons ciblé uniquement les hommes se définissant comme gais ou bisexuels. Puisque la littérature consultée montre qu'il n'y a pas une définition standardisée de l'orientation sexuelle,[18,19] nous avons décidé de la définir à partir de deux critères : (1) l'orientation sexuelle auto-rapportée des participants et (2) le comportement sexuel auto-rapporté (avoir eu une ou plusieurs relations sexuelles avec un autre homme dans la dernière année). Nous considérons que ces deux critères de définition répondent à nos objectifs de recherche. En effet, puisqu'un des objectifs du projet doctoral vise à mieux cerner les besoins en termes de services, dont ceux entourant le VIH, l'activité sexuelle des participants était un élément dont il fallait tenir compte. En outre, la nature qualitative de l'étude ainsi que le recours à la Grille sur l'orientation sexuelle de Klein[16,17] constituent des moyens nous ayant permis une meilleure compréhension du vécu homosexuel, tout en tenant compte de sa complexité et de ses diverses dimensions. En ce qui a

trait à la consommation problématique de drogues, elle a été vérifié avec les questionnaires *Détection et évaluation du besoin d'aide* (DEBA) pour l'alcool et les drogues.[15] Enfin, puisque nous travaillons avec des hommes appartenant à deux groupes stigmatisés (hommes gais ou bisexuels consommant de drogues), notre grille d'entrevue tenait compte de l'interdépendance de ces facteurs en les considérant comme un ensemble. [34]

Sur le recrutement de participants

Dès le début du projet, nous avons établi une collaboration avec deux organisations communautaires impliquées auprès de la population cible : Rézo et la Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-SIDA). Rézo est un organisme voué à la promotion de la santé globale des hommes gais et bisexuels montréalais.[53] Quant à la COCQ-SIDA, il s'agit d'une coalition provinciale regroupant 37 organismes de lutte contre le VIH, dont trois associations montréalaises qui interviennent notamment auprès des hommes ayant des relations sexuelles avec d'autres hommes (HARSAH).[54] La collaboration avec ces organismes a été officialisée avec la direction générale de chacun d'entre eux. Nos interlocuteurs ont contribué à l'identification des variables stratégiques sur lesquelles s'est appuyé notre plan d'échantillonnage. Ils ont également contribué à valider nos stratégies de recrutement et ont proposé des façons de rejoindre la population. Par exemple, il nous été suggéré d'utiliser des médias généraux, dont le journal Métro (distribué gratuitement dans le réseau de transport en commun de Montréal) et de mettre l'accent sur l'information de personne à personne (bouche-à-oreille). De plus, tel que souligné par plusieurs auteurs[6,13], nous avons publicisé l'étude via les sites web des organismes partenaires, ce qui a facilité le recrutement et a permis d'établir la confiance des participants.

Cette collaboration a porté fruit. En effet, nous avions prévu que le recrutement dans le cadre de cette étude s'effectuerait de deux façons. La première, via les organismes communautaires collaborateurs, dont le rôle était de distribuer un dépliant explicatif de l'étude avec les coordonnées de l'étudiant responsable ainsi que de publiciser la recherche sur leur site internet. La deuxième, par l'entremise d'annonces publiées dans une revue destinée à la communauté LGBT (Fugues) et dans un hebdomadaire ciblant la population générale (Voir). Cette première stratégie a permis de rejoindre 17 participants entre juin et août 2012. Des analyses préliminaires ont été effectuées avec ce sous-échantillon afin de caractériser les participants et de vérifier si d'autres stratégies de recrutement étaient nécessaires. Suite aux analyses préliminaires, nous avons constaté que plusieurs participants recrutés socialisaient principalement dans le Village gai montréalais. Cette constatation nous a mené à cibler un média plus large afin de recruter des participants plus diversifiés. Tout en continuant de cibler les médias ci-haut mentionnés, nous avons décidé de placer des annonces à différents moments dans le journal Métro. Cette stratégie nous a permis de rejoindre, entre décembre et mai 2013, 10 participants supplémentaires, lesquels avaient des expériences différentes à celles des participants du premier groupe en termes de leur trajectoire addictive et de leur vécu homosexuel. Nous avons également demandé systématiquement aux participants rencontrés de nous référer des personnes susceptibles de participer à l'étude. Cela nous a permis de rejoindre 8 participants de plus. Ceci est en accord avec la littérature qui considère que la multiplicité des stratégies de recrutement favorise le recrutement des populations difficiles à rejoindre.[32]

