THE UNIVERSITY OF CHICAGO

“DARE TO BE A FUTURE THERAPIST”: UNCERTAINTY AND APPRENTICESHIP IN MENTAL HEALTH SERVICES FOR IMMIGRANTS AND REFUGEES IN PARIS, FRANCE

A DISSERTATION SUBMITTED TO

THE FACULTY OF THE DIVISION OF THE SOCIAL SCIENCES

IN CANDIDACY FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

DEPARTMENT OF COMPARATIVE HUMAN DEVELOPMENT

BY

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CHICAGO, ILLINOIS

DECEMBER 2018

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Acknowledgements

Before taking up apprenticeship as a guiding conceptual force in this dissertation, I wish to pause to express gratitude to those who made my own doctoral apprenticeship possible. I would first like to thank the participants, most of whom remain anonymous, for allowing me to observe their work, ask them questions, and learn about the uncertainties they faced in their professional projects. Some participants were especially hospitable and generous, inviting me to share a meal or drink, or even put me up when I visited from out of town.

I could not have imagined or asked for a better dissertation committee. Michele Friedner introduced me to new literature and, most importantly, remained enthusiastic about my project even though she joined my committee after I had surpassed the initial stages of research. Karin Knorr Cetina was extremely generous in helping me think and work through the big picture questions about my project, whether at its earliest stages or when I was really struggling to put everything together towards the end. Michael Rossi was a constant source of support and encouragement, always had great questions to ask, and never seemed to look at the time during my visits to his office. Eugene Raikhel was unwavering in his guidance as an advisor during just about every moment of uncertainty, from my earliest hesitations about the University of Chicago to the latest stages of writing.

Special thanks are reserved for those who opened the doors for me to conduct my fieldwork in Paris. I first wish to thank Stéphanie Larchanché, who welcomed me to the Centre Minkowska on my first preliminary research trip. I would also like to thank Thierry Baubet, Rachid Bennegadi, Marie-Jo Bourdin, Daniel Delanoë, François Giraud, Kouakou Kouassi, Marie Rose Moro, Jean-Claude Moulin, Christophe Paris, Laura Premat, and Amalini Simon for making my research possible.

Funding for this project, from the first travel grant that took me to Paris to the write up grant that allowed me to complete the dissertation, came from a heterogeneous assortment of foundations and committees united by their generosity. I am eternally grateful for support to carry out my research from a host of external sources: the Society for Psychological Anthropology and the Lemelson Foundation, the Georges Lurcy Educational and Charitable Trust, Sciences Po Paris, and the Agency for Healthcare Research and Quality's (AHRQ) National Research Service Award (NRSA) Institutional Research T32 Training Grant. I am equally grateful for support from sources at the University of Chicago: the France Chicago Center, the Bernice Neugarten Fund, the Mary L. Rynerson Fund, the Lawrence Giannino Fund, the Graduate Student Council, and the Division of the Social Sciences.

I am also grateful for the people who were very influential in the development of this project in its earlier stages: Paul Brodwin, Judith Farquhar, Carolyn Sargent, Jennifer Cole, Don Kulick, John Lucy, Jan Goldstein, E. Summerson Carr, Anne Lovell, and Richard Taub. Patrick Castel was an excellent mentor, a careful and supportive reader, and source of fantastic research literature. Anna-Louise Milne was a great friend and close reader of drafts during some of the most intensive and hectic periods of writing. Janie Lardner, Dan Bertsche, Nia Sotto, and Spencer Bonadeo helped make some of the most stressful moments go quite smoothly.

I shared portions of this project, at times when they were very tentative and drafty, in presentations and workshops and wish to thank the organizers for hosting me and for the participants for their great questions and critical feedback. At the University of Chicago, I wish to thank the inaugural Chicago Ethnography Incubator faculty and graduate student participants and organizers: Kimberly Kay Hoang, Kristen Schilt, Forrest Stuart, Ching Kwan Lee, Megan Comfort, Carla Shedd, David Valentine, Kati Barhona-Lopez, Neil Gong, Hebatalla Gowayed,

Aravind Karunakaran, Mai Thai, and Melissa Osborne. It is rare and very special to find oneself surrounded by such a careful, critical, and generous group of readers.

I wish to thank Madeline Smith, Bastien Craipain, and the participants of the Modern France and the Francophone World workshop. Additionally, I would like to thank Francisco Najera, Angelica Velazquillo, and the participants of the Migration and Incorporation workshop. I would also like to thank Kieran Kelly and the participants of the Medicine and its Objects workshop, as well as Talia Gordon, who was the most generous discussant I could ever ask for. Lastly, I would like to thank Nancy Thebaut and the participants of the University of Chicago Center in Paris graduate workshop, who were a very supportive multidisciplinary audience to several iterations of my project.

At the Universität Siegen, I would like to thank Cornelius Schubert, Ehler Voss, and the participants at the Preparing for Patients conference. At the École des Hautes Études en Sciences Sociales, I would like to thank Simeng Wang, Lila Belkacem, Florence Lévy, and Mohammed Sharqawi and the participants of the Atelier Migrations. At Sciences Po, I would like to thank Renaud Crespin and Olivier Pilmis and the participants in the weekly seminar at the Centre de Sociologie des Organisations. At York University, I would like to thank Martin Webber and the participants in the seminar in the Department of Social Policy and Social Work.

In Paris, I received a great deal of institutional support from the University of Chicago Center in Paris. I would like to thank Sébastien Greppo, Coraline Echasseriau, and Arnaud Coulombel for making my presence at the 'Chicago Center' possible and delightful, as well as Marie Sahakian and Solène Rascle for assisting me with transcribing many of my interviews. I also received generous and hospitable institutional support from Sciences Po on two occasions, first at the Centre de Recherches Internationales (CERI) and then at the Centre de Sociologie des

Organisations (CSO). At the CERI, I wish to thank Riva Kastoryano for welcoming me at the very beginning stages of my fieldwork and for helping me think through some of my earliest research questions. At the CSO, Patrick Castel and Olivier Borraz welcomed me to an intellectually stimulating and collegial environment once I completed my fieldwork.

I am especially grateful for the friendship and camaraderie of certain individuals over the course of my graduate studies. I would first like to thank my PhD cohort—Rita Biagioli, Hae Min Byeon, Christine Fleener, Abena Gyamfuah Sarfo-Mensah, Laura Horton, and Kristina Pagel—who were some of my first friends at the University of Chicago, and who made some of the earliest, most confusing moments quite fun. Other friends provided much needed support in various forms, such as symphony outings, long runs, long dinners, long-distance friendship, bike rides, tennis matches, hikes in some of the most magnificent places, or espresso breaks in the Regenstein and the BNF Richelieu: Mobeen Azhar, Amanda Blair, Sarah Carr, Sean Coyne, John Cropper, Cari Focht, Rosalind Fredericks, Kyle Gardner, Jane Gelfand, Jonah Goodman, Talia Gordon, Christopher Grant, Ramón Gutiérrez, Chris Hedemann, Jesse Jenkinson, Kamaya Jones, Chris Juby, Nico Köhler, Kathryn Macapagal, Mehammed Mack, Brian Mark, Abe Markin, Erin Moore, Kelly Nyikes, Ben Pederson, Nélio Rodrigues, Remy Roque, Julie Savary, Robert Stocker, Elina Suzuki, Tim Widden, Sara Yasin, and Sarah Zimmerman.

I am deeply grateful for my family, especially my parents, Ronnie, Aftab, and Farah, my siblings, as well as Adam, Alicja, Rehan, and Sarah, for their endless support and for knowing not to ask when I would complete my dissertation. Lastly, I would like to thank Raphaël for putting up with me when I was the most insufferable.

Abstract

Mental health professionals and clinical students face uncertainties when attempting to provide care and support to diverse patient populations, such as immigrants, refugees, and their children. These uncertainties may result in misunderstandings and failures to respond to the needs of patients. Uncertainties are due to the limits of clinical knowledge among clinicians and in the field (Fox, 1957), and may be heightened in encounters with patients who speak other languages, whose living conditions are extremely unstable, or who have different ways of expressing their experience of disorder. Broadly, health professionals and students attempt to attenuate these uncertainties by pursuing training in cultural competence or cultural sensitivity, so that they may learn how to better support diverse patients. Cultural competence training in France has been critiqued for advancing essentialist notions of culture and for not respecting universalism and assimilation, which guide the provision of public services. These critiques have prompted clinicians to emphasize the development of the ability to decenter from one's own cultural representations in order to recognize those of others, and become more self-reflexive (Larchanché, 2010; Moro, 1998; Moro, 2002; Sturm, 2005; Sturm, Heidenreich, & Moro, 2008). The emphasis on decentering reflects broader trends that challenge notions of expertise and competence in cultural sensitivity training, and that promote the embrace of uncertainty and the development of a self-aware, "ethical self" (Shaw & Armin, 2011: 244). Leaders in the field of *psychiatrie transculturelle,* or transcultural psychiatry, have suggested that decentering is an essential practice for health professionals, but is difficult to learn and requires rigorous training and supervision (Moro, 1998).

Drawing on twenty-two months of fieldwork, this dissertation examines how clinical students in psychology and psychiatry learned to address uncertainty and develop decentering

practices through apprenticeship (Lave and Wenger, 2009) under the supervision of culturally sensitive clinical psychologists and psychiatrists in mental health settings for immigrant, refugee, and non-francophone patients in Paris. The supervisors in these settings encouraged apprentices to unlearn the rigid modes of thinking and forms of expertise they acquired in their training in psychiatry and psychology. A closer examination of apprentices' activities within these settings reveals that while supervisors promoted the development of openness, flexibility, and the acceptance of uncertainty, apprentices were made to perform roles of diversity in front of patients, simplify and systematize complex patient information into manageable forms, and discipline their speech to adhere to the institutional frameworks of these settings. While intended to train apprentices to minimize or accept uncertainty, these practices provoked new forms of uncertainty. I argue that the divide between the perspectives of apprentices and their supervisors is a rich and crucial site of analysis, as apprentices advanced more inclusive, cosmopolitan, and intersectional ways of conceptualizing cultural diversity in therapeutic interactions. Moreover, I contend that the inconsistencies in practice and rigid pedagogical styles of supervisors prompted apprentices to develop selective and heterogeneous styles of practice following their apprenticeship. This dissertation thus contributes an anthropological lens to the transmission of expertise with an eye towards how cultural sensitivity is learned and uncertainty is addressed through experience.

Introduction: An apprenticeship in cultural sensitivity

An apprentice's first day

At the start of the academic year in September 2015, a group of five graduate students in clinical psychology began their apprenticeship in *psychiatrie transculturelle,* or transcultural psychiatry, a kind of therapy group for multilingual individuals and families who are immigrants or refugees. Many people tend to think of group therapy as involving several patients, but in *psychiatrie transculturelle,* a group of therapists receives one patient or family at a time. In addition to the five graduate students, there were five psychologists, a psychiatrist, and a general practitioner in the group. Anna, a psychologist who would lead the first therapy session that morning, informed the five graduate students that they would not speak during the therapy session since they were still learning how the group functioned. Instead, they were to first observe how the more senior therapists interacted with the patients and with each other. Anna and Pierre-Olivier, the psychiatrist, then briefed the group about the first patient they would receive that morning.

Aisha[1], a woman in her early 30s, had been referred to the group following a one-month hospitalization over the summer. The letter written by the psychiatrist who referred Aisha said she was diagnosed with paranoid schizophrenia, had used cocaine prior to her hospitalization, and had been hospitalized due a manic state in which she spent a great deal of money. The letter also mentioned that Aisha's brother had died in 2010 in the same hospital, though it did not specify his cause of death. The group seemed visibly shocked by this latter detail, and Pierre-Olivier said that this would be a complex case and that it was a *patate chaude,* a hot potato, since he thought the referring psychiatrist was unloading the case onto the *psychiatrie transculturelle*

[1] Aisha, and all other names unless indicated otherwise, are pseudonyms. Additional details have been modified to maintain confidentiality.

group. Pierre-Oliver also instructed the group to not discuss Aisha's cocaine use in the first session, since this might be a sensitive and taboo subject. In *psychiatrie transculturelle* therapy, clinicians support individuals and families to work through difficult histories of migration and acculturation. These therapy groups are not the first line of care, but rather they supplement ongoing psychiatric or psychological treatment. For this reason, the health professionals who refer patients are also expected to attend therapy groups so that the continuity between institutions is maintained.

In this particular session, however, the psychiatrist who referred Aisha did not attend. Moreover, the psychiatrist did not brief Aisha or her family about what *psychiatrie transculturelle* therapy was for or that they would be received by a large group of therapists. Instead, Aisha's older sister, Faiza, stated that they were under the assumption that they were coming for family therapy. Aisha, Faiza, and their mother appeared shocked to be in the presence of such a large group and were initially apprehensive to enter the room where the group was seated in a large semi-circle. Their mother asked if what they discussed in the therapy session would be reported back to the psychiatrist and hospital that had referred Aisha. Anna said that it would not, and she eventually convinced the three women to sit with the group. Anna stated that the group was a space where people could discuss being in France, while being from elsewhere. To illustrate this, Anna stated that she was from Argentina, that Meixiang, a psychologist, was from China, and that I was from the United States. Anna introduced the group of therapists, stating their first names, their function in the group as a student, psychologist, psychiatrist, or general practitioner, and their countries of origin. She also introduced an interpreter in Arabic and Berber, who like Aisha's parents, was from Algeria, and whose services had been solicited from an organization of professional interpreters.

After getting off to a bit of a rocky start, Anna began the therapy session by asking the family questions about their family and medical history. Faiza was the eldest and Aisha was the fourth of five children. Faiza, another sister, and the brother who had passed away, were born in Algeria and moved to France with their mother to join their father who had moved for work years before. Aisha and a younger brother were born in France. Over the course of the therapy session, the group and the family discussed their memories of life in Algeria, the extended family they left behind, their move to France, and the death of their brother.

Anna turned to the other therapists in the group, who would communicate their thoughts to her, and then she would restate them for the family. These thoughts could take various forms, and therapists were encouraged to speak about their own experiences or describe imagery that came to mind as they listened to the exchanges between patients and the principal therapist. The other therapists' speech was to be directed to Anna, who would remain the only therapist to speak directly to the family since a dozen interlocutors would be overwhelming. Upon hearing Faiza and her mother speak Berber, Joel, the general practitioner, asked where the family was from in Algeria and whether they remained in touch with their family. Faiza recounted a trip she and Aisha had taken to Algeria, but stated that they did not go to the village where their parents are from since that would have been "too much." Pierre-Olivier said that he also came from a large family in the east of France, and completely understood how easy it is to feel overwhelmed by distant relatives. Upon noting that all three women were dressed in black, Meixiang said it made her think of an image of a constellation where some stars are bright and others are dark, yet the constellation requires both. Therapists' various forms of input enrich the therapy sessions by building on what was previously exchanged, as well as offering new material.

Aisha, however, seemed less enthusiastic by the propositions offered by the therapists. Until this point, most of the exchanges during this session took place with Faiza and their mother, and Aisha had remained silent. “What is the purpose of these sessions? What are the objectives?” Aisha asked staring intently at Anna. Anna said that the goal of *psychiatrie transculturelle* was to learn about the family history and “how things were organized in the family.” Aisha responded that Anna and the other therapists asked a lot of questions of her mother, questions that she thought were dumb and not relevant. She also stated that they did not need an interpreter; after all, she was born in France and her mother spoke French. Anna defended the presence of the interpreter, stating that it was like hearing “music to hear people speak in their first language.” Anna stated that she felt Aisha was angry and offered to ask about her hospitalization and illness, unless she thought that those were also dumb questions. Aisha was more receptive to this. Anna said she was curious about the diagnosis of paranoid schizophrenia, and asked their mother what she thought was the origin of Aisha’s affliction. She stated that she doubted this diagnosis and instead suggested that the evil eye might be responsible for what Aisha faced. Aisha countered this, stating that she did not believe in the evil eye and stated that she had schizophrenia. Anna turned to Sarah, one of the apprentices in the group, and asked her what she thought. Sarah commented that parents often have ideas about what causes a particular situation but one doesn’t necessarily agree. Aisha smiled but did not respond.

At one point in the therapy session, Aisha and Faiza’s mother produced a photo of her late son and passed it to Anna. His death had been a moment of great trauma for the family. Faiza suffered a long period of depression and during that time, she separated from her husband. She said that the family did not recognize her depression as an illness, though she has been in

recovery and now works as a costume designer at a theater in Paris. Aisha had worked as a receptionist in another large hospital in Paris and her contract ended around the time of her brother's death. It was the combination of these two events, according to their mother, that was the start of Aisha's problems. Their mother also reported that her son's death affected her youngest son as well, since he chain smokes, never takes off his headphones, talks to the wall and punches it from time to time. Faiza said that their other sister was also unwell, but did not elaborate on her condition. Anna said that they would proceed slowly over the course of these sessions, and suggested that they meet again in a month's time.

After the three women left, the group members debriefed and discussed their reactions to the therapy session. Anna noted that the only time that Aisha smiled during the therapy session was in response to Sarah's statement. Anna also complemented Meixiang on her image, stating that she too was drawn to the fact that the three women were dressed in black. Anna then turned to me and said, "You're an anthropologist, what does wearing black signify? Is it a funeral color?" Having absolutely no idea and not wanting to make something up, I answered cautiously that I was not sure but would happily research the topic. Marion, a psychologist, was fascinated by Faiza's comments and wondered aloud what it must be like to work in the theater with such drama playing out in one's family. Anna asked Pierre-Olivier and Joel, the two medical doctors, what they thought about Aisha's diagnosis of schizophrenia and about the extensive mental health problems faced by several members of this family. Joel thought that there was some kind of disorder affecting the family, but stated that they would need to explore this in more depth. Pierre-Olivier suggested that Aicha insisted on the diagnosis for the sake of the therapy group, meaning that she might be taken more seriously if she spoke in biomedical terms. Anna suggested that for the next therapy session, they invite the psychiatrist who referred Aisha.

Pierre-Olivier pushed back on this idea, stating that they had already done a lot of work and that the presence of the psychiatrist may require them to backtrack. Moreover, he suggested that inviting the psychiatrist might seem like a transgression since Aisha and Faiza's mother articulated her concerns about sharing information with the psychiatrist and hospital that referred Aisha to this group.

This situation illustrates a central question guiding this dissertation: how do health professionals learn to develop culturally sensitive therapeutic approaches for patients in different situations of migration in France? Clinicians like Anna and her colleagues face uncertainties having to do with the questions to ask patients, the liaison with health professionals in other settings, the use of interpreters, the discussions around diagnoses, and the collaboration among colleagues in a group setting. For example, while Anna and her colleagues thought that the presence of an interpreter may make Aisha and her family feel more at ease, this had the opposite effect and prompted Aisha to assert their ability to speak French. While the therapists thought that the session might be a space where Aisha and her family could discuss their family and migration history, as well as alternative etiologies of mental illness, Aisha questioned the therapeutic value of this material and insisted on the validity of the diagnosis of schizophrenia.

Supervising therapists like Anna, the psychologist introduced above, often instructed apprentices to embrace their uncertainties rather than attempt to minimize them. Additionally, as members of these therapy groups, apprentices play a crucial role in the clinical work of these spaces. In the vignette above, the apprentices remained largely in the background since this was their first day in the therapy group. However, the presence of apprentices in the therapy groups creates an environment of diversity, thereby granting these groups legitimacy. This was evidenced in Anna's attempts to attenuate the concerns of Aisha and her family by presenting the

therapy group as a place where people could talk about being in France while being from somewhere else, and identifying specific group members who embody difference. Additionally, as they become more integrated into the group, apprentices provide a multitude of perspectives that can extend and diffract associations in group therapy settings. Meixiang, Sarah, Pierre-Olivier, and Joel offered proposals that took different forms and served different functions in the therapy session. Supervising therapists instructed apprentices that they needed to listen to their patients and look inward to develop proposals that reflected their own experiences and lives. Additionally, apprentices needed to learn to decenter, or step back from their assumptions and frames of reference in order to better listen to those of others (Moro, 1998: 40; Moro, 2002; 34-35). I assert that supervisors encouraged apprentices to unlearn the kinds of the thinking and reasoning that they had developed in their studies and clinical training since that would not arm them with the kind of expertise that they would need to address the uncertainties that they would face as future therapists.

I contend that *psychiatrie transculturelle* groups and my other field sites are unique settings to consider how apprentice therapists learn to manage uncertainty and develop expertise. This dissertation makes an original contribution by taking the vantage point of apprentice therapists, or the clinical students who underwent long-term training within mental health settings for immigrants and refugees, and under the supervision of psychologists and psychiatrists. I chose to use the term *apprentice therapist* or *apprentice,* as I found it analytically useful and because there was no singular term used to describe these individuals across my fieldsites. In one setting, they were called interns (*stagiaire*), co-therapists (*co-thérapeute*) in another, students (*étudiant*) in a third setting, and therapists-in-training (*thérapeute en formation*) in the last setting. I address the use of these labels in more depth in Chapter 2, but emphasize

here that the terms, *apprentice therapist* and *apprentice*, provide a singular mode to understand and analyze the experiences of these individuals. These terms allowed me to ground the experiences of apprentices to rich body of literature on situated learning and practice-based learning, as opposed to classroom instruction. Moreover, I contend that the concept of apprenticeship enables us to more comprehensively understand the ways that individuals identify and respond to moments of uncertainty.

Throughout the dissertation, I emphasize the significance of the perspectives and experiences of those who undergo apprenticeships, rather than simply the clinicians who supervise apprentice therapists. Because they are new to these settings, apprentices require their supervisors to explain and demonstrate how they go about their work. In so doing, apprentices illuminate many of the subtle aspects of organizations that might otherwise be taken for granted. Additionally, while apprentice therapists come to these clinical settings to learn and train, they also contribute to the ongoing activities of these settings. Their presence is essential in the smooth functioning of therapy sessions, they assist in crucial documentation and administrative tasks, and their presence provides legitimacy to these settings. Additionally, the explicit instructions given by their supervisors, as well as the more implicit, "hidden curriculum" (Hafferty & Franks, 1994: 861) of these clinical pedagogical settings, reveals what apprentices are supposed to take away from their apprenticeship. Lastly, and perhaps the most significantly, by focusing on the experiences of apprentice therapists, we gain insight into the processes by which individuals learn to manage uncertainties and decenter through experience. Rather than considering the management of uncertainty and decentering as straightforward processes that inevitably happen, the perspective in this dissertation is one that suggests that these processes are complex and fraught with challenges.

Understanding the uncertainties of apprentices: An ethnography of an ethnography

In this dissertation, I analyze the experiences of apprentices who underwent long-term training in culturally sensitive mental health services. Another way this dissertation makes an original contribution to existing research on mental health care for immigrants and refugees in France is its conceptual framework of apprenticeship and the management of uncertainty in clinical education and practice. I consider apprenticeship as legitimate peripheral participation in communities of practice, in which the learning experiences of newcomers is reflected through their absorption into these communities (Lave & Wenger, 2009). By focusing on the experiences of apprentices in these settings, I interrogate how relations of teaching and learning are produced and how apprentices learn to engage in mature practice, or the kinds of practice of their supervisors (Lave, 2011: 35). Drawing on research on apprenticeship, uncertainty, and the development of expertise, this project analyzes apprentice therapists' experiences as they progress from newcomers to culturally sensitive therapists. In addition to the important work of Jean Lave and Etienne Wenger (Lave, 2011; Lave & Wenger, 2009; Wenger, 1991), I also draw extensively on ethnographic accounts of apprenticeship in medical education (Becker et al., 2003; Bosk, 2003; Light, 1980; Sinclair, 1997), legal education (Mertz, 2007), boxing (Wacquant, 2004), magic (Jones, 2011), and cattle breeding (Grasseni, 2004) to analyze how individuals become absorbed into their sites of practice.

This project could be considered an ethnography of an ethnography since I analyzed how apprentice therapists learn to enter into the local worlds of patients or clients who use culturally sensitive mental health services. By "local worlds," I refer specifically to the work of Arthur Kleinman (1992) on the ways in which clinicians incorporate ethnographic techniques into their encounters with patients. Kleinman (1992: 130) writes that the:

> “…clinically-oriented ethnographer who conducts such a study begins with a description of the patients’ local words; within each local world, he or she interprets the effects of the family, workplace, medical care, and other relevant institutions on the experience of suffering and treatment…”

Once the clinician-ethnographer has identified the local world, then the next step is to interpret what is at stake for the protagonist (Kleinman, 1992). In this project, I became acquainted with the local worlds of apprentices and their supervisors as the former learned how to identify the local worlds and the matters at stake for patients. These worlds were not simply pre-existing but were produced by apprentices, their supervisors, and patients, meaning that these individuals may have vastly different experiences from one another while occupying a shared space. By focusing on apprentices’ experiences, I closely attend to the meanings apprentices give to the routines and interactions with supervisors in these settings. This project is also an examination of how apprentices learn to accept the uncertainties that are commonplace in their future work as clinicians, as well as how they professionalize, or undergo what Dominic Boyer (2008:44) refers to as “expertisation.”

Uncertainty and its management have been prominent features of social studies of medicine and clinical education since the 1950s. Seminal studies, notably those conducted by medical sociologist Renée Fox (1957; 1980; 2000), have emphasized the limits of knowledge possessed by individual practitioners and within the fields that these individuals practice. In the context of clinical encounters with patients or clients in different situations of migration, health professionals and clinical students may face additional layers of uncertainty about how to best support these individuals when they do not share a language, when these individuals may have different ways of putting words to their experience with mental illness, or when their living conditions—in terms of legal status, stability of housing and work, and connectedness in their host societies—are extremely precarious. Indeed, linguistic, cultural, and social factors can have

a profound effect on the expression, treatment of mental illness. Moreover, the uncertainties faced by health professionals with regards to these factors may result in miscommunications and misdiagnoses. For example, the adjustment disorder and post-traumatic stress disorder (PTSD) of immigrant and refugee patients may be misidentified as psychosis (Adeponle et al., 2012: 151-152).

Uncertainty is indeed inevitable, but practitioners may take various measures to attempt to manage it. Health professionals may wish to attenuate the uncertainty they face regarding their patients' practices, beliefs, and attitudes by enhancing their cultural knowledge and understanding in order to address their patients' particular needs (Kai et al., 2007: 1768). In this sense, one strategy for managing uncertainty involves the development of what has often been referred to as cultural competence, or the necessary know-how to work in intercultural situations. The general objective in cultural competence training is to provide clinicians with knowledge so that they are better prepared when faced with unfamiliar intercultural situations. Despite the good intentions, cultural competence training has often been critiqued by social scientists and clinicians for using static and closed definitions of culture, for considering culture as an element to be tracked and corrected (Santiago-Irizarty, 2001: 131), for equating culture with group membership (Kirmayer, 2012: 155), for overemphasizing culture dimensions in lieu of other factors (Kleinman and Benson, 2006: 1673), and for failing to recognize that biomedicine is a cultural system itself (Taylor, 2003). Taken together, these different critiques often aligned on the notion that culture was often seen as the patient's problem that the professional had to learn about in order to conduct her or his work properly.

However, a more recent turn in cultural competence training has emphasized the importance of cultivating dispositions of openness and empathy among clinicians in lieu of

mastering lists of traits about patients' presumed backgrounds (Jenks, 2011; Shaw & Armin, 2011). In fact, a 2013 special issue of the journal *Culture, Medicine, and Psychiatry,* arguably an important forum for discussions and debates concerning the relation between culture and mental health, provided a rich account of the successes and failures of different cultural competence education programs in a variety of medical education contexts. Importantly, the issue's guest editors identified the distinction between *knowledge*- and *process*-based forms of cultural competence training (Willen & Carpenter-Song, 2013). Whereas the former has emphasized the acquisition of expertise, the latter has prioritized the engagement with what anthropologists Susan Shaw and Julie Armin (2011: 244) have termed an "ethical self-fashioning," or the development of a posture of empathy and self-awareness. These perspectives, taken together, assert that recent approaches in cultural competence training divert attention from the patient's culture and instead focus on the professional's self-awareness.

France is a unique setting to consider training in cultural competence, which for some time has emphasized the cultivation of dispositions of openness among clinicians. This is due largely to its culture-blind socio-political context and because of controversies associated with earlier practices of ethnopsychiatry. In secularized France, the attention to cultural and linguistic difference has been seen as in opposition to universal values guiding the provision of health and other public services (Fassin & Rechtman, 2005). The practices of ethnopsychiatry during the 1980s and 1990s, notably those led by the psychologist Tobie Nathan, were fiercely criticized for trapping patients within their so-called cultural origins, thereby ignoring their subjectivity and their lived experiences of social and economic deprivation (Fassin, 1999: 168-169). This form of ethnopsychiatry was also in opposition to the French public health system and challenged biomedical perspectives in psychiatry (Fassin & Rechtman, 2005: 361).

The next generation of therapists, including the renowned child and adolescent psychiatrist Marie Rose Moro, distanced themselves from Nathan and ethnopsychiatry and adopted a more dynamic notion of culture (Moro, 1998: 42-44). In so doing, they developed a more moderate practice that sought to work in cooperation with the public health system and that did not seek to challenge global biomedical currents in psychiatry (Fassin & Rechtman, 2005: 362). Moro named her approach *psychiatrie transculturelle,* transcultural psychiatry, and has, for decades, emphasized the importance of decentering, or *décentrage,* which refers to the ability to distance oneself from one's own representations and biases that professionals working with diverse immigrant groups must cultivate (Moro, 1998: 40; Moro, 2002: 34-35).

In addition to *psychiatrie transculturelle,* another major school of thought in psychotherapy for immigrant, refugee, and multilingual patients is known as *anthropologie médicale clinique,* or clinical medical anthropology. This approach was developed by clinicians at the Centre Françoise Minkowska, which since the 1950s has provided psychotherapy in the first language of patients. In *anthropologie médicale clinique,* clinicians take a more holistic, person-centered approach in which they pay close attention to the patient's voice, or way a patient understands disorders, as well as the social context that impacts the patient's experience of disorder. Just as in Moro's *psychiatrie transculturelle,* in *anthropologie médicale clinique,* therapists must distance themselves from their own representations of illness acquired from their clinical training and instead attend to patients' explanatory models (Larchanché, 2010: 169).

In reflecting on the work of Moro and the clinicians at the Minkowska Center, anthropologist Stéphanie Larchanché has observed a self-reflexive turn in the positions of clinicians and professionals, and suggests that these individuals do not think of culture as something to know about but rather as something to anticipate (Larchanché 2010: 204). Indeed,

as others have illustrated, reflexivity is an integral component in the task of decentering (Sturm, 2005: 96-97; Sturm, Heidenreich, & Moro, 2008: 40; Sturm, Nadig, Moro, 2011: 210). Significantly, these perspectives suggest that French approaches in cultural sensitivity training are aligned with process-oriented approaches that emphasize openness and ethical self-fashioning, the dismantling of the notion of expertise, and the embrace of uncertainty (Guzder & Rousseau, 2013; Jenks, 2011; Kai et al., 2007; Kirmayer, 2013; Shaw & Armin, 2011; Willen & Carpenter-Song, 2013).

The development of self-reflection and acceptance of uncertainty may seem straightforward, but it is not. Indeed, accepting uncertainty may be easier said than done, particular in clinical and caring environments where the wellbeing of individuals is at stake, where competition between professionals is high, and where training emphasizes the acquisition of expertise. Moro (1998: 46; 2002: 34-35; 2010: 200; 2015: 19-20) has explained that while decentering is the most important practice that professionals can learn, it is also one of the most difficult. The ability to decenter is acquired through rigorous training, daily work, and supervision (Moro, 2015: 21). Thus, this dissertation makes an original contribution by analyzing how decentering is learned through apprenticeship or situated learning within sites of practice.

An examination of the interior of this intensive training, particularly as experienced by apprentices, is important since "increased attention must be paid not just to how cultural competence is *taught* but how it is *learned"* (Jenks, 2011: 230, original emphasis). If apprentices are learning to cultivate outlooks in lieu of acquiring specialized knowledge, then the analysis of the experience of this intensive training is also conceptually significant since apprentices are learning to demonstrate ways of knowing within pedagogical environments that are trying to do away with notions of expertise. Indeed, Larchanché (2010: 189-190) has observed that clinicians

in mental health settings for immigrants face a double bind, wherein they attempt to do away with the notion that knowing about culture requires expertise, while simultaneously maintaining their expert position. Additionally, Lila Belkacem (2013; 2015) has identified how health and social service institutions validate the approaches of culturally sensitive mental health settings by referring patients, even though these institutions do not value or recognize the cultures of patients or clients. My research builds on, yet departs from, these studies by analyzing the technicalities of how apprentice therapists develop culturally sensitive practices in settings that are constrained by these double binds and paradoxes. In other words, how do apprentices develop expertise in settings where there are no experts and in a socio-political context that does not recognize this expertise?

Drawing on conceptual research that stresses situated learning, I propose a framework that gives an account of how apprentices attempt to embrace uncertainty and develop practices of decentering within culturally sensitive mental health settings. My objective is to assemble streams of literature on situated learning and the management of uncertainty, and think through the contribution of this literature to research on cultural competence and sensitivity in mental health, particularly in the socially and historically significant context of France. In so doing, I intend to set the stage to consider how apprentices experience routines, perform tasks, and inhabit institutionally created roles.

Apprenticeship as method

By becoming an apprentice, one learns repertoires and is integrated or professionalized as a member within specific communities (Lave & Wenger, 2009). I therefore became an apprentice as a method of becoming a participant within the communities of practice where I

conducted research. In lieu of participant observation, I conducted what sociologist Loïc Wacquant (2004: 6; 2011: 87) refers to as "observant participation" in the training activities of my field sites. By becoming an apprentice, I wanted to analyze the process of learning in these sites and learn how to develop an idealized practice (Downey, Dalidowicz, & Mason, 2014: 3). While I had permission to conduct research in my field sites and introduced myself as a researcher, I had the same role or function as the other apprentice therapists[2]. Thus, another original contribution of this dissertation is its use of apprenticeship as both a conceptual framework to consider learning within mental health settings for immigrants and refugees and methodological approach to understand the experiences of apprentice therapists. In the following chapters, I investigated the activities in which apprentices were engaged, and analyzed their deeper meaning and significance in becoming professionalized as therapists. By participating in the training activities in these sites as an apprentice, I was able to develop an understanding of the pedagogical function of these activities from within and recognize "how practices come together to shape expertise" (Downey, Dalidowicz, & Mason, 2014: 9).

Over the course of twenty-two months, I conducted ethnographic fieldwork in four settings in Paris and the suburbs: three *psychiatrie transculturelle* consultations like the therapy group introduced in the opening vignette, and the Centre Minkowska, where *anthropologie médicale clinique* was practiced. I briefly describe each of these settings below.

[2] I obtained permission from the supervisors in each of my field sites and this project was approved by the Institutional Review Board of the University of Chicago.

Consultation psychiatrie transculturelle

The first *psychiatrie transculturelle* therapy group where I conducted fieldwork, founded by a clinical psychologist in 1989, was located in a sector[3] or district-based, part-time outpatient treatment center (*Centre d'accueil thérapeutique à temps partiel,* CATTP), in the north of Paris. The therapy group convened one day per week, and could conduct with consultations with up to four patients in a day. This may come as a surprise to many, particularly those who work as mental health professionals and who face severe time constraints in their work. As described in more detail in chapter 1, in *psychiatrie transculturelle* sessions, a group of therapists receives one patient and her or his family and referring health professionals for one hour. Additional time is devoted before each session to discuss previous sessions, and after each session for debriefing.

During my fieldwork in the therapy group in the CATTP, the psychologist who founded the group continued to practice, though often discussed slowing down and eventually retiring. In addition to this psychologist, four other psychologists, one psychiatrist, and a general practitioner were among the permanent members, which brought the total number of supervising therapists to seven. The large number of therapists meant that several among them could lead therapy groups. This was significant because apprentices could observe and engage in different ways of working. One of the permanent psychologists had been an apprentice therapist in the group a few years before and rejoined the group over the course of my fieldwork. In addition to these permanent members, five graduate students in clinical psychology undertook an apprenticeship in the group over the course of the year beginning in September. Most of the patients received in this group, or their parents, were from North and West Africa and South Asia, and the most frequent sources

[3] Outpatient centers like this one are organized into geographic catchment areas, or sectors, and individuals consult mental health professionals in the sector in which they reside (Petitjean, 2009; Verdoux 2007: 64).

of patients were other clinical settings in the same district, such as outpatient day hospitals (*hôpital de jour,* HDJ), and centers that support young people with disabilities to undertake professional training (*institut médico-professionnel,* IMPro).

Psychiatrie transculturelle therapy sessions in the CATTP took place in a basement-level room, below most of the consultation rooms in this setting. When patients arrived for therapy, they would descend the stairs and wait on a sofa that was just outside of the room. The room itself was furnished with a dozen chairs, arranged in a circle, a small coffee table placed in the middle of the room, and a few pieces of children's furniture, including a small bookshelf and an easel. A large window allowed light from the street level to fill the room. The room had initially been designed for observation. Another large window connected this room to an adjacent room where observers could look on, and next to this large window was a small window through which a camera that could record what took place in the room. Neither of these features was used in *psychiatrie transculturelle* therapy sessions. In fact, shades were drawn in the large window and the supervising clinicians often placed an A4-sized sheet of paper in the small window to block the camera. The supervisors blocked the camera at the request of a patient who did not want the therapy sessions audio or video recorded. The therapy group did use an audio recorder, to assist in the transcription of notes from each session, but did not use the recorder with this patient or with anyone else who did not consent to the sessions being recorded. While the therapy group never used the camera, nor were there ever observers in the adjacent room, these features nevertheless created a clinical, scientific sentiment that could be experienced by patients as one of surveillance.

Consultation psychiatrie transculturelle familiale

The second *psychiatrie transculturelle* group, for families, founded by a psychologist in 2001, was located in a center providing psychological and pedagogical support (*centre médico-psycho-pédagogique,* CMPP), in a suburb in the south of Paris (Delanoë & Hamlat, 2012; Delanoë, 2017). This group, which met one morning per week, received parents and families whose children had been referred by school psychologists or social workers due to learning difficulties, behavioral problems, or other adjustment issues. Unlike in the group in the CATTP, this group had one principal therapist, a psychiatrist with a PhD in anthropology, who led the therapy groups. In addition, there was a clinical psychologist who assisted this psychiatrist on a regular basis, as well as another psychiatrist, who participated on a more occasional basis. This group received 8-10 apprentice therapists per year. Patients and families in this group came from North and West Africa, though more recently, this group received many patients and families from China (Philippe, Simon-Radinez, & Delanoë, 2018). A few apprentices in this group also undertook apprenticeships in the group above in the CATTP and drew comparisons between the two. Some described this particular group as more fragile because, unlike the group at the CATTP, this therapy group had one supervising therapist. Therefore, in the event that this therapist was not available, the group would need to reschedule the therapy session.

Similar to the sessions at the CATTP, the *psychiatrie transculturelle* therapy sessions took place in the lower level of the CMPP. But unlike the therapy room at the CATTP, which featured objects of surveillance and few furnishings for children, the therapy room at the CMPP appeared to be designed for children. There were a dozen chairs organized in a semi circle, with a small picnic table in the middle, where children could sit and entertain themselves with several boxes of toys, sculpting clay, and crayons and markers. The semi circle ended at one of the

walls, which was outfitted with a large chalkboard, wooden climbing bars, and a basketball hoop. In fact, during one family therapy session, I was seated in the semi circle near the wall and under the basketball hoop. The supervising psychiatrist was trying to carry on a conversation with a mother, while her energetic eight year-old son was running around the room, playing with different toys for a few moments before discarding them and moving on to another set of toys in another section of the room. Moments later, the young boy picked up a basketball and made a successful shot that nearly landed on my head. I caught the ball and handed it back to the boy, and, upon noticing this, the psychiatrist stopped his conversation with the boy's mother to engage him in conversation. Typically, in these family therapy sessions, an auxiliary therapist (*thérapeute auxiliaire*) would accompany a child or children while they played, which would allow the supervising psychiatrist to more fully engage with the parents. Apprentice therapists would fill this auxiliary role, and would give their impressions after the therapy sessions when the family had left and the group debriefed. On this particular day, the auxiliary therapist struggled to keep up with the young boy, who seemed curious to explore every toy in the room. Significantly, this therapy setting felt quite different from the one in the CATTP. The different configurations of the therapy rooms in each setting created an atmosphere that felt either orderly and somewhat laboratory-like, as in the CATTP, or slightly chaotic yet welcoming, as in the CMPP. Moreover, the therapeutic space in this latter setting produced a different kind of role for apprentice therapists, which was absent in the CATTP.

Consultation trauma

The third *psychiatrie transculturelle* group was for people who had experienced trauma, and was located in the department of child and adolescent psychopathology, general psychiatry,

and addiction medicine at the Avicenne Hospital, a large university hospital in a northern suburb of Paris. Founded as the Franco-Muslim hospital in 1935, it "was supposed to welcome colonial subjects from North Africa in a way that respected their culture and their traditions" while simultaneously "protect[ing] Paris as the Centre of the Colonial Empire from the Infected Other" (Sturm, Heidenreich, Moro, 2008: 34). In 1961, Avicenne was incorporated into the public hospital system, known as the *Assistance Publique – Hôpitaux de Paris* or *APHP,* and was thus open to the general population, and in 1971, it became the teaching hospital of the University of Paris Nord (13) [4] (Sturm, Heidenreich, & Moro, 2008). In fact, it was at the Avicenne Hospital where the head of the department of child and adolescent psychiatry invited Tobie Nathan to establish an ethnopsychiatry consultation in the 1980s to better serve the immigrant population (Sturm, Heidenreich, & Moro, 2008: 34). Professor Marie Rose Moro, a student of Nathan's, took over his consultation and became the head of the child and adolescent psychiatry department, before eventually moving to the Hôpital Cochin and becoming the head of child and adolescent psychiatry at the University of Paris Descartes (5). Professor Thierry Baubet, a student of Moro's, became the head of the department, though at the time of writing, Professor Moro continued to lead the consultation at Avicenne.

The trauma consultation resembled other *psychiatrie transculturelle* groups in terms of its group composition and theoretical orientation, but was modified for individuals with diagnoses of post-traumatic stress disorder, or experiences of trauma due to violent experiences of migration (Baubet et al., 2005; Baubet, 2008). This consultation received patients who were from, or whose parents were from, a variety of countries of origin, such as Pakistan and the Democratic Republic of the Congo, and referral sources, such as hospitals and outpatient mental

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[4] The numerals following the names of these universities correspond to the thirteen public Universities of Paris that replaced the University of Paris.

health centers. The group was composed one psychiatrist with a PhD in psychology and four psychologists. The trauma therapy group met in the office of the head of the psychiatry department, and the walls of the office were lined with books and art accumulated over years of travel. The large office accommodated several chairs, to be filled by the members of the therapy group, and a small, colorful plastic table and chairs for children. During my fieldwork, there were three apprentice therapists, one graduate student in clinical psychology and two residents in psychiatry. Because of its focus on trauma, this therapy group had fewer therapists than the others.

While the architecture of the main entrance of the Avicenne hospital may be reminiscent of a colonial past, the psychiatry department, at least at the time of my research, was located in a more recently constructed building that was separate from the main hospital. Aside from the gates of the main hospital, one might never suspect that this setting would be a space that catered to immigrant or refugee patients. In fact, all four of my fieldsites were located within offices or buildings that resembled most health or social service settings. Moreover, most of the physical rooms where consultations and therapy sessions took place were shared, multipurpose rooms, which prevented supervising clinicians and their apprentices from creating a permanent space that conveyed a culturally sensitive and welcoming atmosphere. Rather, certain transitory and movable features, such as a colorful tablecloth acquired on one of the supervisor's trips abroad, might be introduced to add an element of color and make the space seem less clinical.

In each of the *psychiatrie transculturelle* therapy groups, I regularly attended the weekly therapy sessions until late July, when the group paused for the summer holidays. And in each of the groups, I was invited to remain with the group during the upcoming year, and did so until the end of my fieldwork December 2016. I opted to stay with the groups since it would allow me to

observe how fresh cohorts of apprentices joined the groups. Each therapy group had its permanent members and yearly cohorts of apprentices, though the groups were somewhat fluid and welcomed other professionals at various points in the year and on an ongoing or ad hoc basis. For example, a psychiatrist, who worked in an addiction treatment center and who had previously undertaken the *psychiatrie transculturelle* professional development course (described in more detail below), occasionally attended the *psychiatrie transculturelle* therapy group at the CATTP. A psychologist, with a PhD in anthropology, also joined group at the CATTP, though on a regular basis. This psychologist had completed her professional training abroad, and her degree was not recognized in France. This precluded her from gaining employment as a psychologist, so she joined the *psychiatrie transculturelle* group therapy group as a volunteer in the interim while completing the necessary procedures associated with converting her degree. Another psychiatrist, who had also completed the professional development program and was in the early stages of launching his own *psychiatrie transculturelle* therapy group in the suburbs of Paris, attended the therapy group in the CMPP on a fairly regular basis.

Centre Minkowska

Unlike the *psychiatrie transculturelle* therapy groups, which met once per week in various kinds of health settings, the Centre Minkowska had its own premises and received patients on a regular basis throughout the week. The center employed approximately ten psychologists and ten psychiatrists, who worked on a part-time basis, as well as a social worker, two administrative directors, receptionists, and research and program coordinators who worked on a full-time basis. The clinical staff spoke a multitude of languages, including Arabic,

Portuguese, Vietnamese, Lingala, Russian, Wolof, Serbian, Spanish and English, reflecting the diverse linguistic and geographic origins of the patients this center received. Moreover, a variety of health, educational, social service, and legal institutions served as sources of patients. Most apprentices were graduate students in clinical psychology, though medical and social work students, as well as health professionals, occasionally undertook apprenticeships. Unlike in the *psychiatrie transculturelle* therapy groups, where most apprentices spent the academic year in the groups, apprentices in the Minkowska Center undertook apprenticeships of various durations, ranging from a few weeks to an academic year.

Psychotherapy with a psychiatrist or psychologist at the Minkowska Center was conducted on an individual basis in individual consultation rooms. As a result, one or two apprentices could shadow clinicians when they conducted initial consultations with patients, thought they remained silent during consultation and could only ask questions at the end when the patient had left the consultation. During my fieldwork, I was able to observe initial consultations with patients, when they were received for an evaluation to determine whether they would see a psychiatrist or psychologist, and when they would begin therapy. I became frustrated as I found that observing consultations on an ongoing basis with the same patient over time was not possible. Many apprentices in the center shared this frustration, since they found that they had a partial and discontinuous view of how the Minkowska clinicians conducted therapy. As I would gradually learn, this discontinuity was due to the apprehension of most of the clinicians to allow apprentices into their consultation on an ongoing basis, and to the fact that many of the patients at the Minkowska Center faced a great deal of instability in their everyday lives, and did not always attend therapy sessions on a regular basis.

The main activity of apprentices was to participate in assessment meetings, known as the *Médiacor*, a term made up of the first letters of the words, *médiation*, *accueil*, and *orientation,* which reflected the principal assessment functions of these meetings: to mediate between patients and referring professionals and institutions, to receive or welcome patients at the Minkowska Center, or orient or refer patients to a tertiary institution or professional. The *Médiacor* unit was created in 2009 because the Minkowska clinicians and administrative staff required clarification after they received an excessive number of unjustified referrals for individuals who may have benefitted from receiving mental health services elsewhere (Bennegadi & Bourdin, 2009: 98; Larchanché, 2010: 242). Many of these referrals were incomplete, inappropriate, or incoherent, and the *Médiacor* unit, made up of psychologists, psychiatrists, social workers, a medical anthropologist, a medical secretary, as well as apprentice therapists, thus served to sort through and triage the referrals. The meetings of the unit took place in a large conference room at the back of the Minkowska Center and out of view from patients. The room itself featured a large central table, around which apprentice therapists and their supervisors would sit while examining and discussing the referral documents. I contend that the *Médiacor* unit, while initially conceived as an administrative project to facilitate assessment and intake procedures at the Minkowska Center, gradually evolved to become a pedagogical project for apprentices, who otherwise had few opportunities to interact with clinicians and observe consultations with patients. In this project, I therefore analyzed these assessment meetings as the principal site of encounter between apprentices and supervisors in the Minkowska Center.

Apprentices and their supervisors

Apprentices varied greatly in their personal and professional trajectories. Most were graduate students completing their first (M1) or second (M2) year of their master's degrees in clinical psychology. In France, graduate programs in clinical psychology typically require students to undertake an internship alongside of their classroom-based training. In most cases, graduate students undertake two different internships during their M1 and M2 years in order to gain exposure to different clinical settings, practices, and patient or client groups. Each university varies in its requirements for what counts as an internship, though most require students to spend an entire academic year in their internship site or gain a certain number of hours of clinical training over the course of the year. In some instances, graduate students may complete multiple internships if they need to make up the total required hours or if they wish to gain additional experience. Perhaps unsurprisingly, the internships conducted in the M1 year influence those conducted in the M2 year, as students may wish to specialize and because their supervisors' recommendations may be helpful in securing an internship for the following year.

Apprentices came from several universities in Paris and its suburbs, though they often studied at the universities that had formal agreements with my fieldsites or at universities where supervising clinicians might be on the faculty, such as the University of Paris Descartes (5) or the University of Paris Nord (13). For example, the Minkowska Center received many students from the Paris branch of the Sigmund Freud University, a private Vienna-based university specializing in psychotherapy. These links between my fieldsites and universities were significant to the ease in which graduate students might conduct apprenticeships. In fact, one M2 student from the University of Paris Diderot (7) had to take additional measures to ensure that his apprenticeship in one of the *psychiatrie transculturelle* therapy groups would be recognized and

validated. I asked him why this was the case, and he told me how many on the faculty were reticent or even resistant to this form of therapy, due in part to the reputation of ethnopsychiatry and to the alternative theoretical frameworks and practical approaches preferred by those faculty. While I do not wish to address these ideological oppositions in this section of the dissertation, I identify them now as they may lead to practical challenges for graduate students who may wish to undertake apprenticeships in these settings.

Despite the shared desire to pursue professional projects that promote psychological wellbeing, and a shared interest to work with immigrant, refugee, and non-francophone individuals, the apprentice therapists were by no means a homogenous group. They ranged in age from their early twenties to forties, and while for some, clinical psychology was their first professional project, others had a variety of experiences prior to starting their graduate work. One was a priest, another worked as a high school teacher, another had completed a doctorate in comparative literature, and others had previously worked in careers seemingly distant from clinical psychology, such as marketing or finance. Some had children and others worked jobs alongside of their studies. Apprentice therapists' interest in working with individuals in different situations of migration was informed by their lived experiences and their desire to take action in a sociopolitical context where those who have faced displacement, particularly forced displacement, may experience a great deal of psychosocial vulnerability. Most apprentices had spent time abroad, had parents who were immigrants, or were, themselves, born outside of France. Some had come to France to study from a variety of countries, such as Hungary, India, China, Russia, Brazil, and Swaziland. Most grew up in France but many had parents who migrated to France from countries such as Tunisia, Portugal, and Algeria. Most were multilingual and in fact, some had worked as interpreters on a professional basis.

Supervising clinicians were also a somewhat heterogeneous group. Most were clinical psychologists or psychiatrists, though others had trained as social workers or general practitioners. Many had been born outside of France, in countries like Argentina or Morocco. Others have provided rich accounts of the lives of the clinicians in *psychiatrie transculturelle* groups and at the Minkowska Center. Larchanché's (2010) account includes life histories of some of the leaders in the field of specialized mental health care for immigrants, all of whom were immigrants themselves, and Marie Rose Moro and her colleagues (Moro et al., 2004) produced an autobiographical volume on the members of her *psychiatrie transculturelle* therapy group at the Avicenne hospital. In fact, most writing on *psychiatrie transculturelle* alludes the notion that the therapy team is comprised of clinicians with their own migration and acculturation experiences. My project departs from these perspectives by drawing on the experiences of the next generation of therapists, who I contend offer more hybrid, inclusive, and intersectional ways of thinking with regards to being and belonging in France today. While others have identified how clinicians' experiences of migration were an asset in their work with immigrant and refugee patients (Fassin & Rechtman, 2005: 360-361; Larchanché, 2010: 146), I assert that apprentice therapists' lived, multiple experiences of French and transnational identities and allegiances are an asset that informs and adds nuance to the ways they think about culture in therapy.

Supplementing apprenticeship fieldwork

During the 2015-2016 academic year, I also enrolled in two professional development courses (*diplôme universitaire* or D.U.) offered by the University of Paris Descartes. The first, *Psychiatrie et Compétences Transculturelles,* or Psychiatry and Transcultural Competences, was

directed by Marie Rose Moro and was taught by members of the network that she leads, the International Association for Ethnopsychoanalysis (*Association internationale d'ethnopsychanalyse*, or AIEP). During the year when I participated, I was in a cohort of 55 individuals that met twice per month at the University of Paris Descartes, where Moro is professor, or at the Maison de Solenn, an adolescent treatment center at the Cochin Hospital, which Professor Moro directs. The second course, *Santé, Maladie, Soins, Médiation, et Cultures,* or Health, Illness, Care, Mediation, and Cultures, was directed and taught by clinicians and affiliates of the Minkowska Center. In this program, I was in a cohort of 26 individuals that met twice per month at the Minkowska Center or at the Georges Pompidou European Hospital in the 15th arrondissement of Paris.

Unlike the settings described above, which mostly provided apprenticeship opportunities to clinical students, these professional development programs targeted health and social service professionals working in a variety of organizational contexts who wished to better support patients and clients in different situations of migration. The programs were primarily classroom based, where instructors gave lectures on topics, discussed clinical cases that they had encountered, or invited the program participants to discuss difficult cases in their own work. I found the instruction to be decontextualized and distant from practice, and thus chose not to analyze these professional development programs as I did with my other field sites. After all, my interest in this project lies in apprenticeship, or situated learning within sites of practice. However, it is worth noting that some apprentice therapists completed these professional development programs following their apprenticeships and some graduates of these programs joined the therapy settings, such as the psychiatrists in the CMPP and the CATTP mentioned above.

I treated the two professional development programs as a means to supplement and facilitate my fieldwork in two principal ways: to gain a better understanding of the history and theoretical bases of *psychiatrie transculturelle* and *anthropologie médicale clinique* approaches, and to expand my own network of professionals affiliated with or interested in these approaches. This latter point is especially crucial, since my enrollment in these programs facilitated my ability to carry out fieldwork in my principal field sites, and opened doors to learn about the new practices that I detail in chapter 6.

In addition to my apprenticeship fieldwork, I conducted interviews with 65 apprentices and supervisors. These interviews were open-ended and often served to clarify or elaborate upon my observations. Interviews with apprentices tended to focus on topics such as the relations between their university training and apprenticeship, the instruction they received from their supervisors, as well as their professional development goals. In interviews with supervisors, I wanted to know how they selected apprentices, what teaching strategies they preferred, and what they wanted apprentices to gain from their apprenticeship experience.

Justifying multiple, specific sites

I chose to limit my fieldwork to the *psychiatrie transculturelle* and *anthropologie médicale clinique* approaches since these are the two leading approaches in thinking about the place of culture in psychotherapy in France today (Wang, 2016: 156n5). Moreover, it is worth noting that there are several *psychiatrie transculturelle* therapy groups in Paris, its suburbs, and in other cities in France, such as Bordeaux and Toulouse. Knowing that these therapy groups met once per week for a half or full day, I knew early on that I wanted to observe and participate in two or three groups to gain a fuller perspective of how they function as sites of apprenticeship.

