Mental health & precarity

les CAHIERS de RHIZOME

Peer support, interpreting, and mediation

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Artiste : Tallafe, artist painter

Born on 29 December 1981 in Abéché , the second largest city in Chad, Tallafe was attracted to painting from an early age. From the age of 14, he explored colour by borrowing paint cans from his father, who was a bodybuilder. From that moment on, he knew he wanted to be an artist. As a young adult, he left his native country for the Nteherlands. He strayed there for two years before moving to England, where he joined the Oldham School of Arts in Manchester in 2004. During his training, Tallafe explored different media and plsatic forms (collage, clay sculpture). He then chose to move torads acrylic on canvas as a return to his roots. For the style, he trained in the art of the portrait and in abtratction. His inspiration comes from his dreams, drawing abstract forms animated by shimmering colours. At the same time, he discovered through the British media the dramas of child soldiers and corruption them in his art. From then on, tall silhouettes emerge within Tallafe's colours, presenting, through their anonymity, an abstratction that questions the public. In 2008 , with his professional artist diploma in hand, he returned to Chaad. A year later, in search of new been show in several exhibition centres in France, at the UNESCO House, but also in Germany, Belgium and Switzerland.. His painting *Confluences* won the « Prix de la ville de Sainte-Geneviève-des-Bois » at the Salon de l'Hurepoix 2012. In 2013, Tallafe was featured in the community of the Singa association.
Link to dicover the artist's work and commitments : https://tallafe.com/ atallafe@yahoo.fr

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Mental health & precarity

les CAHIERS de RHIZOME

Rhizome is an interdisciplinary journal devoted to problems at the intersection of the fields of mental health and precariousness. It is supported and published by Orspere-Samdarra, the national observatory for mental health, vulnerability and society, since its creation in April 2000. The themes are varied and are determined by practical, political and/or clinical issues.
Rhizome's ambition is to support practices and political decisions and to contribute to scientific controversy.

Like a rhizome, its contributors and readers participate in the enlargement of the network of people concerned by psychosocial issues, whether from the point of view of suffering, the clinic, or intervention... More broadly, the journal contributes to questioning contemporary individualisation, its characteristics, its effects and the responses provided by institutions, devices collectives, users, stakeholders...

Rhizome is a space for dialogue between the sciences, in particular between the human, social and medical sciences, between practices, between the people concerned by the disorder or precariousness and the people working with them. With reference to to the rhizome theory developed by Gilles Deleuze and Félix Guattari, this network aims to be non-hierarchical.

Attention is paid to the diversity of contributions, both nationally and national and international level. *Rhizome* is funded by the Directorate-General for Health and the Directorate-General for Social and distributed free of charge to a wide readership composed of social workers, health workers, students, and people from various from various backgrounds. Available on the Cairn platform and on the Orspere-Samdarra website, the magazine is freely available in two formats, the *Bulletins de Rhizome* (3 issues per year) and the *Cahiers de Rhizome* (1 issue per year). Each issue of the *Cahiers* is built around a specific theme linked to a research project conducted by research conducted by the Orspere-Samdarra. A call for contributions is issued at the beginning of the year. The format is more than 100 pages and articles, which may be longer, are selected on the basis of their are selected on the basis of their quality, but also on the basis of their relevance to the theme and the issue's problematic.

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MEDIATORS, PEERS, AND INTERPRETERS: COMING TO THE CARE SECTOR'S RESCUE

We are currently witnessing certain transformations in the health and social care sectors, some of which are peaceful, others not so much. On the one hand, the professions that are practiced within health and social care establishments are in a "weakened" position. For example, psychologists are debating the relevance of developments in public psychiatry services, which include an expansion of the concept of "recovery," and the development of psychosocial rehabilitation, while also reflecting on their own place in these developments. Health care and social workers are raising the problem of the lack of resources available to carry out their job, in facilities described as being "in crisis." On the other hand, certain job roles — some newer than others — are undergoing development, including those of peer health mediators and interpreters, and their number is growing year on year. This change is qualitative even more than it is quantitative, given that the training courses now being offered imply the "increased skill" of these workers.

While these two dynamics may have appeared to be in competition, they now tend to complement each other. Less audible today are those voices that previously objected to the presence of peer health mediators in health care services, or asked to be able to work with people speaking a different language without an interpreter (using theoretical assessment tools instead). In fact, they are now being contradicted by the reality of modern-day practices, which are governed by regulatory frameworks that are becoming weaker, despite their core features remaining intact. The explosion of demand for psychological support, especially in the case of more vulnerable people, bears witness to this. Moreover, those working in mediation roles are now operating in the health care sector in collaboration with professionals who might previously have insisted on carrying out their mission alone. In highlighting these developments, this issue of *Rhizome* focuses on developing situations in the fields of mental health care and social work, where various types of third parties are now active.

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A wide variety of scenarios and practices are described in the articles in this issue, revealing a diverse range of viewpoints and perspectives. Taken together, they help us to reflect on the various questions that arise in all their complexity. Ranging from a consideration of the triangulation of the therapeutic relationship when an interpreter is present, to the dissolution of categories in situations of institutionalized peer support, the various articles draw our attention to stories and questions— particularly those of actors and researchers in the field—, to the concepts of professionalization and training (whether introduced externally or internally), and to analysis and reflection, especially on the subject of experience. The perspectives offered are, to varying degrees, either objectivizing, subjective, analytical, or general. The observations made are based on experiential, introspective, and declarative material (in the case of interview-based work), on self-confrontation, and on practices taking place in situ. Let us now emphasize two contextual elements underpinning the development of health, linguistic, and social mediation.

From a multitude of individuals to the need for mediation

The modern process of individualization, whether in its positive form (with a continuous movement toward emancipation) or its negative form (involving social fragmentation), has accelerated the heterogenization of society. We need only visit a hospital's emergency room or any other relevant facility to convince ourselves of this. This development, which can only grow in significance, also affects service provision for vulnerable and migrant populations. The administrative categories that are applied (such as "asylum seeker" and "RSA recipient"[1]) are culturally and socially heterogeneous.

For example, the last ten years has seen a continual rise in the number of new migrants arriving in France. Migrants have many care needs, which are largely dealt with by the *permanences d'accès aux soins de santé* (PASS) (health care access services) and by *équipes mobiles psychiatrie précarité* (EMPP) (mobile mental health outreach teams for vulnerable individuals). Controversy has arisen among care providers over the specific needs of migrants and the question of whether certain tailored measures need to be put in place, such as ethnopsychiatry in mental health care. The late twentieth century saw considerable tension between the various different theoretical schools (corresponding to a similar number of types of care facility). Nowadays they tend to dissipate in the face of expectations for effective health care and an increasing number of initiatives for providing bespoke care services for migrants, particularly involving mediators and/or interpreters. Public authorities are now in agreement that migrants are not a specific group of service users as such; rather, they are a group with specific needs. This use of third-party mediators appears as an opportunity to offer adapted

[1] Translator's note: RSA stands for *revenu de solidarité active* and is an income support benefit available in France for those who are unemployed or on a low income.

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and personalized care services without having to set up specialist care services that correspond to service users' particular administrative or ethnic categories. What is more, the authorities are now promoting the use of interpreters and mediators[2] in care teams, and are encouraging those who provide these services to professionalize and specialize.

In general, individuals appear fragile while being agents of their own recognition, and are less and less reducible to their institutional status. Within the paradigm of current practice, whether in health or social care, support is provided from a perspective whereby those who are struggling or suffering are afforded social recognition. To achieve this, it is increasingly necessary to involve the relevant bodies, activities, and individuals who are able to offer mediation. It is no longer simply a matter of homogenizing individual profiles in order to offer some sort of health or social care "treatment." In a context where the autonomy of service users or patients and their active participation in the care process are encouraged, and with all types of intervention becoming increasingly personalized, mediation seems to be all the more essential. The need to rely on the strengths, skills, and resources of the individuals concerned is affecting the nature of interactions between those who provide support and those who receive it — between caregivers and patients — and this may require the use of (peer) mediators or interpreters.

The effectiveness of peers

The rapid development of "peer support" over recent years is largely down to it being perceived as a great help to the individuals who benefit from it. Finding oneself alone is hard, and seeking assistance from professionals (i.e., non-peers) is sometimes not enough. Sharing resources, references, ideas, questions, and knowledge is very useful and often effective (Gardien 2019). Indeed, knowledge is often learned or built up on the basis of experience of social vulnerability and/or mental health problems, and this sharing of experience can lead individuals (whether as "patients" or "service users") to access knowledge other than that provided by professionals.

Different peer figures can come together or coexist within the various programs, and they question the relationship with knowledge or experience depending on the practical challenges that arise. For instance, individuals need to be understood and possibly translated, and it may be useful for individuals to meet up with others who have similar problems. Although the efforts of peer mediators are promoted in social work, their participation in care programs for migrants gives rise to other problems, especially in relation to their recognition (or not) of being part of the community in which they are

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[2] Under Article 90 of Law no. 2016-41 of January 26, 2016, on the Modernization of the Health-Care System (Loi n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé), "Health mediation and linguistic interpretation are aimed at improving access to rights, prevention, and the care of persons who are remote from preventive and care services, taking their specific circumstances into account."

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working. What skills were used as the basis for selecting them? How are they involved in relationships? In what way are they peers? Is the knowledge that is built up in this context transferable or objectifiable? These questions bring us to the debate around the formalization and training of mediators, peers, and interpreters, which will be dealt with thematically in the articles that follow.

Mediators, peers, and interpreters

In making the call for contributions for this issue of *Rhizome*, we chose to decompartmentalize peer support as practiced with migrants in the fields of health, social care, and interpreting. There are two reasons for this. The first is scientific. Under the "RÉfugiés, MIgrants et leurs LAngues face aux services de Santé" (REMILAS) (Refugees, Migrants and their Languages in Healthcare Encounters) research project, part of whose work is presented in this issue, perspectives are drawn from detailed observation of practices in situ. Drawing from this project, we have observed how the historical and theoretical distinction between a "mediator" and an "interpreter" may not correspond to the reality found in actual practice. In focusing on the actions of these individuals during consultations, we can first of all see the extent to which the concept of mediation (which is often reduced to an idea of providing insights through cultural awareness or providing support with administrative tasks) corresponds to the sum of many small actions carried out in various situations. This can come down to choosing a particular word, taking just one extra minute at the end of a meeting, or the mediator's general positioning. The articles clearly show how interpreters can act as de facto mediators. The fact that these fields of activity are in dialogue with each other and the fact that the reader can make the different contributions resonate with each other seem to us to indicate the presence of a heuristic dimension.