Puisque nous voulions recruter des hommes qui se reconnaissent comme gais ou bisexuels, nous croyions qu'en effectuant le recrutement par l'intermédiaire d'organismes communautaires ayant des missions différentes et par le biais des médias ciblant deux publics différents, nous pourrions obtenir une bonne diversification de l'échantillon sans compromettre la saturation des données,[55] ce qui fut le cas. En outre, tel que proposé par différents chercheurs,[1,2,10] nous avons évalué et ajusté nos stratégies de recrutement au fur et à mesure que la collecte des données avançait. Par exemple, nous avons évalué le langage utilisé dans les annonces publiés dans les médias et avons effectué des changements afin de rejoindre des hommes pouvant avoir une consommation problématique de substances mais ne le reconnaissant pas. Rappelons qu'un des critères de sélection de notre étude était d'avoir une consommation problématique de substances. Par conséquent les annonces diffusées ciblaient spécifiquement cette population.

Lors des analyses préliminaires nous avons constaté que la majorité des participants présentaient effectivement une consommation problématique et qu'ils se trouvaient, pour la plupart, dans une période de réflexion quant à l'arrêt ou la diminution de leur consommation. Cela reflétait donc une certaine prise de conscience de leur problématique qui teintait leur trajectoire de consommation. Ainsi, afin d'avoir une plus grande variété quant aux trajectoires de consommation des participants, nous avons décidé de changer le libellé des annonces afin de rejoindre des participants pouvant avoir une consommation problématique mais ne se reconnaissant

pas comme tels. En outre, lors des premières entrevues nous avons remarqué que les participants préféraient le tutoiement et que cela favorisait la relation de confiance avec l'intervieweur. En ce sens, nous avons également changé le vouvoiement par le tutoiement dans les annonces.

Bien qu'en ayant recours à cette deuxième annonce nous ayons dû refuser plus de participants (quatre refus comparativement à deux dans la première phase de recrutement en raison de ne pas avoir une consommation problématique), nous avons réussi à recruter des participants ne se trouvant pas à une étape de réflexion quant à l'éventuelle diminution ou l'arrêt de leur consommation. Cela nous a permis une meilleure diversification de l'échantillon, permettant ainsi de documenter avec plus de nuances les expériences relatives aux trajectoires de consommation. De plus, rappelons que le changement de langage constitue une stratégie de recrutement utilisée par d'autres auteurs.[23]

Précisons que nous avons décidé de recruter uniquement des participants nés au Canada afin de restreindre l'hétérogénéité de l'échantillon et d'atteindre plus facilement la saturation empirique, c'est-à-dire, lorsque les entrevues ou observations n'apportent plus d'informations qui justifient la continuation de la collecte des données.[55] Cette décision a été prise à la lumière de ce que plusieurs auteurs avancent concernant l'origine ethnoculturelle et l'orientation sexuelle. Ainsi plusieurs auteurs considèrent que l'origine ethnoculturelle a une influence importante sur la construction de l'identité des lesbiennes, gais, bisexuels, transsexuels et transgenres (*LGBT*) ainsi que sur leur utilisation de services de santé.[56-58] Ces constats concernent les immigrants LGBT de première et deuxième génération ainsi que les nouveaux arrivants (à des degrés variés). Par ailleurs, soulignons que les enjeux entourant les minorités sexuelles appartenant à une minorité ethnoculturelle sont multiples et chacun de ces enjeux peut faire l'objet d'une étude spécifique afin d'établir de conclusions valides et utiles. Ainsi, il serait important de mener des travaux de recherche spécifiques pour ces enjeux complexes, encore peu documentés.[59]

Conclusion

La recherche auprès des minorités sexuelles, notamment le processus entourant le recrutement représent un défi important pour les chercheurs. Nous croyons cependant que certains éléments clés peuvent contribuer à relever ces défis : le contact avec des acteurs du terrain qui connaissent la population cible, la prise en compte des facteurs qui peuvent interagir avec le phénomène à l'étude, l'évaluation constante des méthodes de recrutement employées, et la flexibilité pour changer nos pratiques en cours de route ainsi que la prise en compte des différentes situations qui peuvent émerger tout au long du processus de recherche. Nous ne prétendons pas que ces stratégies constituent une panacée, toutefois elles peuvent guider certains chercheurs s'intéressant à la recherche auprès des minorités sexuelles. Enfin, il nous apparaît essentiel que davantage d'ouvrages méthodologiques tenant compte des particularités des groupes sociaux minoritaires soient publiés.

References

1.Watters JK, Biernacki P. Targeted Sampling: Options for the Study of Hidden Populations. Soc Probl 1989;36(4):416-30.