For this reason, I chose to focus on the therapy groups based in and around Paris, since the groups outside of Paris also met fairly infrequently and were often the only group of their kind in that particular city or region. In Paris, however, I could spend Monday afternoon in the *consultation trauma,* Tuesday in the consultation *consultation psychiatrie transculturelle*, Wednesday morning in the consultation *consultation psychiatrie transculturelle familiale,* and other afternoons at the Centre Minowska. Among the *psychiatrie transculturelle* groups in Paris, I selected the three above because of their heterogeneity in terms of their publics, the institutions in which they were based, the composition of the groups, and because the supervisors in each group responded enthusiastically to my research interests. Moreover, my own engagement with these sites varied in terms of the duration and intensity of fieldwork, which is inevitable in multi-sited fieldwork (Marcus, 1995: 100). However, my objective was not compare across sites, but rather to analyze how these varied communities of practice could produce heterogeneous relations of teaching and learning among apprentices and supervisors.

Some might wonder why I did not include Marie Rose Moro's therapy groups at the Avicenne or Cochin hospitals among my field sites. After all, these are easily the most well known *psychiatrie transculturelle* groups in France. Her groups were often in high demand among residents in psychiatry, graduate students in clinical psychology, and other professionals who wanted to learn from her. I was invited to participate in these consultations on an occasional basis, but was informed that requests by apprentices to participate on a regular basis had been made far in advance of my own. Moreover, her groups met on the same days and times as two of my other field sites. One psychologist in another therapy group joked that apprentices in Moro's therapy groups often had to sit in the hallway and try to listen through the door of the consultation room. Another apprentice informed me that her friends undertaking apprenticeships

in Moro's therapy groups were instructed to take notes but were otherwise excluded from participating in the groups. Additionally, early on in my fieldwork I had considered attempting to include the *ethnopsychiatrie* therapy group at the *Centre Georges Devereux,* directed by Tobie Nathan and his colleagues. However, this center and its clinicians were less involved in efforts to provide training to clinical students and professionals than *psychiatrie transculturelle* and *anthropologie médicale clinique.* The center's website suggested that their most recent training opportunities were launched in 2005 and my emails to various points of contact went unanswered.

While I was grateful for the opportunity to be absorbed in my field sites in the same ways that my informant apprentice therapists were, I felt ill at ease on the occasions when I was introduced as a student in clinical psychology. Indeed, other clinical ethnographers have described predicaments wherein being identified in such a way may facilitate access but may misrepresent the kinds of expertise they possess or their position within their field sites (Raikhel, 2009: 210-211). Similarly, in my experience, I was concerned that by being introduced to patients as an apprentice therapist, others might think that I had the same kind of training, responsibilities, or clinical expertise as my informants did. However, as I would come to realize over the course of my fieldwork, apprentice therapists were rarely in direct, individual contact with patients and the culture of these settings was such that they, and I, were there to learn from the supervising clinicians. Moreover, these introductions were conducted collectively, meaning that one of the supervising therapists would introduce a group of us as apprentice therapists without singling out individual participants.

Chapter organization

This dissertation is comprised of six chapters that analyze culturally sensitive mental health settings for immigrant and refugee patients as cultures of expertise and communities of practice wherein apprentices learn to develop techniques of decentering as they become future therapists. Chapter 1 provides an overview of culturally sensitive mental health service settings and places them within a broader socio-political context of universalism and resistance towards the acknowledgement of cultural identities. This contextual chapter serves to situate cultural competence training in France within its socio-political context and within debates and controversies concerning cultural competence more broadly. These debates, raised by social scientists and clinicians, examine whether cultural sensitivity and empathy can be considered as competences to be mastered, and whether a focus on culture risks overlooking structural forms of discrimination that many immigrants may face (e.g. Fassin, 1999; Kirmayer, 2012; Kleinman & Benson, 2006; Larchanché, 2010; Metzl & Hansen, 2014). Additionally, this chapter sketches out a conceptual framework to consider how novice therapists learn to manage uncertainties and develop culturally sensitive therapeutic techniques while undertaking apprenticeships within these settings. This chapter also provides a conceptual basis to understand how learning processes, as experienced by students, provide new insights in the rich and relatively saturated area of cultural competence training. I argue that by attending to the ways in which these mental health settings as sites of apprenticeship, it becomes possible to understand how apprentice therapists learn to develop expertise and address uncertainties. As I will demonstrate in the ethnographic chapters that follow, this framework provides a new way to think through how novices observe, experience, and at times, question and challenge the ways that their supervisors demonstrate culturally sensitive therapy.

Chapter 2 analyzes the presence and visibility of apprentices in their apprenticeship sites. In France, culture and religion are considered matters of the private sphere and plural identities are not recognized as they are considered by many to infringe upon one's Frenchness. However, previous research in France has emphasized the importance of culturally diverse therapy teams and the ways that therapists' cultural and linguistic diversity could permit patients to open up in therapy sessions. I approached these therapeutic settings as theatrical spaces wherein belonging, cosmopolitanism, and Frenchness were contested and performed. I place this chapter at the beginning of the dissertation to illustrate how apprentices were casted into roles that they would learn to perform as they progressed in their apprenticeship. Throughout my field sites, apprentices played an important role in representing this diversity. In *psychiatrie transculturelle* group therapy, apprentices were selected based on their experiences of migration, or those of their parents and grandparents, and their linguistic abilities. In the Minkowska Center, apprentices who were multilingual and could serve as ad hoc interpreters were often given more opportunities to observe and participate in therapeutic encounters with patients. Because of their diversity, apprentices provided these settings with the legitimacy to carry out therapeutic work. My analysis demonstrates that in both kinds of settings, apprentices felt insufficiently implicated in the therapeutic work of the settings, and at times, instrumentally used to cultivate environments of diversity. Often, supervisors focused on a single stand of apprentices' identity, such as nationality, which did not reflect the ways that apprentices wished to represent themselves, and which ignored the multitude of other forms of belonging. I argue that by neglecting the perspectives of apprentices, prior research on this topic has missed an important opportunity to rethink the value of cultural diversity in therapy since apprentices proposed far more intersectional and inclusive ways of portraying diversity.

In chapter 3, I focus on how apprentices became more implicated and took on more responsibilities by producing the documentary artifacts used in these therapeutic settings. Apprentices spent a significant portion of their apprenticeship taking notes, reading referral documents and filling out forms. While these paperwork routines seem mundane, I suggest that they have a mediating effect on training since they familiarized apprentices with the guidelines and operating frameworks of these therapeutic settings. Apprentices were responsible for maintaining the institutional memory of these settings by producing a transcribed account of therapy sessions and by aiding in patient assessment procedures by using forms to identify important patient details. While these routines conferred responsibility to apprentices, they also made apprentices culpable when information was missing. Faced with a mass of information about patients, I suggest that these paperwork routines guided apprentices to prioritize and value certain aspects of patients' illness experiences, cultural and migration histories, and their clinical encounters with health professionals. I argue that these paperwork routines focused the attention of apprentices to certain details, which had the result of neglecting other details and simplifying complex pieces of information to make them more manageable. While these routines served to reduce the uncertainties that apprentices faced, they tended to create additional and new forms of uncertainties. Apprentices critiqued these routines, stating that they distracted them from more important clinical work, and they suggested alternative ways of managing large amounts of information about patients.

Chapter 4 interrogates how apprentices learned to develop specific repertoires of speech over the course of their apprenticeship. This chapter builds on the previous two, since the scripts that apprentices needed to follow were established by their supervisors when casting apprentices into specific, visible roles and reinforced through the paperwork routines, which served to frame

the way apprentices approached information concerning patients. I contend that the verbal performances of apprentices were an important site at which to understand the tension between improvisation and authority. In the group therapy sessions, apprentices were instructed to speak in ways that reflected their own experiences and lives, yet their supervisors and peers harshly evaluated them by ignoring their proposals or questioning their sincerity. In their public presentations of patient information, apprentices were encouraged to speculate about patient cases during moments of uncertainty so as to improvise and build confidence about how to handle the unknown. However, the questions and reactions of supervisors suggested that they had specific answers in mind that were inaccessible to apprentices. I argue that the use of rigid disciplinary evaluation techniques in environments of free association resulted in additional uncertainties faced by apprentices, who were trying to navigate the logic of these therapeutic settings.

Chapters 2 through 4 come together to illustrate different sides of a central tension present in these therapeutic settings, one between creativity, openness, and flexibility, and systematicity, routine, and bureaucracy. My analysis suggests that due to this tension, more uncertainties were created than minimized, which prompted me to question whether it was possible learn how to embrace uncertainty with the pedagogical techniques used in these apprenticeship sites. It seemed to me that while supervisors were attempting to encourage apprentices to become more open, self-aware, and empathetic therapists, they had a very specific vision for how that could be achieved. In Chapter 5, I turned to the supervisors to understand what exactly it was that they wanted apprentices to retain from their apprenticeship. Drawing on the perspectives of supervisors, I analyzed what supervisors considered to be the vision they wanted to transmit to apprentices. Drawing on the perspectives of apprentices, I analyzed how

they learned to see patients and their circumstances as their supervisors did. My analysis suggests that the transmission of a singular institutional vision was perhaps not a possible or even desired outcome. Rather, I contend that apprentices assembled a selective and heterogeneous style of practice based on their apprenticeship experiences. In other words, apprentices found the practices, styles of reasoning, and even demeanors of certain supervisors to be more effective, workable, and transparent than others, and apprentices therefore opted to pick and choose rather than appropriate an entire institutional vision.

Chapter 6 evaluates how apprentices have developed new ways of working after having undergone apprenticeships in these therapeutic settings. Since my apprentice informants were still in the early stages of their careers at the end of their apprenticeship, I needed to extend my informant pool to include individuals who had completed apprenticeships or related forms of training in years prior to my ethnographic investigation. I turned to the graduates of the two professional development programs that aimed to train health professionals to apply the approaches of *psychiatrie transculturelle* and *anthropologie médicale clinique* in their clinical work. By contacting the alumni of these programs, I was able to meet, interview, and observe the practices of several professionals who had completed this professional development program and an apprenticeship. I present case studies of new group work practices established in Normandy and Lyon, and I also analyze other former apprentices' appropriation of techniques gained during their apprenticeship into their individual work with patients or clients.

In this dissertation, I argue that apprentices' perspectives have largely been neglected in research on cultural sensitivity training. By considering culturally sensitive mental health settings as communities of practice, and by focusing on the learning experiences of apprentices, I suggest that apprentices offer more inclusive perspectives about how to mobilize cultural diversity in

psychotherapy. More specifically, while supervisors often framed cultural diversity in terms of nationality, apprentices advanced more hybrid and cosmopolitan forms of being and belonging that incorporated elements of generation and religion. Additionally, I assert that the supervisors' rigid pedagogical methods, which often seek to minimize the uncertainties faced by apprentices, unintentionally produce new and different forms of uncertainties. Indeed, reducing complex information about migration histories and cultural representations, to boxes to be checked and short answers to be filled in, served to confuse apprentices about how this complexity should be recognized and embraced. Lastly, because apprentices observe different styles of practice among their supervisors, identify contradictions, and at times, experience a lack of transparency, apprentices selectively appropriate practices and outlooks rather than a unified institutional vision.

Chapter 1. Immigrant mental health services as sites of apprenticeship

Whose crisis?

In 2015, over one million people entered Europe as migrants or refugees, raising new concerns about the support and integration of these newly arrived individuals. Many referred to this situation using the language of crisis. For example, in an annual risk analysis for the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union (2016: 14), the EU border agency more commonly known as Frontex, the year 2015 "was marked by an unprecedented number of detections of illegal border crossing…revealing a migration crisis without equivalent in Europe since World War II." Yet others have framed this mass displacement in terms of force since these individuals had to flee due to violence and political instability, economic deprivation, and environmental degradation. Human Rights Watch claimed that by "accounting for the misrepresentations of nationality and the presence of migrants seeking to improve their lives, this should be understood broadly as a refugee crisis," (Human Rights Watch, 2015: 1). Whether framed as a migration or refugee crisis, the notion of crisis seems to suggest that this new migration disrupts a seemingly normal European social fabric (De Genova, Mezzo, & Pickles, 2014: 5). Moreover, in *The Borders of "Europe,"* Nicholas De Genova (2017: 13-17, original emphasis) asks, "*Whose crisis?"* since some may see the crisis of border management as a crisis of sovereignty, whereas others may be more cognizant of the struggles of migrants and refugees who exercise freedom of movement in order to "realize their heterogeneous migratory projects." These new arrivals in Europe, as well as various measures taken to stem these arrivals, have resulted in individuals living in marginal and precarious states of limbo, and have resulted in the proliferation of different legal statuses (De Genova, Mezzo, & Pickles, 2014: 26).

It perhaps goes without saying that these forms of legal limbo may engender various forms of physical and psychological anguish. Individuals working in front line health and social services may face a different kind of crisis wherein they are unprepared to support those experiencing various forms of instability. In fact, during an interview in late 2015, the executive director of the Minkowska Center in Paris, which provides psychological support for migrants and refugees, underscored the importance of training for professionals in the health domain:

> "What we've determined is that professionals are impacted quite hard by this reality of migration flows. And we know this because we talk to them on the phone, they call us asking questions about their practice with a patient and they ask us for training…so nowadays, professionals no longer ask themselves whether they need to learn how to support patients from all over the world. It's become obvious that they do. It's obvious that for everyone these migration flows are increasing and we need to adapt, especially when we work in healthcare. In hospitals, for example, which receive everyone, it's important that everyone is trained."

These new migration flows also impact front line workers, who face uncertainties about how to adapt their practice with patients who speak languages other than French, who face unstable administrative and housing conditions, and who may speak about disorder in ways that do not map onto diagnostic categories. As this director suggested, every health professional needs to be trained to address these uncertainties. The training, often referred to by my interlocutors as cultural competence, was a form of acquired knowing and professional identity that prepared front line health workers for migrant patient populations. Yet, as illustrated throughout this dissertation, rather than being trained to acquire technical expertise, those who underwent training were encouraged to learn to become more open and self-aware. Moreover, those who provided training often insisted that their so-called expertise was not really expertise at all. Rather, it was more of an internal temperament that individuals needed to uncover. By uncovering this temperament, individuals would learn to embrace the uncertainties they encountered in their professional work. How do individuals learn to develop forms of expertise

in environments of no expertise? How do individuals manage divergent demands to embrace uncertainty and minimize it?

Chapter overview

This chapter reviews and assembles complementary streams of literature on uncertainty, apprenticeship, expertise, and professionalization, and brings these streams into conversation with literature on discrepant notions of culture blindness and cultural diversity in the provision of health care services in France. The first half of the chapter draws on literature on the politics of migration and identity, both generally and within health settings, to present the socio-historical context in which immigrant mental health services, and the apprentice opportunities they provide, exist. This section concludes by reviewing previous ethnographic research within mental health services for immigrants in France and raising questions about new areas for inquiry. The second half of the chapter synthesizes streams of conceptual and ethnographic research on apprenticeship, the development of expert skills and performance, and the management of uncertainty, particularly in clinical education contexts. By interrogating these streams of research, I propose new ways to think through the pedagogical spaces of immigrant mental health settings, particularly from the perspectives of apprentice therapists. My aim in this chapter is to provide a comprehensive background in which to consider apprentices' activities, tasks, and efforts to translate the localized knowledge they develop to broader institutional contexts that I analyzed in more detail in the following chapters.

New arrivals, old problems

In France, renewed debates concerning national identity, the integration of immigrants and the second generation, and ethnic and racial discrimination, have been observed, particularly following major events, such as the riots in 2005 or the 2015 terror attacks (Foner & Simon, 2015: 2). Moreover, following the November 2015 terror attacks, France called for the increased securitization of the external borders of the European Union's Schengen Zone (De Genova, 2017: 14). That Marine Le Pen and the Front National, a political party known for its nativist and anti-immigration stances, made it to the final round of the 2017 French presidential election, confirms fears that xenophobia and anti-immigrant bias are not only on the rise, but are becoming normalized at the highest levels of government. These major events have raised uncertainties in the general public not only about how care and support newly arrived individuals who have fled war, economic insecurity, and devastation due to climate change, but also as to how notions of French identity would be maintained in the face of an increasingly diverse population.

However, immigration, and the debates it evokes concerning identity, belonging, and integration in France and elsewhere in Europe are certainly not new. France, like many other Western European countries, has been a country of migration for some time. At the end of the 19th century, immigrants came to France from bordering countries, such as Spain and Italy, as industries developed, and as refugees from countries such as Russia and Armenia fled state persecution (Tortelli et al., 2017). Moreover, immigrant workers supplied the labor force to rebuild European countries following the World War II (Castles, 1986; Fassin, 2005). While official records of immigration date back to the mid 19th century, it was not until after World War II that that France began to codify and regulate immigration (Hamilton, Simon, Veniard,

2004). The French government created the *Office National d'Immigration* (ONI) in 1945 to recruit foreign workers and between 1946 and 1970, two million European migrant workers came to France with nearly 700,000 dependents (Castles, 1986: 763). Other workers came from former French colonies in North and West Africa as well as the Caribbean. The ONI only dealt with workers from European countries since citizens from France's former colonies were able to enter France freely until the late 1960s; by 1970 there were over 600,000 Algerians, 140,000 Moroccans, and 90,000 Tunisians in France (Castles, 1986: 764).

Since the late 1960s, restrictive immigration policies in France have shaped the lives of many immigrants, who have oscillated between situations of transience and permanence, and legality and illegality, in working to "obtain, retain, or regain" documentation and the immigration status it confers (Sargent & Larchanché-Kim, 2006: 11). During the late 1960s and 1970s, several factors, including the maturing of the baby boomer generation, the entrance of large numbers of women into the labor market, the recession caused by the oil crisis of 1973, and the end of the guest worker program in what was then the Federal Republic of Germany and other European countries, led to the decline in the need for foreign workers and, as a result, the French government ended the guest worker program in 1974 (Castles, 1986; Hamilton, Simon, Veniard, 2004). Unemployment remained a concern in France following this period, prompting the government to modify their policies concerning immigration (Mann, 2003: 364). Immigrants became an easy target to blame for unemployment and thinly stretched social resources, and right-wing groups found this to be an opportunity to advance racist and xenophobic sentiments (Castles, 1986: 765). In the 1990s, the conservative government's minister of the interior, Charles Pasqua, promoted what have often been referred to as "Pasqua Laws," legislation that increased the waiting period for family reunification, prevented foreign graduates from accepting

employment in France, permitted the police to deport foreigners, and denied residence permits to foreign spouses who had resided illegally in France prior to their marriage (Hamilton, Simon, Veniard, 2004). These laws had the effect of leaving thousand of irregular immigrants without any legal channel to regularize their status (Nicholls, 2013: 7).

After the French government ended guest worker program in the 1970s, family reunification became one of the principal means through which foreigners could obtain legal entry and citizenship (Cole, 2014a: S89; Mbodj-Pouye, 2016: 298; Tortelli et al., 2017: 578). Yet even more desperate measures were taken by immigrants to gain the right to remain in France. For example, scholars have described a transition from a period up to the 1970s when the healthy, productive bodies of immigrant workers were required supply the labor force, to a more recent period in which immigrants needed to make use of illness and disability in order to secure the right to stay in France (Fassin, 2005: 372). Since French law has permitted individuals to remain in France with life threatening conditions and who would otherwise be unable to pursue treatment in their countries of origin, many individuals in France who were undocumented or unauthorized turned to this “illness clause” as method of obtaining papers; however, the visas granted were restricted to seeking care and therefore excluded these individuals from pursuing formal and legal channels to employment (Ticktin, 2011: 95). As a result, these individuals’ ability to build a life for themselves and their families in France was highly restricted and they were forced to pursue work in the informal economy, which could be unsteady and potentially exploitative.

Restrictive policies also affected those who sought state protection, as asylum seekers became viewed with increasing suspicion by authorities and the public (Fassin, 2005; Fassin & D’Halluin, 2005; Fassin & D’Halluin, 2007). Didier Fassin (2005: 368-369) describes how

public authorities changed their attitudes towards asylum in the 1990s, as evidenced by data from the French office for asylum (OFPRA): in 1981, 20,000 individuals applied for asylum in France and 80% were recognized as refugees, whereas in 1999, 30,000 individuals applied for asylum and 80% were rejected. Fassin explains that asylum seekers came to be seen as undocumented migrants seeking to work the system unless they could demonstrate evidence to the contrary (2005: 369). Asylum seekers therefore needed to provide evidence of persecution in order to be recognized as legitimate refugees. This evidence often took the form of physical or psychological disorder that required the expertise of clinicians in order to be recognized (Fassin & D'Halluin, 2005; Fassin & D'Halluin, 2007). As a result, the increasing weight given to medical experts and the mistrust of asylum seekers' stories resulted in what Liisa Malkki (1996: 386) has described as the silencing or "speechlessness" of refugees in the face of organizations whose object of care and control they are.

National identity crises

The increasingly restrictive immigration and state protection policies in the 1980s and 1990s took place within a sociopolitical climate where citizenship and belonging were being contested. As Richard Keller (2008: 209) has noted, "as a cog in the machinery of postwar capitalism, the laboring migrant's body was essential to economic growth; but as a potential rapist and murderer, his body generated fear among the French population." In the 1980s, the right-wing Front National came to prominence amid worsening perceptions of immigrants and an increase in xenophobia (Bertossi, 2012: 253; Mann, 2003: 364; Hamilton, Simon, & Veniard, 2004). The Pasqua laws of the 1990s drew upon xenophobic discourses and have been considered to reinforce a culture of racism in France (Nicholls, 2013: 7). These laws and public

sentiment had a profound impact on those who wished to settle in France. Individuals applying for naturalization had to demonstrate their assimilation to the French community, which was measured in a large part by the applicant's knowledge of French; those applicants who could not demonstrate this could have their applications declared non-admissible (Weil, 2008: 234-235). In fact, even during naturalization ceremonies—the moments that some might view as the final apex in becoming French—the language of state officials leading the ceremonies, such as the one quoted below, suggested that there remained a division between naturalized citizens and those born in France (Fassin & Mazouz, 2009: 39):

> "In requesting French citizenship, you have expressed the desire to adhere to the fundamental values of the Republic and the rules of democracy…The fact that your request was accepted shows that you have sufficiently adopted the lifestyle and customs of our country—not to the point where you entirely resemble native French people [*Français de souche*], yet enough so that you fee at east among us."

Immigrants and their descendants have often been viewed by authorities with suspicion when attempting to demonstrate various ways of what Levitt and Glick Schiller (2004) have described as ways of being and ways of belonging within the societies in which they reside, such as in occupying urban public spaces to enact social or economic exchanges (Kleinman, 2012; 2014), advocating for tenants' rights in public housing facilities (Mbodj-Pouye, 2016), in pursuing bi-national marriage (Cole, 2014a; 2014b).

Another important fact that makes France stand out among other countries with large immigrant populations is its strictness regarding its culture- and colorblindness. The French political culture of Republicanism affirms color-blindness and does not recognize particular claims based on religion or race (Lamont, 2001: 2-5). Republicanism is typically considered to

have its origins in the French Revolution[5] and is characterized by "colorblind assimilation and universal citizenship" (Bertossi, 2012: 248). By being an archetype of colorblind society, attempts to introduce ethnicity within statistical databases have often resulted in heated debates among academics, policy makers, and antiracist organizations, all the while excluding racialized minorities (Simon, 2017: 2330).

Previous research on identity and belonging in France focused on the challenges that arise when identities, such as those associated with religion, ethnicity, and language, conflict with the demands of the state (Tilly, 1995: 232; Kastoryano, 2002: 8). Practices and expressions of these identities have been considered disruptive to the link between the state and its citizens (Bowen, 2007: 156; Diouf, 2012: 34). These identities are therefore not officially recognized in the public sphere and are instead considered as sealed off from public life; as a result, many aspects of public policy in France are informed by this distinction between the private and public spheres (Lamont, 2001: 6; Kastoryano, 2007: 422; Raveaud, 2008: 74-75). An individual is therefore tied to one of these institutions or to the state, but not both, and a hyphenated ethnic

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[5] It was not until the Revolution that specific rights and responsibilities entailed through citizenship were accorded. During the *ancient régime,* or the period prior to the Revolution, citizenship did not exist on a national scale (Tilly, 1995). While there were provisions for foreigners during this period, it was not until after the revolution that specific state sanctioned codes for citizenship were established. As Rogers Brubaker (1992) has described, membership to different sectors of society occurred at the sub-state level, meaning that there were no codified or enacted rules concerning citizenship. After the Revolution, however, political rights and the concept of citizenship was sharpened to the extent that regulations concerning the rights and obligations of foreigners were put into place and managed by the state (Brubaker, 1996). Citizens were therefore considered equal in the eyes of the state, and it was the state, rather than sub-state entities, that established distinctions between citizens and noncitizens. In addition to the emphasis on equality of citizens that developed during the Revolution, the enactment of *laïcité,* or secularism, in 1946 was a further was a further step in establishing the neutrality of the state (Kastoryano, 2002). Yet while the common perception is that Republicanism dates back to the French Revolution, Bertossi (2012: 252) has suggested that starting in the 1980s, counter-narratives about the meanings of Republicanism were advanced around issues of integration and nationality, anti-discrimination, *laïcité,* and cultural order.

and national identity is considered impossible (Scott, 2007: 11), particularly since public claims to a dual identity is considered to inevitably weaken the sense of being French (Foner & Simon, 2015: 16). In this view, identity is often perceived to be a sort of "finite stock," meaning that belonging to another country necessarily limits one's possibility of French belonging and is considered a "conflict of loyalty" (Simon, 2012: 3).

Yet research on minorities in France challenges this widely held notion that one cannot hold multiple allegiances. The largest survey conducted among ethnic minorities, launched by the National Institute for Demography (INED) and the National Institute for Statistics and Economic Research (INSEE), surveyed the experiential aspects of holding dual nationalities, feelings of belonging, and feeling at home in France (Simon, 2012). Respondents reported that having multiple identities and allegiances was complementary with their commitment to Frenchness and was even an enhancement (Simon, 2012: 6). However, adopting plural allegiances and identities was hampered by the perceptions of others, who may question or deny the Frenchness of individuals, particularly those considered more "visible minorities," based on skin color, accent, and surname (Simon, 2012: 13-15). These expressions of multiple forms of belonging, as well as their denial, prompt scholars like Simon to suggest that discourses that reject multiculturalism in France need to be updated (2012: 14-15).

Clinical settings as sites of contested belonging and legitimacy

Clinical settings, like other public agencies, are certainly not immune to the debates on belonging and national identity in France. In fact, clinical settings provide a unique lens to consider these debates since, on the one hand, these settings are considered culturally neutral though they actively reproduce stereotypes about belonging and difference, and on the other,

clinical settings have often been sites of exclusion of migrant groups, whose legitimacy and deservingness has been called into question by those charged with providing care and support.

State institutions, such as public hospitals are often considered "culturally neutral" among those who work within these establishments since their primary role is to care for patients and cure diseases (Bertossi and Prud'homme, 2011: 2-3). This perceived neutrality is not unique to France—medicine in general has been considered to be a "culture of no culture" (Taylor, 2003: 159; see also Ascoli et al., 2012: 7). However, these institutions establish and reproduce identities about migrant communities through routine interactions that signal inclusion or exclusion within the broader society (Sargent and Erikson, 2013: 50). In spite of an apparent adherence to universal principles in the provision of care to all patients, however, the personnel within hospital settings often invoke culturalist explanations and ethnic stereotypes for behavior considered deviant in routine medical procedures among migrant patients (Cognet, 2001: 101; Kotobi, 2000: 62; Nacu, 2011: 115; Sargent & Larchanché, 2009: 4). Public hospitals and other state facilities are not simply "receptacles of ideas or passive sponges of national identity" (Bowen et al. 2013: 13). Rather, these institutions and their staff are actively involved in the shaping of ideas concerning identity, assimilation, and exclusion.

More than a question of access to health services

Individuals residing legally in France are entitled to social security and have the right to healthcare, either through universal medical coverage or through state medial aid (Fassin 2004: 206-207). Undocumented or unauthorized immigrants are also eligible for state medical aid, though they need to provide proof of residence, an identity document (even if it does not confer the right to stay in France), and proof that their income falls below a particular threshold

(Geeraert, 2018). As a result, those who cannot provide these details may be excluded from accessing health services, even though they may have the right (Cuadra 2011: 268-269; Henry et al., 2010: 265; Médecins du Monde, 2015: 39-44; Verdoux 2007: 65). Moreover, health coverage for these individuals may be restricted to curative health care, meaning that the patient bears a large portion or the entirety of the cost many routine procedures; additionally, the low income threshold required for free of charge health care services suggests that working poor individuals and households may be required to pay for a significant portion of their healthcare costs (Fassin, 2004: 207).

Policy makers and clinicians often attribute the discrepancy between entitlements and access to health care to immigrants' perceived avoidance or lack of knowledge about the health system, or to perceptions that services may be disorganized or that health workers may be ill-informed about the rights and entitlements for immigrants and foreigners (Fassin, 2004: 207). Yet an important third explanation has to do with the social production of the "illegitimacy" of immigrants, particularly those without documents or authorization, which may be reinforced by front line health and social service workers and internalized by migrants themselves (Fassin, 2004: 208). More specifically, "intangible obstacles," such as stigmatization, fear, and distrust of clinicians or social service professionals (Larchanché, 2012: 858), as well as more tangible ones, such as a lack of language proficiency or fixed housing (André & Azzedine, 2016: 11; Chambon & Le Goff 2016: 135-136), may hinder unauthorized immigrants' access to the health care to which they have the right.

Perhaps more than other areas of health and medicine, mental health care is a particularly crucial site to consider how belonging and legitimacy are produced, since these may have an impact on psychosocial vulnerability. Psychiatric epidemiological research in France among

immigrant populations, their descendants, and minority groups is relatively scarce, due to a lack of statistics on race and ethnicity in France, though trends suggest that there is an increased risk of psychosocial vulnerability associated with migration status and being an ethnic minority (Tortelli et al., 2017: 580). Others have described how migrant groups accumulate psychological, social, and administrative vulnerabilities that may have a profound impact on their mental health (Chambon & Le Goff, 2016: 130). Moreover, these authors assert that this vulnerability is exacerbated among undocumented or unauthorized migrants. Indeed, this vulnerability reflects the lived experience of illegality and its related state of deportability, or the persistent possibility of deportation (Andersson, 2014; De Genova, 2002; Willen, 2007). In other words, undocumented or unauthorized individuals may live in fear of being apprehended, which seeps into their everyday actions so that any activity, no matter how mundane, potentially becomes a possibility for apprehension. Moreover, in addition to preventing individuals from accessing the health care to which they may be entitled, the experience of illegality and the fear of deportation may themselves provoke anxiety or other significant mental health problems (Aviv, 2017; Dreby, 2015: 25-26; Médecins Sans Frontiers, 2013: 13). These experiences of illegality, illegitimacy, and exclusion represent forms of structural violence, which refers to the translation between large-scale forces, like poverty, racism—and restrictive immigration policies that guide prevention and deterrence measures and policing—and individual experiences of disease, distress, and hardship (Farmer, 1997: 261-262). Physician and anthropologist Seth Holmes has described how the social inequalities caused by structural violence have injurious effects on bodies (2013: 43). In the context of migration, structural violence exists in the conditions that push people to undertake dangerous and uncertain journeys, as well as in threats to life and livelihood in policies that advance prevention and deterrence measures (De Léon, 2014: 16;

Jones, 2016: 27-28; Mahdavi, 2011: 95-97). As the next section will illustrate, efforts to address the vulnerabilities and experiences resulting from migration have distinct origins in France.

From colonial psychiatry to ethnopsychiatry

Europe's colonial past has had a great influence on its migration context today (De Genova, 2017: 18). In *The Empire of Trauma*, Didier Fassin and Richard Rechtman describe how the psychiatry of immigration in France developed between "two historical eras dominated by two images of otherness: the native, in the colonial era (whether resident in the colonies or the metropolis), and then the foreigner, in the post-colonial world (whether this foreigner had official status or not, and whether he was seeking work or requesting asylum)" (Fassin & Rechtman, 2009: 226; see also Larchanché, 2010: 92-93). Colonial psychiatry, due to its abusive practices and racist ideologies concerning mental disorder, has been a notorious and enduring backdrop as approaches were conceived to address the mental health needs of migrant populations, largely from the former colonies, in mainland France. Colonial psychiatrists had a significant amount of discretionary power in their services, which they considered laboratories for experimentation, and carried reckless and abusive therapeutic techniques like electroshock and psychosurgery (Collignon, 2006: 538). Practices in psychiatry closely corresponded to a "colonial order that constantly reiterated natives' biological inferiority, their simplemindedness, and their incapacity to adapt to modern civilization" (Keller, 2008: 9). The effect of this was that those who were colonized were prevented from staking claims regarding their political and cultural legitimacy (Keller, 2008: 164).

Fassin and Rechtman (2009: 227-229) have noted that the racialized and essentialist approaches, notably those associated with the Algiers School, came to be known as "ethnopsychiatry." This school was a major site of training during the era, and its

ethnopsychiatrists overemphasized differences—in terms of bodies, traditions, and customs—as more important than biology in understanding mental illness (Collignon, 2006: 538-539; Keller, 2008: 122). Colonial ethnopsychiatrists' attempts to identify specific traits in colonial subjects, such as a "Muslim mentality," resulted in interpretations that demonstrated more about the colonial mindset than local psychopathology (Fassin & Rechtman, 2009: 227-229). Significantly, the characterizations of disorder in colonial psychiatry resemble discourses of clinicians concerning the presence of foreigners today (Beneduce & Pompelli, 2005: 368). Whether practitioners took up the traditions of colonial psychiatry or fiercely opposed them, the psychiatry of migration remained marked by a history of colonial psychiatry (Fassin & Rechtman, 2009: 231).

In mainland France, mental health settings that aim to address the vulnerabilities experienced by migrant groups and that take into account the cultural variability of the expression and experience of mental illness have existed since the 1950s (Fassin & Rechtman, 2005: 353; Fassin & Rechtman, 2009: 226; Hémon, 2002: 184). One of the earliest mental health settings for immigrants in France was created by psychiatrist Eugene Minkowski after World War II and provided psychiatric consultations in languages spoken by individuals who had arrived in France from Eastern Europe (Fassin & Rechtman, 2009: 231; Hémon, 2002: 184). In 1962, the setting became part of an independent association and was named the Françoise Minkowska Center (Fassin & Rechtman, 2009: 231; Hémon, 2002: 184), after Minkowski's wife and partner. The clinical practice in this center relied on universal models of mental illness, rather than individual interpretations, and emphasized patients' experiences of exile rather than their cultures or countries of origin (Fassin & Rechtman, 2009: 231). Eva Hémon, a psychiatrist who practiced at the center until her retirement in 2014, wrote that consultations were initially

conducted in French, German, Polish, and Russian, though in the decades that followed, demographic changes led this setting to develop additional consultations for migrant populations based on their regions of origin, such as Southeast Asia, the Maghreb, sub-Saharan Africa, Turkey, and Latin America (Hemon, 2002: 184; see also Fassin & Rechtman, 2009: 232).

During the 2000s, however, the Minkowska Center changed its orientation from one in which different clinical teams received patients from different regional areas to one in which all of its therapeutic staff were trained in cultural competence and could therefore receive patients regardless of their regional, linguistic, or cultural background. The reason for this change was in order to gain official recognition and accreditation from the health authorities, which considered the previous arrangements to provide differential treatment to patients based on their origins. The newer approach was renamed *anthropologie médicale clinique,* clinical medical anthropology. This drew on the work of the American psychiatrist and anthropologist, Arthur Kleinman, whose research on mental illness in different cultural contexts during the 1980s demonstrated the importance of patients' explanatory models, or different ways of understanding and treating their illness. Kleinman (1980: 72-80; 1988: 3-8) emphasized three terms that explain the dimension of illness: *illness, sickness,* and *disease.* In this framework, *illness* refers to that which the patient expresses regarding her or his difficulties, her or his search for meaning, and solutions for treatment. *Sickness* is everything that concerns the living conditions and the social realities of the person, such as housing, employment, and administrative status. *Disease* refers to the aspects interpreted by the therapist based on the symptoms and the clinical elements of the patient (Paris, Bourdin, and Bennegadi, 2009: 21-22; Larchanché, Sargent, and Bourdin, 2011: 18). This approach was considered to avoid overstating the culture of origin of a person, yet it also does not deny the existence of cultural particularities (Larchanché & Bourdin, 2014: 155). In other

words, this approach is said to permit health professionals to avoid “pathologizing” that which is cultural and “culturalizing” that which is pathological, a pitfall frequently experienced by mental health professionals (Paris, Bourdin, and Bennegadi, 2009: 20). The confrontation of explanatory models in clinical encounters requires therapists to distance themselves from their own representations linked to their professional training (Larchanché, 2010: 169).

While described by Fassin & Rechtman (2009: 231) as initially emphasizing patients’ experiences of exile rather than their cultures of origin, the center currently boasts its more than fifty years of expertise in transcultural care on its website[6]. Moreover, while Minkowski and his colleagues may have been among the earliest to receive patients in exile, they were not the only ones to develop specific settings for patients in different situations of migration. In addition to this center, which directed its care to migrant populations, other settings like Comede and the Centre Primo Levi were established to provide medical and psychological care for asylum seekers and trauma survivors, respectively (Fassin & Rechtman, 2009: 235).

Ethnopsychiatry, another dominant current in the mental health care of migrant populations in France, developed from Georges Devereux’s theories of ethnopsychoanalysis, and became most well known in the 1980s and 1990s through the work of Devereux’s student, Tobie Nathan. Devereux’s theories emphasized the important relation between psychoanalysis and anthropology. More specifically, Devereux explained that these two fields offer complementary explanations of a fact or phenomenon, but are not additive, and therefore cannot be held simultaneously (1953: 654; 1978: 1-2). In other words, by deploying the discourses of these two fields simultaneously, the therapist would risk seeing the patient as a cultural informant and spokesperson, rather than an individual who requires care (Gouriou, 2012: 215). Devereux

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[6] http://www.minkowska.com/content/consultations-de-psychiatrie-transculturelle-centr%C3%A9e-sur-la-personne-migrante-et-r%C3%A9fugi%C3%A9e

(1953: 633) also emphasized culture as a universal phenomenon. More specifically, Devereux did not seek to reify cultural particularities to the point of considering them distinct from other cultural particularities, but rather was interested in universal cultural models that had various incarnations (Gouriou, 2012: 214).

Tobie Nathan, a psychologist, drew on the theories of Devereux to develop the practice of ethnopsychiatry (Sturm, Heidenreich, & Moro, 2008). He created a group consultation with multiple therapeutic professionals to receive a single patient at a time from “non-occidental cultures” (Nathan, 2013: 60). In this approach, the aim of clinical work was to identify the problems of patients and families, re-build links with the cultures of origin of patients, and provide assistance in the relation between families and the government services in charge of them (Streit, 1997: 322). These clinical objectives could be achieved in the group therapy setting, with the use of the patient’s first language, and with the use of traditional etiologies as well as therapeutic objects (Moro, 1992: 79-80; Streit, 1997: 323). Fassin and Rechtman (2009: 240) note a distinction between the “universalist” reading of migration and violence used within the Centre Minkowska, Comede, and the Centre Primo Levi, from the “differentialist” reading of ethnopsychiatry. In other words, Nathan and his fellow practitioners of ethnospychiatry considered the causes, manifestations, and therapeutic responses to mental illness to be different from those that French or Western patients might experience.

Ethnopsychiatry is often, as Didier Fassin and Richard Rechtman (2005: 352) point out, erroneously assumed to be the origin of mental health services for immigrants in France. Yet, despite not being the first, ethnopsychiatry is perhaps the most well known—it has certainly generated the most controversy. Both ethnopsychiatry and its most famous practitioner, Tobie Nathan, have drawn significant criticism from clinicians—including some of his former

students—and social scientists for several reasons. First, Nathan's approach drew upon a closed and static definition of culture rather than one that was more hybrid and dynamic (Corin, 1997: 356). Keller (2008: 217-218) has argued that by situating patients within their cultural milieux, Nathan's ethnopsychiatry reinforced the notion of cultural difference as the origin of psychopathology. Second, Nathan's approach was accused of trapping patients within their presumed cultures. By referring to filiation and cultural origins, ethnopsychiatry imprisoned patients within their cultural ancestry and origins and left little possibility for the establishment of roots or assimilation into the host society (Mack, 2016: 292n10). As a result, clinicians focused primarily on the presumed cultures of patients rather than their subjective unconscious conflicts (Zadje, 2011: 188). Simply put, the place given to culture did not leave much room for the patient's subjectivity or singularity (Gard, 2015: 114). Additionally, the emphasis on cultural dimensions deliberately ignored the social and economic conditions faced by many immigrants (Fassin, 1999: 168-169; Rechtman, 2003: 168; Rechtman, 2000: 47). Lastly, ethnopsychiatry attacked psychiatric knowledge by denouncing its inherent inability to take into account cultural otherness (Fassin & Rechtman, 2005: 361) and was seen by many clinicians to challenge the French Republican model of integration (Corin 1997: 335).

Defenders of Nathan, however, have emphasized the innovation and activism behind his approach: "…these critiques unfairly misrepresent both Nathan's own personal convictions and the purpose of his work, which is ultimately to arrive at a general theory of therapeutic influence, inclusive of all healing practices worldwide instead of being predicated only on Western psychological concepts," (Zajde, 2011: 188). Moreover, others have described how ethnopsychiatry practitioners have attempted "to give patients back an identity, to re-affiliate them, to re-territorialize them," (Latour, 2010: 49). In other words, Nathan's defenders suggested

that he attempted to open up avenues for alternatives forms of healing that would be more inclusive of individuals who often felt ignored or dismissed in mainstream mental health services in France.

Marie Rose Moro, a child and adolescent psychiatrist and former student of Nathan's, took over the consultation in 1989 and maintained some aspects of it, while using a less stigmatizing conception of culture (Sturm, Heidenreich, & Moro, 2008: 35). Moro rebranded certain aspects of ethnopsychiatry as *psychiatrie transculturelle,* or transcultural psychiatry, which positioned her work in alignment with approaches taken in Anglo-Saxon countries (Moro, 1998: 37). To this day, *psychiatrie transculturelle* continues to emphasize the importance of the complementary relation between anthropology and psychoanalysis initially posited by Devereux (Moro, 1998) and recognizes traditional etiologies of disorder (Delanoë, 2017). Additionally, *psychiatrie transculturelle* is also guided by the theoretical fundamental of a universal psyche, meaning that while the psyche is the same for everyone, cultural coding may engender divergent manifestations or representations of disorder (Radjack, Rizzi, Harf, & Moro, 2017: 562).

Moreover, *psychiatrie transculturelle* has also maintained the group therapy setting introduced by Nathan (Fassin & Rechtman, 2005: 362; Sturm, Heidenreich, & Moro, 2008: 35). During a therapy session, a group of a dozen or so therapists with diverse migration histories, cultural origins, and linguistic abilities would receive a single patient, her or his family, professional(s) from the referring institution, and an interpreter in instances where there was not a shared language between the patient and one of the therapists[7]. The rationale for the group

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[7] Not all *psychiatrie transculturelle* therapy groups function in the same manner with regards to the use of interpreters. In some settings, external professional interpreters may be hired to carry out this work. In others, however, therapists or interns, when they shared a language with a patient, would serve as interpreters. This variation may be due to financial considerations that permit or prohibit hiring a professional interpreter, as well as more organizational guidelines

therapy setting has to do with the notion that in certain cultural groups, individuals are considered to be in constant interaction with the group to which they belong, and the group allows for the "materialization of alterity" and its transformation into a therapeutic tool (Mouchenik, Rosso, & Lefebvre, 2017: 81; see also Sturm, Heidenreich, & Moro, 2008: 35). The therapists were mostly psychologists and psychiatrists, though it was also possible to that nurses, social workers, general practitioners, anthropologists, and sociologists would be present. One psychiatrist or psychologist would be designated the "principal therapist," who would lead the group of therapists in their interactions with the patient. The role of others, the "co-therapists," was to formulate their impressions, associations, or interpretations in an indirect way through the use of images or parables or discussions about cultural representations that they are familiar with (Sturm, Baubet, & Moro, 2007: 213; see also Measham, Hedenreich-Dutray, Rousseau, & Nadeau, 2014: 84). *Psychiatrie transculturelle* groups did not exist in one particular center, but were located within a variety of psychiatry services in hospitals or outpatient mental health services.

Despite retaining the filiation to Devereux's ethnopsychoanalysis, attention to traditional etiologies of disorder, and group therapy setting, Moro's *psychiatrie transculturelle* differed from ethnopsychiatry in the way it conceptualized culture. In this context, culture was defined as a dynamic process based in interactions and that permits a way of coding the ensemble of the lived experiences of a person (Moro, 1998: 12-15). Cultural representations could be thought of as ways of thinking that structure and give coherence to this ensemble of experience (Moro, 1998: 12). These representations would therefore provide a framework for the development of

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concerning the collapsing of the roles between interpreter and therapist. A rich account of a therapist's double role as a therapist and interpreter in one *psychiatrie transculturelle* group can be found in Hernandez-Ariza et al. (2008).

narratives in consultation sessions (Sturm, Baubet, Moro, 2007: 212; 2010:36) and cultural differences may be a source of creativity (Mestre 2006: 190).

Unlike the "differentialist" orientation that Fassin and Rechtman (2009: 240) noted in ethnopsychiatry, *psychiatrie transculturelle* sought to create an open dialogue with the patient about different systems of cultural representations and to establish links between the systems of the patient and those of the therapists (Sturm, Baubet, Moro 2010: 28; Sturm, Nadig, Moro, 2011: 208). Put more simply, *psychiatrie transculturelle* therapy aimed to establish similarities between therapists' and patients' cultural representations. One of the ways that therapists could make this happen was by learning to engage in the complex process of *décentrage,* or decentering, wherein therapists learn to distance themselves from their own cultural representations to avoid ethnocentric perspectives (Moro, 1998: 46; Moro, 2002: 34-35; Sturm, Nadig, Moro, 2011: 210; Moro, Baubet, 2013: 147).

Ethnographic research in immigrant mental health settings in France

The ethnographic research of psychologist Gesine Sturm (2005; Sturm, Nadig, & Moro, 2010), anthropologist Stéphanie Larchanché (2010), and sociologist Lila Belkacem (2013; 2015) in the kinds of mental health settings described above has been crucial in elucidating how patients and therapists co-construct cultural representations, how self-reflexive sensibilities are essential among therapists, and how these settings mediate between immigrant patients and different kinds of institutions. Sturm's (2005: 322) research identified how the space of *psychiatrie transculturelle* therapy groups were constructed around three axes: the establishment of a therapeutic alliance between therapists and patients, the work of symbols, and mediation work. During therapy, the vision of patients is confronted by those of the co-therapists, not with

the intention of imposing a particular reading of the situation, but rather with the intention of creating new ways of thinking through problems (Sturm, 2005: 323; see also Sturm, 2006: 38). Therapeutic competence involves a constant process of self-reflexivity among therapists, who must question their own cultural position in their interactions with patients (Sturm, 2005: 96-97). Moreover, Sturm described how *psychiatrie transculturelle* therapy groups were a space of mediation between immigrant patients or families and the professionals who refer them. Conflict between families and professionals was often based on the latter groups' requests for therapy—which are often articulated in terms of problems of communication—mediation therefore became necessary over the course of therapy (Sturm, 2005: 331).

Larchanché (2010) also examined how "specialized" or what Fassin and Recthman (2005: 360) refer to as "specific" mental health services—meaning those that cater to migrant or non-francophone patient populations—mediate between culturally diverse patients and the professionals in the institutions that refer these patients. These professionals would often have stereotypical views of cultural difference, which prompted them to refer patients to these specialized services whose clinicians are culturally competent. Yet the culturally competent clinicians asserted that their self-reflexivity, as evidenced by their own immigration experiences or exposure to culturally diverse populations, is what characterizes their profession (Larchanché, 2010: 145-146), rather than encyclopedic knowledge about different cultural groups. These services, Larchanché (2010: 189-190) argues, have been caught up in a "double bind" since on the one hand their clinicians are trying to promote less essentialist ideas of culture often formulated in external professionals' requests for culturally sensitive therapy, and on the other hand, these clinicians attempt to preserve their authoritative position by catering to the need for cultural expertise.

Belkacem (2015: 62) has described how ethnoclinical mediation consultations[8] are a space where the words of migrants are heard, not only in terms of the languages they speak, but also in terms of their needs and their representations. But Belkacem (2013: 84) has also referred to a paradox of "assimilationist pressure" wherein institutions sponsor specific treatment for the cultures that they deny and devalue. This paradox is especially evident in the work of therapists, who have worked to recognize the "double cultures" and "roots" of immigrant families in an attempt to challenge the social processes of stigma and devalorization experienced these families; however, the therapists may unwittingly reproduce many of the culturalist ideas and discourses that shape these processes (Belkacem, 2013: 70-71). This is because these therapists, like the professionals in the institutions that refer individuals, mobilize similar essentialist representations and vocabularies concerning roots, countries of origin, and cultures (Belkacem, 2015: 63). Like Larchanché, Belkacem (2015: 64) describes how the validation of therapists' approaches by various institutions reinforces these therapists' legitimacy in the field of specialized mental health and assures the continuity of their profession.

Moreover, within these therapeutic spaces, Belkacem has observed an asymmetry in the knowledge possessed by therapists and their interns, which is due to the latter group's age, status as students, gender, and often, their categorization as "French" (2015: 55). This asymmetry also contributes to the reproduction of essentialist ideas and discourses of culture and origins, even

[8] Belkacem (2013:70; 2015: 47) describes how these consultations resemble the group therapy methods proposed by Tobie Nathan. The group is composed of therapists who are often immigrants from West Africa, as well as mediators who speak the languages of the parents and are presumed to posses cultural knowledge linked to the ethnic group or regional area of the families. Children and their parents are referred to these consultations by child protection services (such as Aide sociale à l'enfance, Protection judiciaire de la jeunesse, Protection maternelle et infantile) and are court mandated. The ethnoclinicians' role is to resolve problems deemed specific to migrant families, or attributed to culture shock in France, or those problems that socio-judicial professionals do not understand.

when these ideas and discourses are valorized. Taken together, the perspectives of Sturm, Larchanché, and Belkacem illustrate the dynamics and nuance within immigrant mental health settings and in the relations between these settings and the institutions that supply them with patients.

Cultural competence training in France

In addition to their clinical and mediation work, these settings also train graduate students in clinical psychology and psychiatry, as well as professionals, to develop the skills and sensibilities often referred to as cultural competence, which has been defined as the understanding of cultural and social factors' influence on patients' health beliefs and behaviors, as well as an understanding of how these factors interact at multiple levels of health delivery systems (Betancourt et al., 2003: 297; see also Bennegadi, 2009: 8; Bennegadi, 2014: 145; Bouznah, 2015: 554; Guerrero, 2012: 9). The notion of cultural competence has drawn criticism and inspired debates from clinicians and social scientists for several reasons: culture has been perceived to be a static assortment of traits shared by all members of a particular group, patients or clients have been perceived to be the bearers of culture, whereas professionals were immune from reflecting on their own professional and personal backgrounds; culture has been seen as a barrier to care that needed to be overcome; and, an emphasis on cultural factors has overshadowed the attention to the social determinants and inequalities experienced by patients (Carpenter-Song et al. 2007; Castañeda, 2012: 834; Castañeda et al., 2015: 379-380; Dogra and Karnik, 2003; Fox, 2005; Holmes 2012: 880; Jenks 2011; Kleinman and Benson, 2006; Kirmayer 2012; Larchanché, 2010; Santiago-Irizarty, 2001; Taylor, 2003). Alternatives to cultural competence have been proposed, such as critical consciousness (Kumagai & Lypson,

2009: 783), cultural humility (Hook et al., 2013; Fisher-Borne et al, 2015; Tervalon & Murray-García 1998), cultural responsiveness (Sue et al., 1991), cultural safety (Kirmayer 2012), and structural competence (Ali & Sichel, 2014; Hansen, Braslow, & Rohrbaugh, 2018; Hansen & Metzl, 2017; Metzl & Hansen, 2014)[9]. In spite of these alternatives, however, others caution that if attention remains at the individual level, it is thus diverted "from the organizational and structural factors that play important roles in health inequalities" (Shaw & Armin, 2011: 256; see also Castañeda et al., 2015: 380 and Larchanché, 2010: 336).

The debates concerning cultural competence described above have not taken place to the same extent in France. Instead, debates have arisen from conflicting perspectives on assimilation and cultural sensitivity, the perception that migrant or non-francophone populations do not

[9] Critical consciousness refers to the knowledge and awareness to carry out the social roles and responsibilities of a clinician, which requires critical self-reflection, or stepping back to understand one's assumptions, biases, values, and a heightened dness of the conditions of injustice in the world (Kumagai & Lypson, 2009: 783). Cultural humility emphasizes a long-term commitment to self-evaluation and critique, to redressing power imbalances between health workers and patients, and to establishing partnerships with communities (Tervalon & Murray-García, 1998: 123). Cultural humility is comprised of several attributes, including openness, self-awareness, being egoless, participation in supportive interactions, and self-reflection and critique (Foronda et al., 2016: 211). Culturally responsive strategies in health care services involve training therapists to work with culturally diverse patients and clients, employing bicultural or bilingual health care workers, and establishing parallel services that are devoted to ethnic minority groups (Sue et al., 1991: 533). Cultural safety "moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care" (National Aboriginal Health Organization, 2008: 3; cf. Kirmayer, 2012: 157). More recent approaches in clinical education emphasize an awareness of structural elements—as opposed to cultural or ethnic identities—that might have an impact on the experience of illness and access to care (Metzl and Hansen, 2014). In "structural competence" training, an illness should be addressed as a downstream implication linked to upstream decisions, such as the absence of stable housing or work discrimination (Schneider, 2013; cf Ali and Sichel, 2014: 3). One way that health professionals can turn structural competence into action is through activities of advocacy, namely incorporating recognition of structural determinants of health into education, supporting collective action that aims to change practices and policies, and initiating action to challenge social injustices (Kirmayer, Kronick, Rousseau, 2018: 119).

require or deserve any additional attention, and the controversial history of earlier approaches like ethnopsychiatry. A rich body of research has illustrated the tensions between the attention to cultural particularities and their significance in healthcare, and the universalist and assimilationist perspectives that reject this attention as *culturalist* (André & Azzedine, 2016; Bertossi and Prud'homme, 2011; Fassin and Rechtman 2005; Fassin & Rechtman, 2009; Nacu, 2011; Sargent and Erikson, 2013; Sargent & Larchanché, 2009; Sicot and Touhami, 2015; Sturm, Nadig, Moro, 2011). Moreover, migrant populations and minorities in France have not been considered populations that needed specific health or mental health services (Fassin & Rechtman, 2005: 352; Fassin & Rechtman, 2009: 226; Mestre, 2006: 186). In fact, some mental health professionals perceive these groups, particularly those who are undocumented, to lack the legitimacy to remain in France (Chambon & Le Goff, 2016: 130). This generalized resistance to cultural sensitivity in France has been exacerbated by the particular legacy of ethnopsychiatry, whose critics argued that it did not respect universalism and that it drew on essentialist and closed notions of culture. As a result, the development of cultural competence, both as a professional project and as an area of research, has remained relatively marginal in France.

This marginality seems to be especially obvious in the lack of attention professionals and institutions have given to the cultural particularities in the experience and expression of mental illness and the vulnerabilities that migrant populations may face. A fairly recent study conducted among mental health professionals demonstrated that most had not received any training in cultural sensitivity or how culture may play a role in healthcare (Sicot and Touhami, 2015a: 107). Moreover, even when professionals are open to the cultural or structural factors that impact their patients' mental health, they may practice in ill-equipped or resistant institutional settings. For instance, in an absence of institutional resources or regulations, professionals report having

to cope and come up with a creative assortment of solutions, often referred to as *bricolage,* to better serve these populations (Bertossi and Prud'homme, 2011: 3; Sicot and Touhami, 2015b). One example of this is enlistment of ad hoc or informal interpreters, such as family members or institutional personnel, who may be unable to interpret complex or sensitive information. Even when there is funding to train professionals, the training may not be sufficient when the institutions themselves are dysfunctional. For example, institutions or teams may request for training for a particular population—typically articulated as a cultural group—yet often masked behind these requests are tensions between healthcare professionals or disorganization within services (Kessar 2012: 236-237).