The second reason for this decompartmentalization is more strategic and political. In keeping with *Rhizome*'s editorial line, what matters more than focusing on the psychiatry, psychology, or sociology applying to "vulnerable" or "sick" people or to "migrants," is asking how an analysis of these groups can recalibrate the approaches taken by social and health care services. It may therefore be a question of examining such services by envisaging them as a testing ground for practices that are set to develop while society evolves, individualizes, and becomes less norm-based. Indeed, we increasingly observe that purely technical knowledge is not enough. On that basis, human mediation needs to develop, especially for vulnerable individuals and/or migrants.

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Peer support and recovery

This issue of *Rhizome* starts and finishes with articles written in a personal style by authors who set out their own experiences. With a nod to the individualization mentioned earlier, this issue reflects two positions: the first seeks out recurrences and similarities — that is, elements that can be generalized across the whole range of practices; while the second emphasizes unique, individual, or uncommon cases. This distinction could be perceived as a tension between the particular and the general.

Camille Niard, Philippe Maugiron, and Nicolas Franck link the development of peer support to that of the concept and practices of recovery. Mediators emphasize that they bring hope and can demonstrate that "recovery is possible," or that it is possible "to develop a life plan in spite of illness." In this sense, the perspective brought by mediators aligns with that of many clinicians. Camille Niard talks about her "attentive and sensitive listening practice," and how she gives "special importance to non-verbal communication." She defines herself as a "go-between," commenting, "You do not decide to become someone's peer. You find out when you meet them. […] As a third party, both a professional within a team and an affected person, the peer health mediator encourages rising above labels and going beyond the established framework, in a safe way." Her words echo what mental health practitioners generally say about their practice.

The articles by Aurélien Troisœufs and Lise Demailly discuss the value given to experiential knowledge. Health care facilities are experiencing a true paradigm shift. Knowledge that is not necessarily academic or scientific may be shared, including experiences of suffering, illness, hospitalization, recovery, and "the little things." Émilie Charlier presents the work of a support group in Belgium involving "experts by experience" (*experts du vécu*) and facilitators (who are "responsible for the environment" of the group), in which participants can identify with each other's stories. Once again, this type of analysis tends to echo what some psychologists have said about their own work, especially if this involves analytical or group theory.

Status tensions

In her article, Laëtitia Schweitzer sounds a dissonant, or at least highly reflexive, note. She highlights "the importance of not simply accepting a positivist vision of peer work, a view that may itself produce some effect, in an absolute context devoid of all contingency or any situational features." The development of peer work belongs to a context of increasingly precarious work in the fields of social work and health care. Schweitzer goes on to note that there is "confusion between peer work and the participation of

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individuals who are receiving support. Peer workers are, by implication, the representatives of these individuals and, on the grounds of parity, they give them a voice before the bodies that coordinate their medical and social support." The articles on peer mediators generally focus on questions linked to their status, rather than on matters of practice.

The series of articles on situations involving interpreters bear witness to their practices and feature their reflections, based on interviews and analyses of consultations. The major questions that cut across these contributions, especially those regarding the neutrality of interpreters, their position as participants in interactions, and the confidence that the other participants have in them (or not), have elicited remarkably consistent responses, consolidated through the lens of different points of view and insights. All the articles show that the interpreter does achieve a job of mediation and does not conform to the norm of neutrality that is taught and set out as good practice. That said, the articles also show that this question is not entirely binary: the interpreter is a participant who is engaged in a given situation, and adapts his or her practice accordingly, as do the interlocutors themselves. This provides an explanation for the changes, fluctuations, oscillations, and switches that the authors identify.

The neutral and transparent interpreter

The article by Elizaveta Chernyshova and Anna Claudia Ticca focuses on a psychiatric consultation in which an interpreter is present, and challenges the image of the interpreter as a "machine" that is often advanced as the ideal model of neutrality. Based on a detailed analysis of two extracts, the article highlights how analyzing an interaction "turn by turn" revealed that the interpreter oscillated between two roles, that of the "translation machine" (Bot 2005) and that of a full participant, asserting himself as an interlocutor with a voice and a presence in the interaction, or even as a co-therapist. This article clearly shows that the quality of the interpreting "is not solely the responsibility of the third party but is in fact dependent on a joint endeavor involving all participants."

The same issue of neutrality (here, we may talk about the transparency of the interpreter's intervention) is discussed in the article by Vanessa Piccoli and Véronique Traverso. The idea behind their contribution is that, beyond the specificities and individual cases, recurring discursive practices in consultations with interpreters can be identified, the detailed description of which can facilitate training and discussions of good practice and standards. Their article describes a procedure observed in psychological consultations with migrants, whereby interpreters, in translating a description that a patient

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gives of his or her emotional state (whether past or present), will comment on the patient's lexical choices and on any non-equivalence between the languages concerned. In doing this, interpreters depart from their classic neutrality and erase any illusion that language is transparent.

This issue is further examined in Anne-Marie Cervera's contribution. From an introspective standpoint, Cervera reconstructs the reflective processes that she is called to put into practice professionally as an interpreter. In recounting this inner journey, she describes the challenges involved in gaining the trust of the patient as well as the complexity of translation in mental health care contexts, which is masked by the apparent simplicity of the language used. In particular, the article reveals the series of decisions that she must make at each point in the interaction, not just in identifying meaning and translating, but using different methods to revisit a translation already produced if the subsequent exchanges show that it did not correspond to what the patient originally wanted to express.

The interpreter as a full-fledged participant

The interpreter's position as a full participant was addressed earlier in relation to the issue of neutrality. In a second series of articles, this neutrality is revisited, placed at the center of reflections through a questioning of trust, collaboration methods, and the interpreter's continual adaptation of modes of intervention to the contingencies of the consultation.

Iona Atger, Djamel Khouas, and Stéphanie Larchanché report back on research activities whose goal was to improve collaboration between mental health care professionals and professional interpreters. On the basis of this work, their article discusses several of the challenges cited by health care professionals in working with interpreters, including issues of trust, loss of control, lost time, and, again, neutrality. As with previous articles, these three authors consider that, while neutrality always remains a goal for interpreters, it "becomes a chimera" in the field of mental health care. The idea put forward by the authors is that the optimal position of the interpreter is a shifting one. Their research has led them to postulate that simultaneous training or support is required for interpreters and health care professionals in order to allow a shift from a relationship of mistrust to one of trust. The authors finish by reflecting on how they came to find it relaxing to work with an interpreter, the increased length of the consultation (due to the interpreter's inputs) giving them time to think, observe, and work out the meaning of the remarks made in the other person's language.

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Orest Weber and Florence Faucherre present an online teaching kit that they have developed, which encourages learners to adopt a clinical and discursive approach in analyzing a set of video recordings of psychiatric consultations involving interpreters. Their article identifies six recurring challenges for interpreters, including when participants make reference to emotions and when patients use language that is difficult to understand. They then show how the teaching kit looks at these challenges, presenting one of the extracts that features in the kit, accompanied by a commentary, as well as advice and strategies that could be taken on board when dealing with such cases.

In line with the article by Elizaveta Chernyshova and Anna Claudia Ticca and that of Anne-Marie Cervera, Anne-Sophie Haeringer examines the issue of the interpreter's choice of words when translating, this time from a perspective of inherent risk. She observes how a solution that may have been found to address one difficulty at a given moment may be liable to create a fresh problem later.

Amandine Bachini and Élodie Berenguer, in collaboration with the translator-orderlies Hachimia Abdallah, Sitti Demassi, Zaliffa Gue, and Moinamaoulida Kassim, report on the situation at a medical-psychological treatment center in the French *département* of Mayotte, where translation services are provided by the local Mahoran hospital staff, who have received no special training or official recognition of their competence as interpreters. The article clearly shows how a triangulation of the therapeutic relationship facilitated by the presence of interpreters "brings with it moments of pause conducive to reflection, and creates another temporality with breathing space and a rhythm of exchanges that bring together a secondarization of psychological processes." In parallel to this, the authors raise the issue of the place and status of the staff who provide the interpreting services and the invisibility of their role in patient care, emphasizing the prevailing hierarchy of knowledge — the clinical, academic knowledge of French-speaking care professionals coming in above the experiential and cultural knowledge expressed in local languages. There are parallels between this investigation and the issues of colonial heritage, and the authors refer to "scarring ambivalences" when it comes to the recognition of the socio-professional status of the Mahoran hospital staff who provide translation services.

Ada Luz Duque's article, which is based on her experience as a professional interpreter, begins with the premise that the use of an interpreter's services generally addresses a need for linguistic understanding, rather than any real willingness to engage multidisciplinary support. From this starting point, Duque examines the position of the interpreter in the patient–caregiver–interpreter triangle, stressing the point that the interpreter — perhaps inevitably — brings his or her own interpretation, who brings — perhaps

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inevitably — his or her own interpretation and affects to the situation. Duque also demonstrates how the changing and necessarily improvised nature of the interpreter's work means that it can always be adapted depending on what transpires, despite sometimes being analyzed in "too fixed a manner." She laments how rarely consideration is given to opportunities to work together in developing practices and approaches to care in a non-standardized way.

Nicolas Chambon and Roman Pétrouchine use a case analysis to examine how a "'traumatic event' is described, objectivized, and translated during a medical assessment attended by a professional interpreter." The activity of mediation is considered in the context of general concerns, where some of the knowledge shared by the patient and third parties (interpreter and social worker) may relate to matters that do not concern the doctor but that must still be taken into account.

Experience and concern

The article by Gwen Le Goff and Natacha Carbonel mentions some of the recurring questions that have arisen in situations involving interpreters, approaching them from the point of view of migrants. The article highlights the expectations that are placed on interpreters, including the emotional and relational aspects of their work, and the resistance strategies (such as a rejection of induced dependency and a lack of trust) that are adopted to avoid the need to use them. This is striking, and it would certainly be interesting to inform certain professionals about this reverse reflection of their own concerns and difficulties. The article also explores the desire to share one's life experience with others, in particular by becoming an interpreter.