2.Kelly BC. Sampling and Recruitment Issues in Qualitative Drugs Research: Reflections on the Study of Club Drug Users in Metro New York. Subs use misuse 2010;45:671-83.

3.Gorman EM. Research with gay drugs users and the interface with HIV: Current methodological issues for social work research. J Gay Lesbian Soc Serv 2003;15(1-2):79-94.

4.Substance Abuse and Mental Health Services Administration. Leading Change: A plan for SAMHSA's Roles and Actions 2011-2014. 2011;SAMHSA, 11-4629:1-117.

5.Keogh P, Reid D, Bourne A, Weatherburn P, Hickson F, Jessup K, et al. Wasted opportunities. Problematic alcohol and drug use among gay and bisexual men. 2009:1-52.

6.Moradi B, Mohr JJ, Worthington RL, Fassinger RE. Counseling psychology research on sexual (orientation) minority issues: Conceptual and methodological challenges and opportunities. J Couns Psychol 2009;56(1):5-22.

7.Organisation mondiale de la santé, Programme des Nations Unies sur le VIH/SIDA. Surveillance de deuxième génération du VIH : Les dix prochaines années. 2000:1-46.

8.Poupart J. Tradition de Chicago et interactionnisme : des méthodes qualitatives à la sociologie de la déviance. Rech Qual 2011;30(1):178-99.

9.Vadez A, Sifaneck SJ. Qualitative Methodological Issues in Drug Use Research. Subs use misuse 2010;45:645-47.

10.Sifaneck SJN, Alan. The Ethnographic Accessing, Sampling and Screening of Hidden Populations: Heroin Sniffers in New York City. Addict Res Theory 2001;9(6):519-43.

11.Lindesmith AR. A Sociological Theory of Drug Addiction. Am J Sociol 1938;43(4):593-613.

12.Becker HS. Becoming a Marihuana User. Am J Sociol 1953;59(3):235-42.

13.Klein H, Lambing TP, Moskowitz DA, Washington TA, Gilbert LK. Recommendations for Performing Internet-Based Research on Sensitive Subject Matter with 'Hidden' or Difficult-to-Reach Populations. J Gay Lesbian Soc Serv 2010 Oct;22(4):371-98.

14.Hammack PL. The Life Course Development of Human Sexual Orientation: An Integrative Paradigm. Hum Dev 2005;48:267-90.

15.Tremblay J, Rouillard P, Sirois M. Dépistage/évaluation du besoin d'aide - Drogues. 2001. Montréal : RIS Q

16.Klein F, Sepekoff B, Wolf TJ. Sexual orientation: A multi-variable dynamic process. J Homosex 1985;11:35-49.

17.Klein F. The bisexual option (2nd ed.). New York: Haworth Press; 1993.

18.Dean L, Meyer IH, Robinson K, Sell RL, Sember R, Silenzio VMB, et al. Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns. J Gay Lesbian Med Assoc 2000;4(3):101-50.

19.Julien D, Chartrand É. Recension des études utilisant un échantillon probabiliste sur la santé des personnes gaies, lesbiennes et bisexuelles. Can Psychol 2005;46(4):235-50.

20.DeBlaere C, Brewster ME, Sarkees A, Moradi B. Conducting Research with LGB People of Color: Methodological Challenges and Strategies. J Couns Psychol 2010;38(3):331-62.

21.Kanouse DE, Bluthenthal RN, Bogart MY, Perry S, Sand K, Shoptaw S. Recruiting Drug-Using Men who Have Sex with Men into Behavioral Interventions: A Two-Stage Approach. J Urban Health; 2005;82(1):i109-19.

22.Benoit E, Pass M, Randolph D, Murray D, Downing J. Reaching and engaging non-gay identified, non-disclosing Black men who have sex with both men and women. Cult Health Sex 2012;14(9):975-90.

23.Grov C, Bux D, Parsons JT, Morgenstern I. Recruiting Hard-to-Reach Drug-Using Men Who Have Sex With Men into an Intervention Study: Lessons Learned and Implications for Applied Research. Subs use misuse 2009;44:1855-71.

24.Lépine P. Synthèse des connaissances scientifiques et cliniques sur la prise en charge des personnes membres de minorités sexuelles ayant un problème de dépendance à l'alcool ou aux drogues. 2011:1-44. Montréal: Centre Dollard-Cormier, Institut universitaire.

25.Mackesy-Amiti ME, Fendrich M, Johnson TP. Substance-related problems and treatment among men who have sex with men in comparison with other men in Chicago. J Subs Abuse Treat 2009;36:227-33.