Despite this resistance, professionals in healthcare institutions in France have been gradually moving towards measures that facilitate access to social and health services for people in various migratory situations (Cohen-Emerique, 2011: 12). Moreover, health professionals have often expressed an interest in learning to better understand and be better trained with regards to the cultural backgrounds of their patients and the impact of these backgrounds in healthcare (Kotobi, 2000: 65), as well as a desire to better understand the landscape of social and clinical organizations that support "precarious" patient populations like migrants groups (Sainte Marie et al., 2015: 679). *Psychiatrie transculturelle* and *anthropologie médicale clinique* currently represent the principal currents in thinking about the place of culture in health and mental health following the approach of ethnopsychiatry in the 1980s and 1990s (Wang, 2016: 156n5). Unlike ethnopsychiatry, these approaches, and notably *psychiatrie transculturelle*, use more hybrid definitions of culture (Moro, 1998), are more moderate in their engagements with the public health system (Fassin & Rechtman, 2005), and even mediate between immigrant

families and the professionals who often request therapy for these families in these settings (Sturm, 2005).

Both schools of thought fall within what Larchanché (2010) has described as a self-reflexive field, as the principal practitioners of these approaches have emphasized the importance of being able to decenter, or step aside from one's own preconceptions. Larchanché's perspective reemphasizes that of Sturm (2005: 96-97), who has described that *psychiatrie transculturelle* therapeutic work requires therapists to constantly reflect on their own cultural positions; this reflection may involve a sort of confrontation that may be either seem vastly different or strangely familiar since many of the therapists may share experiences of migration or cultural or linguistic diversity with patients. Indeed, for decades, Marie Rose Moro has argued that the process of decentering is essential practice to acquire (1998: 46; 2002: 34-35). Taken together, these perspectives reflect a broader emphasis on process-oriented approaches that emphasize openness and ethical self-fashioning in lieu of developing extensive knowledge (Jenks, 2011; Shaw & Armin, 2011; Willen & Carpenter-Song, 2013).

Some leaders in transcultural psychiatry have proposed doing away with the notions of "competence" and "expertise" and have instead stressed the need to embrace, rather than attempt to minimize, the uncertainty created within contexts of cultural diversity (Guzder & Rousseau, 2013: 351-352; Kirmayer, 2013: 369). Indeed, as Kai et al. (2007: 1771) have described, "becoming more comfortable with cultural difference and the uncertainty it creates may require greater development of self-reflection on one's own cultural identities as an individual and as a health professional." If leaders in *psychiatrie transculturelle* in France and their international colleagues suggest that we need to do away with the notion of expertise and instead promote the development of self-reflexivity and the embrace of uncertainty, then this suggests the need to

understand how novices develop expertise in settings where their supervisors are trying to do away with notions of expertise, and how they settle divergent and competing imperatives to embrace uncertainty and to minimize it.

Learning to decenter, or step aside from one's assumptions, appears to be one of the ways in which graduate students and health professionals are encouraged to address the uncertainties they face when encountering culturally diverse patient populations. While decentering may perhaps seem like a straightforward task that therapists—or anyone for that matter—should cultivate, in practice it is extremely complex. Indeed, Moro has explained that while decentering is the most important practice that professionals can learn, it is also one of the most difficult to acquire, as it involves rigorous training, daily work, and supervision (Moro, 1998: 46; 2002: 34-35; 2010: 200; 2015: 21). Little is known about the learning experiences of novice therapists who attempt to develop, among other things, a capacity to decenter by undertaking rigorous training and supervision within immigrant mental health settings, and this project intends to address this gap.

Scant attention has been paid to the experiential aspects of training in cultural sensitivity in France. At the time of writing, only one study had examined a university-based professional development program in cultural competence for health and social service professionals in France (Larchanché, 2010). This study explored these professionals' motivations for undertaking this training, their ideas concerning culture, and their anticipated use of the training in their workplaces; it found that these professionals were drawn to this training based on exposure to culturally diverse patient populations and their feelings of helplessness or incompetence in responses to clinical situations with their patients (Larchanché, 2010: 152-154). These professionals anticipated developing flexible ways that were not necessarily culturally adapted to

address the needs of their patients or clients (Larchanché, 2010: 160-161). This analysis is crucial, but further research needs to address how individuals learn through practice. In a classroom setting, the knowledge shared is often abstract and decontextualized. More specifically, clinical situations are often framed as cases where the instructor caps the amount of relevant information necessary to solve the case. As a result, students do not get to see the clinical encounter for themselves and sort through the vast amount of clinical and contextual information that observing such an encounter would permit. Moreover, even when instructors draw on actual clinical situations that they've encountered in their practice, these situations are always extracted from the contexts in which they occurred. Therefore, while training settings, such as the one Larchanché surveyed, may be included in a reflexive field, there is little opportunity for students to observe how their instructors reflect when faced with different clinical situations.

Settings where more hands-on learning takes place, such as within immigrant mental health settings themselves, need to be analyzed since they permit students to see real clinical scenarios, observe their supervisors' processes of reflection, and pose questions or be quizzed by their supervisors during or immediately following clinical encounters. Moreover, while clinical work and instruction may emphasize the development of decentering, openness, and self-awareness, little is known about how these are learned in practice, or how these individuals become experts (Boyer, 2008: 44) and become what Donald Schön (1983) refers to as reflective practitioners.

Throughout this project, I conceptualize immigrant mental health settings as laboratories where ideas concerning culture, identity, belonging, and their relevance in therapy are tried out, debated, and learned. Therefore, in addition to their therapeutic and mediation work, I consider

these settings to be important pedagogical spaces wherein clinical students or professionals learn to navigate a fine line between cultural sensitivity and stereotyping as they attempt to reconcile the assimilationist and universalist imperatives that guide the provision of health services in France with the distinct, and at times competing, imperatives of attention to cultural particularities within these therapeutic spaces. Little is known about how clinical students in psychology, psychiatry, and other mental health fields who undergo intensive training within these settings learn to address uncertainty and manage the potentially different and conflicting demands of their university and practical training. While often an overlooked group, the apprentices of these settings offer an abundance of insight concerning the experiential elements of the transmission of expertise and the process of learning in action. As the next generation of therapists, they are armed with different perspectives and confronted with vastly different problems than their predecessors. More specifically, these settings were developed primarily in response to the mental health needs of workers from former colonies, and recent migration flows pose new and distinct challenges in the reception and support of diverse patient populations. Indeed, the "interacting layers of diversity" in the populations who use health care and social services require more flexible interventions among practitioners (Sturm, Guerraoui, Bonnet, Gouzinski, and Raynaud, 2017: 446-447). Moreover, if, as Simon (2012: 9) has suggested, many immigrants and descendants feel that their multiple identities and allegiances are complementary, then this new generation of therapists likely offers far more progressive and innovative perspectives concerning the inclusion of individuals in contexts of "hyperdiversity" (Hannah, 2011).

Apprenticeship in cultures of expertise

I consider immigrant mental health settings to be what Jean Lave and Etienne Wenger (1991; Wenger, 1999; Lave, 2011) refer to be communities of practice, wherein newcomers engage in legitimate peripheral participation in the activities of more advanced practitioners. Borrowing the concept from Dominic Boyer (2008: 43) I also consider these settings to be "cultures of expertise," which are often able to "monitor the acquisition and subsequent circulation of their expert knowledge." Prior research has described how training is often thought of as the transmission of explicit, abstract knowledge within surroundings that exclude the complexities of practice and the communities of practitioners, and where the setting in which learning takes place is assumed to not matter (Brown & Dugiud, 1991: 47; Collins, Brown, Newman, 1989: 486). In this project, I was particularly interested in the experiences of individuals who underwent longer-term learning experiences within mental health settings, and under the close supervision of their practitioner supervisors. By undertaking apprenticeship within these communities of practice, apprentices learn to become reflective practitioners, develop expertise, and manage their uncertainties. In this second half of this chapter, I present these concepts and their contributions to the context of cultural sensitivity training in the settings described above.

In "Situated Learning," Jean Lave and Etienne Wenger (2009) define apprenticeship as legitimate peripheral participation within communities of practice. Individuals must be accepted as legitimate members of these communities and the peripherality of their participation suggests that there are multiple, varied, and inclusive ways of being located within the fields of participation (Lave & Wenger, 2009: 35-36). In other words, newcomers learn through increasing participation within communities of practice and by developing knowledgeable

identities as members of these communities. Apprentices learn to think and act in increasingly knowledgeable ways through their legitimate peripheral participation with masters or those who do something well (Lave, 1997: 19). Wenger (1998: 73) has further elaborated on communities of practice, by stating that they are characterized by mutual engagement, joint enterprise, and a shared repertoire. In other words, people engage in actions whose meanings they negotiate together, there is a collective process of negotiation that reflects the complexity of this engagement, and the shared repertoire includes routines, words, concepts, tools, stories, that the community has produced (Wenger, 1998: 73-83). Broadly, the work of Lave and Wenger illustrates how individuals learn repertoires and are integrated or professionalized as members within specific groups of practitioners.

Conceptually, apprenticeship provides a richer account for how individuals learn, rather than simply how they are taught or instructed (Brown & Duguid, 1991: 48). Apprenticeship avoids the "instructionist bias" and allows us to understand how the work of learning goes on and gets accomplished (Lave, 2011: 86). Additionally, as opposed to training, apprenticeship permits a deeper exploration of the messiness and complexity of learning environments. Apprenticeship emphasizes the centrality of activity in learning, and it highlights the "enculturating" nature of learning (Brown, Collins, & Duguid, 1989: 39). If individuals learn by through their enculturation into a community of practice, then they may absorb more than just the direct, formal teaching that takes place. For example, in medical education, Frederic W. Hafferty and Ronald Franks (1994: 869) describe how the "culture of medicine" is reflected not in the formal, but in the hidden curriculum, which refers to the subtle features, such as interactions with peers, stories told by supervisors, and the general climate of sites of learning, that take place outside of lectures and other formal teaching moments. These features may be

overlooked by supervisors, thought they may have an important impact on students' memories and experiences of their apprenticeships. The processes of enculturation, both formal and informal, are important since training involves the acquisition of a professional identity in addition to new knowledge and skills (Hafferty & Franks, 1994: 865).

Other scholars of apprenticeship have proposed numerous methods, including modeling, coaching, scaffolding, articulation, and reflection that apprentices and their supervisors use to promote the use, management, and discovery of knowledge (Collins, Brown, & Newman, 1989: 480). By observing their supervisors carry out a task, students can build a conceptual model of the processes that are necessary to accomplish that particular task (Collins, Brown, & Newman, 1989: 481; Benner, Tanner, & Chesla, 2009: 235). For example, in nursing, modeling experts is necessary in learning a complex, response-based skill, such as comforting premature infants (Benner, Tanner, & Chesla, 2009: 255). But environment in which experts carry out tasks and solve problems while apprentices simply observe them is not sufficient to provide students with models for learning; rather, students must be drawn into the cultures of expert practice (Collins, Brown, & Newman, 1989: 488). Therefore, more interactive methods, like coaching, permit supervisors observe students as they carry out a task, then provide hints and feedback so that students' performance approximates expert performance (Collins, Brown, & Newman, 1989: 481).

Scaffolding refers to the support that supervisors provide to students and the eventual fading out of this support until students are able to carry out a task on their own (Collins, Brown, & Newman, 1989: 482). The method of articulation requires supervisors to query their students in order to get them to formulate their knowledge, reasoning, and processes of problem solving (Collins, Brown, & Newman, 1989: 482). Similarly, Dreyfus and Dreyfus (2009: 22) describe

how experiential learning takes place in conditions where feedback on performance is provided and when there are opportunities for learners to articulate and reflect on their learning experiences. In the *Reflective Practitioner,* Donald Schön (1983: 119) provides an example of this in an interaction between a supervisor and apprentice psychotherapist, wherein the supervisor's questioning of the apprentice illustrate a repertoire of meanings and psychodynamic patterns available to the supervisor but not (yet) to the apprentice. In another example, when attending surgeons question their subordinates, they can construct what Charles Bosk (2003: 94-95) refers to as a "binding definition of reality," since they have more clinical experience and expertise. Taking these perspectives together, the process of questioning apprentices illustrates how supervisors evaluate apprentices' performances, and how the reasoning and range of expertise of supervisors remain out of reach for apprentices. In the current project, I pay close attention to the methods used within immigrant mental health settings to evaluate the extent to which apprentices are learning what their supervisors want them to learn.

In addition to the methods used, the characteristics of communities of practice that foster or hinder learning and membership must also be taken into consideration. Rather than focus on explicit teaching, an emphasis on apprenticeship permits us to observe how learners pick up the ambient culture of a community of practice (Brown, Collins, Duguid, 1989: 34). Indeed, the acculturation is embedded within a specific context since individuals learn to think and act within a particular organizational milieu (Saks & Ashforth, 1997: 269). Similarly, anthropologist Mary Douglas (1986: 48) has described how past experiences are encoded in the in the rules of institutions and states that, "the more fully the institutions encode expectations, the more they put uncertainty under control." Organizational or workplace cultures are made up of rules of thumb, specialized language, ideologies, shared standards of relevance about the critical aspects of the

work that is carried out, models of behavior and etiquette, and customs and rituals about how one is to interact with supervisors, peers, subordinates, and those outside of the organization (Van Maanen & Schein, 1979: 210). The ensemble of these perspectives suggests that learning the rules entails learning how to be part of an organization, which can be a sort of reprieve when dealing with unfamiliar situations.

In the context of nursing, Benner, Tanner, and Chesla (1990: 17; 2009: 235) emphasize the importance of organizational cultures, which include qualities of trust and a sense of possibility, and which support the development of clinical knowledge, recognize the significance of instantaneous nursing judgments, acknowledge the moral agency of nurses, and promote interdisciplinary dialogue with shared authority for decision making. The culture of the nursing unit establishes a vision for what is considered excellent and ordinary taken-for-granted practices, ways of thinking, and ways of being that get transmitted (Benner, Tanner, & Chesla, 2009: 263-266).

In the present context, I evaluate the seemingly mundane features of apprenticeship in immigrant mental health settings, including the rules supervisors provide to apprentices, the routines and tasks apprentices complete, and the meanings that apprentices give these features. As I will argue in the following chapters, many of the tasks assigned to apprentices in these settings served multiple purposes: these tasks contributed to the ongoing work of these settings, they served pedagogical functions since they focus the attention of apprentices to information that supervisors considered relevant, and they provided legitimacy to the clinical work of these settings.

While term, "workplace culture," certainly risks the same shortcomings—that it's static, essentialist, homogenizing—associated with the term "culture," I find that the features associated

with workplace cultures to be helpful in thinking about the extent to which apprentices familiarize themselves with ambient contexts of immigrant mental health settings and gradually move from the periphery to the center of these settings as they advance in their apprenticeships. I find especially valuable Knorr Cetina's (1999: 8; 2007: 364) characterization of culture as both a nexus of lifeworlds and as the aggregate patterns and dynamics that are on display in expert practice and that vary among settings of expertise. I was especially interested in the variance in the cultures of expertise in each of the settings analyzed throughout this project.

Additionally, I find Paul Brodwin's (2013) description of the ethos of an organization to be particularly helpful, especially in thinking about the socialization of apprentices. Brodwin (2013: 56) describes how the ethos of a workplace permits individuals to manage everyday difficulties, imagine that their individual actions contribute to a larger, collective purpose, yet the ethos of a workplace can also be thought of as an implicit demand that individuals pledge allegiance to the institutional framework and ideals that guide ordinary action. In the present context, I pay close attention to what the ethos of each immigrant mental health setting entailed and how the ethos of each setting guided the actions of apprentice therapists as they became more familiar with their apprenticeship sites.

Additionally, it perhaps goes without saying that not everyone within an organizational setting will experience its culture in the same way. For example, in their classic study of medical education, Becker et al. (2003: 46) describe "student culture" as a body of collective understandings shared by students about matters related to their roles as students, a role that comes with its own rights, responsibilities, and obligations. In other words, students do not share the same perspectives or encounter the same kinds of problems as their supervisors. Moreover, their separation from others, such as their supervisors, within an organization engenders the

development of a sub-world comprised of students (Van Maanen & Schein, 1979: 233). In the current project, I considered the extent to which apprentices were included or kept separate from their supervisors. To the extent that sub-worlds developed, I paid close attention to the ways in which these were important spaces of learning and reflection for apprentices.

In presenting its definitions, methodological and contextual considerations, I elucidate how apprenticeship conceptually informs us about the experience of learning. Apprenticeship is a particularly valuable framework in the context of cultural sensitivity training since it emphasizes processes of learning over those of teaching. To my knowledge, this project is the first to consider apprenticeship in immigrant mental health settings in France, or elsewhere for that matter. By focusing on apprentice therapists' legitimate peripheral participation within these settings, I pay close attention to the settings where situated learning takes place and the processes of enculturation and professionalization of apprentices. More specifically, I am interested in formal and informal teaching moments in these settings, the activities for apprentices to carry out in these settings, and the interactions that take place between apprentices and their peers and supervisors. The next section turns to another area of literature on expertise and its development within communities of experts. As I will illustrate, this area of literature provides additional conceptual scaffolding to understand how apprentices learn to develop particular ways of knowing about the experiences of mental illness and treatment practices among the people who seek care in immigrant mental health settings.

Learning to perform as an expert

Building on these foundational elements of apprenticeship, the interactive and performative dimensions of expertise offer particularly valuable ways of understanding what

happens as individuals become integrated within communities of practice. Broadly speaking, expertise has been described as the capacity to perform a task that involves a network of actors, concepts, and institutional arrangements (Eyal, 2013: 877). Numerous scholars have emphasized the performative dimensions of knowledge and expertise (Candlin & Candlin, 2002: 119; Carr, 2010: 17; Engeström, 1992: 5; Ericsson & Charness, 1994: 725; Smith, 2014: 16). Indeed, Frank Blackler has described that "rather than regarding *knowledge* as something that people have, it is suggested that *knowing* is better regarded as something that they do" (1995: 1023, original emphasis), and Donald Schön (1983: 49, original emphasis) has emphasized how "our knowing is *in* our action." The performance of expertise is interactive or co-participative since experts must engage with their objects of study and with other actors (Candlin & Candlin 2002: 116; Carr, 2010: 18; Engström, 1992: 5). Some have referred to this as "pooled expertise" since it is dialogically assembled from multiple perspectives (Benner, Tanner, & Chesla, 2009: 235-236).

Moreover, the performance of expertise takes place within institutional contexts that develop and "authorize certain knowledge practices" and that "provide boundaries between ways of knowing the very same object" (Carr, 2010: 24). Indeed, as anthropologist Cristina Grasseni (2007: 7) has described, "different schoolings may allow differently trained people to derive different, or conflicting information, from the same visual artifact." In other words, expertise is ideological, since it is shaped within particular systems of understanding (Carr, 2010: 18; Calafat, 2011: 100; Grasseni, 2007: 7-8). Within the context of psychiatric settings, Allan Young (1999: 198-199) describes how "clinical ideologies" represent a local knowledge system that is embedded within a specific institutional structure that reflects the mission of the structure, its therapeutic orientation, and its division, which compels clinicians to act in particular ways. Taking these perspectives together, expertise is co-participative and institutionally defined and

negotiated. In this project, I was interested to learn how expertise was assembled in immigrant mental health settings so as to better understand how they functioned as sites of apprenticeship.

Newcomers do not learn explicit, formal "expert knowledge," but rather the embodied ability to behave as members of a community of experts (Brown & Duguid, 1991: 48). This embodied ability reflects a tacit way of knowing that individuals are said to be incapable or controlling or feeling (Polanyi, 2009: 14) since tacit knowledge is an unarticulated form of knowledge (Knorr Cetina, 1999: 99). Perhaps this is why Michael Polanyi (2009: 17-18) describes tacit knowing as a "way to know more than we can tell." Tacit knowledge is difficult to codify and is part of a long-term accumulated process of learning (Howell, 1996: 97). The acquisition of tacit knowledge must be investigated differently than the learning of items of information (Collins, 1974: 168). Instead, it requires close attention to the "communities in which [individuals'] knowing *how* was shaped," (Duguid, 2005: 114, original emphasis).

Individuals become experts by being socialized into communities of experts (Carr, 2010: 19; Eyal, 2013: 870). Defined as a process of acquisition of the knowledge and skills required to assume a role within an organization contexts (Van Maanen & Schein, 1979: 211), socialization takes place through exchanges of information and experience with peers and with superiors (Bergeron and Castel, 2014: 168). It is through these interactions that uncertainty is reduced and the work environment becomes more predictable, understandable, and controllable (Saks & Ashforth, 1997: 236).

Language is an essential dimension in process of socialization (Kulick and Schieffelin, 2004: 350). Indeed, joining a community of practitioners necessarily involves learning how to participate in their conversations, which involves the acquisition of scripts, vocabularies, and ways of speaking (Jones, 2011: 26; Wenger, 1998). By sharing a form of talk, individuals are

able to make collective interpretations, establish and negotiate priorities, and signals membership within a group (Black, 1995: 1039). Taking these perspectives together, in order to become socialized into a community of practice, a newcomer must learn to speak and carry oneself like a member of that community.

In the present context, I pay close attention to the ways in which newcomers come to engage with their supervisors and peers in order to develop the co-participative or pooled expertise within these settings. More specifically, I pay close attention to the ways in which apprentices are socialized in these settings by learning to acquire scripts, or the expressions, vocabularies, and formulations often heard and used in these settings. In using the notion of scripts, I draw on the work of Anna Wierzbicka and colleagues (Goddard & Wierzbicka, 2004; Wierzbicka, 1994) on cultural scripts and Erving Goffman's (1959; 1974) dramaturgical analysis. Cultural scripts can be thought of as an "unspoken cultural grammar" about ideas—such as expectations, thoughts, assumptions, and norms—and they are mostly tacit, though they may also be explicit (Wierzbicka, 1994: 17-19). They combine insider knowledge but are intelligible to outsiders (Goddard & Wierzbicka, 2004: 162). Goffman's analysis of performance and theatrical frames is also helpful in thinking about the scripting of social interactions. Scripts are a source of broad hints concerning the structure of a particular domain (Goffman, 1974: 53). Taken together, these perspectives permit the understanding of how apprentices learn to navigate sites of apprenticeship and understand what is expected of them.

Additionally, I consider the clinical ideologies, to borrow Young's (1999) term, of these settings and the ways that these ideologies shape the apprentices' scripts. Lastly, rather than assuming that apprentices simply acquire these scripts, and therefore become members of these communities, by being present, I analyze the disciplinary techniques that are applied and are

gradually internalized by apprentices as they advance in their apprenticeships. The next section considers how individuals progress from novice to expert and develop new ways of reasoning.

From novice to expert

Other scholars of expertise have also noted an important stepwise progression from novice to expert (Dreyfus & Dreyfus, 2005). Indeed, not all achieve expertise despite having a great deal of experience in their domain of specialization (Dreyfus & Dreyfus, 2009: 9), so it is therefore important to consider how individuals approximate something like expertise rather than assuming that they will inevitably achieve it. While it may go without mention that individuals do not necessarily progress from novice to expert in a straightforward manner, these scholars classify the features and experience of each step. Within the context of nursing, for example, Patricia Benner and colleagues (1992: 27) describe how nurses with differing levels of practice inhabit different clinical worlds; each level of practice is characterized by advances in clinical knowledge and a resulting shift in a nurse's grasp of the clinical world.

Initially, instructors may need to break down a task into features so that a beginner can recognize these features without the desired skill; however, as these authors caution, novices cannot simply follow rules but they need to understand the context in which these rules make sense (Dreyfus & Dreyfus, 2005: 782-783; 2009: 9-11). Advanced beginners develop an understanding of the context and begin to recognize new situational aspects of a particular domain (Dreyfus & Dreyfus, 2005: 783; Dreyfus & Dreyfus, 2009: 11). Advanced beginner nurses, for example, experience a concern to organize and prioritize tasks and failure to successful do so raises considerable anxiety; in fact, the self-consciousness experienced by advanced beginners takes place because they are working at the edges of safety and knowledge

(Benner, Tanner, & Chesla, 1992: 16-17). Competent individuals learn to devise a plan or adopt a perspective, which helps them become more discriminating between features and aspects; however, these individuals rely on rules and guidelines to decide on which perspectives or plans to adopt (Dreyfus & Dreyfus, 2005: 784; Dreyfus & Dreyfus, 2009: 12-14). Proficiency is achieved when reasoned responses to a particular situation are replaced by almost immediate intuitive reactions: "Action becomes easier and less stressful as the learner simply sees what needs to be done rather than using a calculative procedure to select one of several possible alternatives" (Dreyfus & Dreyfus, 2005: 786). For nurses, the competent individual's practice of going down a checklist differs from the proficient individual's recognition of a contextually determined shift in priorities (Benner, Tanner, & Chesla, 1992: 24). Moreover, proficient nurses have more confidence in their ability to notice the important things and therefore experience anxiety about the consequences of what they might leave out (ibid., p. 25). What distinguishes expert from proficient performers, however, is the ability to make more subtle and refined discriminations in order to achieve an immediate, intuitive situational response (Dreyfus & Dreyfus, 2005: 787; Dreyfus & Dreyfus, 2009: 15).

Gradually, as one progresses from novice to expert, one relies less on rules than on intuition. Expert nurses can manage rapidly changing situations with ease and can attend to many other aspects of care that would go unnoticed by less experienced nurses (Benner, Tanner, & Chesla, 1992: 26). In fact, as Dreyfus and Dreyfus (2005: 788) identify, experts may have a hard time identifying the rules that guide their action since they are not following any. This formulation of expertise is valuable because it illustrates the complex pathway between being a novice and an expert. It provides conceptual landmarks to consider how learners' participation approximates that of a full member of a community of practice. Indeed, as Brown, Collins, and

Duguid (1989: 40) have identified, “students need to observe how practitioners at various levels behave and talk to get a sense of how expertise is manifest in conversation and other activities.” In other words, apprentices’ interactions with their supervisors and their more advanced peers are crucial. The perspectives above illustrate that novices tend to rely on rules, whereas experts are guided by their intuition and are able to see things that are not obvious to novices. This does not suggest that experts do not reflect on their actions. They do not think about the *rules* for choosing goals or their *reasons* for choosing possible actions, but they *reflect* on the goal or perspective that seems evident to them and on the action that seems appropriate to achieving their goal (Dreyfus & Dreyfus, 2009: 16, my emphasis).

In this project, I have no intention of categorizing apprentices according to these different steps, though I find the distinctions in the characteristics and modes of reasoning between the different stages to be conceptually useful. I pay close attention to the rules and guidelines given to apprentices in immigrant mental health settings, as well as how apprentices internalize these rules and guidelines. In so doing, I evaluate how their process of reflection develops from one in which they seem to rely on guidelines to one in which they rely on their intuition. The next section considers reflective practices in more depth and how developing a reflective capacity may be an antidote to the uncertainties that apprentices face.

Cultural competence training for uncertainty

In contexts of cultural diversity, professionals may wish to reduce the uncertainties of working with patients who are from different cultures in order to avoid potential misunderstandings during clinical encounters (Kai et al., 2007). Indeed, as others have described, misunderstandings between staff and the people who use health and social services often arise

from a lack of necessary information due to a professional not knowing how to ask or not listening to a patient (Cattacin and Dagmar, 2014: 29).

In the *Reflective Practitioner,* Donald Schön (1983: 13-14) describes a "crisis of confidence in professional knowledge," or the mismatch between professional knowledge and situations of practice. These situations of practice are rife with features of complexity, instability, and uncertainty and these features are not simply removed or resolved by applying specialized knowledge (Schön, 1983: 19). Here, I draw on a rich body of scholarship on uncertainty in medical practice (Bosk, 2003; Fox, 1957; Parsons, 1991), as well as in psychiatric practice in particular (Kirmayer, 1994; Light, 1980). While it "looms so large in medical practice" (Parsons, 1991: 313), uncertainty may hinder clinicians' abilities to prevent, diagnose, and treat disease and illness (Fox, 1980: 409).

In the seminal article, "Training for Uncertainty," Renée C. Fox (1957: 208) describes how clinicians and clinical students face three types of uncertainty: the first type results from these individuals' incomplete or imperfect mastery of available clinical knowledge; the second type arises from limitations in the clinical knowledge that is currently available; and the third type has to do with difficulties in distinguishing between the first two. This latter type of uncertainty arises when individuals cannot tell if their lack of knowledge is their own fault or that of the field (Fox, 2000: 5). Building on Fox's work, Donald Light (1980: 279-282) states that there are additional types of uncertainty that psychiatrists in training face: uncertainties of diagnosis, procedure, of collegial relations, and a client's or patient's response. Moreover, Laurence Kirmayer (1994: 190) reminds us that, "patients are not inert objects of interpretation, …[but rather are] interpreters of experience who have their own constructions of meaning that

not only affect their account of symptoms but, to varying degrees, influence the nature and course of illness."

Over the course of their training, clinicians and students gradually learn to acknowledge uncertainty as a given (Fox, 1957: 214; 1980: 7). Students may also attempt to cope with uncertainty by attempting to gain medical knowledge and skill, by realizing that they are not alone in their experience of uncertainty, and by developing relationships with their supervisors, which permits students to observe how those with more experience reason and organize information (Fox 1957: 218-226). One of the most oft-documented encounters between students and their supervisors and a fundamental feature of clinical training and professionalization has been the case conference. As an important moment of socialization, scholars have described that during these encounters, students learn to develop ways of thinking and speaking about patients by observing their peers present patient cases and by presenting patients themselves (Anspach, 1988; Atkinson, 1995; Bosk, 2003; Davenport, 2000; Good, 1994; Good & DelVecchio Good, 2000; Light, 1980; Menchik, 2015; Schön, 1983). Case presentations reveal clinicians' processes of inquiry, or how they perceive, describe, listen to patients, as well as how they identify possible explanations and conceive of possible strategies of diagnosis or treatment (Schön, 1983: 317). Case presentations illustrate models of psychotherapy, solve problems in diagnosis, treatment, and management, and provide a steady stream of clinical examples (Light, 1980: 190). Yet they are also sites at which senior clinicians enact their authority and where the amount of learning that apprentice clinicians have yet to do is rendered obvious (Bosk, 2003: 124-125).

Case presentations in clinical training are the scenarios in which individuals' uncertainties are rendered visible to their peers and supervisors. Seth Holmes and Maya Ponte (2011: 165) describe how the structure of patient presentations in medical education 'encases'

the patient, or transforms the uncertainty of illness experience into a more recognizable case for students. During patient presentations, students are required to sort through and focus on the most pertinent information; this involves leaving out details concerning a patient's illness narrative since these details would generate uncertainty regarding the potential causes and treatments of the patient's condition (Holmes & Ponte, 2011: 172). More advanced, and reflective, practitioners can give an artistic performance in these presentations, as evidenced by their selective management of large amounts of information, their ability to invent and infer, and their capacity to hold several ways of looking at things without disrupting the flow of inquiry, all the while doing these things with a sense of simplicity and spontaneity that may be confusing to students (Schön, 1983: 130).

Additionally, Holmes and Ponte (2011: 165) point out that these patient presentations serve a disciplining function for medical students, whose uncertainty of experience and identity is transformed into a recognizable professional identity and demeanor. By adopting certain ways of speaking, students learn to communicate efficiently and "perform citizenship in the biomedical profession" (Holmes & Ponte, 2011: 179-180). In other words, by engaging in training activities such as patient presentations, students attempt to manage their uncertainties concerning the afflictions of their patients and with regards to their own professionalization.

Taking these points together, uncertainty is a pervasive feature of clinical practice that affects both students and their supervisors. Fox has explained how training for uncertainty involves the development skills and knowledge, learning that uncertainty is a common feature that affects everyone, and undergoing supervision. Case presentations are public performances where individuals learn how to reflect in their problem solving, by observing others and by practicing themselves. Moreover, in mental health care for culturally diverse patient groups,

clinical case presentations among a multidisciplinary group of professionals may be a site at which the group challenges biomedical perspectives in psychiatry and recognizes and integrates the expertise and perspectives of other professions represented in the group (Dinh et al., 2012: 273). Others have suggested that clinicians should closely attend to the patient's own understanding of their illness and in so doing, constructively engage with uncertainty (Adeponle, Groleau, & Kirmayer, 2015: 34). Moreover, when clinicians inform patients of the possibility of uncertainty, they allow for greater communication and shared decision-making and promote an acceptance of the unknown (Henry, 2006: 322).

In the current context, I pay attention to formal and informal teaching moments where apprentice therapists in immigrant mental health settings learn to acquire concepts and vocabularies, recognize symptoms, and identify treatment strategies, but also learn to frame patients' conditions in the ways that their supervisors deem acceptable and non-stigmatizing. More specifically, I analyze pedagogical and performative moments in these settings where apprentices observe the ways that their peers and supervisors reflect in their problem solving, and also perform in front of their peers and supervisors.

Concluding remarks

As the director of the Minkowska Center noted, all health workers need to adapt their practices to respond to the new arrivals of people in different situations of migration in France. This raises an important question about how one learns to holistically take into account the person in terms of her or his languages spoken, ways of understanding disorder, and structural conditions that affect her or his everyday life. This may result in a crisis of uncertainty for health professionals and clinical students, who may easily fall back on their training and may resort to

cultural stereotypes to account for how culturally diverse patient populations understand their conditions and pursue treatment. Therefore, special attention needs to be paid to the process by which health professionals and clinical students learn to recognize cultural diversity and its relevance in therapeutic encounters.

Taking together the perspectives on apprenticeship, expertise, reflection in action, and uncertainty, I establish the conceptual scaffolding to analyze how apprentices learn to inhabit the roles created for them in immigrant mental health settings. More specifically, this scaffolding permits the analysis of how apprentices develop forms of expertise in settings of no expertise, since their supervisors encourage them to look inward to develop self-awareness and openness rather than training them to acquire information about immigrant and non-francophone patients. Additionally, this scaffolding allows for the understanding of how apprentices manage distinct and competing imperatives to embrace uncertainty and minimize it.

As I will illustrate throughout the following chapters, a focus on those who undergo apprenticeship is powerful for several reasons. The newness and unfamiliarity experienced by apprentices render explicit the guiding principles and rules of organizations. Their fresh perspectives, questions, and critiques assist in identifying blind spots in taken-for-granted practices. Taking these two points together, it is possible to grasp the discrepancy between ideal and actual practices. Moreover, by focusing on the activities of apprentices, we can understand how apprentices contribute to the ongoing clinical and administrative work of the settings where they carry out their apprenticeships, and better understand what their supervisors want them to retain from their training. Moreover, we can develop a more thorough understanding of how processes of decentering and managing uncertainty are learned through practice.

Chapter 2. Activities of presence: Visibility, responsibility, and legitimacy

The group ritual

At the beginning of *psychiatrie transculturelle* group consultation sessions, the principal therapist, who was a psychologist or psychiatrist, welcomed the patient, accompanying professional, and at times, family members, into the consultation room. Prior to the start of a session, these individuals remained in the waiting room while the group, made up of 10 to 12 therapists, discussed the notes from the previous consultation session. Once the group was ready to start, the principal therapist exited the room and returned with the patient and accompanying individuals. Once the patient entered the room, the group stood, in a somewhat ceremonious manner, to greet the patient and only sat when the patient sat. The group sat in a circle or semi-circle, with the patient seated in between the principal therapist and the referring professional. This arrangement was pragmatic since it was the principal therapist who conversed directly with the patient, whereas the other co-therapists only spoke when called upon by the principal therapist. This arrangement was also representative of the fact that the patient was in between institutions and their professionals, since patients were referred when there were misunderstandings or when the referring professional did not feel well equipped to support the patient. This group ritual, as some of my informants described it, was how each *psychiatrie transculturelle* session begins.

Next, the co-therapists in the group were introduced to the patient. Typically, the principal therapist introduced these individuals, though in some instances co-therapists introduced themselves. These introductions were carried out in every session, even in instances in which the patient had attended therapy sessions for years. The reason for this, I was told, was to maintain the continuity and familiarity of the group since therapy sessions typically only took place every

one to two months. Moreover, each academic year, the composition of the group changed with new apprentices joining the group and replacing those from the previous year. Introductions of each group member typically involved the person's first name, role or function in the group, and country of origin.

In one session, a woman from the Democratic Republic of Congo came to the group as a patient for the first time. She seemed initially apprehensive to enter into the consultation room because of the size of the group, though eventually she agreed. The principal therapist said, "Je vais vous présenter les membres du groupe [I will introduce you to the group members]," then proceeded to introduce the members of the group, "This is József, a graduate student in clinical psychology from Hungary; Maria, an anthropologist from Mexico; Pauline, a graduate student in clinical psychology who is of Algerian origin; Meixiang, a psychologist from China; Claire, a graduate student in clinical psychology; Pierre-Olivier, a psychiatrist." Then, the principal therapist finished Claire and Pierre-Olivier's introduction with, "They're French. They're from here."

At the end of the consultation, everyone stood once again and the principal therapist accompanied the patient out of the room and returned alone. The time after the session was reserved to reflect upon the events of the consultation session, their own reactions to what was discussed, and the material that they would cover in subsequent consultation sessions. During this particular group discussion, however, Claire and Pierre-Olivier spoke up about the way that the principal therapist had introduced everyone. Claire, the graduate student, said that she did not appreciate being introduced as being "from here." Pierre-Olivier, the psychiatrist, stated that this kind of introduction made him question his place in the group. Pauline, another graduate student, stated that she felt uncomfortable being introduced as of Algerian origin. After all, it was her

mother who was from Algeria, and Pauline felt that she was expected to speak in a way that reflected her *Algerianness* if she was introduced in this way. Pierre-Olivier added that it did not make sense to say that Meixiang was from China since it is such a large and diverse country and that she, being from Shanghai, likely had little in common with someone from Beijing. Meixiang stated that she probably had more in common with someone from Beijing than with someone from the rural outskirts of Shanghai. Pierre-Olivier then turned to me and asked how I would introduce myself. I said that I would introduce myself as from the United States. József joked that I should start introducing myself as being from Chicago in order to distinguish myself from Americans from more conservative areas of the country. After all, this moment took place shortly after the 2016 U.S. presidential election and József and I frequently commiserated over our dismay with the prospect and reality of xenophobic heads of state in the United States and Hungary.

After the discussion, the principal therapist, Meixiang, and I discussed this exchange. The principal therapist said that the introductions served a purpose for patients and families in the consultation since they allowed these individuals to see and learn about the diverse origins of the therapists. The principal therapist also stated that many of the apprentices were reflecting on their own identities and origins and that these introductions were perhaps as important for them as they were for the patients. While I had read about the former point in the literature on *psychiatrie transculturelle* psychotherapy, I was struck by the psychologist's latter point about how the casting of co-therapists was a formative moment for the apprentices in the group. Indeed, the comments suggested an assumption that apprentices would eventually become more comfortable speaking about their identities and origins and get over their hang-ups about these introductions.

This situation illustrates that co-therapists were not always introduced in the ways that they would choose to introduce themselves, but rather in the ways that were beneficial to the work of the group. As a result, co-therapists, such as Pauline, may find that they must perform a certain identity when they've been introduced in a particular way. Additionally, co-therapists seen as being French or "from here," such as Claire or Pierre-Olivier, may question their position in and contribution to the group. And co-therapists like Meixiang may be labeled as Chinese without any attention to regional, linguistic, or urban particularities. Perhaps more importantly, this situation also illustrates how the casting of identities and roles within these therapeutic spaces seems to be imposed by supervisors, yet this casting is also a site at which apprentice therapists question and at times push back against what they consider to be reductive and problematic practices of their supervisors.

Chapter overview

This chapter analyzes activities of presence, one of several activities in which apprentices were engaged during their apprenticeships in immigrant mental health settings. Presence includes responsibility, visibility, and legitimacy. In fact, the idea of presence came from an interview with an apprentice, whom I call József, who used the word, "presence," to describe how responsible and implicated he felt in the clinical work of two *psychiatrie transculturelle* consultations. By adopting the term "presence," I refer not only to the ways in which apprentices were presented or introduced to patients by their supervisors, but also the ways in which their visible presence was integral to the work of these settings. More specifically, I address three interrelated questions: how do apprentices respond to the use of their identities and linguistic capabilities by their supervisors? How do the ways that apprentices present themselves impact

their entrance into these apprenticeship sites? In situations in which apprentices were regarded as cultural or linguistic interpreters, how do they manage the dual role as an expert informant and an apprentice?

To address these questions, I consider the experiences of apprentices in two types of immigrant mental health settings. In *psychiatrie transculturelle* therapy groups, such as the one described above, supervisors invoked apprentices' diverse identities in consultation sessions in order to encourage patients to speak of their own cultural identities and migration histories. In the Minkowska Center, however, apprentices had a purely observational role and thus remained relatively absent unless they shared a language with patients and could serve as interpreters. By focusing on the experiences of apprentices in these settings, I am particularly interested in process of professionalization in which apprentices were engaged, and the kinds of knowledge, values, and professional identities that supervisors wanted apprentices to retain from their apprenticeships. In the present context, I illustrate that while diversity in apprentices' identities and linguistic capabilities granted them access to these communities of practice (Lave & Wenger, 2009), these apprentices often found that their supervisors rendered them either insufficiently visible or instrumentally visible. I argue that by casting apprentices into particular roles, supervisors gained legitimacy for these communities of practice. However, apprentices were unable to determine the scripts for the roles in which they were casted and felt that they were used instrumentally since they could not represent themselves. By critiquing their supervisors, apprentices proposed more inclusive, intersectional, and cosmopolitan ways of conceptualizing cultural diversity and its therapeutic importance. This was especially significant as it reflected more current and progressive ways of thinking about being French and being in France.

Some—notably the supervisors in these settings—may find this to be a harsh critique; however, I draw on the wise words of Becker et al. (2003: 15), "this is how things look and feel down under…for the students," to emphasize that I am attempting to provide a coherent space for apprentices' concerns. After all, most of my reflection and analysis in this project depart from the vantage point of the apprentices in these settings.

I have found the work of Erving Goffman (1959) and Cristiana Giordano (2014) to be analytically effective in reflecting upon the casting and performance of apprentices in immigrant mental health settings. Goffman (1959: 22-24) describes how in a given situation in which actors are to inhabit an established role, the actor may find that a particular "front" has been established for the role; a front refers to the expressive equipment that an actor intentionally or unintentionally uses during his performance. Giordano (2014: 22) describes the theatricality of health and social service institutions that receive people in different situations of migration, as these settings enable different roles and subjectivities. The stages created within these settings enable patients to work through traumatic experiences (ibid., p. 39) and where ethnopsychiatric practitioners can enact different forms of listening (ibid., p. 231). Drawing on the perspectives of Goffman and Giordano, I suggest that supervisors cast apprentices into roles that suit the needs of the therapeutic settings, but these are roles that apprentices do not necessarily desire to play. By pushing back against their supervisors, apprentices propose alternative scripts for the significance of cultural diversity in therapy.

In the remainder of this chapter, I briefly introduce some background material to consider identity and language mobilization in clinical work. Next, I introduce how in the Minkowska Center, apprentices felt they had insufficient opportunities for patient contact or clinical work. I

then return to the *psychiatrie transculturelle* groups to discuss how apprentices' identities and forms of belonging were magnified and mobilized within these groups.

Tensions between community and national identities in France

As described in more detail in chapter 1, research on citizenship, belonging, and identity in France has focused on the challenges that arise when practices and expressions of identities, particularly those concerning religion, ethnicity, and language, are considered disruptive or incompatible with French identity (Bowen, 2007: 156; Diouf, 2012: 34; Tilly, 1995: 232; Kastoryano, 2002: 8; Kastoryano 2007: 422). Within this context, hyphenated identities are often considered impossible, particularly since public claims to a dual identity are thought to inevitably weaken the sense of being French (Foner & Simon, 2015: 16; Scott, 2007: 11; Simon, 2012: 3).

Public hospitals are considered culturally neutral among those who work within these establishments since their primary role is to care for patients and cure illnesses (Bertossi & Prud'homme 2011: 2-3). However, as Sargent and Erikson (2013: 50) suggested, hospitals establish and reproduce identities about migrant communities through routine interactions that signaled inclusion or exclusion within the broader society. In spite of an apparent adherence to universal principles in the provision of care to all patients, however, the personnel within hospital settings often invoke culturalist explanations and ethnic stereotypes for behavior considered deviant in routine medical procedures among migrant patients (Cognet, 2001: 101; Kotobi, 2000: 62; Nacu, 2011: 115; Sargent & Larchanché, 2009: 4). State institutions, such as hospitals, are not simply "receptacles of ideas or passive sponges of national identity" (Bowen et al. 2013: 13). Rather, these institutions and their staff are actively involved in the shaping of ideas concerning identity, assimilation, and exclusion. In sum, these perspectives illustrate that

while clinical settings are supposedly culture blind, the health workers within these settings produce various kinds of discourses that overemphasize the presumed cultural difference of immigrant patients.

Mobilizing clinicians' identities and histories in mental health services in France

Psychiatrie transculturelle groups and other culturally sensitive mental health settings in France offer a unique window to consider the ways in which notions of identity, belonging, and culture are conceptualized and debated. As described in more detail in the previous chapter, research on *psychiatrie transculturelle* groups in France has emphasized the importance of the cultural hybridity of clinicians and apprentices and the ways that therapists' hybridity could permit patients to open up in therapy sessions (Corin, 1997: 350; Delanoë & Hamlat, 2012: 203; Freeman, 1997: 315-316; Larchanché, 2010: 169; Moro & Baubet, 2013: 148; Streit, 1997: 332-334; Sturm, 2006: 38; Sturm, Heidenreich, & Moro, 2008: 37; Sturm, Nadig, & Moro, 2010; Sturm, Nadig, & Moro, 2011: 211).

A few rich accounts exist on the migration experiences of clinicians in culturally sensitive mental health settings. One can find individual autobiographical (Moro et al., 2004) and biographical (Larchanché, 2010) accounts of senior clinicians in these settings. Psychologist Gesine Sturm and colleagues (Sturm, Nadig, & Moro, 2010) described how therapists within *psychiatrie transculturelle* groups often spoke about their own belonging, whether real or imaginary, to build a therapeutic alliance with a patient. Sturm, reflecting on her own experience in the *psychiatrie transculturelle* group, described how one principal therapist joked about her German accent when introducing her to a patient in a manner that illustrated that she too had imperfect French (Sturm, 2005: 67-68). Sociologist Lila Belkacem (2015: 58) described being

introduced as "not completely French" and "also Algerian" in consultation sessions, which gave her a privileged position in comparison with other interns, who were seen as "French," and not possessing the same cultural competence. Anthropologist Stéphanie Larchanché (2010: 126-127) has described how the presence of culturally diverse clinicians within *psychiatrie transculturelle* settings serves to celebrate cultural hybridity and reframe cultural difference as non-threatening, all the while attempting to reduce the anxieties of patients. Since the therapists in the group have diverse origins and migration histories, their comments and propositions "evoke a multiplicity of theoretical universes," and therefore permit the patient to avoid being tied to one particular discourse (Corin, 1997: 350). Indeed, as initially posited by Tobie Nathan (1994: 131), the culturally diverse setting "helps the patient to understand or to 'experience' that he does not talk like a universal human being but [for example] like a Soninké of Mali, from the village of Kharta, in the region of Khayes," (as cited in Streit, 1997: 334). Moreover, clinicians' own experience of migration was considered favorable since this provides them the authority to understand the specificities of immigrant suffering (Larchanché, 2010: 146; Fassin & Rechtman, 2005: 360-361). According to sociologist Lila Belkacem (2015: 62), the environment established within ethnoclinical family mediation groups (which resemble *psychiatrie transculturelle* groups, particularly in terms of the multicultural composition of the therapeutic team), represents a space where the speech of immigrant patients are heard, not just linguistically, and where their representations and needs are not dismissed, as is often the case in many institutional settings.

My research compliments these perspectives on the experiences of clinicians in France by exploring the processes through which apprentices were encouraged and learned to elicit their own migration histories and linguistic abilities within these therapeutic settings. Rather than assume that apprentices simply join these therapy groups ready to mobilize these histories and

abilities, I consider how they develop particular dispositions and learn to find their places in the groups. Lave and Wenger (2009: 53) described the interwoven processes of constructing identities and learning. They conceptualized identities as “long-term, living relations between persons and their place and participation in communities of practice” (ibid). Moreover, membership in this kind of community involved engagement with other members and therefore, the recognition of others as members of the same community (Wenger, 1998: 149). Therefore, feeling connected to these communities of practice was essential to being able to inhabit one’s role within these communities.

In the present context, the notion of presence subsumes visibility, responsibility, and legitimacy and it refers to the ways that apprentices come to identify with the therapeutic communities of practice in which they undertake their apprenticeship. However, I do not consider presence to be synonymous with identity. After all, as Rogers Brubaker and Fred Cooper (2000: 34) have cautioned, while the concept of “identity” has been used to do a great deal of analytic work, it is “riddled with ambiguity, riven with contradictory meanings, and encumbered by reifying connotations.” These authors called less ambiguous alternatives, such as identification, self-understanding, commonality, and connectedness, which allow for more precise parsing of the work that the concept of identity potentially does. By presence, I intend to focus on the process by which individuals learn to become part of a community, which includes becoming familiar with the norms or rules of that that community and considering themselves and others as part of that community. Presence is therefore a more suitable concept than identity as it refers the ways that apprentices consider their multiple and overlapping forms of belonging, as well as how they become integrated alongside their peers and supervisors in the settings where they conduct their apprenticeships. Importantly, presence also captures the tension between the

ways that apprentices wished to represent themselves and the ways that their supervisors represented them in these settings. As demonstrated throughout this chapter, apprentices were often introduced and given roles that they did not find fitting. I argue that apprentices' activities of presence—or the ways in which they learned to become visible and were made visible—was an essential entrée into their apprenticeship in immigrant mental health settings, yet it was also a space where apprentices advanced more inclusive and multiple forms of belonging than those preferred by their supervisors.

"We closed the travel agency" An institutional story

At the Minkowska Center, any apprentice would have surely heard the expression, "*On a fermé l'agence de voyage* [we closed the travel agency]," from one of the senior staff members. This story described the previous arrangement of the center's clinical teams, wherein patients would be matched with a clinical team. In the earlier days, the center operated with teams specialized in geographic areas or languages, such as team for Spanish and Latin American patients, a team for Sub Saharan African patients, and a team for Portuguese and lusophone patients[10]. Each team consisted of a psychiatrist, psychologist, and social worker, and each team member had familiarity or experience with that area, either having lived there or having spoken a language of the area. As others have described, the medical innovation of this center resided in the use of a patient's first language during consultations with clinicians who were also immigrants from the same countries (Fassin & Rechtman, 2005: 357). Generally speaking, practices of "ethnocultural matching" in therapy may be advantageous in instances when patients or clients only speak foreign languages; but these practices may also be extremely problematic

[10] For a brief description of the different teams, please see Hemon (2002) p. 184 or Larchanché (2010) p. 174.

when individuals are signaled out in ways that reflect prejudice (Kirmayer, 2012: 151-154). Moreover, meta-analytic research has demonstrated that the effectiveness of therapy is largely independent of ethnic or racial matching of clients and patients (Cabral & Smith, 2011: 547). In the earlier days at the Minkowska Center, this arrangement was potentially confusing when deciding whether to send a patient from a lusophone African country, such as Angola or Mozambique, to consult with the team specialized in lusophone or Sub-Saharan African countries. Moreover, the center's senior staff members often described how these teams were also problematic from the standpoint of health authorities, who considered this arrangement as providing differential treatment for different patients. Larchanché (2010: 174-175) has described how despite the intentions of the administrative directors to ensure that the center was in compliance with the public health authorities, certain members of the reception staff continued to match patients with therapists from the same geographic or linguistic or cultural backgrounds. Even at the time of my fieldwork, some clinicians in the center, such as one psychologist originally from Côte d'Ivoire, suggested that the closing of the travel agency seemed to take place more in theory than in practice:

> "On the face of it, one has the impression that it's changed, but in reality, it hasn't changed much. Because, you know Dr. Diouf [a psychiatrist originally from Senegal]? All the Africans [patients], it's Dr. Diouf and me who receive them. And Mr. Garnier because he speaks English, he has a lot of patients from Africa who are Anglophone. And the rest, now it's Drs. Kateb and Lellouche [two psychiatrists of Algerian origin], who have a lot of patients from the Maghreb. So finally, ostensibly, they say it's transversal but in practice, not a whole lot has changed."

The psychologist's comments described that while the travel agency may have appeared closed to the public, the practice of matching patients with clinicians based on their presumed linguistic and cultural proximity remained in place.

In spite of this contradiction, the supervising therapists continued to emphasize to apprentices that any professional could see any patient. I assert that this institutional story, which describes a particular moment in the institution's past, therefore served an important pedagogical purpose. I use the expression "story" not to suggest that it is fictitious, but rather that there may be differing or conflicting versions of it, as evidenced by the psychologist's comments. Moreover, the telling and retelling of the story provided apprentices with a memorable and repeatable instance of institutional history that simultaneously told of a distant and problematic past, as well as reinforced the notion that the cultural or national identity of the clinician was not pertinent to their clinical work.

"We were therapists in training, but we did not do a whole lot of therapy"

Apprentices in this center were referred to as therapists in training (*thérapeutes en formation*, and referred to by supervisors as "TEF") if they were students or research associates (*chercheurs associés*) if they already possessed a professional qualification, rather than *interns* (*stagiaires*). Often, professionals who had trained abroad and whose professional qualifications were not or had not yet been recognized in France could volunteer at this center as a research associate. Despite the name, research associates typically did not conduct any research:

> Psychiatrist: "I had the status of research associate even though I was not researching anything"
> DA: "But did you receive patients at that time?
> Psychiatrist: "No, not at all. Legally, I could not."

One of the supervisors in the center explained that the motivation for the title of therapist in training, which was to create a more active role for apprentices:

> "The word 'intern' in France has a very passive connotation, they are there to watch, to observe, and it's almost as if they are a bother. At most, they're given banal tasks like making photocopies, but nobody looks after them, they're taken on for internships but nobody looks

> after them like people. A therapist in training is someone who is engaged in a relation of communication in an institution, has the capacity to speak with therapists, to learn one's job, and eventually participate in the care of patients."

These comments struck me as important because they emphasized the agency of apprentices and to the centrality of apprentices in the clinical work of the center. Placing this psychiatrist's statement in the context of the framework of apprenticeship, these therapists in training were legitimate peripheral participants within this particular community of practice. Indeed, these comments seem to closely resemble Lave and Wenger's (2009: 95) distinction between observation and participation, the latter of which involves absorbing and being absorbed into the culture of practice. However, perhaps a key word in the psychiatrist's statement above was "eventually," since apprentices universally commented on their lack of clinical exposure during their apprenticeship in this center. Apprentices were able to observe patient evaluations, albeit on an irregular basis. In fact, apprentices often needed to sign up on a dry erase board upon their arrival in order to guarantee a spot in which to observe an evaluation. Often, only two to four apprentices could participate in an evaluation, despite the fact that there may be far more apprentices present in the center on any given day of the week. Decisions regarding how many apprentices could attend were made by the supervising clinicians depending on the severity of the situation experienced by the patient. As a result, apprentices often expressed dismay with not having enough clinical experience and individual supervision with a senior clinician:

> "There was not enough clinical experience and I would have liked to have had a professional who took the time to ask me questions. I left with so many questions, it's a bit frustrating."