This same desire is featured in the article by Olivia Gross, who examines the motivations of applicants for peer health mediator posts, which could allow them, in particular, "to put to work a variety of skills and to find meaning in their life course." The author proposes a reflexive approach when it comes to the practice of peer health mediators. Gross's investigation of the issue can be set alongside that of various professionals who are examining the practices and boundaries of their own field, and more specifically the reason why they intervene . This sort of reflexive stance, which Élodie Gilliot and Mathilde Sorba also address, lies at the heart of the development of practices under what has become known as the "housing first" policy. The authors examine "the practical consequences of a new distribution of roles between the institution, social workers, and supported individuals." Thus, they defend the notion that "the resulting mediation activity, which is deployed in a very pragmatic way, is not reduced to a role of pacifying relations between institutions and users. Instead it is presented as an activity that con-

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sists in allowing a connection to form, or in adapting institutional responses of a technical, legal, material, or social nature to an individual person who has wishes and hopes."

Christian Laval and Eve Gardien underscore the importance of peers helping each other and exchanging knowledge, as well as the risk of diluting this "peer" knowledge for the sake of the mediation role, which seems to lend itself better to recognition by the authorities. This issue concludes with a presentation by Graziella Golf, Thomas d'Hauteville, and Magali Molinié, who are members of a group within the Réseau français sur l'entente de voix (REV) (French Hearing Voices Network). These three authors discuss what people who share sensitive and sometimes common experiences gain from mutual support, and they address issues around the role of the facilitator in such groups. They argue that "peer meetings help people to feel less isolated, to reclaim their own story, and to search for meaning in their experiences."

As you read — and maybe even reread — this issue of *Rhizome*, we invite you to treat it as a meeting space in which a collective (re)questioning on the topic of care and its practices can take place. ◗

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THE PROFESSIONAL PEER SUPPORTER: A NEW ROLE LEADING TO NEW SOLUTIONS

> Suffering is not defined solely by physical pain, nor even by mental pain, but by the reduction, even the destruction, of the capacity for acting, of being-able-to-act, experienced as a violation of self-integrity. (Ricœur 1992 [1990], 190)

Philippe: The origins of my work as a professional peer supporter

I became a peer health mediator because I live with a chronic illness linked to mental health. I first heard about the notion of recovery in mental health when attending a group for psychiatric service users at the end of the 1980s, long before social and health care professionals appropriated the idea as a concept. For over twenty years, I have been working on my recovery by attending groups for psychiatric service users. Because it is not upon leaving hospital, once one has been "stabilized," that everything stops. On the contrary, it was at that point that my journey toward recovery began, by taking back control over the illness, and that a field of possibilities opened up before me. The process of reciprocal identification with my peers and the hope that they have given me have greatly empowered me and given me the courage to begin a process of transformation, both internally and externally, and thus enabled me to transition from a state of ill-being to a state of improved being, but also to develop a life plan, to reintegrate into society, and to ensure that my rights are respected. At present, the five dimensions of recovery defined by Rob Whitley and Robert Drake (Whitley and Drake 2010) are the clinical, the functional, the social, the physical, and the existential dimensions.

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I am recovering in all the areas of my life that are, to some extent, identified by these five dimensions:

- my symptoms are in remission;
- I am working and am autonomous;
- I have a relationship with my family, I have friends, I am in a stable romantic relationship, and I have a satisfactory social life. I am asserting myself as a citizen. I have a place in society;
- my physical health has improved, and I am physically active;
- my life has meaning.

These five dimensions of recovery bring to light a tension between the care establishment, which is focused on the quality of treatment, and the expectations of the patients, who are seeking a better quality of life and increased autonomy. We shall see that professional peer supporters can help to overcome this dilemma.

For me, “to be” in recovery is “to be re-born” or “to be again” and to be able to live with the illness, in spite of the symptoms, while having a life plan and a better quality of life. Recovery is defined more in terms of wellbeing than of illness. We speak of physical, mental, social, and spiritual recovery.

Having myself experienced the benefits of peer support within service user groups, I began working as a peer health mediator in 2012. Those groups enabled me to remain “stabilized,” which in turn enabled me to reintegrate into society. Today, I believe that if I had had the benefit of peer support during my hospitalization, my journey to recovery would have been accelerated. It would probably have had a positive impact in reducing the number of relapses I had. My motivation is to share what I learned from my peers, and what I want to show is that recovery is possible. Transforming practices within teams was not my initial motive, but a subtle consequence of my integration into a health care team. Sharing experiences among peers has given me “experiential” knowledge. It is a kind of intimate knowledge that comes from the experience of the illness and which is known only to service users.

Experiential practices and knowledge: The example of Antoine

I shall now describe the journey taken by Antoine,[1] who I met in a day hospital, in a psychosocial care unit (PSCU) specialized in cognitive remediation with a treatment philosophy aimed at recovery. In 2012, I joined the multidisciplinary team of this day hospital as a peer health mediator.

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[1] Not his real name.

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Antoine had been diagnosed with schizophrenia. In 2015, during his first hospitalization at twenty-two years of age, his doctor referred him to a day hospital. This enabled him to have a cognitive assessment, to create social connections with other patients, and to reflect upon his life plan.

I supported Antoine from the time of his arrival in the PSCU in 2015, until his departure in 2018 due to his change of address and to his plan to return to work through training. Antoine smoked cannabis, which had the potential to weaken his stabilization and increase his chances of relapse. During a team meeting it was decided that I would meet him one-to-one to discuss his cannabis consumption and to give him information about cannabis. During our first meeting, I asked him if he knew what my role was. He had heard from other patients that I was a peer health mediator, without knowing what that meant. This was an opportunity to present this new role to him, but also to reveal to him my own problem with addiction, particularly to nicotine, but also to cannabis. He was pleasantly surprised by this unusual offer of support in a care setting. It immediately made sense to him. He quickly became aware of my practical and intimate knowledge of the subject. We shared a specific common language, a kind of jargon specific to cannabis users. We spoke about the same thing and in the same way. A process of identification began more through verbal expression than through recounting experiences. This helped to quickly establish a relationship of trust, but also to enable Antoine to express himself authentically. I believe that this process of identification speeds up the formation of a relationship. Initially, I asked Antoine if his consumption of cannabis had a negative effect on his life or on his mental state. This was to encourage him to consider the importance of cannabis in his life. By analyzing his daily routine, he was able to quickly realize that his consumption increased when he was playing an online network game, which he tended to play more on weekends, and that the period between 5 p.m. and dinner was difficult for him. The more he played, the more he smoked. Antoine was not addicted, but he was able to express verbally the consequences of his behavior, especially his social isolation linked to the time he spent playing and to his cannabis consumption. These conversations aimed at guiding him toward a change in behavior based on motivation. The use of hope and identification largely contributed to Antoine becoming more empowered in his process of change. It was also an opportunity to inform him about cannabis, which does not interact well with antipsychotic treatment and gaming addiction. It is this scientific fact that enabled him to begin to realize the possible consequences and the risks of cannabis consumption. These exchanges resemble a kind of informal individual therapeutic education of the patient, with particular features linked to intervention and to the specific skills of the professional peer supporter. There was never any question of judging him, nor of making him feel guilty, but of enabling him to better define what was good for him, to take care of

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himself, and to think about whether that was compatible with his own desires. Initially, Antoine, who always attended our meetings of his own free will, tried to stop smoking overnight. This lasted ten days. Experience has shown me that things do not work that way. We tried to understand what had happened, and Antoine realized that he had not been prepared and that he had not sufficiently analyzed the situation. He had needed to try so as to understand that he needed to set himself up with goals to be achieved. Personal experience enabled me to suggest that he try to play online less in the evenings on weekdays and to get some physical exercise. I always asked him whether he felt he was capable of putting into practice what I suggested and told him that it was not compulsory. He needed to find an activity that would fill the time not spent gaming. Antoine likes sports and he took up tennis again with his sister and cycling with his father. Other patients from the day hospital played tennis together. I referred him to this small group, in which he was immediately welcomed. During that period and according to his request, we met up at least once a week. We had agreed that he could ask to have a meeting with me if he needed. In addition, we would often communicate informally. Bit by bit, he succeeded in playing online less, in smoking less, and in focusing on his social life. I know through experience that maintaining social connections, especially through physical exercise, is a way of keeping off drugs.

One of my professional goals is to help people to integrate or reintegrate into society. During the three years he was a patient at the PSCU, Antoine's participation in different groups encouraged and supported the creation and strengthening of his social connections within the day hospital, but also within society. The "Cultures du Coeur" (Cultures of the Heart) group was the first one that I suggested to the team. This organization invites patients to become involved in and access cultural activities, giving them more autonomy outside the framework of patient care. It enables participants to go to the theater or attend exhibitions with family members, friends, or other day hospital patients. Culture seems to us to be a universal medium that facilitates communication and allows one to speak about oneself, one's tastes and emotions, and about one's relationship with what one considers to be beautiful. It is a non-stigmatizing language that facilitates verbal expression, self-affirmation, and encounters with others. Culture and beauty bring people together. They help us to grow and to be more open with ourselves, with others, and with the world. Moreover, culture can be accessed within society, and one must go out to find it. These invitations provide this kind of opportunity in particular. For Antoine, it was also an opportunity to play online less and to strengthen his social connections. When we discovered in the group "D'art, d'art" that his grandmother was a painter, we suggested to him that he organize an outing to meet her and to see her work. He took charge of organizing this outing, which was a real success. Following his participation in the groups "Sport" and "Inclusion sociale,"

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Antoine joined a football club and began to play tennis again with his sister and with other PSCU patients. The group “Rétab” (from *rétablissement*, meaning recovery) is another group that I initiated. It aims to give hope and to empower individuals to begin a process of transformation. By participating in this group, Antoine was able to understand the meaning of recovery better and to hear guest speakers talk about their own life experiences. These moments of sharing facilitate identification and make participants conscious of their own journey and of all the aspects of recovery. Through the hope that they give, these messages, which are always strong and intense, encourage each participant to develop a life plan in spite of illness. To a certain degree, the group “Rétab” has some similarities with group therapeutic patient education (TPE). But in fact, this variation of TPE is more a source of information on health and recovery. We also tackle addiction, citizenship, work, service user associations, support structures, social life, needs, and desires, but also dreams. This group offers a reality of possibilities and the faith that recovery is possible for everyone. Thanks to this group, Antoine gained the deep conviction that he too could recover and have a life plan. It helped him to become active, to become more autonomous, and to return to work by means of professional training. It was during a therapeutic trip organized by five patients with three members of the team that we were able to find out more about each other. Because it did not take place within a health care institution, this therapeutic trip helped us to get to know and to meet one another. Patients abandoned their patient status, so to speak, while professionals left behind their therapeutic outlook, as it were. It was on account of this authenticity that we were all able to reveal more of ourselves. Upon our return, this had brought about a change for all the participants. We had met outside the strict context of our respective statuses and functions. We were no longer merely “the health care providers” or “the cared for,” “the knowers” or “the learners,” but people who communicate more, and who listen to each other better in a more horizontal relationship.