26.Irwin TW, Morgenstern J. Drug-Use Patterns Among Men Who Have Sex with Men Presenting for Alcohol Treatment: Differences in Ethnic and Sexual Identity. J Urban Health 2005;82:i127-33.

27.Velter A, Barin F, Bouyssou A, Le Vu S, Guinard J, Pillonel J, et al. Prévalence du VIH et comportement de dépistage des hommes fréquentant les lieux de convivialité gay parisiens, Prevagay 2009. Bulletin épidémiologique hebdomadaire. Institut de veille sanitaire 2010;45-46:464-67.

28.Stall R, Purcell DW. Intertwining Epidemics: A Review of Research on Substance Use Among Men Who Have Sex with Men and Its Connection to the AIDS Epidemic. AIDS Behav 2000;4(2):181-92.

29.Crosby GM, Stall RD, Paul JP, Barrett DC. Alcohol and drug use patterns have declined between generations of younger gay-bisexual men in San Francisco. Drug Alcohol Depend 1998;52:177-82.

30.Mackesy-Amiti ME, Fendrich M, Johnson TP. Prevalence of recent illicit substance use and reporting bias among MSM and other urban males. Addict Behav 2008;33:1055-60.

31.Rodner S. "I am not a drug abuser, I am a drug user": A discourse analysis of 44 drug users' construction identity. Addict Res Theory 2005;13(4):333-46.

32.Rothblum ED, Factor R, Aaron D. How Did You Hear About the Study ? Or, How to Reach Lesbian and Bisexual Women of Diverse Ages, Ethnicity, and Educational Attainment for Research Projects. J Gay Lesbian Med Assoc 2002;6(2):53-9.

33.Adams H, Phillips L. Experiences of Two-Spirit Lesbian and Gay Native Americans: An Argument for Standpoint Theory in Identity Research. Identity 2006;6(3):273-91.

34.Bowleg L. When Black + Lesbian + Woman ≠ Black Lesbian Woman: The Methodological Challenges of Qualitative and Quantitative Intersectionality Research. Sex Roles 2008;59(5):312-25.

35.Borillo D. L'homophobie. Que sais-je? Paris: PUF; 2000.

36.Williamson IR. Internalized homophobia and health issues affecting lesbian and gay men. Health Educ Res 2000;15:97-107.

37.Hugues TL, Eliason M. Substance Use and Abuse in Lesbian, Gay, Bisexual and Transgender Populations. J Prim Prev 2002;22:263-98.

38.Stall R, Paul J, Greenwood G, Pollack LM, Bein E, Crosby GM, et al. Alcohol use, drug use and alcohol-related problems among men who have sex with men: the Urban Men's Health Study. Addiction 2001;96:1589-1601.

39.Rosario M, Schrimshaw EW, Hunter J, Gwadz M. Gay-Related Stress and Emotional Distress Among Gay, Lesbian, and Bisexual Youths: A Longitudinal Examination. J Consult Clin Psychol 2002;70:967-75.

40.Rosario M, Shrimshaw EW, Hunter J. Disclosure of Sexual Orientation and Subsequent Substance Use and Abuse Among Lesbian, Gay and Bisexual Youths: Critical Role of Disclosure Reactions. Psychol Addict Behav 2009;23:175-84.

41.Rosario M. Elevated Substance Use Among Lesbian and Bisexual Women: Possible Explanations and Intervention Implications for an Urgent Public Health Concern. Subs Use Misuse 2008;43:1268-70.

42.Rosario M, Schrimshaw EW, Hunter J. Predictors of substance use over the time among gay, lesbian, and bisexual youths: An examination of three hypotheses. Addiction 2004;29:1623-31.

43.Meyer IH. Minority Stress and Mental Health in Gay Men. J Health Soc Behav 1995;36(1):38-56.

44.Tin LG. Dictionnaire de l'homophobie. Paris: Presses universitaires de France; 2003.

45.Bettinger TV. Ethical and Methodological Complexities in Research Involving Sexual Minorities. New Horizons Adult Educ Human Res Dev 2010;24(1):43-58.

46.Cabaj RP. Substance abuse in gay men, lesbians, and bisexuals. Washington: American Psychiatric Association; 1996.

47.Bonell C, Weatherburn P, Rhodes T, Hickson F, Keogh P, Elford J. Addressing gay men's use of methamphetamine and other substances. Addict Res Theory 2008;16:417-20.