In fact, one former apprentice critically reflected upon the attention given to the title of *therapist in training,* since the same attention did not seem to be given to the level of responsibility it conferred:

> "I had the impression that 'therapist in training' gave us importance on paper. Officially, we are therapists in training. It's lovely. We are reassured with that title. But, actually, we did not do a whole lot of things from a therapeutic point of view. We were therapists in training, but we did not do a whole lot of therapy. It's not that it was anti-therapeutic, but we did not participate in therapy."

The ability to observe evaluations with patients required the permission of the supervising clinician and the consent of the patient. Yet, as one of the supervising psychologists described, clinicians often did not give permission to apprentices to observe on a long-term basis:

> "The institution cannot impose supervision…and it cannot impose that the therapists accept to take TEFs [therapists in training] into their consultation. So, all psychologists and psychiatrists are free to choose to have a TEF or not in their consultation. Very often, practitioners are not comfortable with that. They don't mind doing it for a first appointment, or an evaluation, but having a TEF in consultations over time can make a lot of practitioners feel uncomfortable because they believe it's not a classical way of doing things."

As this psychologist suggested, not all therapists wanted apprentices present in their consultations, which resulted in some therapists having a reputation of being more open and friendly to apprentices, while others remained more mysterious. This psychologist also explained that many apprentices felt deceived to not have clinical contact during their internships. After all, they came to this center with the intention of seeing patients because they were studying to become clinicians.

As a result, apprentices spent most of their time in this center seated around a large table in a conference room at the back of the center and out of the view of patients, waiting for an opportunity to observe clinical work and participate in the life of the center. Perhaps as a result of this cloistering, the time spent in the conference room was an important moment of exchange for apprentices. Within this space, apprentices discussed prior internships and future career objectives, they gossiped about faculty at their respective universities, they reflected on the occasional clinical situations that they had observed in the center, and they helped each other prepare for the mediation meetings held at the end of the afternoon on select days of the week. In

this sense, the apprentices developed and participated in "an almost separate subworld within the organization comprised solely of recruits," (Van Maanen & Schein, 1979: 233). While out of the view of patients and supervisors, these informal exchanges were important moments during which apprentices could check in with each other and compare experiences of their apprenticeships in an absence of more formal supervision.

One of the principal roles for apprentices was to sort through and present referrals to their supervisors during the *Médiacor* meetings. Apprentices were tasked with organizing information in incoming referrals and identifying missing information. Apprentices performed these tasks so that the staff members could dedicate their time and energy to other activities. Apprentices' participation in intake meetings was also one of the principal moments in which apprentices were present in the ongoing activities of the center. During these intake meetings, a group of five to fifteen apprentice therapists and supervising clinicians convened to discuss the referrals of patients that the center received. These meetings served a triaging function in order to place a patient in the care of a therapist as soon as possible. They were also the principal site of encounter between apprentices and supervising clinicians.

Occasionally, particularly when referrals to the center were unclear, the supervising clinicians invited referring professionals and/or patients to come to the meetings. Upon arriving in the referral meetings, these individuals encountered the large group of clinicians and apprentices. The head psychiatrist introduced the group as having diverse origins, linguistic abilities, and training backgrounds. At times, the psychiatrist went around the group and asked everyone to say where she or he was from or asked what languages each person spoke. The purpose of this introduction was to highlight the multicultural composition of the group. Those who did not speak a language other than French were left with the expression, "I *just* speak

French." The external professionals and patients present in the meeting appeared impressed by the diverse origins of the group. However, despite the presentation of the group, it was typically only one of the psychiatrist supervisors who interacted with professionals or patients while the others looked on. The visibility of the group—both in terms of the number of individuals present and their diversity—provided the supervising psychiatrist, and the center, legitimacy during these encounters with representatives from external institutions. However, the group, and the apprentices in particular, were neither responsible nor implicated within these encounters since they only had an observational role.

Ad hoc interpreters

While apprentices often felt excluded from contact with patients, those with linguistic capacities in addition to French were often asked to serve as interpreters in initial evaluations with patients:

> "I was also involved in interpreting, with English and Turkish, for when patients come for the first time, they have to interview them. And ask them basically what is their complaint, what is their issue, why they were sent there why they need to see someone. And, sometimes, I mean, about half of the time, these people don't speak French or don't speak it at a sufficiently high level so they need someone to interpret, either with a psychiatrist or with a psychologist."

Apprentices generally had no formal training in interpretation or translation. In fact, over the course of my fieldwork, I had been asked to serve as an interpreter between French and English with patients from Nigeria and Tibet. While I was happy to help out and certainly wanted to make myself useful, I personally felt unqualified to do this work. More specifically, while I felt fluent or nearly fluent in French, I was concerned that I would not be able to properly describe symptoms or deploy complex psychiatric or psychoanalytic vocabulary.

My field sites differed in terms of the resources they had at their disposal and in terms of their position regarding the use of apprentices as interpreters. In one *psychiatrie transculturelle* group, the psychiatrist informed me that they had a budget allocation for ten appointments with an interpreter pear year. Therefore, the use of apprentices was crucial. A psychologist in another *psychiatrie transculturelle* group said that they had the resources and that they would not consider asking an apprentice to interpret since they interpretation was seen as another role and skill set that apprentices did not necessarily possess.

It may be understandable that in the context of strained resources and increasing arrivals of people in Europe, settings such this one may need to use apprentices as interpreters. However, the use of ad hoc interpreters raises questions regarding the quality of care that patients receive and the integrity of the profession of trained interpreters. Additionally, apprentices acting as ad hoc interpreters were more involved in the clinical activities of these settings and had greater responsibility for the smooth flow of therapy sessions. These apprentices were potentially at an advantage over their peers within these settings when they could serve as multilingual liaisons between patients and therapists. Yet as the next section shows, there were also disadvantages to being a liaison.

Giving too much of oneself: The risk of "cultural complicity"

In the context of interpretation in clinical encounters, the supervising clinicians Minkowska Center often warned apprentices about the notion of *la complicité culturelle,* or cultural complicity, where a patient may become dependent on them. Others have described how professional interpreters must be able to distance themselves from their own cultural representations in order to avoid cultural complicity, particularly when the professional and

patient are from the same country of origin (Bourdin & Larchanché, 2015: 49). One of the apprentice informants, a psychologist who grew up and studied in Portugal, described an experience of cultural complicity:

> "It's true that I did not know what cultural complicity was until I started at the center. There were two patients from Portugal, a mother and daughter, and I was present in their evaluation with Dr. Lellouche and the team. Then the team decided that Marie [an administrator who is a social worker by training] and I would see the mother and daughter. One week later, the mother came back because her daughter needed a prescription and they hadn't asked the day of their evaluation. She didn't speak very good French and none of the reception staff understood her, so she waited for me at the door because she knew that I was Portuguese. She didn't even try, she didn't have autonomy, it's dependence on another person, and when we have that cultural complicity, that generates dependence and that's not good. I think it's good that they, as they say, 'closed the travel agency' because she wanted for me to ask me to ask one of the doctors to write a prescription. You see that creates complicity because I'm Portuguese and I don't find that healthy. I'd rather be an accessory to the Sudanese man who invited me to have coffee with him to celebrate the fact that he obtained his papers."

The psychologist explained how cultural complicity could arise when a patient and clinician share a similar country of origin and may result in dependence and a lack of autonomy. By being complicit, a therapist is too present or too involved. While supervising clinicians cautioned against complicity, they did not provide sufficient opportunities for apprentices to observe instances of optimal or appropriate amounts of distance between therapists and patients. Moreover, one might also interpret the scenario described by the psychologist above as an instance where the patient was using any means possible to access essential resources.

Casting and scripting: Performing diversity in psychiatrie transculturelle groups

Let's return to the *psychiatrie transculturelle* therapy groups, such as the one described in the opening extract. At the start of the academic year, a new cohort of apprentice co-therapists, made up of graduate students in clinical psychology and psychiatry, began their apprenticeship in the *psychiatrie transculturelle* therapy group. Principal therapists selected five to ten apprentices

from a larger pool of applicants. The variation in the number of apprentices had to do with the capacities of each *psychiatrie transculturelle* therapy, since some groups already had a larger number of permanent co-therapists, including some who had been in the group for several years. I was curious to learn how supervising therapists selected apprentices. Supervisors selected apprentices based on their histories of migration:

> "I select, I try to have a lot of migrant students but I also have a few spots for students who are not migrants. So since we, the principal therapists, are not migrants, we try to have migrants among our students in order to have a transcultural group, and it's mostly with the students that we are able to do that"

Other supervising clinicians, such as Pierre-Olivier, the psychiatrist introduced in the opening anecdote, described how the presence of different skin colors was important for the group:

> "I think that different skin colors are important, meaning that if everyone is white, especially here in France, where there is a history, I think there needs to be different skin colors in order to permit multiple ways of identifying. I say that, and I know how that can make people react, but I think it's an important point…there need to be different phenotypes because if everyone looks like me, it will not work."

Clinical psychologist Nathalie Zajde (2011: 189) has reflected that if a group is comprised of "a dozen 'white' or 'Parisian' psychologists, they will probably give an identical interpretation and approach about the clinical case…what compels a plurality of thinking and diversity of practices is the fact that this particular setting brings together psychologists who are the bearers of theories and practices from distinct cultural universes." While both Zadje and Pierre-Olivier suggested the need for different phenotypes among the group of therapists, Zadje indicated that the presence of therapists of different origins would imply that they have different perspectives, whereas Pierre-Olivier stated that the visible representation of therapists was meant to communicate to patients that therapists also had varied cultural and linguistic origins. Moreover, Pierre-Olivier emphasized that this representation was particularly crucial given France's colonial past and that many patients came from former French colonies.

Additionally, supervisors emphasized the importance of age and maturity of apprentice co-therapists, which contributed to strength of their beliefs:

> "We have a group of people who are of a certain age, who are not that young. Everyone worked before starting his or her studies. They started their lives differently. They have very strong and diverse beliefs, and they have origins that mean a lot to them and that are very diverse[11]"

Generally, each apprentice participated in the group for a year, though some could request to stay longer. Each academic year, a new cohort of apprentices replaced the previous one, bringing new perspectives:

> "I've been in the group for a year and a half and I think it's interesting how each time it's very diverse and we have rich perspectives. The renewal of interns isn't problematic, I think it adds richness since each time we construct and restart with different people. That's what keeps the consultation alive, that it gets renewed all the time with different perspectives and I find that to be a good thing. Maybe for the patients it's complicated because we revisit their histories and we return to what had been said before."

Each new cohort provided legitimacy to these groups through their linguistic abilities, cultural identities, and migration histories, and they also offered a sense of newness to the group. Yet this apprentice also suggested that the renewal of co-therapists might result in material being revisited, which patients may perceive to delay their progress in therapy. I address this issue in more depth in the next chapter.

As prior research has suggested, *psychiatrie transculturelle* groups represent a space where the hybridity of the group members can be considered a therapeutic strategy. Additionally, as my respondents described, the apprentice co-therapists were those who added diversity, and thus legitimacy, to the groups. In fact, one of the psychologists joked that in another *psychiatrie*

[11] The word, *divers(e)*, in the French tends to mean "various," "different," "diverse," or "several," and does not necessarily carry the same connotations as it may in Anglophone or U.S. contexts. However, Meziani-Remichi and Maussen (2017: 1682) have noted that concepts of diversity and diversity management are becoming more prominent in France, particularly in the private sector. In this quotation, as well as the one immediately below it, both interlocutors used the word, *divers* in the French.

transculturelle therapy group, the principal therapist only accepted apprentices if they were of African origin and spoke at least three languages. While this comment was made in jest, it did seem to reflect a broader sentiment that only multilingual first- and second-generation immigrant co-therapists could contribute to the framework of the *psychiatrie transculturelle* therapy groups. I argue that apprentices experienced this sentiment as though their supervisors were using them to represent diversity and otherness. In fact, one apprentice co-therapist commented that she felt she was only selected based only on her origins:

> "I was chosen because of my origins but not because of who I am…we were all chosen because we have diverse origins. A person who is white and French, who has 'French' origins, or distant origins that he or she doesn't know, that person would have a harder time being chosen for the consultation. Because they want to have multiple origins, etc…It's frustrating to be accepted into the consultation because of my origins but not because I might have something interesting to say. For someone who is Armenian or Syrian, they'd say 'Oh that's great. Have you lived there? You can tell us something about your culture.'"

Prior to starting their apprenticeship in *psychiatrie transculturelle* groups, apprentices would apply by submitting a letter of interest detailing their experiences and a curriculum vita. Applications, in which individuals describe their prior experience and objectives, may be an obvious feature of many apprenticeship contexts. But they also represent sites at which potential apprentices perform their goodness of fit for the groups. Indeed, the form and content of students' applications suggest that the process of socialization and the enculturation into the hidden curriculum begin before they undertake their training (Hafferty & Franks, 1994: 865). As the apprentice quoted above suggested, any contribution she could make to the group was framed in terms of a singular element of her identity. Other elements, which may be equally important to apprentices, may be potentially overlooked. In fact, during therapy sessions, when a co-therapist spoke, it was not uncommon to hear a principal therapist ask, "Is that what they say in [name of country]?" This kind of follow-up question had the effect of reducing one's statements to being

tied to a certain country. Yet it also resulted in co-therapists feeling that they needed to produce a particular kind of statement that reflected their presumed origins. This was perhaps one of the more obvious forms of scripts that apprentices were expected to follow.

Drawing on Goffman's (1959) analysis of performance, I contend that supervisors assigned apprentices *fronts* in the form of introductions of being from a particular country or culture of origin. In *psychiatrie transculturelle* therapy groups, apprentices were casted into roles of culturally diverse co-therapists and they used these fronts in their performance. Importantly, while these introductions were brief and took place at the outset of therapy sessions, they had a longer lasting effect of casting apprentices into particular roles in the groups.

Drawing on Giordano (2014), *psychiatrie transculturelle* therapy groups could be considered a stage where patients and clinicians make sense of past traumatic events and current mental health problems. However, the group nature of these settings suggests that the listening that clinicians perform is diffracted across the therapists and the pedagogical nature of these settings suggests that are learning to develop listening techniques. Considering the contributions of Goffman and Girodano in the present context, apprentices learned to inhabit roles and perform the tasks associated with these roles within the therapeutic and theatrical spaces of these settings. While apprentices were learning to become culturally sensitive listeners to the stories of patients, they were also learning to perform the tasks that their supervisors and the institutions had created for them.

In a rich ethnographic account of an ethnoclinical family consultation, Lila Belkacem (2015: 54) brilliantly weaves together the work of Goffman, Judith Butler, and J.L. Austin to demonstrate how these consultations represent a space where the diverse "origins" of patients and therapists are dramatized and that the performativity of these consultations depends on

several felicitous speech acts. Importantly, Belkacem identifies important power dynamics and asymmetries since the students were often categorized by ethnoclinicians as French and lacking migration experience or cultural competence (ibid., p. 55-60; see also Belkacem, 2013: 72). I find Belkacem's analysis of this asymmetry to be crucial in understanding the position of students or apprentices in these settings.

My research departs from Belkacem's in a few principal ways. First, I was interested primarily in apprentices' perceptions of the ways in which their identities and origins were dramatized in these settings. Additionally, I was concerned with the ways in which apprentices' performances were evaluated shaped by their supervisors and peers. Second, my fieldsites presented a different scenario than what Belkacem observed; apprentices were most often the ones who added diversity to the therapy groups and were at times selected based on their origins, languages, or their migration experiences. As a result, these apprentices were positioned simultaneously as those who were learning to become culturally sensitive therapists, yet they were also the ones who were assumed to possess the necessary ways of knowing conferred through their diverse identities and origins. Finally, the apprentices in my fieldsites challenged or at least question their supervisors' and peers' use of identities and origins within these therapy groups. In so doing, they advanced more inclusive and cosmopolitan conceptions of being and belonging in France.

Contesting Frenchness

Some of my informants stated that the emphasis on diversity of group members led to notions of Frenchness being called into question. Indeed, in the opening anecdote of this chapter, Claire and Pierre-Olivier described how being introduced as "from here" made them question

their place in the group. Others, such as Maria, reflected on how participating in a *psychiatrie transculturelle* group was particularly challenging for "French" co-therapists:

> "I also think it's difficult for the French [co-therapists]. French students who are unable to say, 'how can I find difference within myself to show something?' I think it's really difficult for French students."

In her chapter in a manual for the practice of *psychiatrie transculturelle*, psychiatrist Claire Mestre (2006: 190) has described how cultural difference represents a source of creativity in therapy. Yet Maria's statement above suggested that French co-therapists may find it challenging to identify their own experiences of difference and may therefore find it difficult to develop creative therapeutic strategies. One could argue that the "French" co-therapists who felt left out these therapeutic spaces failed to recognize their privilege of being "from here," since they may never have encountered the everyday forms of discrimination or humiliation that many minorities or people in different situations of migration face. One could also argue that diversity and otherness were perhaps being conflated in statements like these, resulting in the notion that what's diverse is taken to represent anything that is not French. Moreover, the distinction between diversity and Frenchness suggest that closed, rather than hybrid definitions of culture were being deployed within these spaces.

I frequently encountered variations of closed definitions of culture over the course of my fieldwork, often manifested in concerns about whether French co-therapists could contribute to *psychiatrie transculturelle* groups. In fact, when visiting a new *psychiatrie transculturelle* group in an outpatient mental health center (*centre médico psychologique*, CMP) in Normandy[12], a concern raised by the psychiatrist on a few occasions was what she referred to as the "monoculturalism" of the group. In other words, this psychiatrist was concerned that everyone in

[12] I describe this new consultation in more depth in Chapter 6.

the group was white and French, with the exception of two interns who were of Turkish origin. It became clear that forms of difference along the lines of culture or nation took precedent over others, such as religion, sexuality, class, or gender, and, as illustrated below, apprentice therapists found this to be problematic and instead proposed more inclusive and intersectional forms of difference and belonging.

In an article describing an ethnopsychiatry consultation, Nathalie Zajde (2011: 189) has highlighted the importance of the experiences and characteristics of the therapists:

> "What is most important here is that psychologists and psychiatrists come from different cultural backgrounds, that they have specific cultural experiences, that they are deeply linked to different systems of reference, that they themselves observe specific religious practices, that they were brought up, and sometimes initiated and even ritually marked in culturally heterogeneous universes."

This statement reinforces the emphasis on therapists' origins and identities, though it also suggests an openness to those who have gained "cultural experiences" or were "ritually marked" in different universes. The statement also raises questions about what might count as a cultural experience sufficient to permit an individual to inhabit or otherwise understand different universes or systems of reference.

It is important to note that not everyone held this particular view regarding the diversity of therapists. While some therapists raised concerns about how a lack of apparent cultural diversity prevented clinicians from conducting *psychiatrie transculturelle* therapy, other clinicians frequently insisted how anyone, regardless of their background, could do this kind of work. Moreover, Moro (2002: 164; see also Moro & Baubet, 2013: 148) has stated that being an immigrant oneself is neither necessary nor sufficient in order to conduct ethnopsychoanalysis; rather, individuals must have experience of *décentrage*, or decentering, and becoming familiar with other cultural systems. Additionally, more recent scholarship has emphasized the

importance of hyperdiversity and intersectionality in intercultural therapy in France (Sturm, Guerraoui, Bonnet, Gouzvinski, and Raynaud, 2017: 458; Sturm, Bonnet, Coussot, Journot, and Raynaud, 2017: 631). Of course, not everyone employed a closed definition of culture that distinguished diversity from Frenchness. As Pierre-Olivier stated, “French culture is already made of multiple cultures that mix and enrich each other reciprocally and are evolving.” Additionally, another psychologist emphasized how individuals use culture differently:

> “Devereux[13] tells us that everyone uses his or her culture in terms of who one is, it’s what he referred to as idiosyncratic. In other words, I’m Ivoirien and Boulé but not all Boulés use the Boulé culture the way I do, there’s a difference.”

These statements harken to Marie Rose Moro’s discussion of culture as a dynamic process that takes place through interaction (1998: 12-15). My interest in this chapter is not to critique how therapists in these settings defined or conceptualized culture. Rather, what interests me is how *psychiatrie transculturelle* consultations are stages where notions of diversity, origins, and culture, as well as what it means to be French, can be contested, and how contesting these notions serves a pedagogical function for apprentice therapists. My research on the experiences of apprentices in these settings foregrounds the rifts that developed between apprentices and supervisors concerning these notions. As the next sections illustrate, newer generations of apprentices, who saw themselves simultaneously as immigrants and as part of the fabric of multicultural France, appeared to challenge their supervisors by advancing more intersectional perspectives on identity.

[13] The psychologist makes reference to Georges Devereux’s (1980 [1956]) distinction between the ethnic and the idiosyncratic unconscious, outlined in his essay, “Normal and Abnormal”

"It's like directing an orchestra"

The construction of a diverse *psychiatrie transculturelle* groups not only involved the visible presence of co-therapists, but also the individual dispositions of each co-therapist. More specifically, my principal therapist informants described how co-therapists were more than just warm bodies in a room; rather, they were actively involved in contributing to the content discussed in therapy group sessions. However, in interviews, several apprentices described feeling that they were often not called upon to the extent that they wished within *psychiatrie transculturelle* groups. Those in the position of principal therapist often encouraged co-therapists to attempt to get their attention if they wanted to speak during therapy sessions. One might try to get the attention of the principal therapist by attempting to make eye contact or even raising one's hand, though some found it difficult to get the attention of the principal therapist:

> "The principal therapist doesn't always give us the floor. It depended on the therapist, and you could tell the difference. But we also didn't feel like we could jump in, we felt a bit restrained in speaking up. They told us that we should get their attention, but it's not easy in a group to get their attention so they can let you speak"

Comments such as these suggest that apprentices needed to make their presence known in order to have the possibility of being called upon in the group. Conversely, co-therapists who did not have something to say or did not wish to be called upon might avoid making eye contact with principal therapists in order to avoid being called upon. On one occasion, the principal therapist, sensing the avoidance of the downward-looking co-therapists, stated, "Your shoes are nice, but I'd like to know what you think."

At times, it seemed that principal therapists called on their co-therapists at random. Yet informants also described how principal therapists expected certain co-therapists in the group to be visible and play particular roles. Anna, the psychologist introduced in this dissertation's

introduction, described the complexities of leading a *psychiatrie transculturelle* group, comparing it to leading an orchestra:

> "When you're the principal therapist, you need to see how it evolves, what is happening with the patient, how they feel, where the flow of the conversation is going, how the group echoes what's going on, how and to whom to call upon because you know the group by heart. It's about how you take what that person says and do something with it, it's like an orchestra."

Maria, introduced in the opening anecdote, also made reference to the role of the principal therapist as being analogous to conducting an orchestra, and reiterated the how the principal therapist calls on certain individuals in certain instances:

> "When Anna is the principal therapist, when she calls upon you, she knows what she wants to hear from you. She chooses the right person at the right time...She knows, more or less, what she wants from each person, but it's really tiring, and it's like directing an orchestra."

Just like a conductor relies on certain musicians or sections at certain points in a symphony, principal therapists relied on certain dispositions of co-therapists at specific points in the therapy sessions. For example, the psychiatrist, Pierre-Olivier, described the importance of having an apprentice from Angola present in the group when one of the other supervisors, originally from Côte d'Ivoire, was absent:

> "During consultations when Kouame was not there, I relied on, I cannot think of a specific situation, on Nélio to help me because, voilà, that's part of how we welcome other cultures, all the physical differences."

Pierre-Olivier's statement represents how supervisors depended upon the visible presence of apprentices to conduct their therapeutic work. In this particular case, Pierre-Olivier needed an apprentice who was black and African to fill a particular role in the therapy group, and it did not seem to matter that these individuals were from different regions of the continent. An apprentice elaborated upon what may be expected of them when called upon during consultation sessions:

> "I had a role that's at times a translator or even an interpreter[14] whenever there were Arabic- or Kabyle-speaking families and the rest of the time, I was equally a student reference about those cultures…I find that it's complicated but also interesting because we are solicited on two dimensions, meaning on the one hand, to translate what the person says but also to provide perspective that's both cultural and psychological because what's understood in one culture is not understood in the same way in another and it's a really interesting experience"

The expectations of principal therapists that co-therapists will perform their parts seems to imply that co-therapists have somewhat scripted roles within *psychiatrie transculturelle* therapy groups. Indeed, while the presence of numerous co-therapists may potentially place limits on the principal therapist's position of dominance (Corin, 1997: 355-356), the principal therapist ultimately directs their moments of intervention. As this apprentice suggested, being an informant about a cultural or linguistic group may be exciting but complicated role to inhabit. Indeed, as Ursula Streit (1997: 333) has described, while all co-therapists participate, the co-therapist from the same or similar culture as the patient plays an important role since this helps the patient to describe what would be said in her or his own cultural group. This experience may be particularly complex since these apprentices were simultaneously learning but were also expected to inhabit authoritative, informant roles. Moreover, apprentices described how they did not necessarily receive explicit instructions as to how to inhabit and manage the differing demands of these roles. The next section delves deeper into apprentices' varied experiences with the establishment and performance of these roles.

[14] While some informants appeared to make a distinction between translation and interpretation, others used these terms interchangeably. When my informants made distinctions, translation tended to refer to a word-for-word transfer of content whereas interpretation referred to providing additional contextual information in order to render the content recognizable and meaningful.

Cosmopolitan performances

As described in the opening anecdote, at the start of each *psychiatrie transculturelle* consultation session, the principal therapist introduced the group members to the patient, typically saying each member's name, function, and then country or culture of origin. Using Goffman's terms (1959), these introductions provide co-therapists with a front, or expressive equipment, with which they could perform a particular role. Many co-therapists described being introduced in ways that did not necessarily correspond to the ways that they would choose to introduce themselves. For instance, Maria, introduced in the opening anecdote, reflected on the discrepancy in the ways she was introduced, both in terms of her country of origin and her profession:

> "I'm always introduced as either Mexican or an anthropologist. But I'm actually from Panama. And I'm also a psychologist, but I'm never introduced as a psychologist. In terms of nationality, it's interesting because the group requires flexibility, sometimes I say I'm Panamanian or Argentine or Mexican, it depends, and I play with that. It's interesting for me and for the group…and I think it's interesting for the group to introduce an anthropologist because that adds diversity."

Co-therapists' origins and identities needed to be able to serve the needs of the group and the directives of the principal therapist. However, Maria's suggestion that she could "play" with the ways in which she mobilized her identities, in terms of her country of origin or her profession, implies that co-therapists were able to navigate the imposed. While Maria, and the group, found interest in the ways that she could play with her identities, one must also consider the ethical implications for patients. Claire, introduced in the opening extract, stated that patients did not necessarily buy into the introductions:

> "It's like we're taking the patients for idiots…under the pretext of being multicultural, it's like we're telling the patient something that's not necessarily true. Meanwhile, I'm pretty sure the patient, who has been in France for a while now, understands that there are a few French people in the room [laughs]"

Claire's comments demonstrate that these introductions were potentially patronizing to patients since they presume that co-therapists could manipulate identities without patients taking notice. Moreover, Claire suggests that the group sought to elicit a particular kind of speech act or narrative from patients when she stated, "I don't know why we absolutely need to specify these pseudo origins in order to make the patient adhere." While it was unclear if the patients in these groups were comforted by this presence of co-therapists with diverse origins, it was clear that the apprentices were uncomfortable, particularly when they regarded these introductions as unfitting or artificial.

In one of the *psychiatrie transculturelle* groups, the apprentice co-therapists asked the principal therapist if they could introduce themselves. The principal therapist agreed, and at the start of the next session, each individual introduced her- or himself. This arrangement permitted co-therapists to describe themselves as they saw fit and speak with their own terms, voices, and accents. József, also introduced in the opening anecdote, described how being able to introduce themselves made the apprentices feel present as equals in the group:

> "It gives you kind of more of a presence, yeah, presence, when you get to introduce yourself. It's like, 'we are a group,' you know? In any group, where you get this tiny thing, 'oh by the way, where is everybody from? We have new people, let's have everybody introduce themselves.' That's a normal way when there's a group of equals. And when there's one person who goes around and introduces everyone else, that's less of a group of equals."

József also mentioned the potential impact self-introductions had on patients in *psychiatrie transculturelle* therapy groups:

> "What I noticed with the patients when we introduced ourselves is that the patient would, 99% of the time, end up saying, '*Okay, et moi, je suis Jonathon et je suis congolais* [Okay, and I'm Jonathon and I am Congolese].' So they would end up announcing their own origins out of peer pressure, in a way. But I think that was a helpful thing, actually. That was a very obvious way how the original idea behind a multiethnic or multi-nationality group kind of accommodates this person."

Additionally, József discussed how speaking for themselves represented an experiment that forced co-therapists to think about their outward presentation:

> "It was a very interesting experiment, to say who I am. Because it forced me to think about this question. And I don't think I was the only one. There was this particular guy who is French, but one of his parents is English, so he ended up saying, '*Je suis anglais* [I am English]' I think, not even '*d'origine anglaise* [I have English roots]' or something like that. I think for everybody, when you say it out loud, in front of the group, because the group is not just the theater, us helping this person, it is a group. There's a lot of things happening for everybody who is in the group. And I think, saying that week after week, in a group, '*Je suis tel ou tel* [I am this or that]' it's a very interesting reflection on who you are. I'm thinking aloud, I've never thought about this before you asked me, it's a good thing when you introduce yourself as opposed to being introduced. Even though it's a bit awkward, it can be awkward…it's a very concise way of saying who you are…It's a very constrained way to formulate your identity."

József's statement that the group is "not just theatre" suggests that these performances have wider effects for patients and co-therapists. As Giordano (2014) might suggest, for patients, the therapy group may be a theatrical space where they can speak about prior traumatic events and, in concert with the co-therapists, enact therapeutic strategies. For apprentices, the groups are a theatrical space where they can learn to listen to patients, reason and reflect like their supervisors, and act out their future-oriented professional dispositions.

József elaborated on the distinction between being of a nationality and having origins in a particular place. Unlike the apprentice he mentioned above, many of the co-therapists preferred using language of origins and roots rather than nationality, particularly since many of them were born in France and it was their parents or grandparents who were born elsewhere or held other nationalities. In the opening anecdote, Pauline, whose mother was from Algeria, felt apprehensive about speaking for Algerians and speaking as an Algerian since it was her mother, and not Pauline, who was from Algeria. Others noticed this apprehension as well. Claire, the apprentice introduced as "from here" in the opening anecdote, reflected on the ways that apprentices' presumed forms of belonging were mobilized in the therapy groups:

> "Pauline is introduced as having Algerian origins, and maybe she knows some [Algerian] recipes, but I'm sorry, she's French...I don't know who in her family is Algerian. She doesn't speak the language, her first name is not Algerian, we're not going to go all the way back to the Middle Ages to say 'oh yeah, my ancestor was Russian' or whatever to introduce ourselves as Russian, because we're looking everywhere to be multicultural"

Claire suggested that the group was trying too hard to demonstrate its multicultural composition and it was overemphasizing its diversity.

Additionally, identifying oneself with respect to a particular nation may prove to be problematic for individuals such as József, who felt apprehensive about stating he was Hungarian due to its sociopolitical connotations:

> "I thought, should I say, Joseph? Should I use my first name in the French way? The moment I say my first name, József, in my own way, I all of a sudden, bring in Hungary, which for me is very intrusive. Because it's different, different vowels, people wouldn't get it, they wouldn't understand what I'm saying, they couldn't repeat it, they wouldn't remember…The other thing was, to say that I am from Hungary. For a while, I felt very uncomfortable about it because especially at the time, you might recall in the news, Hungary was being very nasty to refugees. So I felt very uncomfortable being linked to that."

Atossa Araxia Abrahamian (2014: 13) asks why nations have the last word in determining our identities. Identifying oneself with respect to a nation has the consequence of being associated with the sociopolitical baggage that comes with that nation. Moreover, this kind of identification forecloses more cosmopolitan forms of being. Indeed, as scholars of cosmopolitanism, such as Homi Bhabha (1996), have identified, cosmopolitanism involves the performance of dialogic relations at the interstices between circles of identity. Perhaps a key word is "interstices," since cosmopolitanism involves a combination of attitudes, practices, and abilities attained from experience, contacts, and identification (Vertovec, 2009: 5). In short, cosmopolitanism can be thought of as infinite ways of being and openness to engage with others (Jonas, 2013; Pollock et al., 2002). Taking these perspectives together, cosmopolitanism reflects multiple and accumulated forms of identification, dispositions, and practices that are manifest through

performance. As a result, identifying oneself or being identified with respect to a nation neglects the multiplicity of forms of being and belonging, and stifles the performance of these forms since singular dimensions of identity are emphasized.

By introducing apprentices in a certain way, principal therapists gave them roles that they did not necessarily feel comfortable playing. One apprentice, who was born in France, but whose father was born in the Central African Republic, expressed frustration with being asked about her father's first language and migration history:

> "They asked me, 'Do you speak the language?' It really frustrated me because I don't speak the language of my father. I felt a bit like an exotic object, to tell me that she wanted me to come, but because it was because of potential understandings I have about my father's culture but not as an intern in psychology…If you ask me about my childhood in France, it's easy, I'll tell you about going to the boulangerie with my parents and the smell of croissants and pain au chocolat. I have memories of that.…They said, 'Your father immigrated to France,' but I can talk about leaving my parents' house and moving to the capitol. It's not that far in terms of distance, but it's still another world. It's also a form of migration. There's also the migration from adolescence into adulthood. There are a lot of things like that, a lot of different things that we can know. We're all transcultural at different levels. But that was not as important."

This apprentice's comments suggest that the way that she wished to present herself took secondary importance to the way in which the group wished to present her. The statement "I feel a bit like an exotic object" echoes Rosemary Coombe's (1993: 279-280) discussion of how cultural appropriation involves the representation or visibility of individuals but in an absence of their voice. Additionally, attending to this apprentice's father's migration history potentially foreclosed discussions of other forms of belonging that may be important. These exchanges suggest that supervising clinicians emphasized one strand of apprentices' identities, rather than considering the intersectional or multilayered nature of identities (Crenshaw, 1991; Prins, 2006). Moreover, this emphasis on otherness seemed to reinforce the idea that even the children and

grandchildren of immigrants from prior decades are not immune from being permanently inscribed as being of a "migrant background," (De Genova, 2016: 80).

The apprehension or frustration experienced by apprentices in discussing their origins seemed to reflect the sentiments that many experience when being asked the question, "Where are you from?" Writing about the U.S. context, Anjali Enjeti (2017) described that while seemingly innocent, this question is grounded in the myth that whiteness conveys citizenship and permits white Americans to question the heritage and ancestry of people of color. In the French context, demographer Patrick Simon writes that this question is not in itself pejorative, nor does it imply a value judgment, but its recurrence reinforces feelings of cultural difference (2012: 13). In other words, this question foregrounds the difference of individuals, irrespective of their place of birth. Novelist Taiye Selasi, in a 2014 TED Talk, issued an invitation to jettison the question "Where are you from?" in favor of "where are you a local?" with regards to where individuals spend their time doing what matters to them, with whom, and where they may be unable to engage in such meaningful activities. Indeed, identifying oneself with respect to a particular nation may be less meaningful, particularly since individuals, whether co-therapists or patients, may experience simultaneous forms of being and belonging in France and in their countries of origin or ancestry (Levitt & Glick Schiller, 2004).

While apprentice co-therapists were encouraged to speak about hybrid forms of belonging, and were called upon to do so in a manner that some have described as conducting an orchestra, there were limits to what kinds of information individuals were supposed to share. Anna dissuaded two apprentices, one a Muslim woman and the other a Catholic priest, from delving into forms of belonging surrounding religion:

> Everyone relies on his or her culture, and of course, a bit too much. It's important that Vera doesn't talk too much about Islam, I think that's her minor flaw. And Nélio should not talk too much about the Bible. I tell him 'Nélio, don't talk about god'"

Early on in my fieldwork, Vera and I left the center where the therapy group met to catch the métro, and as we packed our bags, she put on her headscarf, which she never wore during therapy sessions. Vera later told me in an interview that toward the end of her apprenticeship, the supervisors had encouraged her to be cautious about what information she shared when applying for jobs, such as whether to use her married name, mention how many children she had, or state that she spoke fluent Arabic. It seemed that the supervisors were trying to protect her from facing discrimination. In fact, Anna had told Nélio to never introduce himself as a priest:

> "Here in France, there is something enormous against clergy, and Nélio had mentioned during a seminar that he was a priest. So we [the supervisors] asked ourselves, and I told Nélio not to say that he is a priest for fear about how that might be interpreted. There are things that I mentioned to the head doctor [*médecin chef*], that we have a great intern who is from Angola and is a priest, and he looked at me and he said, 'That can't be true, that's impossible,'"

This discouragement from introducing oneself in terms of religion was not uniquely directed at Vera or Nélio:

> "When Josephine introduces herself as Jewish, we're in a culture where at the moment, religion is a very sensitive topic. So she should introduce herself, 'I am Josephine, I was born in France but I have Tunisian heritage, it's a country that's part of the Maghreb.' But if she introduces herself as Jewish, that poses problems."

Now it might seem unsurprising that in a country where the headscarf and other visible symbols of religious affiliation are considered at best, matters for the private sphere, or at worst, symbols that draw public ire (for example, please see Bowen, 2007 or Scott, 2007), that individuals might be discouraged from making known any religious affiliations within public settings. But I was curious to know why, in spaces that purportedly welcomed hybridity and, to some extent, more inclusive forms of Frenchness, would visible or verbal expressions be dissuaded. Significantly, I

continued to remain perplexed that forms of belonging concerning religion, as well as sexuality or gender, seemed of little importance or potentially undermined forms of belonging centered on nation-states. Surely, for a group of apprentices, many of whom were second- or third- or nth-generation immigrants, would these other forms of belonging not take precedence?

Apprentices did not know exactly what or how much to share, and the guidelines about this were often unclear and absent. In chapter 4, I analyze the processes by which apprentices became more familiar with acceptable ways of speaking these settings and by which the authenticity of their seemingly free speech could be policed by their supervisors or peers. However, I briefly mention this here to the illustrate the depth of attention given to ways of speaking that reflect one's identity and to the tensions that arose between apprentices and their supervisors regarding the kinds of statements that they were encouraged to make.

"Am I just a spectator here?" Presence and responsibility

As in the Minkowska Center, apprentices in the *psychiatrie transculturelle* groups suggested that they did not participate as much as they would have liked. For example, apprentices recalled how some principal therapists spent much or most of the time in the consultation speaking with the patient before yielding the floor to co-therapists. The extent to which they were called upon, and the ways in which they were called upon, raised questions among apprentices about their presence as active, responsible contributors to the group, or as mere spectators:

> "Just one more sentence about this idea of presence, because for me, this was a theme that was important throughout the year. Was the question of responsibility of the intern, and I think it's quite linked to this, how much you feel like you're present, how much it matters what you say or it doesn't matter. And I think that is something that I struggled with quite a lot, is this sense of like, to what extent am I almost just a spectator here? It almost doesn't matter if I come or not. It would pretty much be the same if I was there and if I was not there.

> And I did not have a lot of sense of responsibility in either of those places [referring to two therapy groups]."

Some apprentices in each type of setting were not as present as they would have liked to be. Ironically, while the supervisors in Minkowska Center preferred the term "therapist in training" to "intern," the therapists in training seldom had the opportunity to participate in clinical work. In the *psychiatrie transculturelle* therapy groups, the number of therapists present in the group prevented individual apprentices from being able to participate extensively. This left several impressions on apprentices: first, they found that they were spectators and that they could be absent without much of an effect on the group. Second, they found that their supervisors used them as utensils, or "exotic objects," in therapy sessions. Third, they questioned how their visibility but lack of presence might have an impact on the patients and families who came to these settings: "I find that when there are too many people in a room it starts to feel as if we're at a zoo looking at the patients."

The comment, "It almost doesn't matter if I come or not," not only illustrates apprentices' concerns with a lack of visibility and participation, but also suggests that their presence might go unnoticed. In none of my field sites did supervisors officially take attendance, or at least not during each session. Indeed, apprentices may have needed to be absent from time to time, particularly during their exams. In the Minkowska Center, apprentices typically needed to complete a set number of hours in order for their apprenticeship to be considered valid by their university. Because of this, upon the completion of their apprenticeship, apprentices needed one of the supervisors to sign off on a letter claiming that they had in fact been in attendance for the requisite number of apprenticeship hours. In the *psychiatrie transculturelle* group, however, there seemed to be variation across settings and among supervisors in terms of strictness with regards to absences. For example, in one therapy group, a psychiatrist requested that apprentices

simply provide advanced notice of absences. Whereas in another group, when one apprentice had returned after an absence, one of the supervising psychologists asked the group—albeit in a manner that was clearly directed at the apprentice—why they would participate in the therapy group if they were going to be absent.

Some have described how experience and responsibility are "commodities" that students can never seem to get enough of (Becker et al., 2003: 270). But being an apprentice involves being legitimate peripheral participants in communities of practice (Lave & Wenger, 2009: 64). Their position as apprentices in clinical psychology and their diversity granted them access to these communities. Moreover, Lave and Wenger (2009: 95) distinguished between observation and peripheral participation, the latter of which involves absorbing and being absorbed by the culture of practice. In instances where apprentices were simply spectators, as some have described, they miss out on these processes of absorption. The apprentice quoted above illustrated the link between presence and responsibility. In this sense, by not being present, apprentices did not experience the mutuality of engagement or feel accountable to other members of communities of practice (Wenger, 1998: 152).

Concluding remarks

Prior research has detailed how the presence of diverse therapists contributes to the therapeutic work of *psychiatrie transculturelle* consultations since this presence encourages patients to open up and talk about their cultural identities and migration histories. Drawing on Goffman and Giordano, I contend that the construction of diversity in therapy settings entails casting particular roles and dispositions. Apprentices' training in these settings involves their learning to inhabit these roles and perform these dispositions.

In several instances, apprentices were selected because they could provide a combination of racial, linguistic, and experiential authenticity, which lent legitimacy to these settings. My supervisor informants reflected on the importance of apprentices' diversity in terms of their migration experiences, linguistic abilities, maturity, and race. Apprentice informants reflected on the ways in which magnified their diversity to patients within these settings. In one type of setting, they were made especially visible by their difference. In the other, they were introduced as diverse colleagues but may be given little clinical exposure or responsibility.

Apprentices found that they were treated in a tokenistic way since their supervisors emphasized their origins but did not include apprentices in the ways or to the extent that they desired. In their critiques, apprentices recognized the value of multiple and intersectional identities. They also recognized the challenges and limits of being identified or placed with respect to a particular place and instead, advanced more cosmopolitan conceptions of belonging. However, these apprentices were also learning to become members of organizations and communities of practice, which entailed certain norms and rules. In this case, the rules called for ways of being that differed from those that apprentices wished to exhibit and that felt more natural to them. Indeed, as this chapter has demonstrated, these settings involved the scripting of individuals into roles, yet I contend that there were hierarchical and paternalistic rules concerning who got to do the scripting.

By drawing on apprentices' perspectives of their visibility and responsibility, I intended to introduce the ways in which they contributed to the ongoing activities of these settings. The next chapters evaluates how apprentices became implicated in the routines of these settings by producing documentary artifacts and ways of speaking that reflect the frameworks that guide the work of these settings.

Chapter 3. Activities of reading and writing: Navigating paperwork routines

It was late in the afternoon and the *psychiatrie transculturelle* group in an outpatient mental health center in the north of Paris was about to receive its last patient of the day. In the consultation room, the therapy team was seated in a semi-circle. Completing the circle was a young man, his father, and a social worker from a center that provides employment assistance to people with disabilities (*établissement et service d'aide par le travail,* ESAT). At the beginning of the session, the father of the young man stated that it was difficult for him to take time off of work to attend these therapy sessions. Moreover, it was also difficult for his wife, the young man's mother, to attend since she was at home watching two young children. The father said that he was not sure about the utility of these consultation sessions but would continue to come if they would help his son, who had a developmental disability. Next, the principal therapist, a psychologist, asked the social worker about any developments that had taken place since the previous session two months prior. The social worker reported that the young man had secured a placement in a temporary training program in a dry cleaner and that he was pleased with the position.

As the session progressed, the principal therapist turned to the others in the group. One of the co-therapists asked about the father's arrival in France from Burkina Faso. The father said they had already discussed this in a previous consultation session and reminded the group that they were there for his son. Later on in the session, another co-therapist, who had not been present for the previous session, asked a question about a topic that had also been addressed previously. The father pointed to the two audio recorders on the table in the center of the group and suggested that the co-therapist listen to his earlier comments or read through their notes to obtain that information, nodding towards the apprentice who was scribing this therapy session.

He reiterated that he was happy to be present for the benefit of his son but did not appreciate revisiting material that had already been discussed in previous sessions. Another co-therapist, a psychiatrist, attempted to shift the direction of the conversation to the young man's progress in the ESAT and suggested that they could end the session early. Prior to concluding the session, the principal therapist said that the group would be at their disposal if they wished to return, but that they would not plan another appointment.

After the young man, his father, and social worker left, the principal therapist, who seemed quite agitated, said that she had only received the transcript from the previous therapy session the night before and did not have time to read it through and prepare for this particular session. Moreover, she stated that it was essential that they receive the transcripts from previous sessions in a timely manner. In these group therapy sessions, it is the responsibility of apprentice therapists to take notes and transcribe the exchanges and discussions during each session. They must also return the transcripts well in advance of subsequent appointments so that the group may review what has been discussed and chart a subsequent course of action. In this session, the group had hastily looked over and discussed the transcript in the 20-30 minutes prior to the session while they waited for the social worker to arrive. The principal therapist said that patients from African backgrounds do not like being asked the same questions over and over and that it is imperative that they receive the transcript in advance so that they may avoid asking the same questions. The psychiatrist in the group added that *psychiatrie transculturelle* therapy did not seem to be well adapted for this young man's situation. The psychiatrist emphasized that the important development since the last consultation was the placement of the young man in the training program in the dry cleaner, since his lack of placement had been a major concern in the previous session. Another co-therapist said that the referring professional, who had referred other

individuals to the group in the past, had a tendency to refer anyone of West African origin for *psychiatrie transculturelle* therapy.

The situation described above raises several issues: first, the father and some of the co-therapists were not convinced that the *psychiatrie transculturelle* consultation was a good fit for this young man. Second, the principal therapist assumed that the father's irritation was due to the notion that people of African origin do not like being asked questions over and over, and not the result of the actions of the co-therapists. This notion had the subtext that African patients are more indirect in their communication in therapeutic encounters and do not respond well to direct interrogation. I heard various members of this particular therapy group repeat this notion, and was shocked that it went unchallenged since it seemed like the sort of stereotype that these culturally sensitive clinicians would attempt to dispel. Third, the dysfunction of this particular session seemed to be attributed, not to either of these two issues, but to the transcript and its author. Had the co-therapists been better acquainted with the transcript, perhaps they would have offered different propositions during the session and perhaps the father would have reacted differently.

Chapter overview

In this chapter, I analyze apprentices' production of documentary artifacts in culturally sensitive mental health settings. More specifically, I pay close attention to *paperwork routines*, which do far more than simply document the activities of these settings. I assert that paperwork routines serve important enculturating functions for apprentices. In this chapter, I work through the following questions: In what ways does paperwork have a mediating effect on the pedagogical and clinical work in these settings? How does this paperwork familiarize apprentices

with the guidelines and operating frameworks of these settings? In what ways does engaging in paperwork routines address the uncertainties apprentices face in therapeutic contexts with immigrant and non-francophone patients? I argue that these routines were a crucial space where tensions played out between imperatives to embrace the complexity of patient cases and to simplify and systematize these complexities. This is significant in culturally sensitive mental health services, where supervisors consistently encouraged apprentices to accept the uncertainties that they would face as professionals. While paperwork routines were implemented to minimize uncertainties, I argue, throughout this chapter, that they inadvertently produced new kinds of uncertainties.

Following the theatrical metaphor (Giordano, 2014; Goffman, 1959) introduced in the last chapter, the tensions between embracing and minimizing uncertainty play out in interactions between apprentices and supervisors. Moreover, I turn to the work of Paul Brodwin (2011: 190), who has described how documents, such as treatment plans in community psychiatry in the U.S., are a "paperwork technology" that stages interventions. While apprentices' production of documentary artifacts does not directly stage clinical work in these settings, it gives them responsibility and focuses their attention to certain information about patient cases while neglecting other information. Rather than simply focus on the paper itself, I am interested in the coordinating, mediating, and organizing activities that surround paperwork, as well as the ways in which these activities are systematized and standardized. Documents serve as resources where objectivity can be achieved (Harper, 1997: 33). I consider how the work around paper is routinized in order to focus the attention and activities of participants (Heimer, 2001: 49), and thus retrains these apprentices' vision by getting them to focus in depth on some details while glossing over others (Mertz, 2007: 69). Mary Douglas (1986: 92) has described how institutions

have various ways of directing individual memory and channeling perceptions into forms that are compatible with the relations they authorize. This may be accomplished through the completion of seemingly mundane tasks.

In this chapter, I focus on the writing and production of documentary artifacts undertaken by apprentices to gain insight into their worlds as they undertake apprenticeships in *psychiatrie transculturelle* and in the *Médiacor* assessment meetings at the Minkowska Center. Activities of reading and writing were central in the worlds of apprentices. Yet many of the apprentices with whom I spoke described their disinterest and, at times, frustration with paperwork routines. These routines were thought to be of secondary importance to contact with patients. After all, most apprentices who undertake training within these settings were studying clinical psychology, psychiatry, or social work, and they yearned for experience with patients or clients. Yet a great deal of what apprentice therapists did during their apprenticeships involved dealing with or producing some kind of paperwork.

Because apprentices spend so much time writing, paperwork routines thus seemed to be an important point of entry into the local worlds of apprentices (Kleinman, 1992). Through an analysis of how apprentices engage in paperwork routines, I argue that apprentices were not simply recording the events that take place within mental health settings for immigrants. Rather, these routines connect apprentices to past and future clinical encounters since they shift apprentices' attention to specific elements of patient cases and make apprentices responsible for the smooth functioning of clinical activities. Moreover, apprentices' discussion and performance of these routines captured the tension between bureaucracy and openness. As I will argue, this was a significant instance where efforts to manage uncertainty unwittingly produce more of it.

In the sections that follow, I briefly introduce literature on the production of documentary artifacts to establish a framework for understanding what paperwork routines do in the settings. I then analyze the context and tasks associated with each routine. I have structured this chapter to draw on apprentices' engagements with and reflections about two types of paperwork routines: scribing during consultation sessions and investigating referral documents in assessment procedures. By becoming engaged with these routines, apprentices become acquainted with patient information as well as the institutional frameworks of these settings. While these paperwork routines seem mundane, they allow apprentices to reduce the workload of professionals and contribute to the work of these settings while becoming enculturated. However, by engaging in these routines, apprentices often questioned or critiqued their supervisors and the institutional procedures they were expected to follow.

Why focus on paperwork?

Paperwork routines within institutions are ubiquitous and may seem mundane upon initial consideration. But as scholars in different organizational contexts have illustrated (e.g. Barrett 1988; Berg, 1996; Berg & Bowker 1997; Good, 1994; Harper, 1997; Hull, 2003; Hull, 2012), documents and writing do more than simply report or record; they also have a mediating role in the organization of work. In fact, some scholars suggest that documents are agentive in their generative capacity and as agents of change (Irvine-Smith, 2015). By looking back on documents such as medical records, one can gain a great deal of insight about relations between clinicians and patients, between hospitals and their social surroundings, and between medical ideologies and medical practices (Risse & Warner, 1992). Documents may also have an impact on future clinical work. In a hospital in Papua New Guinea, for example, Alice Street (2011: 831)

describes how patients' medical records do not serve to provide diagnostic closure, but rather they allow for different courses of action to take place. Taking these perspectives together, documentary artifacts and their production bind together information about patients' histories with future courses of therapeutic action and thus requires individuals to look backward and forward.

Documents distribute expertise across sites and actors. Documents promote control through their ability to coordinate perspectives and activities (Hull, 2012: 257). Certain types of documents, such as forms, serve to organize attention, particularly when there is little uncertainty about what needs attention (Heimer, 2008: 36). For example, in admissions procedures in hospitals in the U.K., Aled Jones describes how nurses' interactions with patients tend to follow the order of the items on admissions forms (Jones, 2009: 911-912); however, Jones cautions that these documents don't do all the work themselves since they require trained nurses to fill them out. In other words, people possess some contextual background knowledge when they write and read documents, yet the documents support these reading and writing tasks by providing instructions (Østerlund, 2008: 198; Harper, 1997: 38). Additionally, documents allow fairly complicated tasks to be performed by individuals with less experience or training. In describing administrative documents used in domestic violence plea courts in Toronto, Rashmee Singh (2017: 512-513) explains that forms may distill complex legal activities into easily actionable tasks and therefore, transfer expertise to administrative workers.

Documents may be used to accomplish a variety of tasks simultaneously, including tasks related to training within organizations. For example, Ramah McKay notes that intake forms in a Mozambican clinic function as psychotherapeutic tools, clinical evaluations, bureaucratic obstacles, and mechanisms for data collection, project management, and clinical instruction

(McKay, 2012: 553). Moreover, in writing about documents in health settings, Carsten Østerlund (2008: 216) states that documents have a socializing function since medical students must learn to properly use documents when they rotate through different wards and subspecialties.

In addition to the documents themselves, the act of writing transforms both what is being written about and the person who is doing the writing. Anthropologist Byron Good describes how writing in medical education does not simply represent a record of what was exchanged. Rather, it is a formative practice that shapes talk just as much as it reflects it (Good, 1994: 77). Moreover, practices of writing produce a streamlined and decontextualized picture of events, which produces a particular past about a patient (Berg 1996: 516; Berg & Bowker 1997: 516). Good (1994: 77) also explains how the act of writing confers responsibility to medical students and authorizes them to speak about their patients in rounds and meetings with their peers and supervisors.

Paperwork in culturally sensitive mental health settings for immigrants and refugees

Significantly, paperwork preceded patients in these particular mental health settings. These settings are a second line of care, meaning that health or social service professionals request appointments for their patients or clients. Individual patients typically do not walk in or make their own appointments. Therefore, before potential patients step foot in the door, documents containing their medical and social histories have already been transmitted by external professionals and examined by the administrative and clinical staff within these settings. Others have described how requests for culturally competent mental health care for West African patients often couched various forms of disorder—resulting from precarious living arrangements, grim employment prospects, and discrimination—in terms of psychopathology (Larchanché,

2010: 61; Sargent & Larchanché, 2009: 4). In her analysis of referrals for patients of West African origin to the Minkowska Center, Stéphanie Larchanché describes how professionals emphasized presumed cultural differences in lieu of symptoms of mental illness by using language of dysfunctional family situations and vague descriptions of the culture of the *banlieue,* or the less prosperous, working class, and ethnically diverse Parisian suburbs (2010: 226-227). Mental health professions within culturally sensitive mental health settings have worked to clarify the *indications*, or instructions to referring professionals, regarding the guidelines concerning the appropriateness of *psychiatrie transculturelle* therapy for patients (Giraud, 2006: 213-214; Moro, 1998: 98-99). Gesine Sturm (2005: 331) has described how *psychiatrie transculturelle* psychiatry consultations are a space of mediation between patients and their referring clinicians (as well as between patients and their family members); Sturm contends that the conflict is often based on the referral for *psychiatrie transculturelle* therapy since professionals sense that there is a breakdown in communication. Psychologist Kouakou Kouassi (2001: 138) describes how individuals do not request *psychiatrie transculturelle* therapy for themselves; rather it is the referring professionals who formulate this request. However, Kouassi states, patients and their families eventually appropriate referrals and make them their own through their continued attendance in *psychiatrie transculturelle* consultations. To this literature on referrals to culturally sensitive mental health services in France, I add that while referrals reflected the motives of referring professionals or the disorganization of their services, they also served a critical pedagogical function for apprentice therapists, who were learning how to manage a great deal of information about patients.