Antoine has now left the day hospital. He continues to give us updates on how he is doing, but less and less often. He is doing well, and is focusing on getting back to work by attending a training course. His time at the PSCU was beneficial in more ways than one. It enabled him to make new social connections and to end his isolation, while also acting as a springboard for him to develop his life plan and be supported in doing so.

Camille: A third-party professional stance and practice, derived from lay knowledge

From my viewpoint as a “personne concernée” (affected person), in the words of Claude Deutsch (2015), “the question is not whether madness is an illness or not, but

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to reflect upon the situation of people who have been identified as mad."[2] I also support the argument that "however true it is that madness exists, 'the mad person' does not exist" (Deutsch 2015). My practice as a peer health mediator stems from this belief: I support my peers' recovery and empowerment, accepting them entirely as they are, as people with universal aspirations, values, and emotions. I aim to develop an attentive and sensitive listening practice, and I give special importance to non-verbal communication based on my own lived experience that the problem is often due rather to the fact that "one does not know that one knows." Beyond words, the attitude and the energy released reveal something that goes beyond the person's façade and allows us to connect with one another. This kind of listening facilitates the encounter and the recognition of the common denominator that makes the other person a peer. This denominator can be positive or negative. It can concern feelings, thought, behavior, values, aptitude, vulnerability, or lived experience. I look for it while working in close proximity in order to facilitate dialogue and relaxation. I try to make the person reconnect with him- or herself and/or with his or her social environment through this now relaxed exchange. This intermittent support is temporary, and its duration varies. I do not try to remain involved over the long-term. In this way, I resemble the definition of the go-between as a strategic ally that acts upon both the personal and structural aspect of the barrier to wellbeing (Le Bossé 2016).

In order to be effective, the approach must be voluntary and without constraint. If the person does not want to have a meeting with a peer supporter, then it will not succeed. You do not decide to become someone's peer. You find out when you meet them. This shows the subjective nature of the whole approach. However, through the combination of accumulated lay, theoretical, and practical knowledge, and the development of specific tools that come from that knowledge, peer support can become professionalized and institutionalized. A relationship of proximity can be cultivated, even if it is not universal.

Does the peer health mediator transmit a desire to take action? How? Personally, I prefer to facilitate an awakening of consciousness in terms of oneself and of others, to be a mediator of (re)cognition for affected people and for present and future professionals. I am therefore engaged in psychoeducation and in the teaching and raising awareness of practices aimed at recovery.

The relevance of the peer supporter's positioning in psychoeducation

Psychoeducation benefits from being carried out by professional peer supporters and health care providers in a complementary relationship and on an equal footing.

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[2] Translator's note: Unless otherwise stated, all translations of cited foreign language material in this article are our own.

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The psychoeducational approach can be defined as a system proposing that patients and/or those close to them become active participants in their treatment, by acquiring better knowledge of the disorders affecting them and of the strategies to tackle them. This theoretical and experiential knowledge is acquired from (primarily group-based) exchanges with the therapists who establish this system, and from sharing experience with the people involved in it. Adopting a psychoeducational approach nurtures the need to understand, to rationalize, to be reassured, and to be liberated from stigma.

The connection between theory and practice is facilitated by introducing into the care team a person who has experienced the problem and who has found an adaptation strategy, a path toward his or her wellbeing, a place as a member of society, and self-knowledge — in short, someone who is further along his or her path to recovery. The roles, cultures, strategies, and terminologies become complementary, in addition to the listening capacity. Therefore, within this changing framework, the combination of the unconditional acceptance of the health care provider, the questioning techniques, the sense-making by the care provider, and the sharing of experience by the peer supporter, catalyze the emulation and identification that enable psychoeducation to achieve its main goals, which are:

- to accept the illness;
- to transcend the illness (to rediscover the distinction between oneself and the condition);
- to know one's symptoms, the treatments, and the adapted strategies to face it and to avoid relapses;
- to foster destigmatization, disclosure, and the improvement of one's self-esteem;
- to foster therapeutic collaboration by encouraging patients to assert themselves as people in their own right to doctors and other professionals;
- to become a full member of society;
- to improve the understanding that those supporting the patient have of the patient's problem (psychoeducation for close caregivers) (Koubichkine and Schoendorff 2018).

These goals, together with a facilitating and non-judgmental approach, can engender hope and empowerment. The peer supporter contributes an element of relaxation that enables everyone to learn and reassess. Solitude ends, the barriers between patients and health care providers shrink, and everyone's individuality is revealed.

As a peer health mediator, I seek to share what time, relapses, and periods of remission have taught me about reflexivity and practical strategies for facing recurring symptoms. This desire has also been aided by the knowledge and tools I have acquired both during

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training and in the field with the psychiatrists and nurses of the PSCU in which I work. I use all this knowledge with the aim of sharing a peaceful way of being in the world that may be atypical, in order to inspire the participants to cultivate their own way of being, to share it with the group, and to develop their own personal tips for "living with" their illness. In this mission that consists in facilitating self-knowledge and knowledge of one's own problems and oneself (one's strengths and vulnerabilities), peer counseling is the foremost intention. In fact, this is what is sought after in group work: collective counseling. Each participant is nurtured and nurtures others through exchanges, through the attitudes of each participant, and through their own doubts and victories. This corresponds to the horizontality sought after by the peer supporter in his or her practice.

In my opinion, therefore, the peer health mediator is a go-between, bringing a different outlook and serving as a tool. He or she embodies recovery. The peer health mediator gains knowledge from the process and the journey: it is the knowledge of a traveler who has experienced these upheavals, these psychological disorders, and their consequences throughout his or her whole life journey. A traveler who has recovered, overcome, or can live with it and has started to take control of his or her own life. Through small steps that signify great breakthroughs, the traveler has attained wellbeing, by recognizing his or her weaknesses and healing his or her wounds. From now on, the traveler wears his or her scars like a weapon, a tool, a new strength.

This raw material enables peer health mediators to adopt a specific stance to meet their goal as a supporter: to facilitate the supported peers' empowerment so that they can regain their integrity. This also allows those being supported to recognize and/or assume their own specific identity, rather than to place themselves in a pigeonhole. As a third party, both a professional within a team and an affected person, the peer health mediator encourages rising above labels and going beyond the established framework, in a safe way.

Last but not least, when two peers meet, their respective territories expand. Sharing experience increases knowledge. The peer health mediator is the vector enabling this knowledge to be shared, helping other affected people to acquire it and other professionals to recognize its value and to pass it on.

Training to become a peer supporter

Training people who have experienced psychological disorders and recovered from them to become peer supporters consists in making them able to support other people going through the same kind of challenge during their recovery (Franck and Cellard

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2020). To be trained as a peer supporter means being able to use one's experiential knowledge to help others, being able to undertake a psychosocial evaluation and adopt a psychoeducational approach, and being able to support the realization of a recovery plan. In order to do this, one must know the principles and tools of recovery, the main therapeutic tools for mental health care, how to adopt an empathetic attitude, and how to host individual meetings as well as lead groups. Peer support training must impart theoretical and practical knowledge of mental disorders and recovery, of individual rights, of the tools (including psychoeducation) that the peer supporter can rely on when he or she provides support, as well as of the professions and actors in mental health care.

In France, there are now two diploma courses in peer support: the "Sciences sanitaires et sociales, parcours 'Médiateurs de santé-pairs'" (Health Care and Social Sciences, "Peer Health Mediator" pathway) degree offered by the Université Paris 13 in partnership with the Centre collaborateur de l'Organisation mondiale de la santé (CCOMS) (World Health Organization Collaborating Centre for Research and Training in Mental Health)[3] and the university diploma "Pair-aidance en santé mentale" (Peer Support in Mental Health) at the Université Lyon 1 in partnership with the Centre ressource de réhabilitation psychosociale et de remédiation cognitive (Resource Center for Psychosocial Rehabilitation and Cognitive Remediation).[4] ◗

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[3] http://www.ccomssantementalelillefrance.org/?q=presentation-0

[4] https://remediation-cognitive.org/resource-center-for-psychosocial-rehabilitation-and-cognitive-remediation-crr

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PATIENT RESOURCES AND PEER HEALTH MEDIATORS: PEER SUPPORT ROLES IN HEALTH CARE CONTEXTS

In France, significant efforts are currently being made to value and make use of patients' experiential knowledge of illnesses, disabilities, and treatments. These efforts are chiefly being driven by associations, public authorities, and researchers in the humanities and social sciences. As a result of the enthusiasm of those involved, the trend has accelerated over the last five years, resulting in an expansion of peer support activities and an increase in opportunities for those experiencing illness or undergoing treatment to become involved in these activities. This is illustrated by the many terms used to designate the work of those involved. Numerous titles exist to describe those providing peer support, including peer counselor, peer practitioner, peer researcher, peer trainer, peer supporter or helper, expert patient, patient resource (*patient intervenant* in French), and patient teacher.

To discuss what those providing peer support do in the health care system, we shall focus on two roles in particular. In the field of mental health care, the "médiateur de santé-pair" (peer health mediator) diploma was created in 2012 to enable service users to provide support in hospitals (Roelandt and Staedel 2016). This role is generally cited as one of the first examples of the professionalization of service users in the health care system in France (Sarradon-Eck et al. 2012). And in the field of chronic physical diseases, the role of the "patient intervenant/expert" (patient resource/expert patient) is highlighted in a variety of training courses and diplomas, such as those offered since 2009 by the Université des Patients (Tourette-Turgis 2015).