48.Purcell DW, Parsons JT, Halkitis PN, Mizuno Y, Woods WJ. Substance use and sexual transmission risk behavior of HIV-positive men who have sex with men. J Subs Abuse 2001;13:185-200.

49.Purcell DW, Moss S, Remien RH, Woods WJ, Parsons JT. Illicit substance use, sexual risk, and HIV-positive gay and bisexual men: differences by serostatus of casual partners. AIDS 2005;19(S1):S37-47.

50.Otis JG, M., Alary M, Remis RR, Lavoie R, LeClerc R, Vincelette J, et al. Drogues, sexe et risques dans la communauté gaie montréalaise: 1997-2003. Drogues santé société 2006;5(2):161-97.

51.Hickson F, Bonnell C, Weatherburn P, Reid D. Illicit drug use among men who have sex with men in England and Wales. Addict Res Theory 2010;18(1):14-22.

52.Ferrando S, Goggin K, Sewell M, Evans S, Fishman B, Rabkin J. Substance Use Disorders in Gay/Bisexual Men With HIV and AIDS. Am J Addict 1998;7:51-60.

53.Rézo. Rapport annuel 2009-2010. 2010.

54.Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-SIDA). Rapport annuel 2009-2010. 2010.

55.Pires A. Échantillonnage et recherche qualitative: essai théorique et méthodologique. In: Poupart J, Deslauriers JP, Groulx LH, Laperrière A, Mayer L, Pires A, editors. La recherche qualitative. Enjeux épistémologiques et méthodologiques. Montréal: Gaëtan Morin; 1997. p. 113-167.

56.D'Amico E, Julien D, Chartrand E. Développement de l'identité sexuelle chez les jeunes hommes issus des minorités sexuelles et socioculturelles au Québec. In: Brotma S, Lévy JJ, editors. Intersections, cultures, sexualités et genres. Québec: Presses de l'Université du Québec; 2008. p. 133-158.

57.Gagné F, Chamberland L. Parcours migratoires et identités gaies et lesbiennes. In: Brotman S, Lévy JJ, editors. Intersections, cultures, sexualités et genres. Québec: Presses de l'Université du Québec; 2008. p. 159-192.

58.Ryan B, Brotman S, Baradaran AL, E. The Colour of Queer Health Care. Experiences of Multiple Oppression in the Lives of Queer People of Colour in Canada. In: Brotman SL, J.J., editor. Intersections, cultures, sexualités et genres. Québec: Presses de l'Université du Québec; 2008. p. 307-338.

59.Dumas J, Lavoie R, Desjardins Y. Étude de besoins en matière de santé des hommes gaies à Montréal. 2000. Montréal : Rézo.

Remerciements
Nous tenons à remercier les Instituts de recherche en santé du Canada, la Chaire de recherche en toxicomanie de l'Université de Sherbrooke, le projet de recherche ARUC sur les trajectoires addictives et les trajectoires de services, le Centre de recherche de l'hôpital Charles LeMoyne, le Centre de réadaptation en dépendance de Montréal-Institut universitaire, le Groupe de recherche sur les substances psychoactives Québec, le Conseil québécois LGBT ainsi que le Réseau SIDA et maladies infectieuses du FRQ-S pour leur soutien financier.

Nous voudrions remercier également les partenaires communautaires Rézo et COCQ-SIDA ainsi que les 35 participants qui ont généreusement partagé leurs expériences avec nous.

Pour contacter l'auteur:
Jorge Flores-Aranda, M.Sc., Doctorant en sciences cliniques
Université de Sherbrooke, Campus de Longueuil
Faculté de médecine et des sciences de la santé
Département des sciences de la santé communautaire
Service de toxicomanie
150, Place Charles-LeMoyne, bureau 200
Longueuil, Québec, J4K 0A8
Canada
Courriel: jorge.flores.aranda@usherbrooke.ca

Karine Bertrand, Ph.D.
Professeure agrégée
Département des sciences de la santé communautaire
Faculté de médecine et des sciences de la santé
Université de Sherbrooke

Élise Roy, M.D., M.Sc.
Professeure agrégée
Titulaire de la Chaire de recherche en toxicomanie
Département des sciences de la santé communautaire
Faculté de médecine et des sciences de la santé
Université de Sherbrooke

APORIA
LA REVUE EN SCIENCES INFIRMIÈRES • THE NURSING JOURNAL

ABOUT APORIA

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

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

Therefore, *Aporia* adheres to the following principles:

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

SUBMISSION

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

Cover Letter

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

Authorship Credit

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

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

Preparation of the Manuscript

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

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