This literature on documents, writing, and bureaucracy provides a valuable insight into the worlds of apprentices in mental health settings for immigrants in several ways. First, this

literature allows us to understand the enculturating and professionalizing functions of paperwork routines for apprentices who are becoming more legitimate participants in these settings. By learning how to engage in paperwork routines, apprentices learn how these settings function but they also learn how to function as professional therapists. Second, this literature illustrates how writing and specific kinds of documents shift attention of apprentices onto the information considered valuable by supervising clinicians. Third, by being the authors of the writing they produce, apprentices were given responsibility for ensuring the smooth functioning of administrative and clinical activities in these settings. In the sections that follow, I place ethnographic material in conversation with this literature to illustrate how apprentices' production of documentary artifacts illustrated a tension between bureaucratic imperatives to clarify the complexity of patient cases and those imperatives that promote the appreciation of complexity. Documentary artifacts did not simply record the administrative and clinical activities of these settings. Rather, I argue that they served an important socialization function for apprentices, and were meant to reduce uncertainties about how to think about culture in therapy.

By being the authors of the documents they produced, apprentices gained authority over the content of documents, and they were evaluated based on the reliability of their writing. Devices, such as audio recorders, were implemented to facilitate their writing and to ensure more reliable documentation of exchanges during consultation sessions. Additionally, by focusing their attention and incorporating different highlighting practices (Goodwin, 1994; Heimer, 2008; Mertz, 2007), apprentices learned how to write about patients in ways that captured the most important details and that would be legible to future readers. Apprentices also learned how to read below the surface of referral documents in attempts to identify the voices of patients. To facilitate this reading below the surface, their supervisors implemented a form that served as

guidelines or a sort of checklist of items to identify in referral correspondence. Yet while these guidelines were meant to reduce uncertainties about what to look for, they tended to confuse apprentices, who struggled to find these details. Moreover, despite being asked by supervisors to focus their attention on certain details of patient cases, apprentices found inconsistencies in the ways that their supervisors applied these guidelines.. Taken together, this analysis of paperwork routines illustrates that while these routines were supposed to reduce uncertainty about the appropriate place of culture in therapy, they may inadvertently generate new forms of uncertainty.

Authorship, responsibility, and systematicity: Scribing in consultations

In *psychiatrie transculturelle* consultations, such as the one described above, it is the responsibility of one of the apprentice co-therapists to document the exchanges and interactions during the consultation sessions. Here, I use the word *scribing* to refer to joint tasks of note taking and transcribing. Apprentices took notes by hand or on a laptop computer. At the end of the consultation session, handwritten notes were photocopied and left in the individual's file. Leaving a copy of the notes in the file on the premises where the consultation took place ensured that a trace of the consultation session remained in the event that the notes or the recording are lost. The apprentice would then complete the transcription process in advance of the next consultation session, which would take place in one month's time. Transcripts would then be printed and placed in the files, typically alongside the handwritten notes.

Notes were maintained in files, which grew thicker and thicker as more notes were added. Indeed, one could easily spot the files of veteran patients by the amount of space taken up by their files in the cabinet. Also kept within these files were other important documents, such as

medical reports, administrative proceedings, as well as the initial correspondence from referring professionals. This correspondence typically detailed the professional's motivations for referring a particular individual to the *psychiatrie transculturelle* consultation. Over the course of therapy, these referral documents could be revisited, particularly in instances when the group discussed whether *psychiatrie transculturelle* therapy was a good fit for a particular individual. Indeed, as others have described, issues of conflict and the need for mediation may arise over the course of therapy and while patients were not the ones to request therapy—referring professionals would make these requests—their continued attendance in *psychiatrie transculturelle* therapy sessions depended on them and their therapeutic alliance with the therapeutic team (Kouassi, 2001; Sturm, 2005).

In subsequent sessions, apprentice therapists would be asked to present a summary of the general history of the patient and the previous session's events to the group before the start of the subsequent consultation session. Sharing in the taking of notes, being organized about transcriptions, and recalling sufficient information about a patient were required tasks of apprentices. Moreover, apprentices were supposed to divide the workload of scribing equally. Typically, apprentices delegated this work amongst themselves and supervisors would keep track of their arrangements in order to ensure that the work was divided equally and to identify which apprentice was responsible for which transcription. During my fieldwork in one of the *psychiatrie transculturelle* groups, this division of tasks became a point of tension among apprentices since some felt that their peers were not doing their fair share of the scribing.

The apprentice who took notes was then responsible for typing up a transcript of the notes as soon as possible or at least in advance of the next consultation with the patient. When there were delays, supervisors sent emails to the group to ask for certain transcriptions to be

returned and in some instances, identified the person who failed to turn it in on time. As illustrated in the opening extract, the principal therapist attributed the problematic therapy session to the delay in receiving the transcript, and indirectly, to the apprentice responsible for its timely completion. In other words, had the apprentice sent the transcript on time, the principal therapist and the group would have been better prepared, the co-therapists would have offered different propositions, the father of the young man would have reacted differently, and the therapy session may have had a different outcome. While it is of course impossible to prove that this turn of events was entirely the result of the transcript or the apprentice, what these events do demonstrate is that apprentices' (mis)management of scribing activities may be identified by supervisors as the locus of culpability the therapy group doesn't work well together. Moreover, apprenitces' scribing mistakes may be called out in front of the group as a way of disciplining the apprentice responsible and a warning the others to not make the same mistake.

Note taking was a challenging exercise because of the volume of material covered in the 45- to 60-minute consultation session, because individuals may speak softly, quickly, or with an accent, or because it was difficult to follow when a patient was particularly unwell. Having the same role as apprentice therapists, I was also tasked with scribing activities during my fieldwork. I was happy to participate and felt that I was contributing to the work of the group. I was lessening the load of the other apprentices and was producing fragments of group's records. Just like the others, I was responsible for returning transcripts on time and for recalling events that took place in the consultation session for which I had scribed. A typical consultation may have required six or seven hours of transcription, producing a transcript that may be 12 to 20 single spaced pages. Some apprentices pulled all-nighters to complete their transcriptions. Indeed, I imagine most readers of this chapter can sympathize with the trials of transcribing. During the

consultation sessions, apprentices who took notes were generally not called upon to speak, since scribing required a great deal of energy on their part.

One psychologist, who had been an apprentice in the group, explained that during her apprenticeship, two apprentices took notes in each consultation session so that the second note taker could corroborate or correct the account of the first. This psychologist emphasized the challenges of note takers documented different accounts:

> "One patient, particularly when she was quite delusional, said things but didn't really link them and it was as if it was in a dream and I wasn't able to follow even if I understood the words. I wasn't able to take notes except for a few points. The disadvantage is that it's very subjective and at times, my colleague would not take the same notes and we were not at all in agreement. I was convinced of what I noted and my colleague was also convinced, so that was the disadvantage of not recording."

I asked this psychologist how the group would manage in the event that there were different or contradictory versions of the notes. The psychologist explained that both sets of notes would be included in the patient's file and then the therapists in the group would decide what information to retain. Moreover, it is possible that the other therapists in the group may have their own versions of the events that had taken place:

> "The therapists may have their own memories, which are at times different from ours. You see, when we're in a group, we are not always in agreement and everyone remembers that to which he or she is sensitive. But it's not too serious of a problem since psychology is not an exact science."

Disagreements over the content of transcripts did occur from time to time over the course of my fieldwork. In these instances, the group members might turn to the apprentice who scribed to ask for a clarification. For example, while reading through the transcript during a pre-consultation discussion, there was a disagreement about what had been exchanged between the lead therapist and the patient in the previous session. Unfortunately, the apprentice who had

taken the notes was absent that particular day and was unable to attest to the accuracy of the notes. However, the principal therapist who read the transcript emphasized that the apprentice who had taken the notes and transcribed was reliable and that this apprentice's version was likely an accurate portrayal of events. Apprentices were responsible for maintaining the institutional memory of therapy sessions, and could be held responsible when consultation notes weren't present and when there was a discontinuity in between consultation sessions:

> "One has to accept that it's a time taking job, and one also has to accept that at times, the notes won't be there. And for that, you should not hold other people responsible when it's not there."

In moments like these, the author of the notes was as important as the content of the transcript since supervisors would make judgments of reliability of notes and of the events of past therapy sessions. As others have noted (Hull, 2003: 294; Street, 2011: 830), authorship and autography represents a process of assigning singular responsibility for documents. By authoring these documents, apprentices were responsible for maintaining the notes of the consultation. Yet they were also held responsible for the content of the notes. Assessments of the veracity of the notes would depend on who took them, as supervisors considered some apprentices more reliable or serious than others. In fact, it was not uncommon for supervisors to question apprentices on the transcripts if they believed that apprentices had incorrectly documented the exchanges of a previous therapy session. Scribing thus became a moment when supervisors evaluated apprentices in a manner that was visible to the rest of the group. While these evaluations were informal, there were nevertheless important since apprentices would want to remain on their supervisors' good side and would need to rely on their supervisors for references to secure future job placements.

Supervisors introduced certain technologies to facilitate scribing and ensure the accuracy of the transcripts. As I will demonstrate, the implementation of these technologies raised concerns among various therapists about whether to maintain thorough records or whether to trust one's own subjective memory. After all, unlike in many clinical settings, in these *psychiatrie transculturelle* groups, supervisors emphasized the importance of clinicians' own subjective reactions to clinical encounters. In one of the *psychiatrie transculturelle* consultations, the supervising clinicians instituted an audio recorder so that apprentices could check their notes taken during the consultation against the recording. The recorder was placed in the center of the therapy group and on a table that was dressed with a cloth brought back from one of the principal therapist's trips abroad (Figure 3.1).

Figure 3.1. Group therapy recording device

Of all the *psychiatrie transculturelle* consultations in which I had participated over the course of my fieldwork, only one used an audio recorder. Supervising clinicians in the other consultations were not particularly in favor of recording the consultation sessions. The psychologist quoted above gave a potential reason for this difference of opinion regarding the use of recording devices:

> "I think it depends on the inclination of the team, whether they depend on facts or whether they are confident in what they experience. I think that if they're dependent on facts, then it's better to record. But there is also the subjective value of what everyone experiences in the consultation and if the group is confident in their subjective functioning, then it works. But if not, they should record it."

"Confidence in subjective functioning" may be contrasted with reliance on systematizing technologies. The recorder systematized transcription by facilitating the process and ensuring an alignment between what was included in the transcripts and what was said during the exchanges. As the psychologist above states, the ability to verify through the use of a recorder removed the potential for error or for multiple "memories" of the content of the consultation sessions. The psychologist's comments also suggest that different teams engaged differently with "facts" and with "memories." The use of transcripts and supplemental systematizing technologies reflects the ways that documents specify "objectivity of action," and thereby allow organizational actors to "see, recognize, and constitute" the rational basis for one particular action over others (Harper, 1997: 33). Transcripts and recordings provide the proof that certain things were said or courses of action were taken during a therapy session and thus, minimizing the potential for subjective accounts of these sessions. Moreover, this proof provides the basis or justification or future courses of action.

In addition to audio recording consultations, supervising clinicians instituted other measures to facilitate the process of taking notes. In one of the other consultations, notes were taken on the laptop belonging to the consultation. While the group was assembled in a circle, the note taker would sit at a separate table and, like a stenographer, capture the consultation session in real time. The use of the laptop permitted apprentices to avoid a separate transcription process. Moreover, the typed notes could be saved to the laptop, which remained in the physical location of the consultation, thus eliminating the concern that notes taken from the space of the consultation could be lost. The physical separation of the note taker from the group created a distinct role that was both within and outside of the consultation. At times, the clack of the keyboard would carry on and fill the void of silence after an exchange between a patient and therapists. As someone who participated in note taking activities myself, I couldn't help but notice patients staring at the computer. Similarly, at times I also caught the eyes of patients as they focused on the audio recorder. In those moments, I wondered whether these facilitation technologies actually made patients feel ill at ease. While patients had given their consent to the consultations being recorded at the start of the session, these documenting practices may hinder patients from fully opening up during these consultations.

Efforts to make their work more systematic not only reflected a bureaucratic tendency to ensure that there was a record of exchanges, but also this communicated to apprentices that they needed to be rigorous and scientific and "based on facts." This was significant since apprentices saw attempts to routinize complex information about patients as antithetical to the mission of embracing this complexity. By encouraging apprentices to listen to patients and to decenter from the representations of their clinical studies, supervisors emphasized the importance of apprentice therapists' subjective reactions to clinical encounters. The reliance on measures to render their

work systematic or objective was therefore confusing to apprentices, who perceived their supervisors to be sending contradictory messages concerning whether to minimize or embrace uncertainty.

Moving forward: Highlighting practices and capturing the important information

Early on in their apprenticeship, apprentice therapists were unaware of the details that needed to be documented when scribing. Supervising clinicians would tell apprentices to document only the most essential points rather than attempting to produce a verbatim account of the consultation session. At times, supervising clinicians would tell apprentices which points were essential, though apprentices would also need to make judgments about which bits of information to retain for the subsequent consultation. The instructions to focus on the important information in consultation sessions, reflect what Charles Goodwin (1994: 628) describes as highlighting practices, which structure "the perception of others by reshaping a domain of scrutiny so that some phenomena are made salient while others fade into the background." Different principal therapists would emphasize any combination of the material exchanged in the consultations, pre- and post-consultation discussions, body language, displays of emotions such as laughter or crying, the interactions between patients and their family members if the latter were present. Principal therapists might review transcripts with the apprentice who had scribed a particular session in order to ensure that the transcripts had been completed properly, meaning that they contained enough information but did not necessarily incorporate extraneous extracts. For example, one patient, a 60-year old woman who had been seen in the consultation for several years, frequently reported visions and dreams in a great amount of detail. She spoke at great length and at times, it difficult to follow her train of thought. The principal therapists in the group advised apprentices to capture the gist of what she had said in a consultation and any new

developments from the previous session. This required apprentices to be aware of the events of past sessions.

Early on in my fieldwork, the group discussed a transcript prior to a consultation session. The principal therapist for this particular session tended to read directly from the transcript, as if to replay the events from the previous session. Moreover, one could clearly see that this principal therapist had also read it in advance as evidenced by different colored markers that had been used to highlight the passages. The principal therapist seemed to be troubled by one thing in the transcript: the apprentice who had prepared it noted when different co-therapists spoke, but did not distinguish between speakers by using their names. Rather, when looking at the transcript, one simply saw the titles "principal therapist," "patient," and "co-therapist," as if there were only three interlocutors. The apprentice said that she had done this since writing out the names of individual speakers would have been too time consuming The principal therapist insisted that it was important to note the names of those present in the therapy session at the beginning of the transcript and to distinguish between speakers so that one could replay the events of a therapy session. The full name of the patient would be left out at the beginning of the transcript for the purposes of confidentiality and they would be referred to as "Mr." or "Mrs." and the first few letters of their last name or simply "patient" or "p" in the transcript. The apprentice tried to reassure the principal therapist by stating that she knew exactly who said what during the session. After all, she was the one who had diligently taken the notes, listened to the audio recording, and typed up the passages. This did not seem to convince the principal therapist. After all, once she finished her apprenticeship at the end of the academic year, she would no longer be in the consultation and future readers of the transcript would therefore no longer be able to match

a particular statement to a particular interlocutor. Therefore, transcripts needed to be produced for those who would need to decipher them at a future point.

In one group, apprentices were asked to produce a transcript of the consultation session and extract the most important features, which were organized into a cover sheet for the transcript (Figure 3.2).

Figure 3.2. Reproduction of a transcription cover sheet

Consultation number and date:
Family name:

Patient:
Family members present:
Accompanied by:
Principal therapist:
Co-therapists:
Interns:
Interpreter:
Notes taken by:

Summary of the family history	
Summary of ethnopsychoanalytic consultation history	
Participating family members present	
New elements	
Principal themes	
Dreams	
Therapists' imagery[15]	
To note for the next consultation	
Discussion	

In the subsequent consultation session, the apprentice who had scribed the session would present this information to the group and would field questions from the other therapists. Apprentices not

[15] The imagery of co-therapists, analyzed in more depth in the next chapter, is proposed by co-therapists during the consultation sessions and reflects therapists' reactions to something that a patient or another therapist has said.

only needed to take notes and transcribe, but also identify these features in the text and produce a particular structure in which these features were visible. In the event that the group needed more detail or had questions about any of this information, the apprentice could then return to text of the transcript to provide clarification or additional details. Moreover, as the psychologist above described, other group members may have their own "memories" of what happened and could challenge or corroborate with this apprentice.

Upon revisiting this sheet, one could recreate the cast and scene of the previous session. Indeed, this table helped foreground the important information amid a great deal of other textual elements. Through highlighting practices, such as this table, other apprentices learned to focus on the elements their supervisors prioritize in lieu of the mass of other details that may be contained within the transcripts. Future readers of the transcription cover sheet could look back to the patient's family and ethnopsychoanalytic history, as well as forward to the important elements to be explored in the next consultation. During the discussion following therapy sessions, therapists would emphasize certain exchanges as particularly rich, reflect on their own feelings during the consultation, and could ask for clarifications about certain elements. Some, such as this apprentice, considered the content of the discussion to be more important than the exchanges that took place during the therapy session itself:

> "If it is usually forty-five minutes, one consultation, then lets discuss for one hour, at least, and then take notes on that. Because everything is fresh and you can take notes. But then going back and typing the whole thing, it all remains in the dossier [file]. You don't really use it…. You take notes. And then, you can type it. But notes, not transcription, not any 'oui, non, euh.' You can listen to it again and it's completely stupid."

The apprentice quoted above suggests that transcripts do little other than collect dust in patient files. Moreover, the apprentice emphasized that new material that arises may derail the focus on the content of previous sessions:

> “And in most cases, when you don’t talk about the notes at all because each séance [session] is a new séance and what happens at X and Y séance is also very important. So, for example, we discuss this and that, and then suddenly, [the patient’s] mother comes and says ‘j’ai le cancer [I have cancer].’ And then, of course, you’re talking about her cancer and you’re not talking about what we’ve discussed earlier. You see what I mean? Each and every séance, whatever new comes, gets the priority. Which adds to the clinic, it’s the most important thing. It’s not something that you prepared and then you continue, no…the continuity is not something that’s guaranteed. The continuity is flou [vague or unclear], it might work, it may not work…In cases where something new comes from the patient…when she says this huge thing that has happened in between, then that takes all the space. Then in that case, all this is useless. Absolutely useless.”

As this apprentice suggested, continuity between sessions was not guaranteed, particularly when major events took place between sessions. Yet as the opening extract illustrates, therapists did rely on prior transcripts in order to move the therapy session forward. Without this continuity, the groups risk addressing similar material, which may have a detrimental impact the therapeutic work of the group.

Linguistic anthropologist Alessandro Duranti (2006: 307) has suggested that while people tend to assume that transcripts simply document events, they actually have a life or are given a life by those who produce and work with them. This indeed seemed to be the case in my field sites, though I would add that transcripts also play an important coordinating role among apprentices and their supervisors. As Anna-Louise Milne (2017: 75) has described, *psychiatrie transculturelle* therapists treat notes only as evidence of the content discussed during the consultation sessions but they pay little attention the ways that writing may be transformative for the group. My observations and my informants’ comments lend support to this claim that the text of transcripts was treated as though it only served to document the exchanges between patients and therapists. It seemed that even patients thought of the transcripts in this way: as the father of the young man stated in the opening extract, prior material could be located within the notes and the recordings. But scribing work of maintaining an institutional memory also appeared to do

more than establish supporting evidence of past exchanges. Transcripts tended to take a forward direction since they guided subsequent consultations and could be used to generate scientific communications like master's theses or publications. In fact, apprentices were often encouraged to publish their work in journals like *L'Autre*, founded and directed by Marie Rose Moro, or other journals like *Le Carnet Psy* and *L'Evolution Psychiatrique*. Additionally, the supervising clinicians in *psychiatrie transculturelle* therapy groups often used the clinical material from these therapy groups in their own publications, lectures, or conference presentations. Transcripts therefore needed to be written in a way that would be legible to future readers. Moreover, supervisors' instructions that apprentices document the gist or the most important details from consultations suggest that scribing activities focus the attention of apprentices and produce streamlined accounts of the events of consultation sessions.

Scribing socialized apprentices by focusing their attention to the important details in *psychiatrie transculturelle* therapy sessions and by placing apprentices in charge of the institutional memory of the sessions. By authoring transcripts, apprentices learn to minimize the uncertainty of the kinds of details to include and apprentices can recall the content of past therapy sessions when summoned by their supervisors. When scribing needed to be facilitated or there were doubts about subjective accounts of events, technologies like recorders were implemented. I argue that in addition to keeping a systematic record of therapy sessions, scribing was future-directed work (Brodwin, 2011; Street, 2011) that influenced future clinical action and scientific communication.

The next section describes apprentices' involvement in a different paperwork routine in another setting. Prior to the arrival of patients in this setting, patients' referral documents need to be screened to identify important information and assist in intake procedures. Apprentices play a

crucial role in this investigative work, and their involvement serves to enculturate them by focusing their attention on specific details of patient cases and by teaching them to identify the language of referring professionals, which supervisors in this center consider to be inappropriate when discussing immigrant and non-francophone patients.

Reading below the surface: Investigation in an assessment unit

> "The paper, it's a professional who wrote it, it's a letter, it's paper, but though the words you are able to perceive the counter transference of the professional…And I think it's really interesting and it's not what we see in our exercises in class. Generally, the clinical cases are neutral."

The apprentice quoted above described an essential process by which apprentices learned to read below the surface of the text of referral correspondence sent by health professionals to the Minkowska Center. Unlike the group therapy context described above, this center provides individual therapy sessions with a psychiatrist or a psychologist, and ideally in the preferred language of the patient. During their apprenticeships, which may take place for a period of a few weeks to an academic year, apprentices would occasionally observe consultation sessions or patient evaluations, though the majority of their time was spent preparing for mediation meetings. Preparation for these mediation meetings involved reading through incoming referral documents, extracting and summarizing the important information, and inscribing it onto forms.

As described in more detail in the introduction, the Minkowska Center started these mediation meetings in order to examine and address the therapy referrals received from external professionals. Larchanché (2010: 335) has described how external professionals' referrals for West African patients to the Minkowska Center reveal these professionals' generic or problematic notions of culture and cultural difference. To this point, I add that these referrals, whether problematic or not, have also produced important pedagogical opportunities for

apprentices, who were trying to learn about the appropriate place for culture in therapy, and for supervisors, who were attempting to discourage apprentices from using the same problematic language or notions of cultural difference that external professionals often espouse. As the comments of the apprentice quoted above suggest, the referral documents do not portray patients or their situations neutrally since they are written in the voice of the external professionals. Apprentices learned about psychopathology, but they also learned the assumptions, values, and capacities of external professionals and institutions. Yet it is important to note that this learning took place in the absence of the patient and the referring professional. Instead, apprentices gained access to the lives of patients by engaging with various kinds of paperwork. While these documents were just paper, when read below the surface, they provided invaluable insight about conditions of patients and the professionals and institutions that referred them.

Not all of the referrals needed to be examined by this unit, though one of the secretaries estimated that the unit examined around 90% of the referrals:

> "Almost all of the referral requests are processed in the mediation unit because many professionals did not always make the effort to explain the reasons why they referred patients and often the referrals were not always pertinent. At times, they referred patients who were perfectly francophone and there was no cultural dimension and so the patient could have been seen at a CMP [outpatient mental health center] in the sector [geographic area where they reside]…Even if we try to filter as best as possible over the phone and explain to professionals and also to patients how we function, there are always mix ups or cases in which they are not able to manage. So I think that the unit helps us to receive and to screen certain referrals."

Reception staff members have been described as the keepers of the queue since they are concerned with the orderly and efficient flow of patients (Hughes, 1989: 397). The reception staff in this center attempted to control the flow of referrals by providing as much upstream guidance to professionals intending to refer patients to this setting. However, as the secretary stated above, these efforts were not always successful and the reception staff and the members of

the mediation unit would therefore need to address the incoming requests from professionals. The reception staff would handle the referrals that were clear and complete, whereas those that were more complex needed to be examined by the mediation unit. The secretary cited above explained how this complexity was assessed:

> Secretary: Dr. H. told us that for Arabic speaking patients, it is not necessary that their referrals are examined by the unit. Instead, we should ask him or Dr. N. to see if they can see the patient. If it's a bit complicated, then it will be processed by the unit. We do that with the others, if there's a patient who speaks the same language as one of the doctors we will ask the doctor first before sending the referral to be processed in the unit.
>
> DA: when you say "a bit complicated," what do you mean exactly?
>
> Secretary: I don't know how to explain it really, but if it's more than a simple depression, for example, or if there is really a serious illness, or a difficult migration history, then it is processed by the unit. But if it's just a depressive syndrome and that's all, then it's not really necessary.

Before the referral files even reached the mediation unit, a considerable amount of upstream work was undertaken by the reception staff and social worker in order to obtain missing information in the referral files. Near the end of my fieldwork, the staff implemented a form that referring professionals could download from the center's website, fill out, and send by post along with other referral documents (Figure 3.3). This form was created to encourage referring professionals to include relevant patient details in their correspondence and to minimize the amount of follow up work carried out by the administrative and clinical staff.

Figure 3.3. Reproduction of the referral request form

Date: ____________________________________

Referring professional:
_ Psychiatrist
_ Psychologist
_ Social Worker
_ General practitioner
_ Other: ___________

Contact information for the professional(s): ___________________________________

Referring institution:
_Reception center for asylum seekers (CADA)
_Social housing and reinsertion center (CHRS)
_Child welfare services (ASE)
_Other health center
_Other legal aid center
_Other pedagogical center
_Non-profit/association

Address and telephone number: ___________________________________

Family name of the person referred: _____________________________
First name: _____________________________
Address: _____________________________
Telephone: _____________________________
Age: ___________
Country of origin: ________________
Language(s) spoken: __French ___ Other (please specify): ________________________
Family/marital status: ____________________________
Administrative status: ____________________________
Migration trajectory: ____________________________
Reasons for exile: ____________________________
Notion of trauma: __ Yes __ No

Is the person currently seeing a doctor? __ Yes __ No
If yes, doctor's contact details: ___________________________

Has a physical exam been carried out? __ Yes __ No
If yes, what kind (please include results): ____________________________

Is the patient currently taking medication: __ Yes __ No
If yes, please specify: ____________________________________

The patient expresses suffering through:
The cultural representations of the group to which the patient belongs:

Explained through magical/religious values ____ Not provided __
Explained through spiritual values ____ Not provided ___
Explained through traditional values ____ Not provided __

Figure 3.3, continued

This form, along with the other documents sent by external professionals, would eventually be retained in a patient's file. When examining the forms that accompanied the correspondence from external professionals, I tended to see more blank sections towards the bottom the form. At times, professionals would simply write a "?" next to prompt about the ways a patient expresses suffering. Indeed, it might be a stretch to assume that a health professional would feel comfortable or capable asking individuals about their religious, spiritual, or traditional values as

they correspond to cultural representations. In fact, apprentices often had difficulty making distinctions between these values since instructions from supervisors for distinguishing between these were often vague and inchoate. I asked one of the center's administrators if this form seemed to have had an impact on the information that referring professionals provided:

> "A little bit, we still don't have everything, but at least we have their migration pathway and conditions of departure…we know the countries through which they've traveled. We have, more or less, the contact details of the professional and we know if the patients are francophone or if they speak other languages, if there's a medical treatment in place, if the patients have already seen a doctor. We have more, we could say it's more complete. It's still not how we would like it, but it's complicated."

Upon receipt of the documents from the referring professionals, the reception staff would fill out and attach a cover sheet to these documents. The cover sheet included details such as the name of the receptionist who fills out the form, the name and contact details of the person being referred, the name and contact details of the referring professional and institution, the person's age, country of origin, language(s), family and administrative situations, and the reasons for referral to this center. At the end of the document, there was a space for the decision of the mediation unit to be completed and signed by one of the administrators. After filling out the cover sheet, the reception staff would then give the referral documents to the social worker, who would follow up on missing information[16]. After obtaining this information, the social worker would give the referral documents to the apprentices, who would read them, identify certain pieces of information, and then inscribe this information onto another set of forms described below.

The investigative work performed by apprentices aided in the decision making process undertaken by the supervisors in this center. By participating in these paperwork routines, apprentices learned about the mental illness encountered by individuals, the professionals and

[16] The social worker would follow up on this information unless the referral was sent by a medical doctor. In this latter case, one of the center's psychiatrists would follow up with the referring doctor.

institutions who refer these individuals, as well as how this center assessed the needs of these individuals and the capacities of the professionals and institutions. This is not to say that apprentices' work determined the course of action taken individuals referred to this center, but rather that their engagement with these paperwork routines was an integral component in a broader process of work around documents in this center.

Apprentices became attentive to the words of the professionals, who may be fixated on the negative aspects of an individual's case:

> "It's happened several times when I have remarked that, 'The professional, I think he or she is taking sides.' For example, there were letters written by psychologists, and it was really clear that they wanted to unload, 'The adolescent is getting on our nerves, we cannot take it anymore.' They only gave the faults of the adolescent, it was taking sides and I said, 'I think that the psychologist is taking sides, he or she is not neutral, he or she is against the adolescent and wants to get rid of the adolescent, it's not a neutral analysis.'"

By reading below the surface, apprentices became familiar with the tone of professionals, which may reflect their desire to get rid of patients. Getting of patients may be a characteristic practice in a variety of health service contexts, leading to resentment when health professionals perceive their peers to be displacing their work onto others (Dodier & Camus, 1997: 760; Dodier & Camus, 1998: 433-4; Mizrahi, 1986: 221). Both apprentices and supervisors felt that external professionals were simultaneously making problematic assumptions of the cultural identities of patients and unloading them. Moreover, as Patrick Castel (2005: 460) has suggested, patients may serve as a resource for health care workers to learn about the practices of their peers. In this context, the documents describing potential patients teach apprentices and their supervisors about the intentions and resources of external professionals and the institutions in which they work. Other apprentices were more generous in their discussion of referrals, which they considered desperate acts in the context of strained resources:

> "It's shocking, because sometimes you see letters and people say openly, 'We need someone who understands Africans, because this patient is African and we don't understand his problems.' Okay, and, the situation sounds funny, but if you think of it, it's not absurd. If you have a healthcare professional who is not able to help the patient, for a reason or another, I mean, maybe there is another reason but, basically it doesn't work. And the person says, 'Okay, I've tried everything, and this person is African, okay that's, I will send this person to a center where they know, where they have a good handle on culture, cultures.' It's also oversimplification, there are a lot of stereotypes with this decision, but why not? They're trying alternatives."

While shocked by the language of the external professional, this apprentice also understood that these professionals look for any potential resources to assist the patient. External professionals may be well intentioned and may think that culturally competent therapy may be optimal for a patient. These professionals refer patients in an attempt to address the uncertainties of providing care for immigrant and non-francophone patient populations. The deliberation between external professionals and those in this particular center represents an important learning opportunity for apprentices, who themselves face uncertainties about the place of culture in therapy and are navigating a space in which they determine how much cultural difference is the right amount for either culturally sensitive or conventional mental health settings.

Cultural formulas: Guidelines and the bureaucratization of complexity

At times, the referrals contained no more than a few lines scribbled on a doctor's letterhead. At other times, apprentices would need to sort through multiple letters written by different professionals, medical reports, and, at times, statements written by patients themselves. When examining referral documents, apprentices were expected to summarize and organize the information contained in the files according to a form, (Figure 3.4), resembling the one above for external professionals, which provided apprentices with guidelines in the investigation of these files.

Figure 3.4. Reproduction of apprentices' presentation form

Date: ____________________________________

Name of person presenting: ____________________________________

Referring professional:
_ Psychiatrist
_ Psychologist
_ Social Worker
_ General practitioner
_ Other: ___________

Referring institution:
_Reception center for asylum seekers (CADA)
_Social housing and reinsertion center (CHRS)
_Child welfare services (ASE)
_Other health center
_Other legal aid center
_Other pedagogical center
_Non-profit/association

Patient name (first name and last initial for confidentiality): _____________________________
Age: ___________ Not provided __
Country of origin: ________________ Not provided __
Language(s) spoken: ______________ Not provided __
Family/marital status: _____________ Not provided __
Administrative status: _____________ Not provided __
Migration trajectory: ______________ Not provided __
Reasons for exile: ________________ Not provided __
Notion of trauma __ yes __ no

Treatment:
_ Medical
_Psychotherapeutic
_Social Support
_Not provided

Sickness:
The impact of social determinants on the psychological suffering of the patient:
__Neutral __Destructuring
The impact of societal determinants on the psychological suffering of the patient:
__Neutral __Exclusionary __Stigmatizing
Other contextual elements worth noting:
__Individual __Community

Illness:
The patient expresses suffering through:
The cultural representations of the group to which the patient belongs:
Explained through magical/religious values __ Not provided __
Explained through spiritual values __ Not provided ___
Explained through traditional values __ Not provided __

Cultural representations of the bio-psycho-social model:
Neuropsychiatric __

Psychological __
Psychoanalytic __
Holistic __
Sociopolitical __
Not provided __

Adult personality disorder and behavioral problems:
Paranoid personality __
Schizoid personality __
Schizotypal personality __
Antisocial personality __
Borderline personality __
Histrionic personality __
Narcissistic personality __
Dependent personality __
Obsessive compulsive personality __
Not provided __

Quality of the psychological defense mechanisms:
_Mature
_Immature
_Intermediary
_Not provided

Based on the elements of sickness, illness, and personality details, attempt to make a diagnosis (disease):
Therapeutic indications:
_Medical treatment
_Psychotherapy
_Social support

Figure 3.4, continued

Prior to the implementation of this form, apprentices used to read through referral documents and attempt to identify the relevant details themselves. This form was developed to clarify what the supervisors wanted from apprentices in their investigative work, and was divided into four principal sections. The first section contained details regarding the professional and institution referring the patient, as well as biographical details about the patient. The remaining sections were meant to guide apprentices as they sort through the different kinds of information that may be contained in the referral file. These sections corresponded to the pedagogical framework of this center, inspired by the early research of Arthur Kleinman. Apprentices were expected to read through the referral files, extract relevant details about the patient's medical conditions, migration and social history, and cultural representations. By using this form, apprentices were

expected to learn the guidelines for the kinds of information that were considered valuable and those that were distracting. Like the table used in the *psychiatrie transculturelle* group, this form served to highlight important information and render other details less salient (Goodwin, 1994; Heimer, 2008). As others have suggested (Singh, 2017), forms like this one could be considered a technology to train non-expert apprentices to focus their attention, yet, as argued below, the form was also a medium wherein tensions played out between imperatives to the complexity of patient cases and bureaucratic imperatives to reduce this complexity.

When possible, apprentices were often asked to identify the patient's voice in the referral documents. Once they had obtained this information, they would then assemble the details into a coherent portrait of the person being referred to the center. Yet this was undertaken in the absence of the person or the referring clinician, raising questions as to how apprentice therapists could learn what is at stake in the local worlds of patients simply by engaging with documents. At times, the social worker or the one of the administrators would explain the form and how to fill it out to apprentices. More often, however, instructions were not given and apprentices who had spent more time in the center would instruct newcomers on the use of this form. During my fieldwork in this center, I also read referral files and filled out forms. I too, relied on more senior apprentices to assist me in understanding the form and how to identify these features in the texts of the referral documents.

Some apprentices discussed how this form helped them to organize the details contained within referrals:

> "I thought it was quite helpful because you could really structure yourself and really focus on the main information of the case because, sometimes if you have a dossier with a lot of information inside, you would get lost in the details."

Other apprentices stated that the form also helped them to ask others questions when information was missing or unclear:

> "I think that when one is better trained, it's because there's a framework, you are more comfortable to ask questions, receive and give information."

To these apprentices, the form seemed to make complex issues more identifiable and manageable. However, much of the information emphasized on the form was not easily reducible to boxes to be checked or blank spaces to be filled in. Apprentices often expressed confusion over the details on the form, such as the difference between social and societal determinants, and among magical-religious, spiritual, and traditional values. Indeed, as described above, referring professionals were often unable to identify this information, and neither were apprentices. There was little offered by supervisors as to nuances between these details or to their significance in therapy. One apprentice emphasized how most were not equipped to address the questions on this form:

> "I really have doubts that an intern…would have the tools, the theoretical tools to answer this question...Here [indicating on the form] they ask about the illness, about the cultural representations about the group, and if the psychological suffering is centered around spiritual values, or magico-religious values, or traditional values. And this is a very, very tough question. It requires very detailed anthropological knowledge. Because this is not just about other cultural elements appearing in the letter. This is about really having a fine understanding of the person's cultural representations…If the patient complains about being assaulted by spirits, the intern will have to say if this is related to traditional values or spiritual values or to magico-religious values. And very often the answer is not clear, even for seasoned professionals. And they argue about this. But of course, the head of the institution is always right. He has the final word [laughs]."

Even if apprentices were able to distinguish among these details in an abstract sense, they struggled to identify them in the information provided by the referring professionals:

> "I am not able to distinguish between them [elements of illness, sickness, and disease], I mean, I see the distinction, but I don't really see the distinction when I read the referral information."

Referring professionals typically did not provide many of these details. Moreover, despite guidance from their supervisors and peers, apprentices found it difficult to identify the patient's voice in the correspondence from referring professionals. After all, it was the external professionals who referred individuals to this center and who described these individuals' situations. These forms were thus a crucial site where tensions played out between accepting the uncertainty of complex patient situations and the need to minimize uncertainty. I argue that the use of this form generated new forms of uncertainty for apprentices, who considered the need to systematize complexity as contradictory to their supervisors' charge to embrace uncertainty.

Livia Velpry (2008: 254) has described how psychiatrists and other mental health professionals often treat the patient's perspective as an evident, natural, and stable attribute, as well as a tool of empowerment for patients, though she states that it should perhaps be considered as the product of discursive interactions and a resource to be used by patients and therapists in medical settings. In the present context, apprentice therapists were often instructed to uncover the patient's voice or perspective from within a mass of information furnished by referring professionals. Finding the voice of patients was, using Velpry's term, a resource for apprentices since it allowed them to successfully navigate the pedagogical tasks their supervisors had established for them and it allowed them to better understand the needs of patients. Apprentices' difficulty in finding the patient's voice does not necessarily suggest its total absence, but rather that it is framed and often masked by the discourses of clinicians.

Additionally, when looking at apprentices' forms, I often saw more blank spaces than spaces that were filled in. One apprentice commented that parts of the form were never used:

> "It's too bad because you have the top part of the front page with the principal information, and then you have that part on the bottom that you never use…I found it was difficult to fill that out because I didn't think it was practical."

In a minor act of subversion, this same apprentice abandoned the form above and created her own to summarize the referral information. The fact that many sections were left blank reinforces the administrator's comments that external professionals were not providing the kinds of information that those in this center wanted. As Larchanché has described (2010: 61) in the context of referrals of West African patients, the discourses of external professionals in their referral correspondence reveal unscripted perspectives of cultural difference. To this, I would add that the guidelines for apprentices were supposed to arm them with the scripts that these external professionals seemed to lack. However, the extent to which apprentices could use these scripts remained marginal as they could only be deployed while discussing referral documents and since there was an absence of contact with the patient or the referring professional. Sociologist Carol Heimer (2008: 38-41) has described how good forms structure attention when there is little uncertainty about what needs attention; moreover, those of a lower rank within an organization generally fill out forms since the inscription of information into boxes and blank spaces requires a lower level of expertise (see also Singh, 2017). In the present context, the forms were implemented to expand the expertise of supervisors to apprentices so that they might learn how to interpret and organize information about patients as their supervisors do. Drawing on the perspective of Heimer, I argue that by using forms to address complex matters where there was a great deal of uncertainty, this generated new forms of uncertainties for apprentices. Heimer (2008:38) states that forms used in instances in which there is uncertainty about what needs attention, "would be a maze of complicated skip patterns and subsections, most of which would be irrelevant to most of the users." This seemed to be the case as some of the apprentices suggested that they would simply not use certain sections of the forms or would not possess the requisite knowledge to be able to fill in certain details.

"Why us? Why here?" Learning about goodness of fit in assessment meetings

After filling out the forms, the apprentices were asked to present referral documents—and the information contained within—to their supervisors[17]. Then, the supervisors discussed this information and decided whether to receive the person for an initial evaluation, refer them to one of the clinicians in the center for psychotherapy, or refer them to an external, tertiary professional or institution. Each meeting of the mediation unit took approximately one hour, during which the group may discuss three to ten referrals. This variability resulted from the amount of time spent discussing each referral file, which depended on the amount of detail provided in each file and the complexity of each situation.

While initially conceived as an administrative project, the *Médiacor* assessment meetings also served a crucial pedagogical purpose since they were one of the few instances in which apprentices had contact with the supervising clinicians in the center. The discussions that took place during these meetings could be considered an opportunity for apprentices to ask questions about some of the unclear or missing details in referral documents and to observe their supervisors discuss the kinds of patients that this setting receives. Additionally, the unnecessary referrals and the problematic notions of cultural difference that external health professionals may possess were the kinds of practices and ideas that supervisors hoped that their apprentices would avoid. I argue that the problematic referrals the Minkowska Center received were crucial pedagogical tools for apprentices, since the supervisors could use these referrals as examples of how not to speak or act as future therapists.

For example, in one of these meetings, the mediation team discussed the referral file sent by a health educator (*éducateur spécialisé*) from the child welfare services for a 15-year old

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[17]I discuss the performative dimensions of these presentations, as well as their evaluation, in Chapter 4.

adolescent. The educator wrote that this adolescent had come into contact with child welfare services after having committed a misdemeanor. Though the details surrounding the misdemeanor were not included in the letter, the educator stated that the adolescent was in constant conflict with his father, and he refused to respect authority, whether it was parental, educational, or legal.

As the team went over these details, one of the psychiatrists in the group asked, "Why us? Why here?" meaning, what about this adolescent's situation required the culturally sensitive expertise of these professionals in this center? In the referral letter, the educator described how therapeutic work that explores the transmission of parental values and the impact of his double culture on his attitudes would be beneficial. The adolescent was born in France, though his parents were originally from Senegal. Moreover, the educator wrote that it seemed necessary that he, along with his family, have the ability speak with a professional about his place in the family and about his plural identity. As the group discussed the details the educator included in the referral letter, another psychiatrist said that one could really get a glimpse of the feelings of the educator. The first psychiatrist concurred, adding that it seemed that the educator was exoticizing the situation since it seemed like this was more of a judicial issue than a psychotherapeutic one. This psychiatrist suggested that what seemed pathological about this situation was way that the educator saw and described the adolescent. Despite the educator's mention of a "double culture" and "plural identity," the group came to the conclusion that this referral did not seem to be specific to the intercultural context and that it could be considered an implicit request for training for the educator. In other words, it seemed that the educator, not adolescent, would need to come to the center to seek the help of these professionals.

During another mediation meeting, the group discussed the referral sent by a psychologist and nurse in family planning center (*Protection maternelle et infantile*, PMI) to see a Spanish-speaking psychologist. The referral was for a woman from Venezuela who had arrived in France in 2015 after having spent some time in Spain. She fled Venezuela to protect herself and her two-year old child because her husband and another member of her family had been killed. During the meeting, the group discussed her signs of PTSD, such as difficulties sleeping, waking up at night, tachycardia, anxiety attacks, and crying. She was often housed by the 115 and was undocumented[18]. She took an anti-anxiety medication from time to time, but was afraid of being knocked unconscious by the medications and unable to take care of her child. After reviewing the details of her referral, the psychiatrist in the meeting decided that she should come for an evaluation with a Spanish-speaking psychiatrist to determine whether she would need to see a psychiatrist or psychologist on an ongoing basis in the center.

At the end of this meeting, one of the apprentices asked about the cultural dimensions of this woman's case. After all, this center is known for its culturally competent mental health care and there did not seem to be any explicit mention of cultural elements in her referral documents. The psychiatrist stated that there weren't any cultural factors, but rather linguistic and administrative factors since she needed to see a clinician in Spanish and because she may not be able to access care from the local outpatient mental health center because she did not have a

[18] 115 is a phone number for SAMU Social, an emergency housing and support service. Individuals without housing call this number and, when possible, arrangements are made to provide immediate housing for the individual and her or his family. Places are granted on a first-come, first-serve basis, and are provided for one night at a time. This service tends to be overwhelmed, and many who call are not provided with emergency housing. Those who are able to secure housing must call again the following day in order to secure a place, which may ultimately be in a different location.

fixed address. This exchange pushed the psychiatrist and the administrator to clarify the necessity of these meetings:

> Administrator: That's why we have these meetings, because it's easy to say "she doesn't speak French, she comes from this or that country, pfff, let's send them to Minkowska." We need to clarify these requests, which are often for people who are perfectly francophone, who have been in France for a long time, who live in the sector, who have a stable address. There's no reason for these people to come here.
>
> Psychiatrist: inversely, it is not because they talk about *maraboutage* [sorcery] that we are going to receive the person. It's not because we are going to go into the cultural or the exotic that we take patients, but rather because that person has a linguistic dimension or doesn't have an address and cannot benefit from a CMP [outpatient mental health center]
>
> Administrator: it's true, often, professionals who refer patients to us focus on the cultural stories of patients, for example, if the patient is delusional and describes sorcery or *maraboutage,* etc. But that's why we say that the dressing is often cultural, but all things considered, we have someone who has auditory or visual hallucinations and normally any therapist can treat that person

Indeed, the fact that these clinicians can accept patients regardless of their housing or administrative status, as well as conduct consultations in languages such as Spanish, suggests that this setting may be the only option for someone like this woman. While this center espouses cultural competence in its institutional framework and communications with external professionals and organizations, the psychiatrist and administrator suggested that this competence was not necessary in this particular situation. This encounter represents an instance where clinicians made a pragmatic ethical decision to stray from their organizational ethos to ensure this person received care (Brodwin, 2013). In fact, while these clinicians were perceived by external professionals to have cultural expertise, they frequently described instances in which they needed to explain that cultural factors were not pertinent in all situations. These comments reflect Larchanché's (2010: 190) analysis of how these clinicians experience a double bind, in which they must challenge the culturally stigmatizing assumptions upon which referrals are made, but also maintain their authority in providing culturally sensitive care. These clinicians

also engaged in what Brodwin (2013) has described as everyday ethics, when their decisions regarding a person's treatment must depart from institutional procedures. Significantly, apprentices bear witness to the ways in which these clinicians must articulate their position of expertise and their ethical deliberations in relation to other health professionals and institutions. Moreover, apprentices' participation in these mediation meetings, and the work that they performed in advance of these meetings, served to acquaint them with the positioning of this center and the expertise of its clinicians. Yet exchanges, such as the one described above, could also confuse apprentices. On the one hand, the psychiatrist and administrator explained that the attention to presumed cultural factors was not necessary and that structural and linguistic features should be weighed in their decision-making. On the other, apprentices were tasked with using the form to identify cultural representations. So why ask apprentices to look for this information, particularly when, in the case of the adolescent, the attention to this information was seen as exoticizing and when, in the case of the woman, this information did not seem to be pertinent? I argue that in spite of supervisors' encouragement of apprentices to listen to patients and not overly focus on their cultural histories, this form offered contradictory instructions, since it suggested that apprentices should seek out this information.

These apprentices may by puzzled by what they consider to be mixed messages from their supervisors or what they consider to be inconsistent handling of referrals in which similar cases are treated differently by the supervisors:

> "And sometimes…they will say, 'Of course, let's see this patient because he is from Burundi, there's a notion of trauma because he is a refugee and they killed his family and there are some cultural representations that are hard to deal with. So we're going to throw our expertise into the case and do something, because it's our job.' And sometimes, for a similar case they'll say, 'Oh, but for a normal psychology center, this doesn't have anything to do with Africa so what are they talking about? Are they crazy or what?' and then they reply [to the referring professional] and they say, 'No, we're a normal psychology center and we don't really deal with Africans, with anything, we just speak languages, and send this person to

> [another clinical setting], this is not our job'... and sometimes it seems to me that the only difference was how busy the center was at that time, like if they were really overloaded with patients or if they had some space or capacity. And sometimes, it was, it seemed to be an issue of transference. If the professional seemed moved enough by the case, they'd say, 'Oh, we have to see this person.' Or if they were insensitive to it. I know that this can be seen as a criticism, but I have had this impression on several occasions"

As these comments suggest, apprentices observed contradictions in the practices among their supervisors. Indeed, the hidden curriculum of training contexts may be in direct conflict with formal training procedures and guidelines, which may have the effect where students experience the educational practice as something structured around inconsistencies and contradictions (Hafferty & Franks, 1994: 866). The mediation meetings in this center perhaps reflect what Phil Brown (1993) described as a "mystery story" in psychiatric intake procedures, since clinicians are trying to identify the needs and requests of patients using a framework that may be unique to a particular institution. Brown (1993: 256) states, "Although the patient's problems are the original mystery, the intake framework is a mystery built on an earlier one." Seth Messinger (2007: 360) builds on Brown's characterization by stating that clinical teams are made up of different positions and personalities, and each member may consider patient cases in his or her own way. In this center, clinicians and apprentices were trying to uncover the needs of a patient as expressed by an external professional through paperwork rather than through the voice of the patient or the professional. Apprentices experienced additional layers of the mystery story since they were trying to recognize the needs of patients, understand the information provided by referring professionals, and make sense of the guidelines provided by supervisors.

Concluding remarks

Apprentices' involvement in paperwork routines aided in the ongoing clinical and administrative work and these routines enculturated apprentices into the communities of practice

in these settings. Scribing in consultation sessions allowed the *psychiatrie transculturelle* group to recall the material from past consultation sessions and prepare for subsequent sessions. By engaging in these routines, apprentices became responsible for maintaining the memory of *psychiatrie transculturelle* therapy sessions and for identifying patients' voices and referring professionals' motivations in referral documents. Reading referral documents and filling out forms assisted the mediation team in triaging referrals and placing individuals in therapy with clinicians as soon as possible. Apprentices also learned to focus on the information valued by their supervisors when scribing consultations and investigating referral documents. Rather than simply recounting everything from referral files or patient narratives, they needed to know how to extract the most relevant details. Through the use of templates and forms, they learned to organize this information within a particular narrative structure. Put briefly, the paperwork routines in these settings reflected some the ways in which supervisors imposed frameworks onto apprentices so that they could manage their uncertainties regarding the appropriate place of culture in therapy. Through their repetitive engagement in these routines, apprentices became acquainted with the institutional guidelines within culturally sensitive mental health settings.

However, these routines also represented moments during which apprentices questioned or critiqued the institutional procedures in these settings. Supervisors delegated relatively complex tasks—such as giving a detailed yet succinct account of a consultation, recalling the events of previous therapy sessions, as well as identifying cultural representations and social determinants relevant to a patient's situation—to apprentices through activities of taking notes, transcribing, reading referrals and filling out forms. Apprentices asked why so much energy was devoted to capturing the exchanges of *psychiatrie transculturelle* consultations when this information was of questionable utility. As one of the apprentices suggested, a verbatim

transcript loses its value when met with new, poignant information, and it may be no substitute for the *psychiatrie transculturelle* group's discussion of the events of a consultation. Apprentices also suggested that forms were unclear or pointless and that information that they seek out did not exist in the referral documents sent by external professionals.

Due to their complexity, these tasks could not easily be performed through the methods employed, such as with forms or templates. Rather than facilitating these tasks, forms represented bureaucratic imperatives to systematize knowledge about mental illness and disorder among patients. Yet these efforts to systematize, particularly through the use of forms, were antithetical to the simultaneous imperatives of embracing uncertainty by recognizing the complexity of patients' experiences. Put briefly, paperwork technologies meant to reduce uncertainties for apprentices unwittingly generated uncertainties.

Chapter 4. Activities of speaking: proposing imagery and speculation

On my first day in one of the *psychiatrie transculturelle* groups, a psychologist asked me if I had ever participated in this kind of group and if knew how they functioned. At that point in my fieldwork, I had already participated in a few such groups and had read extensively about them. So I said that I had. "Oh good," she said, "then you know not to be too psychological?" At first, I did not realize what she meant by this statement. However, it gradually became apparent that by saying this, she was referring to the way in which apprentice therapists were supposed to interact with their peers and supervising clinicians in the presence of patients during the group consultation. Moreover, the statement, 'don't be too psychological,' could be thought of an invitation to unlearn some of the modes of questioning, reasoning, and analyzing that are acquired during apprentices' general training and coursework in clinical psychology or psychiatry. These comments seem to echo Bruno Latour's (2010: 37) observations from Tobie Nathan's ethnopsychiatry group: "what psychological interviews can do, an ethnopsychiatric session can undo." By leaving these modes aside, one can learn to focus on the material brought by patients and make room for one's own associations and reactions that arise over the course of these consultation sessions. As many interns with whom I spoke stated, what they learned in these settings was quite different from their coursework or in other clinical work.

This chapter analyzes how apprentice therapists learned to appropriate the terminology and ways of speaking used within immigrant mental health settings. Whereas the previous chapter considered how apprentices learned to focus their attention through paperwork routines, this chapter addresses the performative speech acts that apprentices undertook with their peers and supervisors. These speech acts were guided by, and shape the activities of writing and reading described in the previous chapter. Moreover, this chapter considers how apprentices,

through repetitive engagements with supervising clinicians and other apprentices, incorporated disciplining mechanisms to ensure that the ways that they spoke about patients in these settings was deemed acceptable by their supervisors.

Chapter overview

In this chapter, I focus primarily on two kinds of speaking activities undertaken by apprentices: producing associations and imagery in *psychiatrie transculturelle* groups, and presenting patient cases in the assessment meetings in the Minkowska Center. In the first speaking activity, apprentices were responsible for knowing the content of previous sessions so as to avoid revisiting material already discussed. Moreover, their associations and images needed to be authentic and useable in the therapy sessions. As I will demonstrate with transcribed consultation sessions and interviews with apprentices and supervisors, the authenticity and usability of apprentices' speech acts were often policed and assessed by their supervisors, peers, and, at times, the patients. In other words, what apprentices said in a *psychiatrie transculturelle* therapy group mattered since it moved the therapy sessions forward and it was an important manner in which the performance of apprentices was evaluated.

In the second activity of speaking, apprentice therapists were expected to present the incoming patient referrals to the supervising clinicians during the assessment meetings at the Minkowska Center. The purpose of these presentations was to implicate apprentices in the administrative work of the center and assist the supervisors in triaging the incoming patient cases. These case presentations were an opportunity for apprentices to demonstrate their knowledge and authority in front of their supervisors and peers, yet it was also a crucial moment when they were evaluated by their supervisors. Apprentices needed to be clear, concise, and inclusive of the most pertinent information about patient cases, and thus these presentations

could be a thought of as a particular genre of organizing and communicating information about patients. The form described in the previous chapter structured these presentations, so that apprentices presented details in a logical succession and avoided dwelling overly on unnecessary information. As I will illustrate with transcribed case presentations and interviews with apprentices and their supervisors, case presentations are an activity where apprentices learned to anticipate the logic that their supervisors valued, learned to speak in appropriate ways, and avoided the ethnocentric and at times racist language about culturally diverse patients that external clinicians often use.

In both of these activities of speaking, apprentice therapists were engaged in interactive and iterative acts of translation to render patients' histories as recognizable through the use of—and in accordance with—the institutional frameworks of each setting. In other words, the translational work that apprentice therapists undertook involved a reconfiguration of patient histories in order to produce a particular account of the patient that was recognized within the settings in which they train. I argue that while supervisors were encouraging apprentices to think and speak authoritatively and openly about patients, they imposed rigid frameworks for the work that culture does in therapy. This latter point may seem to be characteristic of several different kinds of pedagogical settings. However, in these settings, the supervising clinicians strongly encouraged apprentices to unlearn the rigid ways of thinking about mental illness that they acquired in their clinical training and coursework, and instead embrace the uncertainty and cultivate the openness that they deem necessary to work with culturally and linguistically diverse patients. Paradoxically, supervising clinicians tended to rely on the same rigid styles of discipline and instruction present in university-based training in psychiatry and clinical psychology that they wanted apprentices to unlearn. Here, I turn to the writing of Laurence Kirmayer (1994:

184), who has described how authority is necessary to provide a structure upon which different meanings of illness and suffering can be improvised, yet authoritative meanings also restrict the possibilities for invention by both clinicians and patients. In other words, authority allows for improvisation but also limits the range of improvised performance. As the remainder of this chapter demonstrates, apprentices' perspectives suggest that these styles provoked uncertainty and resulted in apprentices relying on and reproducing the kinds of stereotypes about immigrant patients that their supervisors wished to dispel.