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These roles are usually studied separately in order to identify elements that may help or hinder interactions with health professionals, public authorities, and even researchers. The purpose of this article, however, is to investigate the phenomenon of professionalization. Within the framework of an anthropological study currently being carried out on people recognized as patient resources in neurology, for Parkinson's disease in particular (Troisœufs et al. 2019), we focus on the interactions of those who carry out both of these roles and functions in several different fields of health care.

An increasing volume of research on experiential knowledge

A wealth of literature in the humanities and social sciences is being built up on the topic of service user participation in the health care system, principally in sociology, anthropology, and education sciences. The aim of these three distinct but interrelated approaches is to understand the relational, identity-based, social, and cultural issues involved in the new roles, functions, and responsibilities taken on by people who have experience of illness. Since the 1950s, there have been several in-depth studies in the humanities and social sciences into the place and role of individuals and caregivers who work with those who have the same illness as they do. The issue was first addressed from the specific perspective of caregiver-patient relationships (Strauss et al. 1992). The anthropology of health, for example, set out to create explanatory and interpretive models of people experiencing illness, emphasizing the social and cultural elements involved in their experiences of illness, healing, and care (Laplantine 1986). There have also been studies of group dynamics within the health care community, starting in the 1970s in France, and becoming more widespread in the 1980s and 1990s with mobilizations such as those in the field of AIDS (Epstein 2001).

As a result of this growing interest in the views of those who have experience of illness and the health care system, French researchers have sought to disseminate certain American concepts that have emerged at the intersection of research approaches and activist processes. For example, there are the concepts of "empowerment" and "recovery" employed in the field of North American psychiatry and adapted by French researchers (Greacen and Jouet 2019 [2012]). We could also mention the concept of "capability" (Le Galès, Bungener, and Groupe Capabilités 2015). These approaches aim to prompt biomedical thinking to provide an account of the views of individuals and the energies resulting from direct experiences of illness or treatment within given contexts. Since the 2000s, several works in the humanities and social sciences have aimed to show the importance of taking into account the expertise of individuals that stems from their experience of disease, treatments, and the biomedical or experiential

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knowledge acquired throughout their lives (Gross 2017; Gardien 2017b; Greacen and Jouet 2019).

Education sciences have also made a major contribution to conceptualizing, promoting, and developing this way of participating in the production of knowledge and understanding (Jouet, Flora, and Las Vergnas 2010; Tourette-Turgis, 2015; Gross 2017). This dynamic currently appears in a variety of different forms: some researchers showcase access to training (Tourette-Turgis 2015; Gross et al. 2016; Greacen and Jouet 2019), while other social science researchers demonstrate the methodological value of user participation in the production/coproduction of scientific knowledge (Godrie 2017; Gardien 2017a).

This attention has led to the use of different terms to describe people and their roles. Terms employed include patient trainer (Flora 2012; Jouet, Flora, and Las Vergnas 2010), patient researcher (Godrie 2017), peer health mediator (Roelandt and Steadel 2016), expert patient (Tourette-Turgis 2015), patient teacher (Gross 2017), and patient partner (Pomey et al. 2015). At the international level, numerous initiatives involving the participation and professionalization of health care service users have existed for several years — as can be seen in the Montreal model (Pomey et al. 2015) and in the Expert Patients Programme in the United Kingdom (Rogers et al. 2008).

The literature on the subject reveals two important points. First, there is relatively little research on the effects of the professionalization of peer support from the perspective of the individuals concerned and the associations representing them. In other words, the current focus of researchers and those in the field is more on testing or proving the effects of institutional peer support in the health care/long-term social systems than on illustrating the effects of this institutionalization on the individuals and groups of individuals directly concerned.

Second, it appears that those promoting the professionalization of peer supporters (Tourette-Turgis 2015; Gross 2017; Charoud 2017) or expressing reservations about it (Reach 2009; Grimaldi 2010) are generally involved in the field of training, therapeutic education, or caregiving, and there is still little research in sociology or the anthropology of health on these issues (Godrie 2017; Gardien 2017a, 2017b; Troisœufs 2019).

The objective of this article is to discuss the links between the different roles accorded or taken on in the field of peer support and to study the ways in which those directly concerned perceive them.

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The common origins of "peer health mediators" and "patient resources"

The roles of "peer health mediator" (PHM) and "patient resource/expert patient" (PR/EP) are now generally considered to be examples of the way peer support has become institutionalized in health care. There are many other kinds of role, but these two are generally considered to be the first to have taken root in the French health care system.

It is interesting to note that these two roles seem to share a common history. Both the profession of PHM and the role of PR/EP are associated with "peer support," as first developed in North America during the twentieth century. Both in terms of ideology and in practice, they refer to forms of "self-care" formalized by organizations such as Alcoholics Anonymous (AA). Recognition of peer support in North America emerged as a result of work by groups in the fields of gender, cultural minorities, social vulnerability, psychiatry, disability studies, and in epidemics such as the AIDS epidemic. It was accompanied by a belief in the value of experiential knowledge and was expressed through the dissemination of concepts such as "empowerment," "recovery," and "self-help." As a result of the work of associations in the field of AIDS and hemophilia, these approaches were first adopted in France in the 1980s and 1990s, followed later in the 2000s by the field of psychiatry. The conceptualization and promotion of the "knowledge" derived from personal experience of an illness or treatment were recognized and adopted as a result of these social movements. Peer support in France, provided by PHMs or PRs/EPs, stems from these common roots. In the field of psychiatry and mental health, the EMILIA project (Empowerment of Mental Illness Service Users: Lifelong Learning, Integration and Action, 2005–2010), headed in France by Emmanuelle Jouet and Tim Greacen, is considered to be one of the first French scientific experiments to study the recognition of the experiential knowledge of people directly affected by a mental disorder. Within the same approach, the experimental program "Un chez soi d'abord" ("Housing First") (2012–2016) studied the role of peer support and the autonomy of those facing extreme social vulnerability and difficulty in gaining access to housing (Girard 2010). Authors who have retraced this common history also mention therapeutic patient education (TPE) as having played a role in formalizing and disseminating the recognition of experiential knowledge and its resulting expertise (Jouet, Flora, and Las Vergnas 2010; Fournier and Troisœufs 2018).

While the common historical roots are generally agreed upon among researchers and those working in the field, the names of these two roles reflect the distinctions made by those who carry out the two roles.

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Expertise and diagnostic category

Just as "psychoeducation" refers to a psychiatric specialty in the field of therapeutic education, the term "peer health mediator" (PHM) refers to those working in the field of mental health. The term "patient resource/expert patient" (PR/EP), however, refers to the wider field of chronic illnesses and the field of disability. Although it is claimed that those known as PHMs may be competent in all pathologies (Roelandt and Staedel 2016), those who have been trained explain that they take an interest first and foremost in individuals who are undergoing an experience more or less similar to their own. And although PRs/EPs are active in a wide range of health care situations, trainers, trainees, and health care teams agree that it is currently necessary to ensure the caregiver and the person being cared for both have the same diagnosis and treatment. In general, the two distinct roles refer to the difference between specialists of the body and specialists of the mind and their work in physical and mental health; they thus reflect the way the French health system is currently organized. There are discussions among those in the field over whether it may be possible for peer supporters to work across different fields of health care, as well as debates on the relative importance of the weight given to the terms "peer" and "experience." These debates reveal the theoretical, methodological, and ideological challenges faced by professionals, researchers, and peer supporters working in each health field with regard to whether peer support should be broadened out or, instead, retain its more specific focus.

Distribution of expertise in different areas of care

Right from the start of the process, one of the specific concerns of PHM pilot programs was the desire to train people to work in hospitals. This choice led to resistance from certain care teams (Roelandt and Staedel 2016). Some groups of psychiatric service users also expressed their fears about the support provided by PHMs in hospitals as opposed to within long-term social care services. Whether this was to ensure patient protection or to justify staff positions, the issue at stake was whether or not peer supporters should be permitted to be closely involved in medical activities and care. With respect to PRs/EPs, the approach is different because they work directly with health professionals on TPE, an area that requires information and knowledge sharing. The area is not completely neutral, however, because most TPE programs are carried out within hospitals.

According to the comments of those working in the field, these two types of professional occupy different areas of health care. The PHM, by definition, is intended to provide support mainly in health care facilities, whereas the PR/EP is more involved in chronic illness and long-term social care. The debate over where these new actors

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should be permitted to provide support is a recurring subject and raises questions about the place and role of experiential knowledge in our health care system. Interactions between PHMs and PRs reveal that they have integrated and appropriated the acute/chronic divide, hitherto the prerogative of health care professionals.

Paid or volunteer work?

The issue of compensation, or funding, is always raised in public debates around peer support. PHMs are employees of the hospital in which they work. Those involved in pilot programs and associated researchers have commented that the funding of these posts has been particularly criticized by health care professionals. There has also been discussion in associations around the effects of funding on the process of mutual support. Some people have expressed fears over the ability of PHMs to act and express themselves freely, while others, on the contrary, see reasonable remuneration as a way of legitimizing the place and voice of PHMs in the institution. With regard to PRs/EPs, the sheer diversity of situations, actors, and institutions make it, as yet, impossible to identify a common approach. Within the context of TPE, however, PRs most frequently work as volunteers, as an extension of their involvement in associations. At the same time, however, schemes such as the Université des Patients promote recognition of the "work of patients" by granting them university degrees (Tourette-Turgis 2015). Thus, while the ideological and historical origins are common to both roles, they are recognized in different ways. This difference raises questions for professionals, researchers, and all those involved in peer support. There are current debates among peer supporters that question the effects of salaried work on "experiential knowledge," and the legitimacy of voluntary work in the health care and long-term social systems. These debates and encounters have also enabled the transfer of practices, representations, and demands among peers. Following encounters with PHMs, a number of PRs/EPs are now questioning their status as volunteers and are demanding that their work should be inspired by the role of the PHMs. While the difference between the two may be a source of inspiration, it is essential to consider that it may also initiate competitive relationships between peers. One example of this is the range of different types of qualification.