Managing uncertainty by learning to speak like a clinician

In a variety of domains, the process of professionalization and minimization of uncertainty involves observing how more senior members of a profession reason and go about their work, as well as learning to speak and carry oneself as a member of a particular profession or expert group (Boyer, 2008; Carr, 2010; Fox, 1957; Mertz, 2007). This is no different in the clinical professions, which often require apprentice clinicians to perform their knowledge and be evaluated by their instructors and peers. Clinical case presentations are one form of these verbal performances, and they have often been the focus of the attention of social scientists and clinicians interested in the dynamics of clinical education and collaborative care (Anspach, 1998; Atkinson, 1995; Davenport, 2000; Engeström et al., 2003; Good, 1994; Good & DelVecchio Good, 2000; Holmes & Ponte, 2011; Light, 1980; Menchik, 2015; Schön, 1983). The discursive arrangements of case presentations and meetings are crucial sites of analysis, or "microcosms" wherein practitioners look back on past activity and engage in future-oriented framing activities (Engeström et al., 2003: 288). Moreover, these authors suggest that the discourse of case meetings generates not only solutions for the case that is being discussed, but it also generates more general patterns of activity (ibid., p. 288). The emphasis on future orientation of discourses

in case meetings is especially important when reflecting on apprentices' observations and engagements in clinical talk, which were meant to enculturate them into particular patterns of reasoning and thinking about clinical cases that they would use in their future work.

Others have described the transformative potential of clinical talk on students themselves. The presentation of cases reveals clinicians' processes of inquiry (Schön, 1983: 317), and thus is an important feature in training since it is a manner of communicating information and a process of professional socialization (Anspach, 1998: 359; Atkinson 1992: 469). Case presentations are pedagogical since they involve learning specific vocabulary, learning to focus on important details and organize them in a particular way, and present, rather than talk about, a particular patient (Good & DelVecchio Good, 2000: 54-57). Moreover, these presentations are moments during which clinicians in training can sit back and observe their peers at work (Light, 1980: 190). Holmes and Ponte (2011: 178) describe an internal disciplinary process through which students learn to include certain pieces of information, exclude others, and structure the ways they speak, resulting in their transition from apprentice to profession. Case presentations serve a dual process of managing uncertainty among students and establishing their subjectivity as professional clinicians (Holmes & Ponte, 2011: 166). Taking these points together, these authors suggest that by learning to speak in ways that are deemed appropriate by their supervisors, students become recognizable as professionals.

The remainder of this chapter evaluates two different activities where apprentices were asked to speak in front of their peers and supervisors: presenting associations and imagery in *psychiatrie transculturelle* groups and presenting incoming patient referrals in the Minkowska Center. These speech acts implicated apprentices in the administrative and clinical work of these settings and permitted apprentices to perform their knowledge and learn from their peers and

supervisors. These acts were also moments in which apprentices were evaluated, disciplined, and at times, humiliated when they do not convey information in the ways their supervisors expected them to.

Proposing imagery and associations in psychiatrie transculturelle therapy

As I illustrated in the previous chapter, apprentice were responsible for keeping track of the group therapy sessions through note taking and remembering the content of previous sessions. Yet they also participated in the therapeutic team as co-therapists, lead by the principal therapist, and had an essential role in the functioning of the group. The diverse perspectives and experiences of co-therapists enriched the content discussed in consultation sessions and served as a respite when the principal therapist had exhausted potential points of discussion with a patient. In other words, while the principal therapist began a dialogue with the patient, she or he would eventually turn to the co-therapists to ask for their input. One may recall that consultations last 60 minutes, though duration of time that passed before the principal therapist called on the other co-therapists, the order in which the principal therapist called on them, and the frequency at which the principal therapist asked for their input varied tremendously and was often at the whim of the principal therapist leading the therapy session.

In one of the group consultations, a 42-year old man named Ahmed was referred by a psychiatrist in an outpatient mental health center (*Centre Médico-Psychologique,* or CMP). He had been referred to the CMP by a general practitioner for a depressive state and somatic complains, including chest pain, back pain, arm pain, and feeling like his left side is asleep. The psychiatrist in the CMP referred Ahmed to the consultation in 2009 because he stated that his headaches, insomnia, nightmares, and heartache, began upon his arrival in France from India in 2004. Ahmed is married and has four children and, until a recent trip back to India, had not seen

his family since he left. His first language is Punjabi, but in the two consultations that I was able to observe, and as described in his notes from prior sessions, an interpreter in Urdu accompanied him to the consultation sessions.

Over the years, the group and Ahmed discussed painful moments, including his inability to be present as his kids grew older and at the funerals of his parents. In addition, they discussed his unsuccessful asylum application, his residential permit granted on the basis of his medical treatment, and his inability to find stable housing, work, and send remittances to his family. In one of the consultation sessions, the group and Ahmed discussed his trip to India, his acquisition of a residence permit, and his new job in construction, all of which had happened since the previous consultation session. During the first part of the consultation session, the principal therapist, a psychologist, stated that Ahmed's French has improved and joked that he would not need the assistance of an interpreter at the next session. The principal therapist and Ahmed discussed how Ahmed was able to pray for his parents, about how his son wanted to become a mechanic, and about how his daughters were learning the Qur'an. Next, the principal therapist turned to the co-therapists in the group. Here I reproduce a few extracts of the exchanges based on my notes taken after the session and in consultation with the transcript of the session:

> Co-therapist 1: before he had his papers, it was hard to send money back and his wife was not happy. Now he can and it's a relief. And it makes me think of Moses, who left his son to accomplish his duties. Ahmed has a balance between his country and here, and I wanted to know, did his wife accompany him [to the airport for his return to France]? Did his son accompany him? What did his son say? What did he say to his son?
>
> Principal therapist: that's a lot of questions
>
> Interpreter: excuse me, but I was unable to follow, what did he say at the beginning?
>
> Principal therapist: it started with his duty and having accomplished his duty

> Ahmed [through interpreter]: My wife didn't accompany me, it was my older sister and her son

The comments of the apprentice co-therapist, a master's level student in clinical psychology, transitioned from material proposed earlier (possessing papers and sending remittances), to a discussion of the relationship between Moses and his son, to a series of questions about the last moment's of Ahmed's trip to India. The statements of the principal therapist and the interpreter, as well as the short response of Ahmed, seem to suggest that perhaps the apprentice's comments were too long. At another point in the consultation, the principal therapist called on the psychiatrist in the group:

> Co-therapist 2: Ahmed used to tell us that India would mean death, but finally, we see how he's renewed the relationship. I ask myself if he has spoken with his son since he returned to France.
>
> Ahmed [through interpreter]: we speak on the telephone
>
> Principal therapist: it's a lovely relationship that you've cultivated with your son
>
> Ahmed [through interpreter]: it already existed, but I didn't have my papers and I didn't work and I had a lot of health problems, and it was really hard. And I was treated for my health concerns, and the fact that I have my papers and that I can work, my health is better than before.

Rather than asking a direct question of the patient, the psychiatrist uses the formulation, "I ask myself," to ask Ahmed to elaborate. Later on, the principal therapist called on one of the psychologists in the group:

> Co-therapist 3: I think to myself that Ahmed is a traveler, in India, it's 'Ahmed who went to France' and in France, it's 'Ahmed the Indian.' To be a traveler, it's so rich, it's a big suitcase, and in the suitcase, he carries France and India and he will never lose that.

The suitcase was an example of the kind of imagery co-therapists produced in *psychiatrie transculturelle* therapy sessions. Rather than starting the session with a particular form of imagery in mind, co-therapists were often asked to propose the imagery that came to them by

listening to the dialogue between the patient and the principal therapist. Learning how to come up with imagery on the fly was a task that apprentices were expected to learn over the course of their apprenticeship in *psychiatrie transculturelle* therapy groups. In the session with Ahmed, one of the apprentice co-therapists proposed the next form of imagery:

> Co-therapist 4: I think about the *métro* [the Paris underground subway system]
>
> Principal therapist: why are you talking about the *métro*?
>
> Co-therapist 4: along the journey, some people get off and some people get on and it's kind of like life. Some people will remain with him for the whole journey, others will get off and on along the way. Ahmed went back home and saw old friends, some are closer than others. And he saw his family, and the relationship continues
>
> Ahmed: everyone will leave at some point or another in life. There's a moment for everyone

These extracts are an illustration of the ways that co-therapists engaged with the material proposed in the *psychiatrie transculturelle* group consultation. The principal therapist could turn to the co-therapist at any time over the course of a consultation and ask the co-therapist to speak. Knowing that one may be called upon at any moment was a source of anxiety for the novice co-therapist. Indeed, many apprentices informed me that they were concerned that they would say something irrelevant, insensitive, or would potentially say something that had already been addressed in a previous consultation session. After all, while apprentices participated in these consultation sessions for up to an academic year, patients like Ahmed had been seen in these group consultations for years. Apprentices therefore needed to be ready to have something to say if and when called upon, and one of the most difficult tasks for the novice apprentices was learning how to contribute to these sessions.

In interviews, I asked apprentices what instructions were given by their supervisors to speak during group therapy sessions. My informants stated that they were often given very little

in the way of instructions, but that they were to avoid asking questions regarding details of a patient's life or to interpret what a patient says during a consultation. In the example extract above, the principal therapist commented that the first co-therapist was asking a lot of questions. Supervising clinicians often described how asking questions may be an instinct of apprentice therapists, but was a style of engagement that they should avoid in this therapeutic setting. As one supervising psychiatrist explained:

> "I explain that they should associate, they should not interpret, and they should not ask questions that they would in psychological or psychotherapeutic sessions. They should be attentive to how they [the apprentices] feel and to their associations. It takes about two to three months to function well"

The psychiatrist distinguished between the actions expected of the co-therapists in this consultation (associations and attention to way one feels) as opposed to the actions of a therapist in other kinds of consultations (interpreting and asking questions). In addition, the psychiatrist acknowledged the time required for therapists to learn to undertake these tasks and for the group to function well as a whole. Similarly, a supervising psychologist in another *psychiatrie transculturelle* group described the evolution of the group from the beginning of the year when the apprentice therapists first arrived:

> "In the group like we have now, it's been a long time that we've worked together, we already know each other and it's very easy, because as soon as it [the subject of the conversation] is too delicate, as soon as there is too much affect, once you touch upon culture, you need to be careful, or as soon as you are stuck, you can open up to the group because I know exactly how I can count on you [the group]. In the beginning of the year, when the new apprentice therapists first arrived, it was not the same because you don't know what they'll say, you need to be really careful about who you let speak"

Working well together as a group took time, and supervisors were apprehensive to ask newcomer apprentices to propose anything in the beginning of the academic year, as they were not yet ready. While there was some variation among supervisors, many supervisors began to call upon apprentices after a few therapy sessions. I asked the psychologist quoted above to describe the

kinds of instruction the new apprentice therapist were given in order to be able to conduct themselves in the group:

> "I give them a bibliography, and I don't know if they'll read it, but at least they'll know that there's a lot to know that they do not know. And it's not with their studies in clinical psychology that they'll be able to do this kind of work...they need to be told right away that it's not with psychology that one speaks, it's with their own culture and their own origins, and so they need to look inwards, into their own culture in order to have good things to say that are linked to the anthropology of other cultures. That will open them up, not psychology, everything else. And they need to stop asking questions. They need to show that they have representations, they don't think that they have representations but everyone has representations."

Apprentices needed to look inward, rather than look to their clinical training, to speak in *psychiatrie transculturelle* therapy groups. "Psychology" was not only an inappropriate tool for the clinical situations encountered in *psychiatrie transculturelle* therapy, but it would also get in the way of ways of speaking and thinking that apprentices needed to learn. The psychologist also stated that apprentice therapists needed to summon representations, or imagery, during group consultations rather than posing questions of patients or families or interpreting the kinds of information shared during these consultations. These comments align with the perspectives of many supervising clinicians, who encouraged a sort of unlearning of the rigid ways of thinking in clinical training and coursework.

In addition, I asked apprentice therapists about their experiences with speaking in consultations at the outset of their training. I was particularly interested in how they learned to develop associations and imagery while avoiding making interpretations or asking questions of the patients. These apprentice therapists explained the difficulty they experienced in the beginning of their training:

> "It was a really difficult exercise in the beginning, I didn't authorize myself to talk about my culture."

Several apprentices found speaking in *psychiatrie transculturelle* groups to be difficult because they were not be used to talking about themselves during consultations. Others stated that the mode of reasoning within these consultation sessions was not what they were used to:

> "In the beginning, I was lost, I didn't know what to say, because I was in the mode of psychology. I was not used to anthropology, its terms, its notions, that way of thinking because for it me it was really concrete. Psychology is much more abstract and one talks about the unconscious, but in anthropology we talk about the everyday and action and it is much more concrete. But now I understand that they're linked, that they're not necessarily separable since culture is part of the unconscious and its part of the way that we think."

Here the psychologist described two modes of thinking that were, upon initial consideration, quite distinct; however, this psychologist described how the complementary nature of these two modes of thinking became more apparent over time. A resident in psychiatry described how one must insert oneself into the "mechanism" of the consultation in order to fully understand how it works and the purpose it serves:

> "In the first few consultations, in the beginning, you find it a bit bizarre because you are not used to it. So in the beginning I found it, maybe not bizarre, but slow, because I didn't train myself to have any imagery in my head, and since we weren't called upon to speak, it's long and it's slow and I didn't really understand the purpose of the consultation. I didn't think there was any point. But once I put myself into the mechanism and entered into the logic, I understood the meaning and the technique and the gears…it's not really the same way to practice psychiatry and if you aren't used to it and you are on the outside, you don't understand why they do what they do in the consultation and you find it bizarre and you don't understand."

These consultations may seem unfamiliar to the untrained outsider. Moreover, as the resident stated, apprentices were gradually asked to participate and place themselves within the "mechanism" of the consultation. By inserting themselves into the mechanism, they needed to learn to engage with patient histories in ways that were quite distinct from what they learn in their clinical training in psychiatry or psychology. This involved a process of unlearning the modes of questioning and reasoning they acquired in their clinical training.

I asked apprentices to describe their role as they became more active in these therapy sessions:

> "We are called on to bring a depiction, a reading of the situation from our culture or from a culture that we know or in which we have been immersed."

The resident in psychiatry emphasized the personal nature of the statements made during the consultations:

> "We will take something that the patient says and propose something, we all have our own personal manner, and what everyone says linked to their life, their culture, and when you see that, you authorize yourself to do the same thing. You take what the others in the group say, you see what they do, and you say 'I'm going to give a bit of my own history' and that takes the form of a representation."

Apprentice therapists needed to permit or 'authorize' themselves to speak after having observed what their peers and supervisors do in the group. Many apprentice therapists informed me that they learned to speak in consultation by observing how others in the group engaged with the material proposed by the patient and by the other co-therapists. The product of the speech acts took the form of imagery shared with the group and potentially used by the patient. One psychologist gave an example of the imagery that she used in the consultation:

> "I might talk about the moon and it means nothing, it's really of no use, but talking about it creates a sentiment of otherness, the fact that we can think differently and that we are not obligated to think, 'it's a person who is depressed, it's a person who is persecuted,' and that changes the patient's perceptions of professionals."

Unlike other clinical spaces, the clinicians in *psychiatrie transculturelle* therapy proposed imagery, like the moon, and associations rather than engage in a close interpretation of what the patient discussed during a therapy session. And unlike other forms of psychoanalysis, where patients were engaged in activities of free association, the supervising clinicians and apprentices were also engaged in producing associations in the group approach of *psychiatrie transculturelle*.

Moreover, the associations that apprentices and supervisors were expected to produce were not necessarily 'free,' but rather served to foreground, as the psychologist above suggested, "a sentiment of otherness" on the part of the therapists. Indeed, as described in Chapter 2, apprentice therapists were often casted into roles in *psychiatrie transculturelle* therapy groups and were expected to perform their cultural diversity, even when these performances did not seem genuine and when other forms of diversity and belonging, in terms of gender, sexuality, age, or religion, were not given the same attention. Rather, the scripts that supervisors expected apprentices to follow would guide the imagery and associations that apprentices were expected to produce. The psychologist stated that this imagery had an impact on the consultation since it allowed to the patient to observe a different mode of thinking on the part of the therapist. This, in turn, could have the effect of changing the way that the patient perceived the professionals in the group. Having a different regard of professionals could be of particular importance since the patients who came to these *psychiatrie transculturelle* therapy groups often expressed their frustration with professionals and institutions when there was a lack of understanding and shared decision-making. Yet learning to "create a sentiment of otherness" became a source of uncertainty for apprentices, who were unsure as to whether their imagery and associations were appropriate or usable by the group.

The enactment of the *psychiatrie transculturelle* therapy group drew upon the experiences of all of the members of the group and served to valorize exchanges concerning traditions, dreams, and linguistic expressions. The supervising clinicians cited above described how the ability to enact the clinical space took place over time and once apprentice therapists became accustomed to speaking in the group. Apprentices were initially apprehensive to speak in

the therapy groups because they were concerned they would say something that their peers or supervisors found stupid, or that their comments would potentially be distressing for patients.

Policing sincerity

Apprentices were evaluated when they were explicitly corrected, when they were reprimanded for what they said, or when their supervisors misunderstood or ignored their imagery or associations. Others have documented instances in which principal therapists were dissatisfied with the propositions of individual co-therapists or with the therapy group as a whole (Larchanché, 2010: 137; Sturm, 2005: 91). My research departs from these previous studies since I evaluate how moments of dissatisfaction structured the pedagogical relationship between supervisors and apprentices. Supervising clinicians corrected apprentices who addressed patients directly, when in fact they were supposed to address the principal therapist, who would filter co-therapists' imagery and associations and present these to the patient. For example, one apprentice recounted learning this through trial and error:

> "I hadn't really followed the rule to not address patients directly. And so when Raphaël [the principal therapist] turned to me, I spoke directly to the patient and I looked them right in the eyes. And after the therapy session, during the debriefing, Raphaël said, 'address me, not the patients.' I was a bit upset by his remark, but then I realized that a patient cannot have ten interlocutors as that would be completely destabilizing."

Supervising therapists also corrected apprentices when their comments were not appropriate, or when apprentices asked questions of patients. For example, during one therapy session for a man who had lived in several countries before arriving in France, apprentices asked questions about the details regarding the man's history of migration. These questions seemed to irritate one of the supervising psychologists. When one of the apprentices asked why the man came to France, the psychologist said, with a face cast downward and shaking her head, "You have to stop asking

questions." Later on, after the patient had left and the group discussed the therapy session, the psychologist reiterated her comments that apprentices were not supposed to ask questions during these sessions. Stating that patients don't like being asked questions, the psychologist continued, "If you had asked me why I moved to France, I would tell you that I came for the weather or given some other bullshit answer."

Some saw supervisors' efforts to correct forms of speech as imposing sanctions in environments of free expression:

> "…it's a place where speech should be free, it's a place of exchange and its around this free exchange that something is constructed with families. What I tried to say this year, for example, it's as if there were things that were not transculturally correct or something like that and there was a sort of sanction of speech, that it should not have been said like this, that one should not speak like that, and that I find *that* is not transcultural. Everyone should be able to freely say things in any case, they speak directly to the principal therapist and the principal therapist does what she or he wants with it. It's not a big deal, there is no big deal with the way one speaks. There isn't a good way or a bad way."

These comments reflect the crux of an important tension between free expression and discipline that has captured my interest throughout this project. On the one hand, *psychiatrie transculturelle* therapy groups were spaces where "speech should be free." Yet on the other, speech that was not "transculturally correct" could be sanctioned.

Apprentices were also corrected when their comments were considered to be insincere or inauthentic. More specifically, some questioned the extent to which apprentices' statements were personal, unique, and "honest:"

> Apprentice: "It's not about saying, '*Moi, dans ma culture*… [In my culture…],' no. It's not about that. You can say anything and then say, '*C'est dans ma culture*,' no. You have to be honest, you have to really feel it. But many times, at least two people, like Josephine and Vera [other apprentices], they felt that they had to say something and then they would say anything by adding, '*Moi, dans ma culture'* [laughs]…it's about how you feel. It has to be like that for you, for your culture. So if you say, '*Chez moi au Pakistan, c'est comme ça*,' [In Pakistan, it's like this] or '*Aux Etats-Unis, c'est comme ça'* [in the United States, it's like this] it has to be your own experience. It must be something that you've lived. I remember one example, Josephine said, '*Dans ma culture, en Tunisie, on dit que l'âme…*' [In my

> culture, in Tunisia, one says that the soul…' and then she started talking about philosophy, which has got nothing to do with culture or Tunisia. It's almost saying that it's universal."
>
> DA: "Did you or someone correct her?"
>
> Apprentice: "Later on...I said, '*Ce que tu as dit, ce n'est pas en Tunisie, c'est partout*' [What you said isn't in Tunisia, it's everywhere]"

These statements illustrate that it was not just supervisors who corrected apprentices; they also pushed back against each other's statements. As this apprentice suggested, one could not simply use the expression, "In my culture" to introduce an image. Rather, the speaker needed to be "honest" and present one's "own experience." Moreover, speakers were supposed to avoid general and universal expressions, as these were not considered to be an authentic component of one's experience.

While apprentice therapists found that their comments were corrected by principal therapists or even by their peers, they often found that they received feedback in less direct ways. One's comments might simply be ignored:

> Apprentice: "Well I can give you negative feedback first it's very clear that what you said is just ignored"
>
> DA: "Oh, like you say something and then—"
>
> Apprentice: "The principal therapist is just like, 'Okay, well let's go on to the next person' [laughs], that's very clear. Positive feedback would be…the opposite when they would say, 'whatever he's saying is very interesting.' However the principal therapist takes your world and uses it, it becomes obvious whether in his or her own agenda, or way of working, it is useful or not. That's how I [know], and when you feel, 'oh, they're using it,' they are dwelling on it for a while. Or, when the patient says, 'oh yeah, that's very interesting. I often think about that.' You feel good. I think, 'whatever I just said is relevant.' But when the patient is like, 'no, I've never thought about that,' you're like, 'oh shit, I said something wrong."

Apprentices wanted not only to contribute to the ongoing clinical work of these settings, but also found the praise of their supervisors to be rewarding and an indication that they were. As this

apprentice described, principal therapists determined whether comments were appropriate if they reformulated them for the patient. As mentioned previously, since it was only the principal therapist who spoke directly with patients, the comments of co-therapists were directed towards the principal therapist, who then decided whether to use them or not. But to be considered usable in *psychiatrie transculturelle* therapy groups, apprentices' comments needed to adhere to the "agenda" of principal therapists. The appropriateness or usability of comments was not made explicit but rather became apparent depending on whether and how the principal therapist used them. I contend that not knowing if one's comments were usable in therapeutic interactions was a major source of uncertainty for apprentices, and the ambiguous agendas of principal therapists did not aid apprentices in resolving these uncertainties.

The appropriateness of apprentices' comments was also assessed in the reactions of patients. After all, while apprentices spoke directly to principal therapists, their words were intended for patients. In fact, apprentices discovered that principal therapists did not find their comments to be appropriate, whereas patients and other co-therapists did:

> "I don't know if you were there. [I proposed the image] of a fish, a fish in the river, carrying a lot of weight, like all kinds of boots and stuff that he's, like an underwater fish with all kinds of stuff on the fish, and a hook in the fish's mouth. And then, in order to get rid of the hook, the fish has to go back a bit, so that it's less tense, the line. Anyway, the therapist found it very confusing. He was not having a good day [laughs], he said, 'let's just move on' basically…but then the patient was like, 'No, I actually liked the image.' It was funny because the reason that I remember is that this was narcissistically rewarding. It was narcissistically painful that the principal therapist didn't like it. It was rewarding that the patient was like, 'Yeah, I can identify with that.' And the third level was, a bit later, one of the other interns came back and was like, 'I actually really liked that image,' and then she added something to it."

The "levels," described by this apprentice, refer to the feedback that apprentices received from each of the interlocutors in the group, whether peers, supervisors, or the patients. Moreover,

apprentices defended their peers when they found that principal therapists were attacking them for speaking in ways deemed unacceptable in the therapy sessions:

> "It was interesting for me to see how there is this underlying game where, obviously the other intern, was like 'Oh, why are they attacking him? I need to defend him.' So there's a whole level of these images that are supposedly thrown in, become a kind of kudos."

While apprentices occasionally pushed back on each other when their imagery or associations were not considered genuine or honest, they could come to each other's defense when they suspected that supervisors were being overly critical.

Apprentices inserted themselves—or rather they were inserted by their supervisors—into the "mechanism" of these group therapy sessions through their participation as co-therapists in the group. Apprentices learned to speak in these consultation settings but their speech could not take the form of direct questions or interpretations of the material proposed in the consultation. Instead, they were expected to look inward to associate what patients discussed with their own experiences. This was a complex task that required apprentices to observe their peers, attempt their own speech acts, and at times be corrected by their supervisors or peers. As some apprentices suggested, they were learning to work with material about patients in ways that were quite distinct from what they learn in their coursework or clinical training in psychiatry or psychology. Significantly, supervising clinicians encouraged apprentices to unlearn the modes of questioning and reasoning they acquired in their clinical training and instead, be more open in their engagement with the speech of patients. Despite encouraging openness and the liberty of expression, these supervising clinicians—and fellow apprentices—harshly evaluated and policed the sincerity of imagery and other propositions by ignoring or correcting apprentices. The direct and indirect disciplining techniques used in *psychiatrie transculturelle* therapy suggests that while supervisors seemed to encourage an environment in which associations were ostensibly

free and open among the therapeutic team, the speech that circulated in these spaces needed to adhere to the agendas of the principal therapists leading each session. The next sections analyze the pedagogical functions of another setting that utilized a different approach to working with patients. Unlike the *psychiatrie transculturelle* therapy groups described here, apprentices in the setting described below were actively encouraged to speculate and make interpretations about the elements of patient cases.

"Avoid the exotic and get back into the clinic." Case presentations

At the Minkowska Center, during one of the *Médiacor* assessment meetings, one of the apprentice therapists presented the file for a 16-year old adolescent named Abdoulaye. A nurse and social worker in the vocational high school that Abdoulaye attended referred him to see a psychologist in this particular center. The apprentice therapist stated that Abdoulaye was originally from Guinea and arrived in France after a ten-month journey through several countries, including a seven-month stay in Turkey. The following extract is from the exchange between the apprentice therapist, one of the administrative directors of the center, and one of the psychiatrists:

> Apprentice: In terms of his *sickness*, I don't know the socio-political situation in Guinea or why exactly he left Guinea
>
> Director: And we don't know which Guinea [referring to either Guinea-Conakry, Guinea-Bissau, or Equatorial Guinea]?
>
> Apprentice: We don't know which Guinea. He lived with his grandmother, but he currently lives with his mother, who arrived [in France] over ten years ago. In terms of his *illness*, he is the one asking to see a psychologist since things are not going well at all for him. The journey really shocked him. He says that he changed a lot over the course of the journey, and he often thinks about what he lost over the course of the journey
>
> Psychiatrist: Avoid the exotic and get back into the clinic, what is the semiology that you're thinking of using after all of that?

Apprentice: Trauma

Psychiatrist: You should position yourself around trauma right away, with everything that he has seen, right away, it's certainly trauma

Apprentice: Certainly trauma

Psychiatrist: As soon as you find what's characteristic of trauma, you should say so

Apprentice: In terms of the semiology, he regularly has nightmares, memory problems, difficulties understanding, as well as somatization. With regards to his personality, according to his social worker, he's a remarkable apprentice with excellent grades and flawless behavior. So next, I should present the *disease*?

Psychiatrist: You'll arrive at the *disease*

Apprentice: I would say trauma from his journey, a sudden change in his socio-cultural surroundings, and according to the semiology, to go a bit faster

Psychiatrist: You should speculate

Apprentice: If I speculate, I would say that there is a generalized state of stress, the impact of exhaustion on his attention and concentration, the effects of somatization that we see as well

Psychiatrist: How would you say that if you dare to be a future therapist? What's a generalized state of stress? What does that mean?

Apprentice: It's a state of post-traumatic stress

Psychiatrist: Which means it's traumatic? What makes you think that? In any case, you are dealing with a history like this, you cannot say right away, you cannot try since you don't have all the elements, the nightmares, the difficulty sleeping, all the elements of PTSD [Post-traumatic Stress Disorder]. We're in agreement, we are dealing with trauma and we will see if there is anything else. At least you're at the center of the diagnosis. And he says, "I want to see a psychologist," he wants to talk about what's bothering him?

Apprentice: His journey really shocked him

Psychiatrist: What is it that was shocking? You know that he spent seven months in Turkey. Because apparently there was no mention of a brutal stressor in his country of origin

Apprentice: The way I see it, he thinks often of what he lost during the course of this journey

> Psychiatrist: And what would he have lost?
>
> Apprentice: His roots
>
> Psychiatrist: Why? It's not his roots that pose the first problem. How old is he? Sixteen? What do you think you lose when you go through hell at sixteen, at least psychologically? Your ideas about humanity! The roots will come later, much later. He's not saying "I'm no longer in Guinea" no, no, it's "In what kind of a state am I?"

During these presentations, the apprentice therapists needed to summarize the details presented in the referral documents. As illustrated in the last chapter, referral documents sent by external health and social service professionals could be very detailed or they could include scant information regarding a patient's medical or social history. Generally, apprentice therapists were asked to present the most essential information contained within these documents in a short span of two to three minutes. The supervisors and, at times, other apprentice therapists would ask them for additional details about the referral or the history of the patient. Apprentices were presented with the challenge of trying to determine the kinds of information that supervising clinicians in this center valued and knowing how to consolidate and organize this information into concise, shareable forms. While apprentices could determine what information their supervisors valued from the intake form described in the previous chapter, they gradually learned by repeatedly observing the presentations of their peers and by undertaking these presentations themselves. Supervisors questioned apprentices or encouraged them to speculate to try out and debate different ideas about referred patients' histories and diagnoses. Drawing on interactions between apprentices and their supervisors, I argue that while speculating seemingly allowed apprentices to engage in open and free discussion of complex patient cases, it was a also a crucial site at which apprentices were disciplined to speak about patients in ways deemed appropriate by their supervisors.

From observation to participation

Over the course of my fieldwork, one of the secretaries retired after nearly forty of service in this center. This secretary had been a major presence in the establishment. Her role was different from the reception staff since she had been in charge of preparing the referral documents that were discussed during the *Médiacor* meetings. When I began my fieldwork, the secretary presented information in the referrals to the *Médiacor* group to facilitate the triaging of referrals. During this time, apprentices observed the meetings and could ask questions at the end. Over time, however, they gradually became more integrated in the administrative tasks of organizing the information in referrals. Some staff members informed me that this was due in part, because of the additional workload that resulted from the increase in referrals that this center has received over the years. But it may have also been due to the fact that the staff sensed that apprentices were frustrated with their lack of involvement in the center's clinical work.

Upon this secretary's departure, she gifted the center a large and colorful map of the world, which was hung on the wall in the conference room in which the *Médiacor* meetings took place. The map filled the wall space and added a bit of brightness to an otherwise drab conference room. But it also became worked in to the pedagogical interactions between apprentices and supervisors during the assessment meetings. At times, during apprentices' presentations of referrals, the supervisors occasionally stopped them and asked them to point out on the map the countries from which patients originated or traveled. An apprentice would stop, stand up, walk over to the map, identify a country or transit route, then sit back and continue her or his presentation. During one instance in which I presented referral documents for an individual from Georgia, I was asked to locate Georgia on the map. As my finger was moving east across the Black Sea, one of the psychiatrists, knowing that I was from the United States,

jokingly reminded me that I was to point out the country and not the state of Georgia. This mapping task had the effect of making these presentations more interactive as it momentarily shifted the gaze from the apprentice to the map. At times it had the effect of showcasing when an apprentice had suboptimal skills in geography. I personally found this task to be a somewhat patronizing addition to the presentations, though I obliged when asked to identify Georgia's location. It gradually became clear to me that the supervisors genuinely wanted apprentices to know about the migration trajectories of their patients. Indeed, the supervisors often expressed frustration that referring professionals seemed to posses little geopolitical knowledge about their patients. Indeed, it seemed important to these supervisors that apprentices should be able to point out on a map which Guinea a patient like Abdoulaye came from, and how a stopover in Turkey clearly represented a very complex and circuitous route.

The socializing function of assessment meetings

The administrative directors in the Minkowska Center established the *Médiacor* intake meetings to examine referrals from health and social service professionals and reduce the amount of time that patients like Abdoulaye must wait to see a clinician. After all, patients could wait up to six months to see a clinician in an outpatient mental health center (CMP), a time frame which did not include additional delays resulting from referrals between different health and social service settings. In addition to their triaging function, these meetings were also the principal pedagogical encounter between apprentices and supervising clinicians in this center. In the previous chapter, I analyzed the back stage work that apprentices undertook as they sorted through referral documents to prepare for these meetings. The meetings themselves represent the

front stage where apprentice therapists performed their knowledge of patients through case presentations.

The apprentice therapists played an important role in the *Médiacor* meetings since their presentations facilitated the triaging of incoming referrals. The supervising clinicians did not have the time to read through the referral documents themselves, nor did they have time to contact the external referring professionals when referrals are missing information. Therefore, apprentices made an important contribution to the administrative work of the center. In return, apprentices benefitted by learning about patient cases and the reasoning processes undertaken by clinicians:

> "It's a place to meet and discuss clinical work. Any professional in the center can come to the intake meetings to say, 'I'd like to talk about this case, could we discuss?' Above all, it has become an important place for the apprentice therapists; it's there that they learn the semiology, the course to follow with this or that patient, it's something that they really hold on to."

> "The objective is pedagogical, when they participate in the intake meetings, they see in real time the path of the patient, who referred the patient, why the patient was referred, are the reasons for the referral good or bad? Next, how do we react to the referral? Are we able to do it [to take on the patient in this center]? Is it a valid indication or not? Is there a diagnosis or not?"

The supervisors suggested that these meetings were an important site of exchange and learning about diagnoses, treatment, and the pathways of patients. These meetings were also a principal site at which apprentices' discourses may be assessed and corrected by their supervisors and peers. Indeed, in this setting and in the *psychiatrie transculturelle* groups described earlier, apprentices were not evaluated with exams, but received different forms of formal and informal feedback.

For example, in the presentation of Abdoulaye, the apprentice therapist's use of the terms, *illness, sickness,* and *disease,* was an instance of a particular vocabulary that is a

component of the center's institutional framework of *anthropoologie médicale clinique*. These terms were meant to structure the ways that apprentices present patient cases and, more generally, think about their patients' histories. Indeed learning a vocabulary is an essential component of learning how to give narrative structure to a patient's story (Good and DelVecchio Good, 2000: 54). In the present context, these apprentices were learning to deploy the center's vocabulary to understand immigrant patients' experiences of mental illness. But this vocabulary reflected more than just a set of terms to use with and about patients. Rather, it was meant to impact the ways in which these apprentice therapists engaged with patients. In writing about a clinic for homeless individuals, Beverly Ann Davenport (2000: 323-324) has described how students learned an alternative behavioral vocabulary that would allow them to consider the entirety of a patient's situation; this vocabulary was meant to protect against the potential erosion of the humanistic values apprentices learned during their time in the clinic. Similarly, while apprentices may never employ the terms, *illness, sickness,* and *disease* in their future work, perhaps the specificity of these terms will serve as reminders to watch out for what these terms represent.

By engaging in speculation, apprentice therapists were invited to demonstrate their knowledge about the unknown elements of their patients' histories. In the example of the apprentice's presentation above, the psychiatrist invited the apprentice therapist to speculate since the apprentice did not possess all of the components of Abdoulaye's case. Speculation, in this context, required the apprentice therapist to identify the known and unknown about patient. It also required the apprentice therapists to anticipate how the ensemble of this information could be used to construct a clinical profile.

Speculation and anticipating authority

In an account of how law students learn to think like lawyers, Elizabeth Mertz (2007: 77) has described the multiple functions of speculation: to alert students that there is more taking place beneath the legal texts than obvious upon first glance, to encourage students to be more aware of the strategic effects of proceeding in one way or another in their arguments, to initiate students into a particular genre of storytelling, and to further the opening up of legal readings to a wider array of cultural stories about why things happen. Mertz's analysis of speculation is helpful in the present context as it illuminates how apprentices were attempting to make sense of the scripts and forms of reasoning expected of them by their supervisors. Indeed, just as the first year law students in Mertz's (2007: 77) account were "learning to unravel the cultural logics" of the legal profession, the apprentices in this center were learning to anticipate the kind of authority they would need to perform as future therapists. Moreover, as Cheryl Mattingly (1991: 1000) has described, expert practice among clinicians involves their ability to put all the elements of a patient together in a narrative form. As illustrated in the previous chapter, apprentices drew on information contained in the referral documents, as well as extracted and inscribed certain details onto forms that were meant to guide their presentations in the assessment meetings. During their presentations, apprentices were expected to be able to take the information contained on the forms and present it in a concise and coherent manner. But rather than read directly from their forms, apprentices needed to present the information in a narrative structure that would be recognizable to their supervisors. When information was absent or unclear, they would be asked questions to clarify or invited to speculate. Drawing on the perspectives of Mertz and Mattingly, I suggest that apprentices needed to read beyond the texts of the referral documents and anticipate the kinds of presentation styles their supervisors

expected of them. In the present context, apprentices were discouraged from relying on their forms or notes since that would take more time and would come across as less authoritative or fluid in their presentations. Instead, apprentices were asked to speak with authority as if they were speaking to a future colleague, as reflected in the psychiatrist's question: "How would you ask that if you dare to be a future therapist?"

Writing about nurse-patient discourse, Sally Candlin (2002: 191) has suggested that establishing comprehensive coherence requires individuals to make connections between sentences and sequences of sentences, and to determine how these connections fit with the overall framework of the activity. In other words, individuals with more experience appear to rely less on specific informational guidelines, such as those included on the form. Candlin (2002: 192) quotes Benner (1984), who states that the "expert performer no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful alternative diagnoses and solutions." While the apprentice therapists were not experts, their acquisition of the expertise espoused by their supervisors required them to be able to establish coherence from the referral information and present it in ways that their supervisors saw fit.

In interviews, apprentices described how their presentations during assessment meetings allowed them to demonstrate their knowledge in front of more experienced clinicians:

> And we [apprentice therapists] were asked our opinions even though we did not have the same level of expertise. But, it really seemed like a roundtable where people contribute their different skills and ideas to solve a complex problem.

Similarly, supervising clinicians described how assessment meetings allowed apprentices to observe how more experienced clinicians reflect on patient cases:

> "For me, it is really precious for the therapists in training to see how to reflect on clinical cases, it's an institutional moment, it creates an experience of shared experience and apprenticeship for people in training"

Apprentices were not only asked for their opinion or to observe their peers sand supervisors. Rather, they needed to make clear their reasoning in a manner that was professional and authoritative. Speculation was thus a crucial activity in which apprentices logically combined the known and unknown elements of patient cases. The supervising clinicians reflected on the importance of asking apprentices to speculate:

> "In asking the apprentice therapists to speculate…it makes them think for themselves, it gives them the right to be, and…it's a way to readjust perhaps some people's thinking or beliefs or whatever the case may be. The apprentices therapists need to be able to justify why they're saying that, but I also believe that if it doesn't fit with the framework of the institution, it will be known, the institution will try to correct that thinking."

Speculation served multiple purposes: it allowed apprentices to perform their knowledge and it allowed supervisors to correct apprentices. The tension between speculation and correction reflects the tension between improvisation and authority in clinical contexts (Kirmayer, 1994). As Kirmayer reminds us, authority permits improvisation but also constrains it. By asking apprentices to speculate, supervisors encouraged apprentices to improvise in their understandings of patient cases, but simultaneously confined the possible range of improvisation to the kinds of thinking that were in line with the framework of the institution. In this regard, supervisors constructed what Bosk (2003: 94-95) refers to as a "binding definition of reality," where they set the limits about appropriate forms of improvised knowledge.

Supervisors would ask follow up questions of apprentices to gather new information or to clarify what an apprentice had already presented. If apprentices gave too much information in

their presentations, or presented this information in a jumbled manner, then supervisors might ask questions regarding details that apprentices had already presented. As in other accounts of medical training contexts (Bosk, 2003: 97), when individuals do not provide enough information, their supervisors may need to spend more effort to gain an accurate reading of the situation. Additionally, supervisors in this setting would ask leading questions to guide apprentices toward a particular line of reasoning. A good presentation of a case needs to be contain enough information to follow the chronology of a situation, identify the important aspects in order to construct an image, and illustrate an analysis of how certain information was judged important (Atkinson, 1995: 97). A presentation should not just be a repetition of facts but should show their organization (Atkinson, 1995: 98). Thus, these presentations need to be concise and pertinent and should construct an image of a patient (Atkinson, 1995: 97; Anspach, 1998: 362; Menchik, 2015: 720). Put shortly, presentations should have "no fat, but [have] no meat trimmed" (Light, 1980: 201-202).

Apprentices explained that their interactions with supervisors were confrontational at times. Apprentices did not always appreciate being corrected, though they recognized that 'daring' and learning were closely tied:

> "[One of the supervising psychiatrists] asks our opinions and we have a lot of liberty, but he freaked me out a bit [laughs] because I told myself that if I say something stupid, he is going to tear me down…he corrects people, and his way of doing it scares me. I find that it's not always friendly. But it's good for those who dare and who are not afraid to put themselves out there in a room full of ten people. It's better because they learn a lot faster. They think something, they propose a diagnosis, but then are told, 'Oh no, it's not that, because there is this or that element, so it's not that at all.' And the next time, they won't make that mistake. I think that because I don't dare as much, I retain less."

Apprentices often reported feeling anxious about presenting information in front of their peers and supervisors because of the fear of being 'torn down.' While encouraging apprentices to learn to focus on information often overlooked in psychiatric and psychological consultations, the

supervising clinicians often used the same Socratic methods found in the clinical training that they wanted apprentices to unlearn. Indeed, as Holmes and Ponte (2011: 174) describe in their article on case presentations in medical school, fear was often instilled in students in order to manage their language use and so that they would more easily be identified as a professional. While it might seem unsurprising that supervising clinicians in this setting would use similar kinds of instructional methods as in other clinical education contexts, what was paradoxical was how these supervisors thought these methods would encourage apprentices to unlearn the rigid ways of thinking they acquired in their coursework and clinical training. More specifically, what was surprising was how these supervisors would instill a culture of fear when trying to encourage openness and the embrace of uncertainty. One of the psychiatrists, speaking in the voice of a hypothetical apprentice, justified these practices by emphasizing the importance of making mistakes in this setting and not later on in one's career as a professional:

> "If I am training, that means that I am here to learn. I ask questions and I am not afraid to ask questions and I am not scared to make mistakes because I am in training. It's better that I pose a dumb question now, because that means that I will not ask it later."

Disagreements among the apprentice therapists and supervising clinicians demonstrated that certain ways of thinking about patients in this context were prioritized over others. Yet these disagreements also appeared to serve a pedagogical function as well since, as the apprentice above suggested, those who dared to give an opinion retained information better than those who did not attempt to do so.

In the example of the apprentice therapist's presentation of Abdoulaye, the psychiatrist's statement, "Avoid the exotic and get back into the clinic," illustrated how the psychiatrist redirected the apprentice therapist's thinking about Abdoulaye's case. Before the apprentice therapist could finish discussing Abdoulaye's experience of uprooting, the psychiatrist stopped

him and shifted the discussion towards one of trauma and its components. Case presentations represented a space where apprentices could demonstrate their knowledge but also learn to avoid making assumptions or over-interpretations. When apprentice presentations were not carried out in accordance with supervising clinicians, apprentices would be asked to justify the details included in their presentation or they may be corrected. In training, one of the roles of the supervisors is to help apprentices avoid making conclusions without enough proof (Schön, 1983: 123). In this context, apprentices were invited to speculate, but they needed to discipline their ways of reasoning so as to avoid making incorrect assumptions or over interpret a situation. In the chapter, "Don't Think Zebras," the bioethicist Kathryn Montgomery (2007: 123) explains how students in the beginning of their clinical training have a tendency to think of the most rare and exotic illnesses when they are confronted with the symptoms of a patient. The expression, "don't think of zebras," reflects the advice that supervisors give their students to avoid thinking of the most exotic animal when hearing the sound of galloping. In a similar manner, Schön (1983: 121) describes how those who are in the beginning of their training in psychotherapy tend to leap to interpretations that are not based in the symptoms or the statements of the patients. In the presentation of Abdoulaye, the psychiatrist told the apprentice to avoid focusing on the unknown elements, and instead return to those that were more precise. The statement "Avoid the exotic" could be considered as a request to avoid imprecise or potentially stigmatizing information, and to focus on the elements that can eventually help in diagnosis.

Learning from other apprentices

The lack of explicit instruction regarding how to present information was a significant source of uncertainty for apprentices. Moreover, apprentices pushed back against the notion that

presentations needed to follow a particular framework. One apprentice therapist with whom I spoke expressed frustration since she felt that the supervisors were advancing a specific agenda:

> "For me, there is no wrong way of presenting; it's just a different way of viewing the issue. So sometimes I felt that they [supervising clinicians] were a bit too strict in their opinion."

I inquired about the kinds of instructions that were given to apprentice therapists. In my apprentice-ethnographer role, I was supposed to know this information since I was, after all, undergoing the same training myself. I was also curious to hear how supervisors thought that apprentice therapists learned to conduct these presentations:

> "I would say piece by piece…the reality is that there isn't always someone present that is going to be sure that the person who comes in knows from A to Z, everything, so the apprentice therapist is getting information, left and right, little by little."

Apprentices acquired information in a piecemeal form and from various sources. They often learned from each other, particularly in instances where apprentices who had spent more time in the center provided instructions for newcomers. Near the end of my fieldwork, one of the supervising psychiatrists emailed a PowerPoint file to several of us who had been in the center for some time. The file highlighted the necessary components of apprentices' presentations, and the psychiatrist expected the file's recipients to diffuse this information to their peers. While I did not present this file to the other apprentices, I was an audience member for a few of my peers' presentations.

In addition to being instructed by more experienced peers, apprentices described learning by observing and mimicking their peers:

> "By watching and listening. But, gradually, more precise instructions were given because the professionals were not always satisfied with how the files were presented. So gradually they started giving us clearer instructions, like, "We want this and this and this to be featured in the presentation."

This apprentice therapist's comments illustrate that precise instructions were given after, rather than before apprentices undertook their presentations. Taken together with the comments on the psychologist above, this suggests that apprentice therapists were learning to present in an interactional and iterative manner that reflected a method of trial and error. In other words, apprentices observed their peers' presentations, attempted their own presentations, and were corrected by the supervising clinicians.

Apprentice therapists described learning to speak and present by observing their peers and then trying out their own presentations. Group work allowed apprentices to listen to their supervisors and peers, often those with more experience reason out loud (Fox, 1957: 227). This allowed them to see how their more senior colleagues organized and used information. Indeed, these interactions with peers and with supervisors were a crucial component of socialization (Bergeron and Castel, 2014: 168). Through repetition, apprentice therapists learned what constituted a good presentation or way of speaking within these groups. Learning what supervising clinicians expected required, as one of the apprentice therapists described it, putting oneself out there in front of the group and making mistakes.

Concluding remarks

In these settings, apprentice therapists managed uncertainties by drawing upon the frameworks to make sense of the details contained in patient histories and to speak about patients in recognizable forms to their peers and supervisors. These frameworks required apprentices to utilize a particular vocabulary or way of speaking, such as in employing terms like *illness* or beginning statements with "I ask myself…" when speaking in the groups. Learning to

appropriate these ways of speaking was essential for apprentice therapists to participate in the routine work of these therapeutic settings.

In addition to the guiding role that frameworks provided for apprentice therapists, frameworks also reinforced the legitimacy of the therapeutic settings in which they were used. This is because they represent or establish the boundaries of knowing about a patient's history. Linguistic anthropologist E. Summerson Carr (2010: 20) describes how expertise is ideological because the content that is performed must adhere to pre-existing frames of knowledge. Apprentice therapists and supervising clinicians described certain ways of thinking and speaking about patients that were considered acceptable and appropriate, whereas other ways that would be corrected. Moreover, the implementation of specific guidelines, such as the form to give apprentices a more explicit idea as to which information to extract from referral files, served to solidify the framework of the institution.

Apprentice therapists were engaged in diverse tasks in the therapeutic settings in which they undertook their apprenticeships. It is important to recall that while these apprentices acquired knowledge and experience, their work also contributed to the organization, functioning, and legitimacy of these settings. Indeed, their participation as co-therapists in group therapy sessions allowed the principal therapist to incorporate a variety of perspectives, and their presenting of referral files facilitated the screening procedures of incoming patients. While supervisors encouraged apprentices to unlearn the rigid ways of thinking they acquired in their studies in psychiatry or psychology, they imposed a similarly rigid framework to think about the work that culture does in therapy. The frameworks used in these therapeutic settings mediated the ways that apprentice therapists translated the material provided by patients or referring clinicians into material considered useable by supervising clinicians. Apprentices learned to

apply and appropriate these frameworks by trying them out through interactions with their peers and supervisors.

As one of the residents in psychiatry described, apprentice therapists needed to insert themselves into the mechanisms of the therapeutic settings in which they underwent training. These mechanisms may seem strange at first and require apprentices to think differently about patients than they are used to in their coursework. The objective of this chapter was to evaluate the mechanisms by which apprentices became inserted into the activities within these therapeutic settings and analyze how they learned the frameworks that guided these settings' practices.

In each setting, the activities of speaking conducted by apprentice therapists contributed to the development of a particular story of a patient. In the *psychiatrie transculturelle* group, apprentice therapists contributed to the group dialogue, which was recorded by another apprentice therapist and eventually re-presented in a streamlined form to the group so that the group could determine how to proceed in subsequent consultation sessions. This process continued over the course of the consultation sessions with a particular patient. In the Minkowska Center, drawing on the material presented by the apprentice therapist and the dialogue that it generated, the group decided how to act with regards to a patient. Speaking, a performative act, required apprentices to reconsider how they thought about patients and how they engaged with future colleagues.

However, as with the documentary artifact production discussed in the previous chapter, the rules of appropriate ways of speaking were a source of confusion to apprentices, particularly since these rules contrasted starkly with the liberty of expression seemingly encouraged by supervisors in these environments. This was especially significant since these supervisors made clear distinctions between these settings and other kinds of clinical environments that were

bound to rigid ways of thinking and functioning. I argue the rules regarding appropriate speech, which aimed to reduce uncertainties, inadvertently produced new forms of uncertainties for apprentices, who found the rules to be implicit and the agendas of their supervisors to be ambiguous.

Chapter 5. Activities of seeing: Transmitting a vision of the institution

Having focused on apprentices' involvement in activities of presence, reading and writing, and speaking in immigrant mental health settings, I was curious to learn what supervisors found to be purpose of these activities. During an interview with one of the supervising psychologists, I asked what supervisors were trying to teach or transmit to apprentices through these activities. The psychologist responded, "What is transmitted is a vision of the institution." I would eventually come to understand that vision referred to an ensemble of techniques and ways of thinking about culturally sensitive therapy that apprentices were to appropriate over the course of their training. The psychologist added:

> "It [the institution] is also trying to transmit a belief, which is why it has that framework, according to the institution, [for] the right place for culture in your clinical relationship, in the human relationship.

It seemed that by inhabiting the roles created within these settings and performing the tasks associated with these roles, apprentices were to acquire the institutional visions in these settings. Through the acquisition of a particular institutional vision, apprentices would learn the appropriate ways to think about culture and its relevance in therapy.

Chapter overview

In using the expression "activities of seeing," this chapter analyzes the meanings and experiences of learning to see and consider patients in the ways that supervisors see patients. More specifically, this chapter addresses two questions: What makes up an institutional vision and to what extent do supervisors' and apprentices' perspectives converge regarding the composition of these visions? What kinds of institutional and collaborative conditions, as well as features of professionalization, facilitate the development and transmission of institutional

visions? In using the term, "vision," I draw directly from the psychologist quoted above, and consider vision to mean the set of ideas and dispositions that supervisors want their apprentices to develop. "Seeing" refers to the enactment of these ideas and dispositions, or, in other words, the ways that apprentices learn to see patients and clinical situations through the eyes of their supervisors. Whereas my analysis has largely focused on apprentices in the previous chapters, I now turn to the supervisors and analyze what they consider to make up the "vision" they wish to transmit to apprentices.

The aim in this chapter is to understand what supervisors wanted apprentices to retain from their apprenticeships. In the sections that follow, I intend to think through the notion of vision by considering its relation to scholarship on language and organizations. Next, I turn to the perspectives of supervisors, who commented on what they considered to make up the vision they wish to transmit to apprentices. These supervisors described more general approaches to addressing uncertainty, offered specific rationales for their pedagogical methods, and reflected on some of the challenges that may hinder apprentices from learning to see as they do.

After considering the perspectives of the supervisors, I then evaluate the extent to which these expectations of supervisors mapped on to the experiences of apprentice therapists. In some instances, apprentices described how the training they received in *anthropologie médicale clinique* seemed conceptually rich, but lamented that they had a partial view of the ensemble of clinical activities in the Minkowska Center since their interactions with supervisors were limited to mediation meetings and to observations with select staff clinicians during initial, evaluative appointments with patients. In the *psychiatrie transculturelle* groups, on the other hand, apprentices reflected on what they saw as a collection of practices that were not sufficiently anchored in theory. In other words, apprentices described performing tasks and routinized

activities, often with patients, but without an understanding of the rationale for these tasks or activities. By confronting supervisors' and apprentices' perspectives, I analyze the conditions that favor or obstruct the transmission of an institutional vision. Put simply, I intend to evaluate whether apprentices learn what their supervisors intend for them to learn or whether they become "institutionalized," or absorbed in the matters that are of interest within these settings and have little relevance outside of them (Becker et al., 2003: 432).

Narrowing vision through apprenticeship

In *Seeing Like a State,* James Scott (1998: 11) has described how narrowing vision involves the processes of simplification, rendering legible, and manipulation of knowledge:

> "Certain forms of knowledge and control require a narrowing of vision. The great advantage of such tunnel vision is that it brings into sharp focus certain limited aspects of an otherwise far more complex and unwieldy reality. This very simplification, in turn, makes the phenomenon at the center of the field of vision more legible and hence more susceptible to careful measurement and calculation. Combined with similar observations, an overall aggregate, synoptic view of a selective reality is achieved, making possible a high degree of schematic knowledge, control, and manipulation."

I quote Scott at length here since his discussion is valuable in thinking about how individuals convince others to see as they do. Getting others to appropriate a particular position or way of thinking and consider it to be fact requires "holding [their] focus steady," (Latour, 1990: 24). Seeing and enacting a vision are shaped by and take place within an institutional or environmental context. Moreover, the process of "instituting" is a "future oriented" activity and a "singularity project" (De Pina Cabral, 2011: 492). In other words, the appropriation of an institutionalized way of seeing requires processes of coordinating perspectives so that individuals come to see and interpret phenomena in an organized or meaningful way. Thus, it is important to examine just how individuals learn to develop and "strategically deploy" a particular vision

within institutions (Carr, 2010: 24) or other “culturally, socially, and materially structured” environments (Grasseni, 2004: 43). This is because institutions provide categories of thought, set terms for self-knowledge, and fix identities (Douglas, 1986: 112). Institutional visions become imposed and more durable or formalized through bureaucratic procedures and competences (Durão & Lopes, 2011: 372), as well as guidelines, protocols, and other norms of practice (Castel, 2009: 743; Castel & Crespin, 2015: 58).

Cristina Grasseni (2004: 41) has described how “skilled vision is not necessarily ‘visualist,’” but rather it is a skilled sense that characterizes practices. Grasseni’s analysis emphasizes the importance of local contexts and community in the development of a particular vision (2007: 9). In other words, vision is a form of situated knowledge acquired through legitimate peripheral participation (Lave & Wenger, 2009). Moreover, Grassenti (2004: 53) has described how a skilled vision “implies an active search for information from the environment, and is only obtained through apprenticeship and an education of attention.” Put another way, vision was what supervisors expected and anticipated that apprentices would acquire during their apprenticeship.

Scholars of apprenticeship, professions, and organizations have emphasized the importance of newcomers’ development of a particular vision or perspective in their socialization into a particular group and in the maintenance of the vitality of that group. Vision is a “ductile, situated, contested, and politically fraught means of situating oneself in a community of practice” (Grasseni, 2007: 1-2). Similarly, Charles Goodwin (1994: 606) has described professional vision as “organized ways of seeing and understanding events that are answerable to the distinctive interests of a particular professional group.” These groups determine and shape the exact nature of the kind of vision that they employ. Moreover, as Goodwin has stated, vision provides

individuals with an interpretive capacity to make sense of new events and information. Alessandro Duranti (2006: 305-306) has suggested that individuals assume and constitute a professional vision through activities of transcription. Indeed, as described in chapter 3, apprentices learned to focus their attention to the details that supervisors prioritize through activities such as scribing in consultation sessions. Indeed, skilled visions "orient perceptions and structure understandings" (Grasseni, 2007: 5). Similarly, Van Maanen and Schein (1979: 211) have suggested that newcomers learn to carry themselves within organizational contexts because they have acquired a perspective, or the commonsense beliefs, principles, and understandings that permit individuals to interpret their experiences. Additionally, in their seminar study on student culture in medical education, Becker et al. (2003: 34-37) have described how perspectives differ from values or attitudes since they are contextually specific, contain actions as well as dispositions to act, and have a collective character. Developing a perspective or vision serves the organization since "new members must be taught to see the organizational world as do their more experienced colleagues if the traditions of the organization are to survive" (Van Maanen and Schein, 1979: 211.). Grasseni (2007: 9) has illustrated how contexts, relationships, and processes of apprenticeship put vision firmly in to place within a community of practice. Taking these points together, vision can be thought of as conferring interpretive lenses that are crafted within specific organizational contexts; vision allows individuals to understand their experiences within these organizations.

Developing vision may seem like an obvious expectation of apprentices within communities of practice. In many apprenticeship settings, apprentices may interact with several different supervisors, which Collins, Brown, and Newman (1989: 456-457) state adds richness and variety since apprentices learn that there may be various ways to carry out a particular task

and understand that "no one individual embodies all knowledge or expertise." The dispersal of knowledge and expertise not only adds richness, as these authors describe, but it may also serve a complementary or reinforcement function, particularly in instances in which there are gaps in knowledge. For instance, in the context of nursing, Benner, Tanner and Chesla (2009: 235) have described "lapses in attentiveness by one practitioner are shored up by another and an ethos of collective attentiveness. The inability to see a salient clinical sign or symptom is corrected by others' experiential wisdom and skill of seeing." In this sense, these authors have demonstrated that different practitioners' ways of seeing may by distinct, though cumulative and mutually supportive. Moreover, taking all of these aspects together, we can appreciate that an ensemble of different practitioners enacts the interpretive lenses of vision.

What constitutes vision? The supervisors' perspective

I was curious to know what supervisors wanted apprentice therapists to take away from their time in these particular settings. During my fieldwork, I not only paid careful attention to the kinds of instructions that supervisors gave apprentices, but I was also attentive to any future-directed lessons that supervisors provided. Indeed, as demonstrated in Chapter 4, some supervisors encouraged apprentices to speak in ways that reflected their work as "future therapists." In interviews, I followed up on these directives. Supervisors generally did not explicitly encourage their apprentices to develop new *psychiatrie transculturelle* therapy groups, particularly since they required a substantial amount of resources. Indeed, as supervisors often recounted, for every patient that the group of therapists received, they were not seeing patients on an individual basis. Supervisors instead emphasized that apprentices needed to be able to

recognize the subjectivity of the patient, accept their own experiences of uncertainty, and ask good questions in order to build a therapeutic alliance with a patient.

Supervisors described the importance of learning about the histories of patients. Patients may not readily share these histories because of previous instances in which they felt that they were not heard or taken seriously. As a result, patients may understandably be distrustful of clinical professionals. Therefore, these therapists must work to regain the trust of patients. The therapeutic process for one child psychiatrist, involved learning about these histories:

> "I think that a fundamental element is to know that behind these parents and their children, there is a subject of a history. And that it's a history to be discovered with them, and the therapeutic process will be to discover this history with them…they will, with us, become the subjects of their histories and that is what will help them and their children…this means that when a parent comes and discusses the weight of her or his work, the difficult conditions, feeling disappointed, the difficulties with their child, she or he says 'Yes, back home, we were nobles, my father was a noble,' and we don't see the person the same again…It's always interesting but also heroic, that behind these migrants there are heroes, and their children don't know it."

Therapeutic encounters involved both the uncovering of patients' stories and encouraging the children of patients to recognize their parents face the challenges they currently face in France. Therapy also involved not being afraid or unwilling to engage with patients when they have different ways of speaking about their experiences of mental illness:

> "One needs to do away with the idea that he or she cannot help someone who is from another culture or who speaks another language. Stop being incompetent and overly focusing on culture, because it doesn't mean much. And secondly maybe, be more curious about the culture of the other and don't allow yourself to be scared of what we call a confrontation of explanatory models. The other person has her or his model and I have mine, can we confront them to let both of us speak, in a context of exchange and a therapeutic alliance?"

By recognizing and giving attention to these different explanatory models, one could potentially avoiding ethnocentric perspectives about health, disease, and treatment that may come as a reflex for some practitioners. One psychiatrist emphasized the significance of avoiding falling back on rigid reflexes:

> "We don't know what's going on. We know that the person is suffering, that there are symptoms but we don't know what is going on in that person's head. If our reflex is to catalogue, to say this person is this or that, to respond too quickly, then we are prisoners of a sort of centrism. If we consider that our understanding is at the center of health, then we don't consider that the person could also have a medical culture that can help her or him. Maybe this person needs that I accept that she or he is sick but also that I accept her or his way of seeking treatment."

Another supervisor, a psychologist, advised that by learning to listen to patients required becoming open to the unfamiliar:

> "…they [need to] know that there are other cultures that are very far from theirs, that there are a lot of other truths, and that welcoming a human being means welcoming things that they don't know, and that they should not be afraid. For me, if they leave with that, that's really good."

For some supervisors, accepting uncertainty was an essential capacity in therapeutic encounters, which involved learning that there are "other truths" that may be unknown or unfamiliar to apprentices. These truths needed to be taken seriously by therapists since patients took them seriously. One psychiatrist explained how the life worlds of patients may be very real for patients although they may seem contradictory to apprentices:

> "…There are other worlds from ours, and these worlds exist and are just as real as ours. Sorcery, for them, that's a reality that's just as tangible as the economy or Christianity is for us. We believe in religion, we believe in the liberal economy, that's a belief as well. These are things that are very important for migrants and it's important to welcome these things, to take them seriously, all the while remaining distant…"

Some supervisors reaffirmed these comments and emphasized the need to take a more relativist stance, but stated that this was often easier said than done:

> "…To grant equal validity to all cultural productions, whatever they may be, it seems obvious but in practice, it's always difficult. Because our cultures, we're taken up by our cultures, we're acculturated, and that's part of us"

Others simply emphasized the importance of being able to ask open-ended questions:

> "Above all, I hope that they learn how to receive a person first, how to conduct a consultation. For me, it is super important that interns learn to ask open-ended questions, to

> not put words in the mouths of patients, that's something we have a tendency to do and so we need to learn."

Additionally, this same psychiatrist described that apprentices need to learn flexibility in their approaches since the reality faced by patients is never the same as what is described in books:

> "…We read in books how to conduct a consultation, the questions that one needs to ask, what one should do, the mental exam and all that, but the patient is never a prototype, he or she always things that happen so I like to teach them flexibility and above all the respect that the person is suffering"

The proximity to supervisors in their practice allowed apprentices to see a patient who likely differed greatly from textual case studies, to observe supervisors' interactions with patients and modes of reflection, and to understand the flexibility that supervisors wished to impart upon apprentices. Perhaps one of the most important opportunities for apprentice therapists in these group settings was the possibility to observe the different work styles of their supervisors and be able to absorb certain practices and dispositions.

Different styles in the group: Richness or a "cauldron?"

In each of the mental health settings where I conducted my fieldwork, there were multiple supervising clinicians, which meant that there were several supervisors from whom apprentices could potentially learn. Even in the *psychiatrie transculturelle* therapy groups, where there might only be one principal therapist, there were other psychiatrists or psychologists trained as co-therapists who could serve as mentors for apprentices. Supervisors considered the differences in the styles and personalities of supervisors and group members as a source of richness:

> "We don't have one principal therapist, we have several, we are four. So if some are absent, there's someone who can take over. And there are different ways of working, I find it really rich...Everyone approaches things differently, everyone has her or his style, and experience, and I find that really good. It's a shame when there's a team with only one therapist."

Others remarked on how these differences between group members were a source of friction and that it "heats up" between group members:

> "…It can be contentious…it's like a cauldron, it heats up between us and well, we should do something about it. It heats up regularly, it heats up, that's normal…"

As this psychiatrist suggests, "that's normal," and indeed, it perhaps goes without saying that in any group setting, there will be differences of opinion and occasions of conflict. Moreover, the statement, "we should do something about that," suggests that these moments of friction have generative potential if the group members take the time to reflect on these differences in style or personality. Indeed, as often described by my informants in the *psychiatrie transculturelle* groups, the principal therapist was responsible calling on group members, often referred to in the French as *distribuer la parole* or distributing speech. But distributing speech meant more than simply ensuring that everyone had a chance to speak. It also involved maintaining the harmony and cohesion among the group:

> "…You can tell when we are able to work well as a group. It's like a sequence, we're on one theme, then another theme, and then after we move on to another topic. Everyone has her or his own richness but there's a link. But when it does not work it's like a pearl necklace that's broken and fallen on the ground. There are pearls but it's not at all linked and it cannot help the patient when we aren't able to work as a group. I am going to use another metaphor, I think the principal therapist is the link and we are the pearls and it's the principal therapist that links all the pearls in the consultation and it's not an easy job because one needs to get rid of countertransference and emotions as much as possible when with patients. And also to know all the co-therapists and what they can do and do well and have trust, above all, trust in them because we can bring up things that are surprising and speak about things that are personal…"

During the discussion following the *psychiatrie transculturelle* therapy session, the principal therapist would at times comment on the performance of the group, though this might only take place when the group did very well or poorly. A good performance meant, as the psychologist

suggested, that the group moved fluidly from topic to topic, whereas a bad performance lacked coherence or sequence. In her ethnography of two *psychiatrie transculturelle* therapy groups, Gesine Sturm (2005: 90) described an instance when a principal therapist expressed dismay at the poor group performance, which the therapist attributed to moving too quickly from topic to topic and not sufficiently building up the therapeutic alliance. To this observation, I would add that these discussion sessions were instances in which apprentices could learn about the collective performance of the group in addition to their own performances. As analyzed in the previous chapter, individual contributions of apprentice co-therapists were evaluated informally using various forms of feedback, yet these discussions were also a space wherein apprentices could learn what a good group performance entailed. In the next section, I evaluate the ways that supervisors have reflected upon more direct and interrogative forms of evaluation.

"I try to trouble them, but in a positive way"

As described in the previous chapter, in the Minkowska Center, the mediation meetings were moments during which apprentices were supposed to test out and apply the concepts that their supervisors found important to the clinical work of the center. Apprentices were evaluated informally based on their ability to present and frame patient cases in ways that were in accord with the supervisors. In instances where their presentations were not in accord, they would be corrected. One supervising psychiatrist described the motivations for the kinds of confrontational interactions that took place between supervisors and apprentices:

> "I try to trouble them, but in a positive way, so that they ask themselves good questions…We don't participate in cultural labeling or stigmatization. And when the young people [apprentices] come to train here, they see what we do, they ask questions, and they will not act in a stereotypical manner later on. They will ask good questions."

As described earlier, the supervisors in this setting have found that many of the referrals to this setting are incomplete, unclear, or inappropriate, prompting the creation of the *Médiacor* unit to sort through and triage the referrals. This psychiatrist's comments therefore suggest that the purpose of the confrontational style of engagement was to prevent apprentices from employing the same problematic language that external clinicians often employ in their referral correspondence. Learning how to ask "good questions" was one of the ways that apprentices would learn to avoid acting in the problematic and "stereotypical" ways that supervisors consider external professionals to often act. Put simply, training involved learning how to speak in ways that their supervisors deemed correct. As demonstrated in the last chapter, supervisors used the assessment meetings as a space for apprentices to talk through and act out the referrals made by external professionals. In so doing, they would learn to incorporate the scripts valued by their supervisors and ask questions that followed a particular line of reasoning. This line of reasoning involved the determination as to whether a patient would require the therapeutic and cultural expertise of the clinicians in this particular setting as opposed to other mental health services. Apprentices therefore needed to be familiar with the larger system of mental health and social services:

> One does not have the right to say 'I'm a therapist' in a society and not know how the health care system is structured, one does not have the right…One needs to be in a movement of empathy, but also with decentering, control. Nobody is asking you to get cry about the history of people [patients]. They're asking you, 'what can you do to help?' First of all, it's 'is it here where one can help this person? Is it you who can help this person? If it's not here and not you, do you know where this person can turn for help?' So I know the network, I know the health care system, and I reflect, what is the best way to support this person to be able to be heard and cared for and that's called person-centered care."

By switching to the first person, "So I know the network," this psychiatrist enacts the monologue of the therapist who has developed the ability to ask the right kinds of questions and who has a

handle on the lay of the land of system of mental health and social services. In so doing, the psychiatrist acted out the kind of persona of somebody whose thought process was in alignment with a particular institution (Douglas, 1986). This psychiatrist and other supervisors emphasized the importance of teaching apprentices to ask the right kinds of questions, whether these questions were about their capacities, or about those of the institutions where they work, or about whether the care they can provide matches the needs of patients. In addition to trying to make apprentices learn the style of reasoning that organized "good questions," supervisors also used other narrative devices, such as easily memorable and repeatable stories and slogans, to transmit lessons to apprentices.

The function of institutional adages and stories

Supervisors in these settings often used expressions or told stories that conveyed important messages for their apprentices. More than just catchy phrases or anecdotes of past occurrences, these utterances captured certain truths that were obvious to supervisors but that had not quite sunken in for apprentices. To borrow the expression from John Seely-Brown and Paul Duguid (1991: 45), these stories represent "repositories of accumulated wisdom," that apprentices did not yet possess. As a result, supervisors would tell and retell these stories and expressions in pedagogical situations to illustrate their significance. These adages and stories were at times quite general, without making reference to a specific moment in the institutions' history from which they arose, whereas at other times, these stories and expressions pointed to very specific instances or time periods.

One example of an oft-told expression in one of the settings was "*le stéréotype s'impose, le thérapeute dispose* [the stereotype imposes or establishes itself, the therapist disposes of it]."

This expression was used to illustrate that apprentice therapists should recognize the pervasiveness of stereotypes used by untrained professionals but be able to do away with or distance themselves from these stereotypes in therapeutic encounters. The rhyme of this expression, both in the French and English, and its brevity made it a simple device that apprentices could retain and repeat both within this setting and potentially in their work following their apprenticeship. In addition, the reflexive *s'imposer*, as opposed to the transitive *imposer,* suggests that stereotypes may arise from unknown and multiple sources, while positioning the therapist as the agent in charge of doing away with the stereotypes.

While this story placed future therapists in the position of tackling stereotypes, other instructional statements and expressions used by supervising therapists appeared to be generalized abstractions rooted in stereotypes. For example, the statement that Africans do not like being asked similar questions repeatedly, described in Chapter 3, served to inform apprentices to avoid asking patients, especially African patients, questions and to ensure to keep a handle on the material discussed in past therapy sessions. The expression, that one should not remain silent in the group when African patients are present, informed apprentices that they should have something ready to say during the consultations in case they are called upon, as patients, particularly African patients, will otherwise wonder what they are thinking during their silence. While these statements conveyed valuable lessons—such as avoiding prying interrogative techniques and being an active and present participant in therapy—they left stereotypes unchallenged and explicitly reproduced them. Moreover, while these statements were deployed from time to time and served a pedagogical purpose, they did not appear to be based on any specific instance.

In other cases, however, supervisors attempted to instruct apprentices using statements that reflected a particular event or circumstance and were accompanied by a story. For example, in Chapter 2, I briefly described how the senior staff members in the Minkowska Center often recounted the expression, “We closed the travel agency,” and the corresponding story of the previous arrangements in the center, wherein patients were matched with clinical teams who had shared the same backgrounds as patients or otherwise demonstrated regional expertise. That particular story was told in the manner as if to say, “This is how things used to be done, but not anymore,” and served the purpose of informing apprentices that any therapist could see any patient as long as they had a language in common or had an interpreter, and to dispense with the notion that patients and therapists needed to share the same cultural or linguistic background. Indeed, in referral correspondence, one would occasionally find that external professionals made requests on behalf of their patients, such as that they see an “Arab doctor,” requests that the supervisors wanted apprentices to avoid.

Another expression with an accompanying story that was often deployed in this setting was “You have a person in front of you, not a culture.” Like the story of the travel agency, this story served a pedagogical purpose, but drew on a specific encounter with an external psychologist from a center that supports people with multiple disabilities. The psychologist had contacted one of the supervisors, a social worker, with concerns about a family from Sri Lanka who had a child with a disability. The psychologist requested a bibliography about Tamil culture and invited the supervisors to come and give a presentation about Tamil culture to the psychologist’s team. In response, the social worker invited the psychologist and accompanying team members to come to the center. The social worker recounted, with a great deal of pride, that over the course of nearly 45 minutes, they did not once talk about Tamil culture. Then, as the

social worker recounted the story, she asked, as if to ask both the team members in the story but also the apprentices present, “So the parents are in denial about the disabilities of their child, is that Tamil? It’s universal! How many parents are there who are in denial about their children’s disabilities? We need to help them.” The social worker described that while it would be better to have some knowledge about Tamil culture, that doesn’t stop one from asking the parents directly. Then the social worker continued to pose hypothetical questions that the team members in the story and the apprentices present in the exchange could ask a patient:

> “What happens in your country when there is a child with this kind of disability? Are there particular beliefs? Are there rituals? Is it seen as benevolent or malevolent? It’s better to ask and to have more information and you will know a lot more than if I give you a bibliography”

The social worker described how the team left the center without the bibliography that they had initially sought and that the psychologist got back in touch to say, “Madame, we don’t need you anymore.” Once the social worker finished recalling these particular events, she spoke in a manner that reflected a more general lesson:

> “So, they realized that, indeed, you need to take into account that you have a person in front of you, a person or parents or a child. You don’t have a culture in front of you. So I find that this case perfectly illustrates the work of the *Médiacor*, which also pedagogical work…It also illustrates that the work is person-centered transcultural psychiatry”

On the surface, this story may seem like a mundane communicative practice between a supervisor and a group of apprentices. However, by digging deeper, one can understand how the telling of this story may convincingly articulate an important message. Rather than giving instructions or explicating so-called best practices to apprentices, the social worker is reporting on a specific encounter that actually happened. In so doing, the social worker recreated the scene, describing how she held the printed request for a bibliography in her hand while keeping an eye

on the time with her watch, and acted out the exchanges with the professionals by recounting her utterances and those of the team.

This story reflects a form of reported speech wherein the social worker reports on previous events in a manner that seems to connect the people in the story—the psychologist and team members—and the people hearing the story—the apprentices. Writing about reported speech in legal trials, Gregory Matoesian (2001: 106) has emphasized how speakers use prior utterances, rather than simply impressions, as "a discursive strategy of affect, evidentiality, and authority" to influence an audience. Moreover, Matoesian states that the "reported voice subtly leaks into the voice of the reporting speaker as an emotive strategy and as a method of endowing utterances with authority" (2001: 114). In the present context, this story and its performance by the social worker served to model to apprentices the kinds of encounters that they might come up against in their future work as professionals. Others have described the role of institutional story telling in contexts of professional training. Charles Bosk described how attending surgeons used various forms of horror stories to teach lessons of caution, care, and thoroughness to their subordinate surgeons-in-training, and this served to simultaneously impart hospital lore and avoid directly criticizing subordinates' performance (2003: 104). Moreover, Donald Schön (1983: 327) has described how individual members of institutions—such as the social worker in the present scenario—contribute to the "accumulation of organizational reservoirs of knowledge" about the environment, strategies, and experiences that occasionally become exemplars for future action. Schön has explained how these contributions enter into "organizational memories," thus permitting others to draw on them as they go about conducting their roles (ibid.).

The apprentices' perspective

A few months after I had completed my fieldwork, I met up with József, introduced in Chapter 2. At that point, József had successfully completed his graduate studies and had subsequently qualified as a clinical psychologist. We were walking near the national library in the 13th arrondissement of Paris and reminiscing about the time we spent in two *psychiatrie transculturelle* consultations. After all, József was one of my informants who could comment on undertaking concurrent apprenticeships in two of my fieldsites. At one point, József said, "I feel like I've seen the ass of the elephant, but I want to know what the rest of it looks like." Questioning the larger impact of *psychiatrie transculturelle* groups, József said that he left the groups wondering whether other kinds of mental health organizations functioned in similar ways. Reflecting on his apprenticeship in the groups, József said that there was a lack of discussion regarding the ways in which *psychiatrie transculturelle* groups fit in the broader landscape of mental health organizations. While somewhat humorous, these comments came as a surprise since they seemed to reflect a discrepancy between what supervisors wanted apprentices to retain and what apprentices felt that they retained. In other words, while supervisors like the psychologist at the start of this chapter stated that apprentices acquire an institutional vision by partaking in their apprenticeships, and while the psychiatrist quoted earlier suggested that apprentices need to know the network and system of mental health and social services, József's comments suggest that apprentices remain perplexed about how these culturally sensitive mental health settings for immigrants and non-francophone individuals were situated more broadly among other institutions.

Richness or a cacophony?

A few of my apprentice informants, like József, had conducted apprenticeships in multiple locations where I had conducted fieldwork and I found their perspectives to be particularly valuable as they could compare the settings and comment on the differences that may not be obvious to others. József, for example, remarked that one of the *psychiatrie transculturelle* groups had multiple principal therapists who led consultation sessions and who had different styles of engagement with patients and with the group:

> József: "You had at least four people who had a lot of experience as professionals, who had their own personality, their own background, their own ways of thinking, their own approach…When you contribute, they each kind of gave, they interacted in their own way, with their own premises, with their own experience, with their own history, with their own approach. One is a Lacanian, the other is Freudian, the third is I don't know what, some are stronger in terms of their conviction when it comes to ethnopsychiatry. Others are more open, I don't know. So, there was more of a, you know in music, when you have different, like a multi tone?"
>
> DA: "You mean like different chords?"
>
> József: "When several people talk at the same time, which I think could, it had the risk of becoming a cacophony"
>
> DA: "Oh right, okay"
>
> József: "Instead of a symphony, but definitely made it less clear for those of us who were there as interns what the kind of *the*, if there was one, underlying hypothesis, is. Whereas, the difference with Paul [name of individual who is the only principal therapist in another *psychiatrie transculturelle* group] was that he was *the* only and dominant person, and who I think is also just somebody who has a very theoretical mindset. He's more of a theorist, he's more of a thinker than any of the other people at the other consultation. So he probably had a quite distilled idea as a psychiatrist and as an anthropologist. In parentheses, it's also helpful that he's an anthropologist and a psychiatrist and not just somebody who comes from a different culture and is a psychiatrist. Because I think that allows him to think clearly on both of these levels. So I think the fact that he's alone and also the fact of his own character and way of thinking, scientific mindset that eventually infiltrated into how we see things." (I061, original emphasis)

I quote József at length here because he raises several important issues regarding how apprentices perceive the "mindsets," "personalities," and "ways of thinking" of their supervisors.

Indeed, while the *psychiatrie transculturelle* groups with several principal therapists allowed apprentices to observe different styles of reasoning, from József's point of view, this potentially led to a "cacophony" or jumble of ideas wherein supervisors sent multiple and mixed messages to apprentices about what direction or objective the therapy group was emphasizing. Indeed, as described by the supervisors above, the groups could "heat up" from time to time. These moments of friction could be confusing for apprentices who depended on their supervisors to provide a sense of cohesion among group members.

Additionally, as József suggested, the "scientific mindset" of one of the principal therapists, due in part to his dual credentials as a psychiatrist and anthropologist and dominant position as the sole principal therapist, made him more impressionable on apprentices. József's comments add complexity to characterizations that the multiple perspectives of different supervisors enrich apprentices' experiences (Collins, Brown, and Newman, 1989), or that these perspectives are complementary. This complexity may be particularly apparent in scenarios where apprentices face uncertainties of optimal courses of action or where apprentices observe contradictions in their supervisors' practices.

Partial apprenticeship? Or a lack of transparency?

As described in chapter 2, in the Minkowska Center, apprentice therapists found that they were not able to observe consultation sessions to the extent that they would have liked and therefore expressed dismay over their inability to see how clinicians functioned. The principal pedagogical opportunity for apprentices was their participation in the *Médiacor* meetings, where they carried out research on patient referrals and presented patient cases to an interdisciplinary group of professionals. However, since these activities took place in an absence of patients,

apprentices rarely observed how different psychiatrists and psychologists applied *anthropologie médicale clinique* in actual clinical situations. One supervising psychiatrist described how the tasks of the *Médiacor* meetings, which require apprentices to identify the elements of illness, sickness, and disease, do not directly map on to clinical practice with patients:

> "It's mostly a mental schema that you use to know that patients will explain their suffering with their own words, their way of doing things, and give yourself time to understand what it means for them before applying your *disease* label. And after, adding the *sickness*, I think that in mental health one should always do this because it is not just migrants and refugees but above all in the cases of migrants and refugees, the social condition and social suffering can be linked, not only in terms of very practical ways, but also in terms of the loss of their status or everything that they had in their countries of origin, that contributes something. But at the same time, when I see my patients, I do not have a list where I say, 'that's *sickness,* that's *illness,* and that's *disease.*' It's an exercise that we do in the mediation meetings for the therapists in training, professionals, and others so that they learn to see that as a reflex."

This psychiatrist emphasized the importance of an awareness of these concepts in clinical practice, but suggested that the deployment of these concepts was more of an exercise reserved for training rather than clinical encounters. Apprentices also tended to think of these concepts in terms of ideas that they tossed around in the mediation unit meetings, but they struggled to understand their utility when engaged in therapeutic encounters with patients. For example, a research associate at the Minkowska Center, a psychologist, spoke about a significant rift between theory and practice that was observable to apprentices:

> "…It's medical anthropology but it is something very theoretical that they teach us in the mediation unit while diagnosing a situation. But after, in practice, I don't know what happens. There isn't really training to be a therapist, it's more 'We do this,' but what is that exactly? I don't know."

The expression, "diagnosing a situation," is particularly telling since this assessment took place in the absence of a patient and with the limited information provided in the referral documents provided by the referring professional. The patient's voice or perspective, which was considered an evident and natural attribute in this setting as in many others (Velpry, 2008: 254), was often

difficult to identify since all apprentices had to go off of were the words of the clinicians who referred patients. Apprentices therefore had a partial or constricted view, since they often felt that they did not see the entirety of the situation that affected a patient. Indeed, the theoretical basis of *anthropologie médicale clinique* was reinforced since apprentices often had limited access to clinical encounters with patients. Moreover, despite the fact that the center employed several psychiatrists and psychologists, apprentices' observations of clinical encounters, when possible, were limited to only a handful of therapists' consultations. Indeed, as illustrated earlier, some therapists had reputations of being more open to working with apprentices, while others remained more mysterious since they rarely, if ever, interacted with apprentices. Moreover, the supervisors who occasionally allowed apprentices to observe their clinical work with patients tended to be the same clinicians who regularly participated in the *Médiacor* meetings. One of these supervisors, a psychiatrist, explained how it was harder for apprentices to see what actually happened in therapy since they only were able to observe evaluations with patients, which typically preceded ongoing therapy:

> "…For the therapists in training, for whom, 90% of the time, it is evaluations. They don't come to see the follow-up care, it's not possible and it's not the same exchange. In the evaluation, your objective is to ask enough questions to be able to make a hypothesis about a diagnosis, to see if there is a pathology or not and also, as a psychiatrist, if I make a diagnosis, it's also about what I think is necessary as a psycho-pharmacological therapy, if needed and if ongoing psychotherapy is necessary. And for example, it's hard for them to understand that what we know about the person is written on the form that's derived [from their referral] and all of that, if we suspect that there is trauma, it's not essentially necessary to ask directly about that. We're not in a rush. Even if we need to leave the evaluation with an idea, sometimes in an hour you don't and it's not a big deal. What is a big deal is rushing the person to speak."

The psychiatrist's comments illustrate that apprentices did not get a full picture of what therapy in this particular setting entailed since their view of the patient was constructed from the *Médiacor* meetings and from their limited opportunities to observe initial evaluation sessions.

Moreover, as this psychiatrist has identified, the style of engagement with a patient is different in this sort of context since clinicians are more on a hypothesis-building mission, whereas apprentices may yearn to see a fuller, more comprehensive, picture of the patient as she or he experiences change over the course of ongoing therapy. Since apprentices were only able to acquire an incomplete glimpse into this psychiatrist's practice, they were left wondering about the ways other clinicians work:

> "I know that there were other therapists who I did not get to see work…that's why I think that the therapists at the center, when they close their doors, everyone does what they want, it's not necessarily what they present to us in the [mediation meetings]."

These comments suggest that what apprentices are taught in the *Médiacor* meetings does not necessarily translate to what is carried out in clinical practice among the therapists. This suggests that not all clinicians at the Minkowska Center adhere to the institutional framework of *anthropologie médicale clinique.* Indeed, others have already considered this hypothesis to a certain extent (Larchanché, 2010: 340). More importantly, without having the opportunity to observe how different clinicians practice psychotherapy, apprentices were left frustrated with the lack of transparency among their supervisors and questioned the utility of the center's institutional framework. Indeed, the suggestion that "everyone does what they want" was backed by the fact that most therapists in the setting did not participate in the mediation meetings and most did not allow, at least on an ongoing basis, apprentices to participate in their consultations. Therefore, there appeared to be few opportunities for apprentice therapists to learn to learn to see and interact with patients in the ways that most of the therapists in this center did.

Having deeper, ongoing engagement with a broader range of supervisors in this setting would allow apprentices to see how different therapists interact with patients, define culture and conceptualize its relevance in therapy, and reconcile the center's approach with their own

therapeutic strategies. Indeed, scholars concerned with ethics education in clinical contexts have emphasized how all supervisors—not just those who teach about ethics—should be willing and able to identify the ethical issues they encounter, and share these experiences and knowledge with apprentices (Hafferty & Franks, 1994: 868). Similarly, a study among medical apprentices in cultural competence training programs reported that apprentices felt unable to apply what they learned, particularly when they do not see their clinical instructors modeling practice (Beagan, 2003: 614). Taken together, these perspectives from ethics and cultural competence training suggest that apprentices learn when presented with sufficient opportunities to observe how a variety of supervisors model the practices that apprentices were expected to acquire. However, my observations and the comments from my interviewees reveal that the same therapists who allowed apprentices into their consultations were also those who were more actively engaged in the *anthropologie médicale clinique* framework that ostensibly characterized the clinical work of the center and all of its practitioners. As a result, I suggest that the institutional framework does not seem to be fully appropriable by apprentice therapists since they lack the opportunities to see it put into action. The lack of involvement of the rest of the center's therapists in pedagogical endeavors, and in the *Médiacor* meetings in particular, suggests that apprentices in this setting experience a partial apprenticeship where they observe specific practitioners and are allowed to observe surface-level practice. As a result, their participation within these communities never approximates anything more than distant, peripheral participation. I argue that as a result of this partial apprenticeship, apprentices do not fully acquire this institution's vision, but rather they assemble a selective and heterogeneous style of practice that potentially draws on some characteristics or values espoused by this institution.

Not grounded in theory?

While *anthropologie médicale clinique* may have seemed too theoretical to apprentices, the *psychiatrie transculturelle* group at times seemed insufficiently theorized. In other words, apprentices did not always know the rationale behind their practices:

> "And in the *psychiatrie transculturelle* consultation, it's an approach that I'd say is more French, a bit of psychoanalysis, a bit of classical anthropology, but the emphasis is above all on know-how. You don't really know why you're doing [what you're doing], but you learn to do it. It's more about practice."

As described earlier, not all apprentices had encountered *psychiatrie transculturelle* psychiatry in their coursework, nor were they familiar with the intricacies of the *psychiatrie transculturelle* group practices. However, others, like József, had read about *psychiatrie transculturelle* before starting their internships and were surprised to find distinctions between theory and practice:

> "When people talked…[they were] either very psychological, with an underlying psychological hypothesis. Or often, even kind of encouraging, or very much talking to the person rather than giving an image that comes to me or talking about myself. And I remember one of the things that for me was confusing for a while was first of all, I didn't feel like theoretically, it wasn't very close to what I had read it should be like and secondly, that nobody seemed to care about this."

József's comments that the co-therapists were very psychological in their speech seem somewhat ironic, especially since, as asserted in the last chapter, supervisors often instructed apprentices to not be "too psychological" by relying on interpretations of modes of questioning. József elaborated on this further by describing the kinds of comments and propositions that therapists made during the group sessions, which seemed to advance a particular agenda rather than draw on the reflections of the therapists in the group:

> "I guess I was frustrated that, about the whole idea that we're trying to get a message across. You know, I think a lot of the times when people speak, you know, you have this kind of underlying agenda, like "I think this is what is going on with you, and I'm going to try to say something that is going to help you" and I was very uncomfortable with that, I didn't like that at all…And also to have an effect, to seek an effect, an impact. Whereas, from what I understood, the idea would have been more to kind of let yourself be a filter, something

> comes in an then you reflect on your own experience. Or you just let an image come to you as a poet, almost…And, I was a bit frustrated to what degree it was far from the theory. And it's also my personal approach, but I'm very careful about interpretation, and I felt that there was a lot of underlying interpretation going on all the time and it wasn't explicit."

As described in chapter 4, supervisors in *psychiatrie transculturelle* therapy groups emphasized in their instructions to apprentices that they should not interpret what a patient says. Yet József's comments here suggest that there was a great deal of interpretation that was taking place in the group and that there was an absence of discussion concerning the rift between theory and practice. This discrepancy may be confusing for apprentices who were attempting to find coherence between their course readings and clinical encounters.

"We are first and foremost psychologists before being transcultural"

The apprentices' comments above reveal an important distinction between the perspectives of supervisors and apprentices regarding the transmission of knowledge that was supposedly taking place in these settings. This distinction raises the question as to the extent to which apprentices were training to be culturally sensitive clinicians or individuals savvy in the methods of the approaches of these settings. One apprentice expressed frustration with what seemed to be a distinction between training in psychology and transcultural training:

> "Above all, we're here as intern psychologists not a transcultural intern…we are first and foremost psychologists before being transcultural [practitioners]. It's really frustrating."

These comments may initially seem surprising since clinical apprentices or interns in psychology or psychiatry may opt to undertake apprenticeships in these settings as opposed to other mental health services for the general population. However, these comments reflect a sentiment that apprentices did not necessarily gain the experience they wanted to become clinicians in broader range of service settings. Put differently, by only observing and participating in consultations

with individuals who supposedly required culturally sensitive therapy, these apprentices felt that they were not gaining exposure to how other kinds of services functioned. Across my field sites, most apprentices rarely, if ever, participated in the clinical activities undertaken by their supervisors outside of immigrant mental health settings. In the Minkowska Center, most of the clinicians were employed on a part time basis and worked in other public or private settings. The *psychiatrie transculturelle* groups were often one service within a clinical establishment that offered other clinical services. In the latter case, apprentices typically did not participate in the activities of these other services, though in some instances they may have shadowed supervisors in their individual consultations. It was this lack of exposure to the institutional life beyond the *psychiatrie transculturelle* consultations or immigrant mental health settings more generally that made József quip that he only saw a certain portion of the elephant rather than how this approach or these types of settings fit into the broader fabric of mental health services.

The frustration that apprentices described was noticed by some of the supervisors. One psychiatrist described the tension that existed between one of the *psychiatrie transculturelle* consultations and the establishment within which it was based. The psychiatrist described that with the exception of a few clinicians in the establishment, others were resistant to the *psychiatrie transculturelle* group. The resistance was representative of broader sentiments of opposition or suspicion of culturally sensitive mental health services in France, described in more detail in chapter 1. The psychiatrist asked me if I felt this resistance, since many apprentice therapists felt it:

> "Didn't you feel it last year? Because the pure ethnopsychoanalytic interns can feel it and can suffer from it…But I know that the first year that I participated [in the group] there were some who told me 'Oh gosh, we feel like we're really ethno interns, we turn up as a group and we sit around.'"

This psychiatrist's comments suggest that apprentices, who participated in the *psychiatrie transculturelle* therapy groups, and only these groups, felt excluded from the other clinical activities of these establishments. As a result, their apprenticeship only provided them with a partial glimpse into the work of their supervisors and into the role that these kinds of settings have within other kinds of mental health care services.

Concluding remarks

In *How Institutions Think,* Mary Douglas (1986: 63, 112) describes institutions as "machines for thinking and decision making" that "control the memory of [their] members." In other words, institutions direct perceptions in ways that they deem to be in alignment with their orientation. In this chapter, I evaluated the extent that the institutions of *psychiatrie transculturelle* and *anthropologie médicale clinique* directed the perceptions of apprentices. I analyzed what supervisors believed to constitute the institutional visions that they wished apprentices would appropriate, and I analyzed apprentices' experiences in taking up these visions. I found that supervisors and apprentices had quite different outlooks on the meanings of these visions and the extent to which they could be appropriated. Due to differing styles of practice and a lack of transparency among supervisors, I contend that apprentices were only partially exposed to the visions of institutions and thus could only selectively appropriate certain forms of practice that they determined to be valuable beyond their apprenticeships.

The distinction between supervisors' and apprentice therapists' perspectives was quite revealing. While there had certainly been points of overlap in what supervisors wanted apprentices to develop and retain from their apprenticeship in these settings, there were also points where apprentices questioned the approaches used in these settings. Supervisors did not

necessarily intend for apprentices to start up new *psychiatrie transculturelle* groups or open centers that use an *anthropologie médicale clinique* framework. Rather, they hoped that their apprentices would be better positioned to accept uncertainty and understand the need for flexibility and openness in conducting consultations with patients.

Supervisors in the Minkowska Center and the *psychiatrie transculturelle* therapy groups used a variety of techniques to transmit their ways of knowing and doing to their apprentices. These techniques included institutional stories that contained pooled institutional wisdom acquired over years of experience, as well as confrontational teaching styles that were unsettling but that would perhaps better prepare apprentices for the harsh realities they would face in their future professional projects. Apprentices, however, remained perplexed about how to apply the concepts that their supervisors encouraged them to understand, or they described that the practices within these settings were unmoored from theory. In the Minkowska Center, apprentices rarely had the chance to see the conceptual framework of *anthropologie médicale clinique* in action. In other words, while supervisors emphasized this framework in the *Médiacor* meetings, apprentices had insufficient opportunities to learn how different clinicians used it or even thought about it in their encounters with patients. Rather, apprentices suggested that it was more talk than action. Indeed, as both apprentices and supervisors in the Minkowska Center have clearly identified, clinicians willing to allow apprentices into their consultations were few and far between. Those that did welcome apprentices typically only allowed them to observe the beginnings of what could eventually become an ongoing therapeutic program. In short, apprentices had a very constricted view of the forms of practice within this setting and, I contend, experienced a partial apprenticeship.

One of the strengths of the *psychiatrie transculturelle* therapy groups was the fact that there were multiple supervisors from whom apprentices could learn. As supervisors suggested, the variety of practitioners and practices added both richness and friction. This friction had the potential to be productive both pedagogically and clinically if explored properly. Apprentices, however, could interpret this friction as a cacophony of perspectives and a lack of cohesion among the therapy team. Moreover, in the *psychiatrie transculturelle* groups, apprentices seemed to understand what was expected of them during the therapy sessions, but they did not always understand why they were doing what they were doing. Moreover, at times, apprentices reported that the practices in the groups seemed somewhat untethered from the theories that steer *psychiatrie transculturelle* practices. For instance, one apprentice commented that therapists were making interpretations whereas, as described in the previous chapter, supervisors explicitly instructed apprentices not to interpret what patients bring to the consultation. As a result, supervising therapists were considered by apprentices to be pushing a particular agenda with patients, rather than allowing the consultation to take place at the rhythm of the patient.

The perspectives of apprentices are crucial since they identify blind spots, inconsistencies, or instances of insincerity in the practices of their supervisors. Inconsistencies, blind spots, and insincerity in practice are, of course, a feature of every community of practice and organization. Yet in the absence of transparency and when not engaged in a productive manner, these inconsistencies and blind spots in practice produce additional uncertainties for apprentices. They also foreclose the possibility of developing an institutional vision.

Chapter 6. New practices

On a Saturday morning in a large classroom at the University of Paris Descartes, one of the most renowned medical schools in Paris, I sat next to a psychiatrist from a city in the east of France. Both of us were taking notes as the person teaching the course, a psychologist, gave a lecture on the *psychiatrie transculturelle* consultation and how it functions. This lecture took place early on in a bi-monthly professional development program, led by Marie Rose Moro over the course of one academic year, for professionals in the health, social, educational, and legal services who wished to learn to better provide care and support for individuals in different situations of migration or individuals who were not francophone. Many of these professionals were based in Paris or the suburbs, though others, like the psychiatrist seated next to me, came from other cities in France. Others who attended the bi-monthly courses hailed from places such as Luxembourg and Belgium.

As the psychologist provided clinical examples concerning individuals who had undergone therapy in the *psychiatrie transculturelle* group, the psychiatrist turned to me in astonishment: "This is so rich, so fascinating. But we could never do this in the clinic where I work. We just don't have the resources to do this kind of work." These comments were echoed by many others in this professional development program, who were concerned about putting into practice *psychiatrie transculturelle* approaches into a diverse array of environments, particularly those in which their colleagues or supervisors may be uninterested or unwilling to implement such approaches.

Chapter overview

In this chapter, I consider how individuals who have undergone apprenticeships and other forms of cultural sensitivity training have attempted, succeeded, and at times, failed to incorporate these approaches in different types of establishments. More specifically, this chapter addresses the following questions: To what extent does the expertise gained from these apprenticeships become reproduced in a variety of settings? In what ways do these apprenticeships have a transformative effect on apprentices in their future work?

Both of these questions chart how apprenticeship translates into new ways of doing clinical work (Kirmayer, 2013: 371), but while the first addresses the extent to which those who have undergone apprenticeships and related forms of training have adapted what they have learned to different contexts, the second of these questions deals with former apprentices' own reflections of making use of their past apprenticeship in their current practice. To attend to these questions, I could not simply focus on the apprentices featured in the previous chapters. After all, they were only at the stages of completing their apprenticeships and many of them had not yet completed their graduate training or had secured a professional position. Instead, I knew I needed to draw on the experiences of a wider range of individuals who had already completed their apprenticeships or other forms of intensive training.

I therefore contacted health and social service professionals who had enrolled in professional development programs that were based at the University of Paris Descartes and affiliated with the Minkowska Center and the *psychiatrie transculturelle* network. I was able to get in touch with these individuals with the assistance of the coordinators of both professional development programs. Some of these professionals only participated in these development programs, however, others had previously conducted apprenticeships in one or several

psychiatrie transculturelle groups or at the Minkowska Center, and others conducted apprenticeships concurrently with the development program or following the program. These heterogeneous combinations of apprenticeship and professional development training were reflective of the fact that these individuals had differing levels of professional commitments and were in various stages of their careers. In other words, while some were participants were graduate students with requirements to undertake some form of practical training over the course of the academic year, others were in the mist of working full time and needed to arrange time off in order to participate in apprenticeships or in the professional development program. Others had not yet secured employment and undertook these courses as a way to expand their network and gain additional credentials, and some had retired but were passionate about life long learning.

By expanding my pool of potential informants to individuals who had undertaken this professional development program and apprenticeships in previous years, I had the opportunity to analyze instances of the development of new practices, both in terms of new *psychiatrie transculturelle* therapeutic groups and in terms of the ways that individual professionals modified their own therapeutic techniques. Rather than analyze the content of these professional development programs, which were mostly classroom-based, or interview participants who were currently enrolled in professional development programs, which had been done in previous research (Larchanché, 2010), I focused on how the individuals who had completed these programs in previous years (as early as 2005) had developed new ways of working in the years following their apprenticeship or professional development training. This retroactive examination allowed me to learn about new practices that had actually been implemented, as opposed to those that program participants anticipated implementing. Moreover, rather than simply interview professionals about their experiences, I was able to observe new group therapy

and training practices and learn about their experiences as they reflected upon their new ways of working resulting from their apprenticeships.

In the remainder of this chapter, I outline three forms of new practices that have resulted from apprenticeships. The first of these forms considers new therapy groups that have been developed by former apprentices in Lyon and Caen. In some instances, these groups emulate those from which former apprentices underwent their apprenticeships, whereas in others, they have been modified significantly to modify the local needs of the areas they serve and the resources of the professionals involved. The second form deals with the evolution of *psychiatrie transculturelle* therapy groups and how individuals who were once apprentices graduated to a more advanced status and would eventually become principal therapists. The last of these forms has to do with changes that individual professionals have made in their practices as a result of their apprenticeships.

"Inspired by Paris, but we do things our own way"

While centralized in Paris, the *psychiatrie transculturelle* approach has taken shape elsewhere in France. In Lyon, the third largest city in France, I visited a therapy team established in 2015 in an outpatient mental health center (CMP), and which operated with incremental funding from the regional health agency (*Agence régionale de santé,* or ARS). The team was comprised of a psychiatrist, psychologist, social worker, health educator (*éducateur specialisé*), secretary, and supervisor (*cadre de santé*), though therapy sessions typically did not include these latter two professionals. Two of the founders of the team, the health educator and the psychiatrist had extensive apprenticeship experience: the health educator had completed the *psychiatrie transculturelle* professional development course and had undertaken practical

training in a *psychiatrie transculturelle* therapy group, and the psychiatrist had completed a portion of her residency in psychiatry under the guidance of Marie Rose Moro at the Avicenne Hospital. According to their annual report, most of the families they received in consultation did not have stable administrative statuses, and many of these families were seeking asylum[19]. The therapy team was called a *dispositif d'écoute transculturelle* (DET), which I have loosely translated as transcultural support system. The team members referred to themselves as consultants rather than therapists. Unlike the *psychiatrie transculturelle* groups where I had conducted more extensive ethnographic fieldwork, the DET team was small and featured a balanced disciplinary representation. Moreover, the DET often worked in pairs—led by either the psychiatrist or psychologist and accompanied by either the health educator or the social worker—to provide a greater number of consultations. The DET could receive patients or families on its premises in the CMP or conduct mobile consultations in a variety of other institutional settings.

While the psychiatrist or the psychologist was the principal consultant during each consultation session, the principal consultant did not mediate the conversation as they did in the *psychiatrie transculturelle* therapy groups. Guillaume, the health educator, told me that they were not rigid with their conversation, adding that "the group was inspired by Paris, but we do things in our own way." This approach, Guillaume informed me, was more flexible than in Paris since it allowed consultants to speak with patients when they determined it was necessary. Moreover, the flexibility was apparent in the sharing of tasks, such as note keeping. Despite being one of the principal consultants, Juliette, a psychiatrist, described that she was often the one who took notes during the consultations that she led. In the future, the addition of team

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[19] Centre Hospitalier St Cyr au Mont d'Or. Dispositif d'écoute transculturelle 2016 Rapport d'activité, p. 6

members and apprentice therapists may result in different arrangments. During the times when I visited, there were no interns or students in the team since, as Guillaume explained it, they only had funding for six-month periods and hesitated to take anyone on since they did not know if they would have funding to continue to operate. However, the group welcomed the idea of supervising apprentice therapists since their newness and questions may identify blind spots and weaknesses to be addressed.

In Caen, a city in Normandy, a psychologist and health educator who had completed the professional development course were in the midst of establishing another *psychiatrie transculturelle* therapy group at an outpatient mental health center (CMP). My first visit to the therapy group was with the coordinator of the *psychiatrie transculturelle* professional development program, a psychologist who worked closely with Marie Rose Moro at the Cochin Hospital in Paris and who was supervising this new therapy group. The therapy group was in a much more embryonic stage than the group in Lyon during my visits. The psychologist and health educator were preparing a funding application for the ARS and had yet to receive any patients. Yet the group was significantly larger than the team in Lyon. There were ten people who wished to participate, including two interns in the CMP. The group had yet to secure funding for essential expenses, such as to pay for interpreters. However, the two interns could speak Turkish, which was fortuitous, considering that the first patient they would eventually receive was a Turkish speaker. During this first visit, the therapy group asked questions of the supervising psychologist. The psychiatrist in the group was concerned about what she referred to as “monoculturalism” and asked if they could even conduct *psychiatrie transculturelle* group therapy if all of the therapists in the group were white. The supervising psychologist reminded the psychiatrist that everyone has a culture and that what is most important is that they are

trained and have ears to listen to what their patients had to say. These comments reflected the point that Marie Rose Moro has long argued that being culturally diverse oneself and having lived migration experience are neither necessary nor sufficient to carry out *psychiatrie transculturelle* therapeutic work. Rather, Moro, has argued, one needs to be able to decenter (2002: 164). The supervising psychologist equally cautioned that the group should not expect the patient to open up about aspects of their migration or cultural history, such as sorcery for example, during the first therapy session. Rather, these kinds of cultural matters typically were not discussed until the fourth or fifth session, after the group had constructed a therapeutic alliance.

On my second visit to the therapy group in Caen, I did not accompany the psychologist who was supervising the group. The psychiatrist, who was concerned about monoculturalism during the earlier visit with the supervising psychologist, asked "Won't it slow us down if we're a group that is not very colorful, culturally speaking?" That the group was comprised of white French professionals remained a concern, which had clearly not been assuaged by the supervising psychologist on the previous visit.

The group had watched the film, "J'ai révé d'une grande étendue d'eau[20]," which documented Marie Rose Moro's *psychiatrie transculturelle* consultation at the Avicenne Hospital. After watching the film, the group role-played a therapy session, and I was invited to attend the debriefing following the role-play. During the debriefing, the group discussed whether to stand up when the patient arrived, as well as how they would introduce themselves to the patients. Some of the group members were concerned that the role-play did not resemble the film since the group was too focused on psychopathology. I asked the psychologist, Sylvie, and the

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[20] *J'ai rêvé d'une grande étendue d'eau,* directed by Laurence Petit-Jouvet (2002; Paris, France, Abacaris Films), DVD.

health educator, Clémence, about their ideal model for a therapy group. Sylvie said that she had participated in three different *psychiatrie transculturelle* groups in Paris, but said that the ideal was Marie Rose Moro's group. Sylvie then turned to Clémence for her input, who laughed as she replied:

> "We're inspired [by Moro's group] but we know that being a new setting, we cannot have that kind of set up since we don't have the same financial support, we don't have the same experience, etcetera, I think it's important that we detach as well and do things based on our own means and personalities, and put ourselves into it."

The development *psychiatrie transculturelle* groups that met local needs and drew on existing resources was not unique to Caen and Lyon. For example, in Toulouse, psychologist Gesine Sturm and colleagues describe the development of an intercultural consultation for children and families that did not propose "a new approach to transcultural psychiatry, but rather a local adaptation to the structure and needs of the service-providing institution, the functioning of the team and the profile of the service-using families" (Sturm, Guerraoui, Bonnet, Gouzinski, & Raynaud, 2017: 450; Sturm, Bonnet, Coussot, Journot, & Raynaud, 2017: 639). In addition to developing new *psychiatrie transculturelle* therapy groups in new locales, therapists in existing groups have needed to address situations that had previously been given less attention in *psychiatrie transculturelle* groups, such international adoption, unaccompanied minors, and radicalization (Harf & al., 2013; Ludot, Radjack, & Moro, 2016; Radjack, Hieron, Woestelandt, & Moro, 2015; Radjack, Rizzi, Harf, & Moro, 2017).

Of course, attempting to recreate Marie Rose Moro's *psychiatrie transculturelle* therapy groups at the Avicenne and Cochin Hospitals is neither possible nor is it desirable. After all, Moro's consultations have existed for decades and have a far greater amount of resources available to hire interpreters or recruit apprentices in psychology or psychiatry. This is due in part to Moro's renowned international reputation and the fact that these consultations are located

in large teaching hospitals in Paris and the suburbs. Moreover, in an interview, Moro highlighted that the major objectives of professional development were not to expand or reproduce *psychiatrie transculturelle* groups, but rather to prepare professionals to address the uncertainties that they face in their work when supporting diverse patients who face a range of complex problems:

> "The objective is to augment competences and sensibility, so that they question themselves, that they know where to look, that they know how and when to use a [*psychiatrie transculturelle* group]…it is not at all about creating new groups. Because you need more than just the D.U. [*dîplome universitaire,* or professional development course], you need the D.U., plus supervision, plus some who do a master's degree, plus supervision during several years, a seminar. In my opinion, you need to lead a seminar[21] before starting a group. It's a lot, there were several groups that fortunately resulted from the D.U., and the D.U. offers the possibility to do it."

There were other ways that individuals who had undertaken an apprenticeship in a *psychiatrie transculturelle* group, or who had participated in the professional development program, could take on additional responsibilities without creating new therapy groups. The next section considers the process by which one becomes a principal therapist who would lead the therapy groups and interact directly with patients.

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[21] Several *psychiatrie transculturelle* therapy groups had an accompanying seminar, during which principal therapists and/or other members of the therapy groups would present clinical case studies on a bimonthly basis. The supervisors and senior group members typically chose the themes for the seminar at the start of the academic year, and the themes often dealt with issues frequently encountered by the *psychiatrie transculturelle* groups. Moreover, time was reserved at the end of the seminars for discussion, and external professionals could also ask questions about issues that arose in their own work. Some seminars were open to members of the AIEP (Association Internationale d'EthnoPsychanalyse), whereas others were open to any individuals for a fee ranging from 40 to 250 euros per year, depending on one's status as a student or professional.

Becoming a principal therapist

After their apprenticeships in the *psychiatrie transculturelle* therapy groups, most apprentices moved on to other training or professional activities. Some stayed on or joined other *psychiatrie transculturelle* groups, even after they had completed their graduate studies and became qualified professionals. One psychologist commented that she had a separate, liminal role that was neither apprentice nor principal therapist, but "the role between the two, between the interns and the old timers [*J'ai le rôle entre les deux, entre les stagiaires et les vieux*]." These individuals participated in the group therapy sessions, but they were not required to take or transcribe notes, and they did not lead therapy session as a principal therapist. Over time, however, principal therapists may retire or may wish to reduce their workload. After all, leading an orchestra required a great deal of energy. Moreover, as they gain more experience, therapists may wish to take on more advanced and active roles. While I began this project with an interest in the experiences of newcomers in these settings, I was also curious to learn about the ongoing apprenticeship and socialization experiences of those who were neither interns nor old timers. I asked the principal therapists what it would involve to become a principal therapist. Some emphasized how being able to do this was a long, complex process that required years of experience:

> "It's really complicated, Pierre-Olivier and I are old timers, we have a lot of time under our belt as therapists plain and simple, leading groups, so on an do so forth, we have a ton of experience, and it's not just anyone…"

Yet for others the process drew more on the individuals' own feelings of being capable:

> In the beginning, I was not the principal therapist with Marguerite. I was a co-therapist and she said, 'It would be good if you did this,' and so it involves a subjective element. You feel it, you want or feel a desire to do it, you feel capable."