Real-life experience and experience gained in training

Actors involved in these initiatives (and others) are demanding that experiential knowledge should be legitimized by means of training, whether at university, in associations, or provided through a range of different training bodies. Thus, in the transformations currently taking place in peer support in health care, training appears to be both a way

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of achieving professional status and providing a way of categorizing work and professions and enabling specialization. PHM training is delivered at the Université Paris 13 (Bobigny) within the framework of a degree in health care and social sciences, with students following the "peer health mediator" pathway (240 hours). The degree may lead to a master's degree within the institution's research laboratory (LEPS). While the PHMs also have training in therapeutic education in their program, there are also other university training institutions such as the Université des Patients that grant university diplomas, bachelor's and master's degrees, and theses in the field of therapeutic education. Alongside these university courses, associations, training centers, and cross-disciplinary bodies for patient education ("unités transversales pour l'éducation du patient") (UTEPs) offer forty-hour training courses. When these courses are taken by people who state they are suffering from an illness, they become training courses to become PRs/EPs. Those who take part in the courses may then use the generic title of "peer supporter" or one of the terms related to a specific activity, in the same way as those who have a university qualification.

The issues of equivalence, recruitment criteria, and proof of competence also concern the medical professions. The wide variety of diplomas available, however, and the desire to protect this recognition of professional status should not cause us to lose sight of the nature of the people hired for these roles. In this respect, there should be studies into the experience of illness of those in these roles, and concerted analysis of the effects of these roles on patient movements. There is one fairly recent phenomenon that can be observed in public discussion of peer support. During scientific or medical symposia or seminars, it is increasingly common to see people proudly displaying their status and training as a PHM or PR/EP. The desire to have one's own status recognized sometimes involves highlighting one's own special characteristics as compared to those who have other diplomas or similar roles. Some people, for example, draw attention to how long they have studied for, while others focus on the legitimacy of the institution at which they trained (medical, university, association) or the nature of the knowledge they have acquired. Peer relationships have never been free from social, cultural, and personal aspects and based solely on an experience of illness. Professionalization tends to make this phenomenon more visible. Qualified peer supporters sometimes claim greater legitimacy than those who have "only" done forty hours of therapeutic education training. But this institutionalization of peer relationships has also prompted counter-reaction. One movement argues that professional training leads to the standardization of individual characteristics. Adopting the views of this movement, among others, it is argued that knowledge is to be found first of all in the experiences of living with an illness and that of supportive relationships, rather than being something that can be learned or formally transmitted.

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Conclusion

We are entering a new era of peer support in health care. With the institutionalization of peer support, one needs to take into account its widespread use in a range of health care fields and its application in very different professional areas. Current studies on peer support examine the recognition and promotion of support provided by (sometimes professionalized) peer supporters and members of their close circle. With society's attention currently focused on individual experience of the particular disease (by the people concerned), there is relatively little visibility for the collective, social, and associative dynamics that these new activities involve in terms of relationships, identities, and knowledge. The aspects presented here prompt a discussion on the nature of the interaction among peers (and the groups concerned) brought about by these new activities and professions, and the contribution of these groups to our health care system and, more broadly, to society. While it is now less necessary to justify the value of peer support and the importance of experiential knowledge, it is still essential to provide an account of the effects of these new roles on the people who are directly concerned and the way in which they may appropriate them. ◗

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PEER HEALTH MEDIATORS IN MENTAL HEALTH SERVICES: PRACTICE AND IMPACT

In France, “peer health mediators” (“médiateurs de santé-pairs”) are mostly paid peer supporters active in public psychiatric health teams. The simple fact of their presence in these services has an effect on the operational practices of the health teams, as well as on the way in which medical staff talk about patients. But beyond them simply being present, peer health mediators are developing specific support practices that are having an impact on service users and on their teams.

From the observations I made while evaluating research conducted by the Centre collaborateur de l’Organisation mondiale de la santé (CCOMS) (World Health Organization Collaborating Centre for Research and Training in Mental Health), which led to the qualification of a first cohort of trained “peer health mediators”[1] (hereafter PHMs) and the subsequent informal discussions I held with a number of both experienced and recently trained PHMs, it is evident that their practice varies widely, but does have some features in common. There are three key parameters: i) the experiential knowledge of the PHM; ii) the expectations of the team in which he or she works; and iii) the particular, personal way each PHM comes to understand his or her own professional status. Several key constants that are common to all PHMs stand out. I will mostly base my exploration of these on observations carried out *in situ* of encounters between PHMs and service users, of team meetings at which a PHM was present, and on seventy-four interviews conducted with service users who have been supported by a PHM (Demailly et al. 2014; Demailly 2014; Demailly and Garnoussi 2015[2]).

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[1] Peer health mediators from this first cohort were employed initially on renewable fixed-term contracts (in Public Employment Category C), and subsequently in permanent posts.

[2] This article includes elements taken from these works, as well as from more recent observations and reflections.

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The foundation of PHM practice: Experiential knowledge

The introduction of PHMs is predicated on the idea that despite not being scholarly, academic, scientific, or formal, “experiential knowledge” is nonetheless highly valuable and useful to therapeutic practice and contributes to improving the quality of care. Experience can be defined as a specific kind of individual “knowledge,” a kind of awareness that is practical, eclectic, dynamic, and evolving. Experience affects individuals by exposing them to a sequence of circumstances that is necessarily unique. The impact of an experience depends on the subjectivity of the individual who undergoes it. Experience provides a form of knowledge that is quite unique and which, as such, cannot be taught, but which has an effect on relationships with other individuals and thus also on those other individuals themselves.

Interviews and observations carried out by my colleagues and I *in situ* show that this experiential knowledge that PHMs apply in their role forms the core of their skills and is what makes the support they provide unique. Initial PHM training (a university diploma or a vocational degree) is too short for them to gain professional expertise, theoretical awareness, or knowledge of established techniques. But the fact that PHMs’ know-how is predominantly based on experience is precisely what makes their contribution worthwhile and what enables the opening up of new clinical processes. This section details the three areas of experience upon which PHMs are encouraged to draw, and then explains how they turn their experiential knowledge into professional skills.

“Experiential knowledge” of illness, of the care system, and of recovery

The first of these areas of experience has three aspects. It is premised on having been ill, on having been a patient, and on having recovered, at least in part.

- *having been ill*: experience of depression, delusion, of being “overwhelmed” by symptoms; experience of dependency on and withdrawal from psychoactive substances, and of the physical effects of these; experience using self-management techniques; experience of catastrophic moments, of having a diminished will to live, of acting upon this; memories of affective states and emotions; experience of refusing care, of feeling ashamed, of feeling abandoned, of the problems that come about through mental health episodes (contact with the police and the criminal justice system, prison, the street, unemployment, insecurity and instability); and experience of sexual violence or of violence on the street.

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- *having been a patient*: having spent time in psychiatric institutions; experience of different types and degrees of restraint, possibly of hospitalization without consent and isolation; experience of various medications and their primary and secondary effects; experience of being in contact with a public hospital psychiatrist; experience of emotions relating to the fact of having been treated perhaps as just a case, or as just a body or object rather than as a person; a sense of how care staff protect themselves; experience of patient-carer distance, of interaction with other patients, of having seen what kinds of care are helpful, of compliance, of trust, and of learning how to deal with nurses. This experiential knowledge could be described as "the profession of being a patient."

- *having recovered*: having lived through the process of "pulling through." How? With what support? Using which resources? Over how long? With what signs along the way? With what personal commitment? And with what treatment? The experience of having recovered may also have involved the use of religion, kinds of wisdom, sport, art-based activities, participation in clubs and associations, willpower, and so forth.

PHMs' "experiential knowledge" can be understood within these three areas — having been ill, having been a psychiatric care patient, and having recovered — as a kind of wherewithal in dealing with domination. This wherewithal is built up through the experience of illness and of the different processes that accompany it — dereliction, stigmatization, negotiating with institutions, disaffiliation, fighting against oneself and others — but only if the experience has been a formative and instructive one, thought through, and not simply a complete blank, a traumatic but unexamined episode. Dealing with domination is learned during difficult moments in life that the PHMs have got through and the challenges that they have mostly overcome. In doing so, they have achieved a sense of personal empowerment that has pushed them toward applying to become paid peer supporters, and enabled them to be admitted to the PHM training program. They have developed a wiliness, a cunning intelligence that enables them to learn both to "rely on themselves" and to make use of the possibilities offered in the social situations they encounter. Theirs is an intuitive, worldly expertise, reflexive clinical knowledge, grounded in resilience and the regaining of personal autonomy.

Knowledge from prior experience

This is knowledge that comes from any prior professional experience PHMs may have had, as well as any experience of poverty, social class issues, gender relations, particular relationship statuses, work, prior vocational training, or of having their whole life course

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disrupted by their illness. For example, PHMs may have lost their job or had difficulty getting back into work while also struggling against their own limitations and against the social stigmatization that mental illness can provoke in the world of work. This knowledge plays an important role in the integration of PHMs into health teams, particularly that related to professions or associations with which they have previously been involved. This includes making contact, sustaining dialogue, the use of humor, knowing how to write up a project, accessing local resources, becoming familiarized with a city, knowing how to approach organizations and government offices, having networks, having an existing personal repertoire of relational or creative styles, and possessing "interpersonal skills" acquired prior to their illness but that can be reinvested into their professional practice.

PHMs who have technical specialisms or interpersonal skills from previous professional experience find jobs quickest.[3] Those without these find it more difficult to be accepted into a health team, whose members are initially not really sure which tasks to give them. Having experience in managing home life, either before or during illness, also plays a part, for example, knowing how to overcome problems with money, rent, and budgeting, and how to deal with public bodies. This type of experience is often overlooked by psychiatric nursing staff because it is not directly related to the illness and the care plan. Here, PHMs can find a space in which to operate, providing support in these areas, particularly to socially disadvantaged patients. They can play a role in bringing together service users and the various resources available within the community.

Practical knowledge acquired in-role

I will refer to the knowledge acquired by PHMs in their new roles as "practical knowledge" in order to avoid confusion with "experiential knowledge" relating to illness and recovery, despite both being, in cognitive terms, forms of experiential knowledge.

This kind of knowledge includes, for example, techniques that PHMs learn through watching other members of their team; by listening to their language, professional jargon, and team discussions; by observing their methods; by noting the criteria advanced in making diagnoses, and the medications and dosages used; or by attending training events alongside the nurses.

In this way, and perhaps not without some failures along the way, PHMs learn "on the job" the techniques to use in introducing themselves to a patient, how to facilitate a support group, or how to make a home visit. This learning varies according to the particular places in which they work, with hospital-based work, outpatient services, or accompanying patients around the city offering quite different opportunities.