Indeed, feeling prepared was an important criterion for determining readiness to take over as a principal therapist. Since they had not yet received any patients in their therapy group, I asked Sylvie and Clémence, from the group in Caen, how they would determine who would lead the group. Sylvie responded:

> "In this case, it will be me. It's practically imposed since it needs to be someone who is both a clinician and someone who has completed the D.U. [professional development program]. And I'm the one who has done both of those things. It's not at all something that enchants me, because I'd prefer to have a few years of practice as a co-therapist before taking that place. It strikes me as a bit premature [laughs], but that's the way it is."

Sylvie's comments suggest that at times, individuals needed to assume positions of leadership when required by the group to do so. In other instances, more senior members of the group decided when they were ready to take on these advanced roles. One psychologist emphasized several characteristics that suggested that someone was prepared to be a principal therapist:

> "We can determine if someone is ready to be a principal therapist as a function of their position in the group and as a function of the pertinence of their questions and their clinical contributions. So these are the elements that allow us to say that, indeed, in a consultation he or she asked pertinent questions to move things along, and at that time, we will try. Because as I always say, especially with patients from African backgrounds, when we see them we need to first welcome them by getting to know them, [asking] 'Who are you? Where are you from? What do you do? Are your parents still around?...It is not the patient that we see. It's the individual, the person, contrary to classical medical encounters where one only sees the patient. So it is all of those qualities that make us say that the person is fit to direct a consultation. Because if not, when one goes to quickly that poses problems because there are things that are not said and after, when we reread the file, we need to ask as you've seen and it is because the person who leads the consultation has burned through the steps."

Knowing how to move at an appropriate pace required a great deal of preparation. Becoming a principal therapist, for this psychologist, also involved being recognized by the other therapy team members as capable to lead a consultation. Another principal therapist, a psychiatrist, emphasized the importance of having familiarity with various theoretical frameworks with which to draw during consultation sessions.

> "I think that it would be the capacity to have a sufficient amount of hypotheses when faced with [a patient's] story. There's a technique, to know how to conduct a consultation, follow a framework, it is not too complicated, one learns pretty quickly. Afterwards, I think that a decisive element, which, moreover, is not specific, it is in other forms of psychotherapy as well, meaning that we have both experience and theoretical understandings that allow us to have hypotheses for the different kinds of situations that we encounter. I think that allows us to go for it, meaning that we are sufficiently inspired to have a hypothesis or let ourselves see what's coming. But what is reassuring is to have at least a few pre-determined interpretative frameworks that we use or we don't, but we have them. We have a sufficient interpretive framework that we will work with, that we can lean on to address the unknown. And after we either use it or we don't."

For both the psychologist and this psychiatrist, being a principal therapist required having the capacity to anticipate new and unfamiliar material in clinical encounters. Of course, not everyone who undertook an apprenticeship or professional development course attempted to create a *psychiatrie transculturelle* therapy group. The next sections address how individuals reflected on learning how to decenter in their individual therapeutic practices.

Learning to decenter: A change in professional posture

After having undergone an apprenticeship or one of the professional development courses, health professionals reported that instead of acquiring knowledge about the beliefs, attitudes, and practices of patients from different cultural groups, they modified their own professional posture, their own attitudes, behaviors, and the ways in which they spoke with patients or clients. In other words, they reported undergoing a change in their professional posture in lieu of becoming more knowledgeable about their patients.

These professionals initially thought that cultural competence training involved learning about different cultures. In fact, learning about the cultures of their patients or clients was often what interested them in cultural competence training in the first place. For example, one nurse described how her training raised additional questions rather than provide answers:

> "I had thought that it [cultural competence training] was a kind of dictionary, while in fact it's more of a way of thinking about complementarity. It's a training that added questions to those that I had already had. And at the same time, it really made me realize that I didn't need to have very precise understandings, but rather I told myself that I should just trust the patient to explain how he or she experiences his or her culture"

Larchanché (2010: 188) has identified how cultural competence training may raise existential questions, prompting new uncertainties. Significantly, these uncertainties may be productive when they foster humility and openness on the part of the professional. In the quote above, the nurse referred to Devereux's (1978: 2) discussion of complementarity, the complimentary relationship between the frameworks of anthropology and psychoanalysis. This nurse suggested that rather than trying to learn about the particularities of the presumed cultural background of her patients, she would simply listen and be open to what their patients may provide. Others also emphasized the importance of openness towards the life worlds of others. For example, one psychologist described being able to engage with whatever material her patients may bring:

> "People can talk to me about possession, traditional etiologies, or they can talk to me about their migration histories, or they can talk about their social situation. I'm open to that, and it's thanks to this transcultural work. Once I'm open to it, they can sustain a psychological envelope[22] that will permit them to be able to speak about their illness and suffering and what they're living."

In another interview, a nurse described how she initially would have found it difficult to engage with certain practices that her patients carry out. However, this nurse emphasized the importance of empathy and respect in clinical encounters:

[22] The word the psychologist used in this interview was *enveloppe psychique,* which refers to a protective barrier between the unconscious/conscious and external/internal, and which is both containing and dynamic (Mellier, 2014). The term, "envelope," is a metaphor to explain the conditions from which an individual can exist within her/his own body, individuality, and develop a sense of security (Ciccione, 2012: 415). Importantly, the envelope permits exchanges between the individual psyche of the self and the external world (Doron, 2000: 15). For a more comprehensive review of this psychoanalytic concept, please see Anzieu et al. (2000), Ciccone (2012), Houzel (2000), and Mellier (2014).

> "Before, I was a bit too much of a feminist [laughs] and I tended to be quite forward, especially on topics concerning arranged marriages, etc. But actually, no, that doesn't work. It's better to be empathetic and to respect what she will tell me. I'll say 'I'm going to talk to you about excision, I know that that takes place where you're from,' so I try to get them to open up and show them that I'm not going to reprimand her about it, but rather have a discussion with her about what it's prohibited…I ask, 'do you know why it's prohibited in France?' 'No, nobody ever told us.' They know that it's prohibited but they don't know why…and when I explain, I feel that there's an awareness."

In addition to emphasizing the importance of empathy and respect, this nurse also described feeling more open to bringing up potentially sensitive issues, such as *excision*[23]. Not all professionals may feel comfortable speaking with an individual about such a topic, nor may they find it appropriate to imply that this individual has an experience of this procedure based on the region or country where the person is from. Regardless, this nurse's comments reflect the importance of open mindedness and respectful engagement with an individual in the context of practices that may not be mainstream or may be prohibited. Moreover, other professionals, such as this child and adolescent psychiatrist, emphasized the importance of recognizing the realities of patients or clients:

> "There are other worlds than our own. These worlds exist and they are just as real as ours…for them, sorcery is a reality that's just as tangible as the economy or Christianity is for us."

This psychiatrist was not necessarily advocating for a culturally relativist position, but rather he emphasized that the health care workers should recognize the value or importance of the individual's world and representations to that individual. Otherwise, one risks dismissing the perspective of the patient or client.

My interlocutors also described how clinical encounters could be less hierarchical if considered a site of mutual learning. Some professionals, like the two psychologists quoted

[23] "Excision" is the term employed in French that broadly refers to practices of female genital cutting. This term appears alongside of other terms, such as modification or mutilation.

below, described the importance of sharing part of themselves in an effort to make a patient feel more comfortable about speaking about him or herself:

> “I had placed myself in a really artificial position. I was very personally distant from the patient, meaning that I offered nothing of myself, never. I would have considered that to be a mistake. But this training made that idea evolve, and I understood that the therapist can also talk about their own path and be more personally implicated in the care that we provide for a person.”

> “I shared my system [of representations] with the person so that the person would be able to develop his or her own. In sharing mine, I authorized the person to share his or hers. The more one is at ease in their representations, the more the other person is.”

As the first psychologist described, being open to speaking about oneself may seem counterintuitive or even unacceptable in encounters with patients or clients. After all, one tends to consider these encounters to be about the patient or client and not the professional. However, as the second psychologist stated, opening up and sharing something about oneself may be a strategy to encourage patients to open up.

The multiple functions of questions

Another way to manage uncertainty about patients’ or clients’ histories is to ask them questions. Asking questions of patients may serve to address more delicate topics that an individual may not otherwise wish to divulge. For example, one psychologist, who worked with young people who had committed offences and their families, explained that discussing cultural or migration histories serves to get to deeper issues:

> “Right away, I look at their surname, I hear their accent, and so right away, I ask, ‘When did you arrive [in France]?’ and they might say, ‘I was born here, but my parents are from this or that place.’ Or they might say, ‘Barely two years, it’s been ten years, or it’s been 20 years.’ I have a map in my office and I ask, ‘Where are you from? Show me. What language do you speak? You speak two languages, three, four!’ Sometimes they speak several languages. And by doing that, I find that it facilitates our meetings because sometimes, parents are ashamed that their children have committed offences, ‘I’m sick of seeing that my child doesn’t go to school, that he or she hangs out with scum of the

> neighborhood, that he or she's been stopped by the police I don't know how many times,' they're ashamed of that. So by being able to talk about culture, we can go beyond that shame. And by doing that, it's easier than discussing things related to family dysfunction. That's the principle of transcultural psychiatry. Giving room for culture but not staying there, crossing it and getting to what's universal."

The "principle" of this approach is to facilitate exchanges between patients and clients and health care professionals rather than, as this psychologist suggests, dwelling on culture. Others, such as this resident in psychiatry and movement therapist, respectively, emphasized how asking questions helped them build connections with their patients or clients or better understand their symptoms:

> "Before, I paid attention but I never asked patients about their cultural or migration histories. I never asked questions and also, even if the patient mentioned something, I didn't pursue it any further. Now, I am much more attentive to aspects of culture, language, and migration. And I think that will help me create a link with my patient, since I think that my patients will feel that I'm interested in who they are and the uniqueness of their experiences."

> "I have a patient who has auditory and tactile hallucinations. He was put on neuroleptics to remove the auditory hallucinations, but he feels that there is a snake that moves around in his body. With this patient, I bring this up differently than I would with other patients: why a snake? When exactly does it arrive? Does the snake move around all the time or certain moments? I want to see what's behind it all."

Asking questions of individuals not only allows health care workers, like this movement therapist, to better understand these individuals' realities, but it also demonstrates that the worker is interested in the patient. For example, one nurse illustrated how asking questions reflected the humility of the health worker and created a more balanced alliance between the worker and the patient:

> "It's about being humble what I can bring them and what they can bring me. I very often say, 'how do you do this or that? I'm interested.' And I can tell that they react, "ah, someone is interested" and then they explain why they do something. For example, with one mother, I said, "your baby smells so good," and the mother responded, "yes, because I massaged him with this product," and two weeks later she brought the product because I had asked. And she was happy because I showed that I was interested."

Simply demonstrating that one is interested in a patient and listening to her or his story reflects a more horizontal relationship between a clinician and patient since this interest suggests that they can learn from one another. Moreover, as the nurse above stated, showing one's interest reflects the humility of the clinician. As many researchers have suggested, cultural humility, which involves a commitment to self-evaluation and to challenging imbalances in power between clinicians and patients, reflects an alternative approach to addressing patient diversity than cultural competence (Tervalon and Murray-García, 1998: 123; Fisher-Borne et al., 2015: 171).

Of course, upon initial consideration, asking more questions seems like an obvious way to learn more about a person and to demonstrate one's interest. Yet as one psychiatrist identified, one must also be ready for the person's response:

> "There are some things that I just cannot hear, so I can't even imagine asking the question. And if I ask the question, what do I do with the response? How do I analyze it? How do I receive it? What do I do with it? You have a response and if you don't have anthropological understandings because you cannot have them, do you interpret what they say as transgressions or not? If you don't have a book open or anthropological [knowledge], by your own culture you don't understand anything and you don't even know that you don't understand anything."

While some of the professionals I cited earlier stated that they no longer felt that detailed or catalogued understandings of their patients were necessary or even desirable—even though that's what initially drew them to cultural competence training—this psychiatrist's comments suggest that being open without possessing knowledge about one's patients may have its limits. In other words, this psychiatrist cautions that by being more open and being better positioned to ask questions, one potentially becomes privy to something that he or she is not ready to hear. It seems that this psychiatrist cautioned against taking a culturally relativist stance, in which a professional may be open to hearing *anything* that a patient may share. Moreover, while these professionals described how detailed understandings of their patients' or clients' cultures are not

necessary, this psychiatrist suggested that one must possess a baseline of knowledge if one is to be prepared for what an individual may share.

While professionals must come to terms with their own uncertainty, it may also be worthwhile to note that individual patients or clients may have had to explain themselves numerous times to health and social service professionals in various institutions. Indeed, as Phil Brown (1993: 261) describes, patients may also be "detectives" in the mystery story of clinical encounters since they must anticipate what clinicians and institutions want to hear. Moreover, they may view health care workers with suspicion and may be hesitant to open up, particularly if they have had negative experiences with health and social service professionals in the past. Therefore, others, such as this psychologist, described the importance of giving individuals the space to talk about themselves when and how they see fit:

> "I approach in a really delicate manner, I may ask a quick question to see if the person is open and I go at their rhythm, not mine"

However, as another psychiatrist explained, possessing the conceptual tools of *psychiatrie transculturelle* and being a seasoned clinician may not be sufficient in institutional contexts where patients are not used to being asked certain kinds of questions.

> Psychiatrist: "At the Hôpital Cochin [where Marie Rose Moro directs a *psychiatrie transculturelle* therapy group] everything went marvelously well and patients were able to talk about their migration history within a few sessions. But in other establishments where people aren't used to these kinds of questions, and after several attempts, I had the impression that it was just not possible. Even if you have the theoretical basis, and you've already practiced it with other clinicians, it's not possible. Because it breaks up the continuity of care."
>
> DA: "Do you mean that patients are uncomfortable with the questions?"
>
> Psychiatrist: "Exactly, when the objective is to make them feel at ease, it can be a catastrophe. Obviously, it's not always like that, but it can happen and it does happen in several settings."

This psychiatrist's comments suggest that the effectiveness of incorporating an approach in which one wishes to explore the cultural histories of an individual patient or client depend on that individual and the institution in which the encounters take place.

Culture is an easy excuse

While these professionals sought out training to better work with immigrants, they acquired attributes—acceptance of uncertainty, openness, confidence to ask questions, adaptability—that could be beneficial in encounters with anyone. In addition, some professionals who underwent cultural competence training learned that focusing on a patient's presumed culture was not always necessary or even desirable:

> "It's often an easy excuse to say 'it's cultural,' when in reality it's a problem with the care that we provide and we don't know how to respond, so we say that it's cultural"

This nurse's comments illustrate concerns raised by Zahia Kessar (2009: 107-8), who describes how professionals must learn to reflect on their own functioning rather than learn "recipes" for working with particular presumed geo-cultural groups. Upon initial consideration, it may seem ironic that a professional who sought out cultural competence training may describe the attention to an individual's presumed culture as an excuse. However, this perspective demonstrates how professionals, such as the nurse quoted above, have learned to look inwards to their own capacities and those of their colleagues. Additionally, a psychologist explained that trying to understand the "cultural system" of another is not necessarily even possible. Rather, one should perhaps consider looking inwards first:

> "In the end, I find that culture is not always the best point of entry. We wanted to know the cultural system of the other, and now I understand that it's impossible to know the system of the other and that it's better to be content with one's own system and to focus on developing one's own system in order to better understand the other person"

Like the nurse quoted earlier, who said it was impossible to gain knowledge about every culture, this psychologist describes the impossibility of knowing the entirety of one's cultural system. These professionals have accepted the breadth and depth of uncertainty regarding the cultures of their patients or clients. The comments of this psychologist reflect what Shaw and Armin describe as "ethical self-fashioning," whereby health care providers act on their own subjectivities to develop a culturally competent orientation towards their patients or clients (2011: 241). Additionally, Larchanché (2010: 139), in describing *anthropologie médicale clinique*, states that therapists need not possess anthropological expertise but should be more reflexive in their explanatory models. In other words, rather than looking to better understand individual patients or clients, professionals turn inward to question how they engage with these individuals.

A process of professionalization

For professionals who had completed their studies many years before, the professional development training harkened back to their university days. Professionals who completed these training programs undertook a compulsory research project, which resulted in an article or a 30- to 60-page *mémoire*, a thesis project. This was an opportunity for these professionals to draw on a case from their own work and put it into conversation with the theories from the program. Over the course of the year, participants underwent supervision sessions in order to discuss their individual projects and bounce ideas off of the program faculty and their fellow participants. Program participants submitted these projects in April or May and then underwent a *soutenance*, in which they needed to present and defend their work in front of a committee of three to four instructors from the program. This defense and the ongoing supervision represent formal and

informal controls of the ways in which these professionals appropriated the concepts of the training programs into their own work.

Many of my informants told me that they were not *universitaires,* or academics, and that it had been a while since they had prepared a significant research project. Therefore, they found this project to be a daunting task to be completed in addition to their professional and personal commitments. Many interviewees often brought their *mémoire* projects to our interviews to show me the work that they had undertaken regarding the case of a patient or client that required the competences that they developed. Some described sharing their projects with their colleagues in their workplaces. Upon successfully completing the training programs, these professionals received a *diplôme universitaire* (D.U.) or a graduate certificate.

For some professionals, these certificates represented a professional qualification that brokered access, or otherwise that allowed them to legitimize their participation as co-therapists in *psychiatrie transculturelle* consultations. When inquiring about the potential to work with Marie Rose Moro's *psychiatrie transculturelle* group at the Hôpital Cochin in Paris, one psychiatrist, who was multilingual and had experience working abroad with Médecins Sans Frontiers and Médecins du Monde, was told to complete the graduate certificate in order to potentially work with this group. One psychologist who had participated in a *psychiatrie transculturelle* consultation some time before the training described how completing the D.U. allowed her to make her presence more official. A nurse explained that this qualification legitimized her presence in a *psychiatrie transculturelle* consultation since she did not have training in psychology or psychiatry. For professionals who wished to establish new *psychiatrie transculturelle* consultations, this qualification represented a necessary but not sufficient prerequisite. In other words, those who wished to establish these consultations needed this

qualification *as well as* experience participating in a *psychiatrie transculturelle* consultation and supervision from a more experienced therapist. While some of my interviewees were long-time participants in *psychiatrie transculturelle* settings, others conducted internships of varying lengths over the course of their training programs. In addition to providing a qualification to participate in *psychiatrie transculturelle* consultations, this training also represented the possibility of developing and elaborating their knowledge by sharing their experiences with their peers and instructors.

Consolidating and systematizing knowledge

Many participants in these cultural competence training programs had never studied *psychiatrie transculturelle* or *anthropologie médicale clinique* in their initial studies in medicine, nursing, social work, or clinical psychology. Others had read the work of Georges Devereux, Tobie Nathan, Arthur Kleinman, and others. For those who already had some understanding of *psychiatrie transculturelle* or *anthropologie médicale clinique,* these professional development programs could be considered an opportunity to connect their experiences to theory. For example, two psychiatrists who had experience working in *psychiatrie transculturelle* groups described how this training represented an opportunity to bring together their understandings in a coherent, organized manner:

> "I already had experience, I had a lot of reading material, but I didn't have an overall view of the field. I wanted to have access to the entire theoretical corpus."

> "I wanted to consolidate the knowledge that I had acquired in my practice and reading. I had read a lot [about *psychiatrie transculturelle*] but not in a systematic way, so I wanted to systematize my knowledge."

For those who already had knowledge of the field, this training could be a way to deepen that knowledge through instruction from some of the leaders in the field. These training programs

were also a space in which professionals, such as these psychiatrists, could think about their clinical work in the context of the concepts of these programs, alongside other professionals, and with the supervision of the instructional staff. In fact, as many of my informants described, the exchanges with others in their cohort and with the program instructors were particularly valuable.

Developing and reinforcing a multidisciplinary network

Many of my interlocutors described how connections with their classmates, the pedagogical team, and the larger network of professionals with this training were as important as the content of the training itself. More specifically, their participation in this training allowed them to share their experiences with other professionals working in medical, social, and educational settings. Their integration in the group permitted these professionals to get to know others who share the same interests, who do similar work, and who face similar challenges in their workplaces. One psychiatrist described the importance of the network:

> "I also wanted to have the perspectives of other professionals, and I wanted to become professionalized by integrating into the larger group of professionals. I wanted to have the professional support of the association (The International Association of Ethnopsychoanalysis, l'*Association Internationale d'Ethnopsychanalyse,* AIEP) and the others in the association. I wanted to compare and situate my experiences with theirs. I wanted to integrate myself into the ethnopsychoanalysis and transcultural psychiatry community in France, to be affiliated with this group, because the little knowledge that I had was not sufficient."

As this psychiatrist explained, participation in the allowed for the sharing of experiences and the development of connections with those who share similar interests and who were confronted by similar challenges in their work. This psychiatrist also explained that there was an important group effect that played a role in the sharing of experiences:

> "There's a group process that is extremely important, which is deliberately constructed. It's a sort of group ritual. The trainers really reflected upon this."

Indeed, the training staff had reflected upon the dynamics of the group. In one of the programs, at the start of the academic year, participants were asked to agree upon a name for the cohort. At the end of the academic year, in June, this cohort organized a conference, during which several participants presented their *mémoire*. The event concluded with a reception in which participants prepared a meal to be shared. In short, this culminating event was collectively organized and represented the diversity of the participants' interests and skills. At the end of the program, participants stayed in touch, planned happy hours, shared research articles, and forwarded information regarding seminars and conferences.

In the other training program, however, the intentional establishment of a group identity was absent. In other words, cohorts were not named, nor did they have a day dedicated to sharing their work and talents. While the pedagogical team did not attempt to cultivate a strong group relationship, the participants did. Over the course of the program, participants had lunch together between lectures, they shared lecture notes and articles, and they organized a celebratory dinner following the end of everyone's *soutenance*.

Whether "deliberately constructed" by the pedagogical team or the participants themselves, my interlocutors emphasized the importance of the group process as a site at which ideas could be shared and partnerships forged. One psychiatrist emphasized the reciprocal and ongoing nature of knowledge sharing that takes place among members of the larger network:

> "With time and by soaking up the knowledge of certain colleagues who are sensitive and who teach me, it's reciprocal learning that occurs over time. And that continues to nourish itself and be fruitful if maintained, and that's why I participate in the transcultural consultation and why I go to seminars whenever I can."

For others, group exchanges between professionals had encouraged collaborative projects, such as the *psychiatrie transculturelle* therapy groups in Caen and Lyon illustrated at the start of this chapter. Even those with different professional backgrounds working in different establishments described having the possibility of working together in this larger network. For example, Clémence, the health educator from Caen, described meeting Sylvie:

> "We didn't know each other before, we met during this training and found out that we were from the same city. That made us want to start up a project together and we felt stronger about it, two people who had trained together."

Having met in a town outside of where they work and having undergone training together, Sylvie and Clémence were able to collaborate under the supervision of a member of the pedagogical team of the training. Moreover, they considered their different professional backgrounds as an interdisciplinary strength in working together:

> "It's really a decentering, a professional decentering, I'm a health educator and she's a psychologist and we are able to do work together…it's really a process of deconstructing and reconstructing in a manner that's larger and more open"

Clémence expanded the concept of decentering, or the ability to distance oneself from his or her system of representations, to include working with colleagues who come from a different cultural, professional system. Indeed, as Chambon and Le Goff (2016: 132) describe, interdisciplinary teams have the potential for a non-hierarchical circulation of knowledge since non-medical personnel may possess the social expertise about the life of a patient that medical professionals do not. Engaging in professional decentering, as Clémence suggested, allows different types of professionals to recognize and value the expertise of their colleagues having different training.

These professionals emphasize the importance of knowledge sharing and working with colleagues in other disciplines. Moreover, as one of the trainers, a psychologist, described,

psychiatrie transculturelle practices could be used in a variety of disciplines beyond psychiatry. While *psychiatrie transculturelle* knowledge, according to some my interlocutors, could unite different kinds of professionals, others were more cautious about the extent to which this kind of knowledge and practice could be used to promote interdisciplinary initiatives. One psychiatrist, who works with people with addictions and without fixed housing, described significant disciplinary divisions in the work of the psychologists and psychiatrist (collectively referred to here as the "psys") and the social workers:

> "For those we support who are in a very precarious situation, such as those who outside of their country and who don't speak the language, we cannot dissociate sociocultural aspects from the psyche. And we know well that the street becomes a new form of trauma and so we need to work together. It's often the case in psychiatry that the social workers work on one side and the psys the other side…I know for a fact that social workers may feel that they're isolated because they may have a client who is going through a lot but who cannot speak to the team of psys and that just doesn't work. You cannot cut people up into pieces, it's a global problem."

Indeed, as this psychiatrist suggested, complex problems that involve a combination of mental illness, displacement, trauma, homelessness, and/or addiction require the interdisciplinary efforts of clinical and social care professionals. However, institutional cultures that promote professional hierarchy and boundaries in lieu of collaborative group work may hamper interdisciplinary solutions. The next section explores various kinds of challenges that professionals who have undergone apprenticeships or professional development training have faced when attempting to incorporate their newly acquired knowledge in institutions and with colleagues that may be less enthusiastic or open.

Institutional constraints and collegial resistance

In spite of the strategies developed to be more more open with patients or clients, as well as the potential for knowledge sharing and collaboration in the professional network, my

interlocutors explained certain challenges that they faced in their workplaces. At times, they described feeling isolated, and they also discussed how they had to develop improvised responses to institutional constraints.

At times, the professionals with whom I spoke described undertaking cultural competence training because others in their teams or in the establishments where they work had previously undertaken the same training. Moreover, certain institutions provide financial support for professional development training, and excused employees to attend training sessions that took place during working hours. Some professionals described being able to chose any training program that interested them and submit their request to their supervisors or administrators for approval. In other instances, the impetus for this support was rooted in a priority at the institutional level to better serve migrant populations.

However, institutional support, whether for continuing education in general or specifically for assisting immigrants, was not a given. Other professionals described how they did not receive any support and how their participation in cultural competence training required a *démarche personnelle,* or a personal initiative:

> "My participation in this training was really a personal move since I did not have the financial support of the institution and they were not really open to this training. My colleagues were, but the administration was not. When I went to the training sessions on Fridays, I had to use my annual leave."

> "I was the only person on my team who was trained. It was not a team project, and they did nothing to facilitate my participation in this training. I paid for it myself, they just granted me some hours [to attend the sessions], but it was really a personal undertaking."

In addition to having to use annual leave to attend sessions and pay the tuition fees for this training, some professionals felt that neither their supervisors nor their colleagues shared their interest in *psychiatrie transculturelle* or *anthropologie médicale clinique:*

> "What I want to outline is that there's a pretty strong resistance to the transcultural approach. It could be viewed as a threat to other concepts when in fact it's complementary…I have the impression that people are a bit stuck in their ways and they feel threatened if we try to do things another way."

Some described feeling isolated from colleagues who were uninterested or even hostile:

> "I find myself alone here, really isolated. I have the support of the administration here but all of my colleagues are either indifferent or hostile in general, they're not at all interested in ethnopsychoanalysis."

One psychologist described leaving a maternal health service setting after finding that she was unable to convince her colleagues to adapt their practices with certain patients:

> "Some people just don't understand, and that worries them a lot. And so they will diagnose or they'll exclude a patient or they'll react in a violent way, and they cannot say, 'I don't understand and that's okay'…and I left some settings because I wasn't successful in convincing [colleagues] to be open to some ways of mothering, that it was necessary to receive migrant mothers a tiny bit differently, I didn't succeed. The position was too rigid, it tired me out…and I found myself facing a huge closed mindedness towards culture, I think there's a lot of resistance. So I left."

I asked my interlocutors to describe what their colleagues' resistance entailed. One psychiatrist described how forms of resistance may seem quite subtle:

> "For example, during Ramadan, I proposed that patients should be able to rest. On the second floor of the establishment, there's a spot where one can rest and we purchased comfortable deckchairs. I was very attentive, I knew who was observing Ramadan, and I went to see them to ask, 'How are you? You're not too tired? I know that you're observing Ramadan, you can rest.' And I know that people on the team said, 'These patients are coming to sleep, there's no point in them coming to the day hospital.' I think that's a disguised form of resistance. They didn't say it directly, but I had to explain to them that when a patient comes to the day hospital, he or she is coming. We don't know what's going in their lives, but they come. And we need to take into account that it's a period of fasting, the days are long, and it's being attentive by proposing that they can rest. I should say that as the head of the day hospital, people didn't contest. But I could tell that it was difficult for some of them."

Other professionals felt that their colleagues recognized their newly acquired expertise, but this this typically resulted in their colleagues asking them to accept patients considered to be culturally different or difficult. For example, one nurse described being labeled by her colleagues as "Madame Culture," since her colleagues tended to ask her to step in when they encountered

patients from other countries. This may not come as a surprise, and it suggests that untrained colleagues may recognize and value this expertise. Moreover, this same nurse described a system of "retranscribing" in her workplace when anyone undergoes training. Due to funding shortages in this setting, not all personnel can undergo the same training programs. In order to distribute the expertise, those who undergo a particular training are expected to retrain what they learned so that their colleagues may also benefit from this knowledge.

However, not all of my interlocutors were as enthusiastic when their colleagues solicited their expertise, and some, such as this movement therapist and nurse, respectively, felt that these colleagues were unloading unwanted patients onto them:

> "At the moment, I'm trained and I am confronted by members of the team who haven't changed at all with regards to these things. They send me patients and they say, 'you're trained, you can understand this person better. Go for it, try it out, see if you understand better than we do.' But the team is not at all trained and it's complicated because there are things that I've been able to observe and I try to help them out."

> "Except for the psychologist, there are very few colleagues who are interested. When these colleagues are irritated, they say 'you can take this patient because you understand.' They're not asking for my advice, they're delegating."

Additionally, these health professionals worked in a variety of different settings that varied in terms of their resources. It is essential to consider the institutions where these individuals work not just because they may provide financial support for personnel to undergo training, but also because they may be characterized by different types of time and financial constraints. For example, the psychiatrist introduced in the anecdote at the beginning of this chapter described how their clinic did not have the resources to implement a *psychiatrie transculturelle* therapy group as the clinicians in that establishment were already spread too thin and didn't have the

time they wished to dedicate to their patients. A general practitioner described the time constraints faced in the setting where he works:

> "I think there are patients for whom one needs to spend a bit more time in consultations. One also needs to confront explanatory models like they say in *anthropologie médicale clinique*. And so that takes time and in general medicine practice, we don't have that much time. In a private practice, where the cost of the consultation is 23 euros, it's not easy to spend 45 minutes…if it's one patient a day, that's fine, but if it's 15 patients per day, it's not possible."

However, a nurse who works in a maternal and child healthcare center (*Protection maternelle et infantile,* PMI) described how they have the "luxury" of being able to spend more time with patients:

> "Larger institutions like hospitals can't get into the details about a patient's customs, it's true that they're a bit rigid. So when they see a family that has more needs, they often tell them to come here to the PMI where they know that we'll take time and explain things…That's the luxury that we have here, that we can say to people, 'look, I don't have an answer right now. Can we see each other again in two days, so I can find a solution or better understand what is going on?' That's the luxury that hospital services don't have."

Indeed, having the time to research a patient's concern and asking this patient to return two days later appears to be a luxury that professionals working in many public service institutions don't have. Additionally, one of the principal constraints that most professionals, including this psychiatrist and health educator, respectively, faced in their workplaces was the funding for interpretation services for non-francophone patients or clients:

> "We have budgetary constraints, we can bring in a maximum of ten interpreters per year. We cannot have more than that, otherwise it costs the institution too much money. So that's a major element. Any time we can, we ask our interns to be the interpreters, if they're willing."

> "We ask the child welfare services (*aide sociale à l'enfance*, ASE) to help pay for interpreters and we have to fight to have money and we have to provide well-founded arguments in order to have interpretation services."

Yet others claimed that institutional reticence towards interpretation services was not necessarily due to funding. As one psychiatrist in an addiction service described:

> "I think we could have the funding [for interpretation] because the CMP [in the same hospital system] clearly has it. So there are resources, but it's just not customary. I think we could do it. It's also true that we're very busy, though that shouldn't be a barrier, when we see people who are in very precarious situations, we're overloaded when taking care of everyday things for people who don't have housing and who live on the street."

Some of my interlocutors mentioned that in their establishments, there was a list of professionals who spoke different languages and who could be called on to translate when an interpreter was not available:

> "It's complicated, but we're lucky because at the hospital where I work, we've formed a group of health care worker translators. So we have a list that's really diverse, there are health care workers who know how to speak a lot of different languages, even dialects from certain communities. I have one patient who speaks Mandarin, so we'll call that health worker, who could be a plumber, who works at the hospital, we call that person to translate, or at least be present physically. It can be good or bad. It's not a real interpreter, but it's someone who works in healthcare in general."

As the movement therapist explained, this member of the hospital personnel, while being able to speak Mandarin, was "not a real interpreter." In addition, others explained that these individuals are not optimally positioned to be translators since they don't work in the same domain:

> "We refuse people from the list of multilingual people. It's not easy with other [hospital] services, it's not the same kind of work."

> "In terms of the translation, it's not the same because the people aren't health workers. They could be technicians or cleaners but not necessarily health workers, so the translation of hallucinations could be biased, inauthentic, and not objective. We also don't know if they [the translator and the patient] are from opposing ethnic groups, so we don't know if they have prejudices against certain cultural groups."

Professionals, such as these two health educators, also explained how they needed to devise creative solutions in absence of financing for interpretation services:

> "I had experiences of *bricolage*, for example, I had this young man from Egypt who speaks Arabic and I tried to find a doctor who speaks Arabic. I succeeded because another young person spoke about an Egyptian doctor so I put them in contact."

> "In our service for unaccompanied minors, we have thirty-five nationalities represented. We depend a lot on the network, we ask those who were minors in our service to translate since those who have learned French try to help us. Otherwise, if we don't have anyone

> who speaks a particular language, then we contact an interpretation service, which works well but is expensive. If not, there's also a CADA [*Centre d'accueil pour demandeurs d'asile,* a reception and support center for asylum seekers] run by France Terre d'Asile[24], which at least has a translation service that's less expensive but one needs to schedule a meeting well in advance."

While some professionals may had more resources at their disposal to support multilingual patients or clients, these two health educators described needing to piece together solutions in an absence of these resources. They emphasize the importance of collaboration with individuals in, as the latter professional describes, the "network" in order to spread out resources.

Concluding remarks

In this chapter, I evaluated the experiences of health professionals who had previously undertaken apprenticeships or participated in professional development programs in *psychiatrie transculturelle* or *anthropologie médicale clinique.* This chapter therefore departs from the previous chapters, as it investigates how a wider range of professionals had implemented or attempted to implement the lessons they learned in their apprenticeships and training into new clinical or professional contexts. While limited in the sense that it does not consider the experiences of the apprentices featured in the previous chapters, this chapter adds a rich collection of varied experiences of professionals who could reflect on their training several years after its completion.

Rather than learning about different cultures from around the world, what changed over the course of their training was the way in which professionals engaged with patients. As Angela Jenks describes, many contemporary cultural competence training programs have foregone "list of traits" approaches in favor of approaches that intend to promote open-mindedness among

[24] France Terre d'Asile is a French NGO that specializes in the support of asylum seekers. http://www.france-terre-asile.org/objet-social/france-terre-d-asile/presentation/objet-social

health professionals (2011: 209). Rather than attempt to learn about the features of the presumed cultural backgrounds of patients, health care providers are encouraged to re-orient their practice and act on their own subjectivities (Shaw and Armin, 2011: 241). This allows practitioners to develop an 'ethical self' in which they can identify and address racist or prejudicial attitudes that they may have, as well as respect patient autonomy and understand how cultural differences may have an impact on patients' health or wellbeing (Shaw and Armin, 2011: 244). These forms of cultural competence training represent the transition from knowledge-oriented to process-oriented programs[25].

The professionals with whom I spoke described numerous changes in the way they interacted with patients or clients. Many stated that they felt more open with these individuals. Cattacin and Dagmar (2014: 35) describe the importance of openness and the capacity to listen to the histories of people with diverse identities. This capacity and openness are essential, particularly in environments of what Seth Hannah describes as "hyperdiversity." Contexts of hyperdiversity are—as the name suggests—very diverse, dynamic and multidimensional, in which people may identify with different groups (Hannah, 2011: 41). Thinking about hyperdiversity requires a reflection upon Kimberle Crenshaw's concept of intersectionality. Intersectionality, while originally referring to the relations between gender and race in the context of violence against women, may also used to mediate "the tension between assertions of multiple identity and the ongoing necessity of group politics" (Crenshaw, 1991: 1296). In the context of *psychiatrie transculturelle*, hyperdiversity and intersectionality may be especially relevant since the identities and forms of belonging of individuals may or may not be mobilized in therapeutic encounters. As my interlocutors explained, possessing an understanding or

[25] For more details on this distinction, please see Guzder & Rousseau (2013) or Willen (2013)

expertise about different groups or cultures is not necessary or desirable because professionals risk assuming that someone who belongs to a particular group may share all the elements of identity of that particular group. Moreover, the next time that they have a patient or client from that presumed cultural group, they risk making similar assumptions about that person.

Professionals may also run the risk of over-interpreting cultural dimensions in lieu of other factors. As some of my interlocutors explained, it may be better to be open to the ways in which a person experiences his or her cultures than trying to identify and understand cultural dimensions. More specifically, they emphasized focusing on the individual in lieu of the person's presumed cultural background. If the person decides to share an aspect of her or his cultural or migration history, the professional may explore these histories in more depth by being open to what the person has to share, by asking questions, and by being ready to adapt one's therapeutic practices if necessary. But one should always allow individuals themselves to determine if and how to share their stories.

As one of my interlocutors stated, exchanges with patients or clients must take place at the "rhythm" of the client or the patient and not that of the professional. According to Sturm, Baubet, and Moro (2010: 35), the exploration of cultural contexts should always permit the patient to provide her or his opinion, to ask questions, and at times, reject cultural practices. If the patient may not necessarily be used to speaking about his or her cultural or migration history, and the act of exploring these histories may not be something that even interests the patient. Therefore, it's essential to consider whether the patient wishes to explore these histories before embarking upon therapeutic strategies that take cultural dimensions into account.

The capacity to decenter, or distance oneself from her or his own cultural representations, was often invoked by my interlocutors as a crucial concept from their training. It is an approach

that individuals from different professionals backgrounds (e.g. psychiatry, social work, psychology, nursing) and who work in different types of health and social service settings may utilize to support patients or clients. The process of decentering that my interlocutors described represents a shift away from the consideration of culture as a collection of features that characterize a person. Instead, this process reflects a change in the posture of the individual professional. More specifically, my interlocutors described feeling more at ease speaking with patients or clients, asking different kinds of questions, conducting their consultations at the rhythm that patients prefer, and recognizing that trying to understand the culture of the patient was not necessarily the best approach to take.

While decentering appears to avoid some of the critiques of earlier cultural competence initiatives, such overemphasizing the role of culture in health and ignoring the cultural world of the professional, it appears to remain centered on the individual level. Moreover, the constraints in my interlocutors' workplaces represent organization-level barriers to providing culturally competent or humble care. In fact, the experiences of my interlocutors reflect what one of Shaw and Armin's (2011: 256) interviewees described: "I suggest to you that it's very difficult to be a culturally competent physician, nurse, in an organization that does not support it with policies, procedures, and resources." As this quote suggests, clinicians who are trained to decenter may continue to face pushback from their peers and supervisors when trying to put into practice the conceptual tools they acquired during their training. Others have observed this as well. Larchanché (2010: 336) has identified how health and social service professionals conflate cultural difference with structural inequalities, as evidenced with their problematic referrals to mental health settings for immigrants, or they may feel powerless in addressing these inequalities. Indeed, these observations reflect broader warnings to avoid focusing on the

individual level, as opposed to organizational or structural levels (Castañeda et al., 2015: 380). Perhaps, as Sarah Willen (2013: 276) suggests, dual forms of critical consciousness a) that critically examine structural factors that impact health, and b) that require professionals to look within themselves and assess their own attitudes and counter-transference in encounters with patients or clients, may be essential for health care workers who wish to work with diverse groups of individuals.

In addition to changing their practices, my interlocutors explained that the professional network acquired during their training in *psychiatrie transculturelle* was as important as the content of the training itself. These professionals often invoked the sharing of experiences and knowledge, as well as the possibility of working together on projects. Professionalizing, according to one of my informants, involved becoming part of a larger network, and this could be particularly valuable for individuals who felt isolated or who felt that their colleagues were not receptive to *psychiatrie transculturelle* therapy.

My interlocutors also described the complexities associated with their work with other professionals who had not undergone similar training. For example, while many described a transformation in their practices, some professionals, such as the movement therapist quoted above, describe how their colleagues "had not changed." Moreover, some of my interlocutors described how they felt their colleagues would delegate, meaning that they would request trained professionals to take on clients or patients they didn't wish to work with. While acts of delegation suggest that colleagues may recognize the newly acquired expertise of culturally competent professionals, these acts also demonstrate that there may be limited opportunities for the further diffusion of this knowledge in different settings. Situations such as this one demonstrate how *psychiatrie transculturelle* approaches remain marginalized in some settings.

The ability to make an impression on one's colleagues and to implement cultural and linguistic competence within one's workplace appears to depend a great deal on several characteristics. Indeed, as my interlocutors identified, financial and time constraints may hinder the ability to bring in interpreters. As a result, these professionals may have to depend on non-therapist professionals who speak a particular language, share resources with other organizations, or even draw on networks of prior patients or clients. These professionals appeared to have mixed opinions about enlisting the linguistic expertise of those who were not properly trained as interpreters or who were not therapists.

In a study on the organizational characteristics that promote the adoption of cultural competence in substance of abuse treatment centers, Erick Guerrero (2012: 14) describes how managers' cultural sensitivity was associated with the degree of adoption of culturally and linguistically competent practices. Indeed, as one of my psychiatrist interlocutors described, his position as the *chef de service*, or department head, made it possible for him to implement practices in spite of the resistance of his colleagues. Moreover, another psychiatrist was able to lead and maintain a *psychiatrie transculturelle* therapy group in one mental health center—amid hostility from colleagues—because of support from the administration. Therefore, managerial support appears to be essential in the implementation of culturally sensitive or competent initiatives. However, as the other psychiatrist described, support from the administration did not appear to sufficiently counter the isolation he experienced from his peers.

Conclusion: "We're anti-routine"

"We're anti-routine. We're anti-routine and we're anti-dogma." This was how one of the supervising psychiatrists described the pedagogical methods at the Minkowska Center. The psychiatrist continued,

> "It's a will that we all share, to always remain flexible and to question oneself and take care of people and not their culture or language…It's an enormous risk to stigmatize a person and see only their cultural and linguistic references."

The message of this psychiatrist was clear: apprentices should not overemphasize cultural or linguistic, or even structural factors, that impact an individual's experience of mental illness. Rather, one must put the person first by listening to what she or he has to say and then adapting one's practice accordingly. In so doing, one would take a more holistic approach to providing psychotherapy—or other forms of care and social support. Moreover, by taking a stand against dogma and routine, the psychiatrist emphasized the center's commitment to the liberty of expression and communication in pedagogical encounters with apprentices. In fact, in each of my field sites, apprentice therapists were informed by their supervisors that they could speak their mind about how they thought cultural or linguistic diversity was relevant in therapy and in many instances, they were invited to speak of their own migration or family histories.

While the message of this psychiatrist was clear, the method was not. What surprised me about the psychiatrist's comments above was the insistence on avoiding routine and dogma and instead adopting an approach of flexibility. I found this psychiatrist's comments especially surprising because apprentices' comments and my own observations noted the palpable routines and dogma in these therapeutic settings. As I have argued throughout this dissertation, the methods used within culturally sensitive mental health settings to encourage apprentices to

embrace the uncertainties of practice have inadvertently produced new uncertainties for many apprentices.

Perhaps I should not have been surprised by the tension between the pursuit of openness and self-awareness and the rigid and dogmatic forms of control used in these settings. It may go without saying that routines and systems of authority are a fixture of any pedagogical setting. For example, in his account of the training of surgeons, Charles Bosk (2003: 62, original emphasis) noted a similar tension between supervising (attendings) and trainee surgeons (housestaff): "Despite the open-ended nature of the question 'Which approach is better?', attendings in their everyday behavior can be quite dogmatic. Attendings believe that housestaff are on *their* services to learn *their* approach to the surgical management of disease." Similarly, apprentices come to these settings to learn the approaches of *anthropologie médicale clinique* or *psychiatrie transculturelle.*

But these settings were different than other clinical pedagogical contexts. Not only were supervisors promoting flexibility and open dialogue concerning discussions of cultural and linguistic diversity, they were also encouraging the unlearning of the rigid ways of thinking that are often associated with psychotherapeutic training. The cautionary statement, "Don't be too psychological," of the psychologist in chapter 4 suggests that to be able to carry out this kind of therapeutic work, apprentices would need to learn to rely less on their clinical reasoning and expert knowledge. Instead, they would need to look inwards to their own intuition and to the language that their patients gave to their experiences of mental illness. In other words, the source of the expertise was within the apprentices themselves and it was the supervisors who were to help apprentices cultivate this expertise.

This dissertation contributes a perspective on how cultural sensitivity–embodied through openness, self-awareness, and flexibility–is learned and how uncertainties are managed through practice. Taking a framework of apprenticeship, this project evaluated how culturally sensitive mental health settings were communities of practice where apprentices learned to develop new ways of thinking about and responding to the needs of patients in different situations of migration. While prior research in France had emphasized that the essential expertise underpinning cultural sensitivity was the capacity to perform self-reflexivity and the ability to decenter, what was left unaddressed was how those capacities could be developed and cultivated through practice. One of the original contributions of this dissertation is its new way of thinking about familiar material, or more specifically, its approach to understanding the ability to decenter through apprenticeship. This project, therefore, contributes a framework of apprenticeship that illuminates the processes by which the ability to decenter could be learned through practice as well as the challenges that may hinder the acquisition of these capacities. By focusing on learning and practice, rather than teaching or methods that were decontextualized from practice, I contend that the interactions between apprentices and their supervisors within communities of practice are a crucial site of analysis. My analysis of these interactions suggests several significant conclusions: 1) that apprentices offer new, rich perspectives that serve as a much needed update to some of the old ways of thinking of their supervisors, 2) that efforts to minimize uncertainties may unintentionally reproduce more and different forms of uncertainties, and 3) that apprentices selectively appropriate practices and outlooks rather than a unified institutional vision.

I argue that in research on cultural sensitivity training in France, the perspectives of apprentices have, to a large extent, been overlooked. While this is perhaps unsurprising

considering that these individuals are expected to show up in pedagogical settings ready to learn, it is a mistake to neglect the perspectives of apprentices. My research demonstrates that apprentices expose the blind spots in the guidelines and operating frameworks of their apprenticeship sites. Specifically, they identified when problematic notions of culture were being mobilized in therapy and they pointed out contradictions in the practices of their supervisors. Moreover, my research emphasizes how apprentices offer valuable, alternative ways of conceptualizing the significance of cultural diversity in therapy.

While prior research in culturally sensitive mental health settings for immigrants in France had emphasized the importance of the cultural diversity of therapists, my project adds a critical analysis to the ways that therapists' diversity was mobilized in therapeutic encounters. In chapter 2, I analyzed how apprentice therapists were thought to add cultural diversity to their apprenticeship sites and their supervisors often expected them to perform that diversity. By introducing apprentices in ways that magnified their diverse origins—often framed in terms of their nationality—supervisors neglected other, more intersectional and cosmopolitan, forms of belonging. Apprentices, on the other hand, were highly critical of the practices of their supervisors, and they advanced far more inclusive ways of thinking about life trajectories that took into account multiple forms of belonging. These forms comprised region, generation, and religion. Significantly, these apprentices' perspectives reflect more recent and progressive ways of thinking about the multiple ways of being French and belonging in France today.

Supervising clinicians employed several methods to discipline the ways that apprentices thought and spoke about patients. In chapter 3, I analyzed how supervisors attempted to get apprentices to streamline the ways they framed the conditions of patients through the use of documentary artifacts. In so doing, apprentices would thereby learn to attend to and value the

important information about patients. These practices served to simplify, systematize, and bureaucratize complex information in ways that apprentices thought were antithetical to the mission of embracing complexity. Moreover, in chapter 4, I evaluated the techniques that supervisors and apprentices employed to discipline the speech of apprentices. My analysis revealed that despite encouraging an atmosphere in which the liberty of expression was encouraged, supervisors expected apprentices to deploy specific vocabulary or ways of framing their speech and policed the sincerity of apprentices' perspectives. I argue that while supervisors advanced the notion that to embrace uncertainty one had to unlearn rigid ways of thinking, these supervisors simply imposed different but equally rigid ways of thinking that produced new forms of uncertainties. In other words, supervisors were dogmatic and routinized in their being "anti-routine" and "anti-dogma." Apprentices saw through this and developed ways to subvert the approaches of their supervisors, thereby creating new ways to think about complex information about patients and encourage their peers to think more openly. They developed their own ways to sort through referral information and take notes during *psychiatrie transculturelle* therapy sessions. When thinking about how to manage uncertainty in clinical or other professional interactions, this finding is significant as it suggests that routinized ways to minimize uncertainty may inadvertently create new uncertainties.

Supervisors suggested that apprentices would develop an institutional vision of the communities of practice where they conducted apprenticeships. I argue that rather than acquire a unified vision of practice, apprentices selectively appropriated a heterogeneous combination of practices and outlooks that they could deploy in new contextual environments. In chapter 5, I evaluated the extent to which apprentices came to see patients in the ways that their supervisors did. Perhaps due to the different styles of practice of different supervisors or a lack of

transparency, or a combination thereof, apprentices identified moments of flexibility and contradiction in the ways that their supervisors modeled ideal practice. As a result, they selected the practices that would be actionable or desirable in their future work as therapists. In chapter 6, I charted out new ways of working that former apprentices had developed in the years following their apprenticeships or other forms of professional development training. These new practices reflect the ways that apprentices have appropriated certain practices in a variety of different institutional contexts. Several former apprentices described becoming more open and accepting of uncertainty, despite the uncertainties generated throughout their apprenticeship. Moreover, many professionals who had undergone apprenticeships or other professional development programs suggested that the larger networks of professionals was equally, if not more valuable, than the instruction itself. This network was especially powerful when attempting to develop collaborative projects. Others, however, found themselves in situations where collegial or institutional constraints prevented them from fully realizing their projects to implement new practices of cultural sensitivity. This is significant as it suggests that attempts to implement potentially inflexible approaches that do not sufficiently take into account the local contexts of practice, in terms of their resources and constraints, may occur with marginal degrees of success.

By taking the perspectives of apprentice therapists, who were learning to address the uncertainties of clinical practice as well as their uncertainties with how to carry themselves within these settings, I am fully aware that the account provided in this dissertation may be considered, particularly among supervising clinicians, to be critical of supervisors' pedagogical and clinical work. My intention here was not to critique or undermine the important work of supervisors or their workplaces. Rather, throughout this dissertation, I was committed to understanding the apprentices' view and thus, wanted to bring forward some of their concerns

about how to navigate the pedagogical relations within their sites of apprenticeship. Apprentice therapists expressed reservations regarding the depth and ways they were implicated within these clinical settings. They identified that they were casted in these settings in ways that were incongruous with the ways they considered appropriate, and they suggested that the tasks they were assigned were tangential and distracting from the clinical work that they hoped to engage in. Significantly, insufficient supervision and an absence of space for discussion amplified these concerns among apprentices. By highlighting the concerns of apprentice therapists, I am thus able to make several recommendations that may aid supervising clinicians in their vital pedagogical work. These recommendations broadly concern three areas: the development of openness to the experiences of apprentices, a critical reflection of bureaucratic tasks, and an incorporation of more inclusive strategies for engaging apprentices.

My first recommendation is to create more room for discussion with apprentice therapists about their reactions and experiences in these settings. Apprentice therapists greatly appreciated their individual interactions with their supervisors and during group debriefing sessions, but simply wanted more of it. Apprentices found the existing time for discussion to be insufficient and they completed their apprenticeships with unanswered questions. Therefore, additional time should be conferred both on an individual basis, during which apprentice therapists may raise concerns and discuss their objectives as future therapists, and in groups, where they can make sense of the uncertainties they encounter and learn from each other's experiences.

Creating more room for discussion also requires supervisors to be open to the criticism and suggestions of apprentice therapists. In chapter 2, I demonstrated how apprentice therapists were critical of the ways in which their supervisors conceptualized and mobilized culture during therapy sessions. They found that the ways they were introduced to patients and expected to

present themselves in the group setting were not compatible with their own self-presentation. As evidenced in chapter 4, apprentice therapists were corrected or received negative feedback when their statements were not considered sincere or when they did not adhere to the frameworks of these clinical settings. The ideas and speech of apprentices may deviate from their supervisors, but this does not mean that they are less valid or valuable. Supervising clinicians should thus be more open and reflexive with regards to the positions of apprentices. Indeed, supervising clinicians emphasize the importance of being able to decenter in their encounters with patients, and I would suggest that they must also decenter in their pedagogical interactions with apprentice therapists.

The next recommendation is to critically reflect on the tasks assigned to apprentice therapists and determine—in close consultation with apprentices—the extent to which these tasks support apprentices as they address their uncertainties and professionalize as future therapists. As I analyzed in chapter 3, the paperwork routines assigned to apprentice therapists took up a significant portion of their time, and apprentices felt that these routines were a form of busy work that seemed to detract from what they considered to be the most fascinating aspects of therapy. I do not suggest that apprentices should be less implicated in these administrative routines, nor do I suggest that they are not of pedagogical value. Quite the contrary, I found them to be deeply fascinating and informative about the organization of these settings. However, my analysis suggests that apprentices distinguished between administrative and clinical work, and thus, I suggest that supervisors take additional measures to emphasize the significant and inextricable link between these forms of work. Building on my previous recommendation, I contend that supervisors should engage apprentice therapists in discussion about the value of this work. During these discussions, supervisors should specifically recognize how apprentices'

contributions are vital to the functioning of these settings. After all, without the work of apprentice therapists, the administrative and clinical staff at the Minkowska Center would face a backlog in their intake procedures and the supervisors in the *psychiatrie transculturelle* groups would operate without an institutional memory of prior therapy sessions and without an organized plan in subsequent sessions. Additionally, these routines serve an important, albeit perhaps less obvious, professionalizing function for apprentice therapists, and it is up to the supervisors to render this function more explicit.

The last recommendation I can offer based on my findings deals is to give more responsibility to apprentice therapists, or at least be more transparent with apprentices when conferring additional responsibility is not possible. In the Minkowska Center, my apprentice therapist informants almost universally commented on their inability to observe clinical consultations with patients on an ongoing basis. This is a serious matter, given that they were becoming future therapists but felt that they did not have sufficient opportunities to observe the practice of their supervisors. It may be unsurprising that some, such as the research associate quoted in chapter 5, suggested that senior clinicians did what they wanted in their own practice despite the emphasis of *anthropologie médicale clinique* during the *Médiacor* and other pedagogical interactions with apprentices. Drawing on a framework of apprenticeship, I suggest that supervisors gave apprentices a partial view of their practice, which limited apprentices' ability to become more central and integrated within sites of practice. Building on the two previous recommendations, without space for discussion and without overt explanations of how administrative work can be instructive, apprentices' lack of responsibility and exposure to practice results in a particular or incomplete apprenticeship.

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