[3] In the first cohort, for example, opportunities arose for those with experience in business, IT, and personal physical care techniques.

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Taken as a whole, paid work is what gives PHMs professional socialization, sometimes involving several "bumps in the road" as they learn to stick to a timetable and follow the rules, understand the hierarchies, discover colleagues' secrets, but also to avoid clashes, account for their own actions, keep colleagues up to date on their movements, plan their workloads, and distinguish between the personal and the professional. Learning all of these things, which can be challenging, can later inform their practice in supporting long-term unemployed patients who want to get back into work, for example by working with the psychologists on removing cognitive and behavioral obstacles to returning to work.

Turning experiential knowledge into professional skills

Experiential knowledge can of course be used spontaneously and informally in a relationship of mutual support between service users. This is a normal occurrence. But for peer supporters to feel a degree of legitimacy in their professional capacity, their experiential knowledge must be turned into, or must gradually become, professional skills. To do so, they must be consciously aware of this knowledge. One way to achieve this is, for example, by imagining and reflecting upon the effect that communicating their past experience to a service user will have. The way in which a PHM makes him or herself available to a patient, perhaps as a positive role-model — offering hope, countering shame, showing that it is possible to get through the illness, or indeed return to work — could be made conscious and recognized. The PHM could then build up a repertoire of support techniques, taking a vitalistic approach (helping the patient find his or her passion or identify a project), or a behaviorist approach, or via alternative therapies (for example, physical techniques that are easy to incorporate into daily life, or "hacks" for improving everyday life, such as using music, looking after one's physical appearance, physical and dietary discipline, or strictly adhering to a program of medication).

In parallel with this, implicitly, is the need for PHMs to be aware of the feelings that their own illness (past or ongoing) invokes in them when meeting current sufferers — a sense of identification, or of repulsion (toward an illness that is too different and that they may unwittingly stigmatize, even though the peer supporter, in principle, is intended to be an agent of destigmatization); feelings of fear (toward an unfamiliar and disturbing pathology), of empathy with all forms of suffering, of anger; or a "desire to shake up a patient who won't make the effort to get better." PHMs also need to be aware of their emotional response to psychiatric institutions — a desire for revenge, submissiveness, rebellion, complicity, and so on. It is a good idea for them to be able to talk about these issues and for them to have access to continuing in-service training with colleagues, in order to discuss their practice and how they might develop their skills.

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At the heart of this accumulation of the skills and wherewithal that will eventually form the basis of their professional practice lies the question of establishing the appropriate distance with the individuals in their care. In general, PHMs naturally maintain less of a distance than other care staff. For example, in one Centre médico-psychologique (CMP) (Medical-Psychological Treatment Center) the PHM spontaneously gave his cell number to the service users in his care. This could have been surprising, concerning, or plain disturbing for the care team. But from then on, depending on case circumstances, this practice became accepted. "*Thinking about it, it's not so bad. And anyhow, why not?*" was the eventual reaction given to me by the psychiatrist. Meetings with clients tend to take place weekly or fortnightly. To start with, some PHMs were able to decide to offer more frequent support, twice a week, and then stepped back from it: "*But it was quite worrying, it was getting too close for them and for me, too.*" Thus, disorientated by questions of proximity, the first cohort of PHMs avoided them (in part) and reinstated a suitable distance by reducing the frequency of contact. Similarly, they learned the benefits of maintaining an appropriate physical distance after initially adopting a more tactile approach, for example when encouraging or consoling their patients: "*I used to do the usual kisses on the cheek when we met, but then, later, it was hard to re-establish a distance.*" Future cohorts of PHMs will surely benefit from the practical knowledge acquired by the first.

Overall, the level of professional distance used by PHMs marks a more *horizontal* kind of relationship with service users that might be termed one of "camaraderie," enabling a link to be established, encouraging trust, and motivating their patients.

The nature of support work and team expectations

The working practice of PHMs depends very much on the establishment that employs them. I shall not dwell on cases where the integration of a PHM has gone badly, although it is safe to say that opposition can be blunt. With the first cohort, some teams who had not been consulted by their hospital directors or area manager took to discouraging the participation of PHMs, preventing them from working or pressuring them until they resigned. Even now, heads of centers or sub-units who enter into discussion over the possible introduction of a PHM risk having to face reactions of incomprehension or refusal from staff, a problem I myself noticed in hospital-based units where I was carrying out studies. Care staff felt that the introduction of a PHM to the team meant that their professional competence was being called into question.

Let us focus instead on situations in which the PHM is effectively incorporated into the team (notwithstanding the existence of certain tensions, although no more than might

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be expected among fellow professionals or indeed between two people). In these cases, the form and content of the PHMs' practice was influenced by the type of psychiatric unit in which they worked, along with its organizational structure, its rules, its routines, the professional autonomy they were afforded, and the clinical approach of the other professionals.

Patient profile is obviously also significant: PHMs can work in services dealing with extremely disadvantaged groups (Équipe mobile psychiatrie et précarité [EMPP] [Mobile Vulnerable Persons Psychiatric Team]); in more socially mixed patient environments, addressing all requests for help; and in clinical environments based on care contracts. Organizational considerations in place at their service provider or unit likewise determine the nature of their interaction with patients — some PHMs are in frequent contact with patients one-to-one, others never, because they always work alongside other colleagues or in therapy groups. Encounters with patients also vary in kind, and can include face-to-face interviews in a medical training center, home visits, participation in group encounters at, for example, day centers, facilitating discussion groups or institutional service user committees, or running therapeutic workshop and education sessions. However, one organizational feature is constant: PHM meetings with patients are generally prescribed by the psychiatrists and/or agreed upon by the care team, although always with patient consent.

In terms of rule-setting, PHMs take a more low-key approach than others in the team, whether they are psychiatrists who "are a bit moralistic" (according to service users) or nurses. They can sometimes fulfill an educational role during home visits, dealing for example with matters of hygiene in the home, smoking, patients' "slip-ups," or the time they spend on the street. PHMs' less normative approach is perhaps due to the knowledge they have gained from direct personal experience of illness, as they have not so fully internalized the concerns of the public health apparatus. It also, more generally, reflects the differences between their own ethos and the rules of the hospital system. Care teams have varying degrees of tolerance for these differences of perspective and may — or may not— let PHMs modify their interventions.

On the ground, it is generally accepted that PHMs can take their time in meeting those who are receiving care. In high-demand services, it is a rare privilege to be able to meet with this kind of carer. Interviews and visits with PHMs sometimes last over an hour, longer than those with other professionals. One characteristic that differentiates PHMs is their availability and, more generally, their accessibility: individuals receiving care generally view the greater time afforded them by PHMs as a factor in facilitating relationships with them, in feeling at ease, and in allowing them to communicate more

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openly. "*You feel relaxed [with the PHM]*" is a frequent comment from patients, something that enables them to "*talk about everything*."

But differences are emerging, depending on variations in "team culture," organizational traditions, care philosophies, and clinical aims. The arrival of a PHM very often coincides, in fact, with a desire to develop practice, to change the team ethic to one that is more respectful of those receiving care, to a philosophy that is more focused on recovery and rehabilitation. And while recovery and psychosocial rehabilitation are gradually becoming the new orthodoxy in psychiatric care, it is still the case that the practical implementation of these approaches, both at clinical and organizational level, can take many forms.[4] The work of PHMs is directly affected by this. Generally, while they do have a strong presence in therapeutic education and ensuring that patients comply with and adhere to care programs, in the work of maintaining normal relationships with patients, helping them to express themselves and to help other patients, the details of these tasks are subject to the established working methods of the team, its organization, and its overall aim.

A very individual undertaking

The practice of PHMs also depends on personal choices and preferences, on the image that they have of the recovery process, and of the factors that have contributed — and may still contribute — to their own recovery.

The life stories that my colleagues and I have collected are very diverse indeed. Some PHMs have rebuilt their health through "doing," rather than "talking." They say that for them the main point is to energize those receiving care ("*I'm not big on consolation*") so as to encourage them to break free from their social and relational isolation, to find activities with which to keep busy, or to identify the activities that might stir their enthusiasm. They prefer to "go get 'em" [the patients] and "shake 'em up a little."

Others believe that turning to psychotherapy has been the single most significant factor in their own recovery, and accord prime importance in their practice to listening, verbal expression, and respect for the demands of patients (letting service users come to them). Then there are others still who spontaneously take a "behaviorist" approach, seeking ways of countering negative thoughts and behaviors.

Some have been through Alcoholics Anonymous and incorporate into their work a mix of the spirit of mutual support and the behavioral norms that characterize that type of organization, with a degree of rigor on the question of addiction. Meanwhile, oth-

[4] See my ongoing research on the changes in care practices in French public psychiatry: Lise Demailly, "L'évolution des pratiques de soin dans les pôles de psychiatrie publique en France," (Lise Demailly, Ireps/F2RSMPsy).

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er PHMs are clearly more relaxed about the use of cannabis to control anxiety, both for themselves and for patients, rejecting the idea of abstinence. In these cases, even if they cannot present themselves as an example of correct behavior, they can treat complete cessation as simply a difficult-to-reach ideal, one that they themselves are trying to achieve.

For some, the relationship with the patient is guided by a sense of identification that underpins what they say: "*I understand what's happening to you, I've been there, it was tough, but I got through it. Look at me, you can see that I came through it, there is hope, do what I've done*." They give a central role to hope as a key factor in recovery, rather than approaches centered on talking, doing, techniques, or activities. Many value a holistic approach centered on the person, while others tend to work on a particular social or material problem that the patient has. Some relate to every patient they encounter, or who is allocated to them, with what might be described as "unconditional acceptance"; others carry out *a priori* triage of the behaviors or pathologies in each case, in line with their assessment of their own ability to help.

PHM practice contributes to the spread of the philosophy of user *recovery*, both for users who are feeling discouraged and those who hope for a "cure." Sometimes the personal example of the PHM is particularly important in persuading patients that recovery is possible. In time, through discussion, the service user can also learn not to hope for or seek a "cure," but to recover, in other words accept that he or she will probably still have the condition, but will be able to lead a good life. But some PHMs remain attached to the idea of a cure, the possibility that the patient might, in principle, definitively move on from his or her dependence on psychiatric institutions.

Observing the spontaneously occurring anthropologies that inform their practice, several PHMs are helping to spread a positivist representation of personality, illness, and mutual comprehension between human beings. Those receiving care then take away from their meetings the idea that the only people who can fully understand a mental illness and what it is like to experience it are those who have had that particular diagnostic label attached to them, be it specific (for example, bipolar disorder or schizophrenia) or more broad (such as drug addiction or psychosis). Other professionals can only "know *about*" it. To state that people cannot "understand" (by intuition or through empathy) something that they have never experienced for themselves is in complete contrast to a view of being human held by other PHMs. This latter view holds that anybody can experience, at some time in their life, periods of mild depressive symptoms, moments of severe anxiety, momentary loss of control, patterns of neurotic behavior, or the stirrings of potential psychosis, and sees the potentiality for all forms of suffering,

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crisis, mental blockage, or internal otherness as part of the psychological experience of each and every one of us.

PHMs also have differing opinions about institutional psychiatry. Some, particularly in the first cohort, have a more rebellious or militant stance about the lack of respect sometimes afforded to service users (and to themselves). Some strongly question both the monopolistic control of the interpretation of clinical situations, which is normally the preserve of care staff, and the mechanisms deployed by the latter to define or objectivize elements within them, such as diagnostic categories, scales, tests, drug-trialing, and so on. In direct contrast to this, others avoid any criticism of medical knowledge or authority. They recognize that for them advancing such criticism is an untenable position, and that they may be able to explain these institutional limitations to those receiving care. Lastly, there are others who, largely in search of legitimacy, are more readily accepting of institutional authority and are drawn into mimicking the nurses and educators in their way of doing things, and into "sanitizing" their own past.

Conclusion

Clearly, the range of practices used by paid peer supporters in psychiatric services is varied, depending both on how the services in question are organized and on the life stories of those involved. Nonetheless, one constant feature emerges regardless of their subjective positions: PHMs encourage those receiving care to express themselves, to ask psychiatrists questions about their treatment, to inform them of the secondary effects of medications that they find difficult to deal with, and to talk about their life plans and what they need in order to follow them through. In these ways, PHMs are helping to introduce a collaborative process of co-construction of treatment between patients and clinicians. This is a point worth remembering as the key characteristic of their practice, and of the clinical changes they are helping to bring about.

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FORMS OF MEDIATION IN MUTUAL SUPPORT GROUPS FOR PEOPLE LIVING WITH BIPOLAR DISORDER IN FRENCH-SPEAKING BELGIUM

A large number of people in Belgium suffer from a psychological disorder, which very often reduces the degree to which they participate in society (Van Audenhove 2015). Over the last few decades, the organization of health care, particularly of mental health care, has been undergoing transformations that move toward placing greater emphasis on the participation of patients and those in their close circle.

Peer support in Belgium

The patients' rights movement emerged in the 1990s, spurred on by the World Health Organization (WHO), and led Belgian legislation to focus on empowering individuals (Volckrick 2008). In 2005, various service user associations participated in the reflection process, resulting in a policy document that aimed at reorganizing health care as a network. In 2010, the health care reform in Belgium shifted the focus of care toward the community and recovery (Jacob, Macquet, and Natalis 2014). This led to individuals and those in their close circle being recognized as health care partners. Their participation is considered essential and takes place in several ways, for example being involved in consultative bodies, participating in service user groups, and providing expertise. Numerous participatory practices have been developed since the beginning of the 2000s, among them initiatives relating to peer support (Dujardin, Jamoulle, and Sandron 2017).

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Social support involves the exchange of resources — whether emotional, instrumental, or informational in nature — by non-professionals, in the context of social groups or of interaction with members of a single social network (Caron and Guay 2005). Peer support, one of the many forms of social support, involves both formal and informal practices.

The hiring of peer workers is only in its early stages in Belgium (Mormont 2016). These individuals have no official status: the occupation is not recognized and, despite the recent development of some training courses in this area, these do not lead to an official qualification. Often referred to as "peer health mediators" (*médiateurs de santé-pairs*) in France, these workers tend to be known as "experts by experience" (*experts du vécu*) or "peer supporters" (*pairs-aidants*) in French-speaking Belgium. For example, the Belgian federal government employs in its public services some twenty "experts by experience" in the fields of poverty and social exclusion, as part of a pilot project supported by the European Social Fund (ESF) that began in 2004. Present in the project is the idea of "mediation," with these "experts by experience" being envisaged as "the missing link" between the government and its citizens (Casman, Dierckx, and Vranken 2010).

Informal peer support practices are more established and more numerous. They refer to help provided willingly through programs put in place by peers or through mutual support groups (MSGs) (Basset et al. 2010). Meeting Point Self-Help Groups in Belgium defines MSGs as groups of people who have a similar lived experience affecting their quality of life and who decide to act together so that they can feel less powerless about their situation. They mutually provide each other with information and emotional support (Damen, Mortelmans, and Van Hove 2000). Alcoholics Anonymous (AA) is undoubtedly the most popular type of MSG, with more than 200 groups established across Belgium, but MSGs exist for all kind of problems: illness, disability, addiction, behavioral disorders, bereavement, sexuality, life events, and so on. In the area of mental health, there exist groups for those affected by mental health issues and/or groups intended for those in their close circle (AIGS 2016).

A study on the issues and challenges of support groups

As part of my doctoral studies focusing on support groups, I conducted two research projects. The first specifically targeted non-therapeutic groups intended for caregivers close to those affected by life events (Charlier 2018), while the second looked at the impact, issues, and challenges associated with all the different support groups established in French-speaking Belgium. For this second study, I gathered the opinions of

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sixty-seven people involved in these various groups (group leaders, participants, specialists, and ad hoc contributors) by way of an online questionnaire. This data was supplemented by asynchronous online interviews with twenty of the respondents.

Particularly beneficial to me were the insights of participants and leaders of MSGs for people living with bipolar disorder and those in their close circle. This mood disorder is characterized by significant fluctuations in intensity and/or duration, which lead to changes in people's functioning and/or suffering. The disorder has three types: i) bipolar I disorder, which is characterized by depressive episodes and episodes of mania (extremely elevated mood) or mixed episodes; ii) bipolar II disorder, which involves experiencing alternating depressive and hypomanic episodes (the latter referring to a moderately elevated mood); and iii) cyclothymia, which is characterized by numerous periods of moderate depression or of hypomania over a short period of time. Bipolar disorder affects nearly 2 percent of the Belgian population, although some studies suggest that this figure could be as high as 6 percent if all forms of bipolarity were to be taken into account (Jeunieaux 2008).

In this article, I consider the forms of mediation used by those who take part in MSGs for people suffering with bipolar disorder. I do so by drawing upon the testimonies of four group facilitators and former group participants. To preserve their anonymity, I refer to them using aliases. Pierre is involved in several support groups that are part of the same service user association. He has been a group facilitator for three years. Maëlle has been the facilitator of a group for two years. Before taking on leading the group, she was a participant in it for one year. Gautier was involved in the creation of a hybrid group — that is, one managed both by peers and one or several professionals —, which he has now been leading for a few years. He has also attended other support groups. Finally, Étienne is the leader of a group in which he was initially a participant for several months.

The different facets of the facilitator role

The four respondents more readily define themselves as facilitators ("*facilitateurs*") than leaders ("*animateurs*"), so as to highlight the non-hierarchical nature of the relationships within their respective groups. But what does facilitating mutual peer support consist of? Various roles are associated with this position: it involves encouraging participants to speak and talk to each other, "regulating" these exchanges if need be, establishing the group's environment and ensuring it is respected, and so on. This requires the facilitator to find a balance between his or her status as a peer who is affected by the topic and the necessity of leaving room for everyone in the group.

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From what the respondents say, facilitators appear to embody several figures when interacting with their peers in these group settings. These figures are fluid, and can be linked with each other to varying degrees. Facilitators embody one figure or another, depending on the current context, demands, and dynamics. Pierre thus reminds us: "*Each group is different and has its own energy.*"

It is important for the participants to feel interested in the group's theme, and for them to identify — partially, at least — with the stories of other participants. In this sense, the diversity of situations is as much an asset as it is a potential threat to the group's continuity. The first figure that can be identified is an identificatory one: given his or her status as a peer, the facilitator enables participants to more easily identify with the group's theme. He or she also reassures participants of his or her capacity to understand their lived experience, because he or she has "*been there*," and thus encourages them to tell their stories. This is in opposition to the figure of the traditional professional expert, who crystallizes anxieties and the fear of being judged, diagnosed, or looked down upon. If facilitators embody the figure of the lay expert (Alary 2016), it is because of their experiential knowledge and/or their knowledge of the network. For example, Étienne explains that being directly affected by bipolar disorder is an advantage: "*Not being perceived as a professional can help. I have already had one piece of feedback or another saying: 'Me, I don't feel like I'm being analyzed by you,' which is rather more like the experience that they can have with the professionals on their journey*." Nevertheless, Maëlle reports a different experience: as a participant, she was initially fearful of the idea of joining a group led solely by people who were themselves affected by bipolar disorder. She found it reassuring to attend a group in which a professional was present.

Presenting oneself as a peer while at the same time assuming the role of facilitator — distinct from that of participant — is not a simple matter. Maëlle believes that this involves being capable of "*self-giving*," of stepping aside in favor of "*the person who comes looking for some comfort or answers to his or her questions*." This observation is not without echoes of the results of my previous research (Charlier 2018), which focused on non-therapeutic support groups led by professional contributors and intended for caregivers close to people facing difficult life events: the peer-leader of a support group for parents of children with autism confided that she felt she had to maintain a certain distance from her lived experience as a mother so as to "*not break down.*" She said that she could not consider herself a participant, despite the experience she had in common with the members of the group, in order to make way for them and to retain some control of the environment.

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This brings us to the second figure, that of authority. Facilitators are responsible for the environment of the MSGs. Étienne explains how he conceives of his position: it is a question of "*being able to establish this safe environment, being attentive to what each person says to ensure discussion circulates through the group, being able to identify the points at which the leader must decide to intervene a little bit to facilitate this discussion or actually be more reserved.*" Facilitators are committed to providing a reassuring and caring spatial and emotional environment. They provide a space to speak, ensure opportunities to speak circulate around the group, encourage participants to tell their stories if they want to, and spark exchanges and reflection within the group by establishing a favorable atmosphere. Étienne believes it is vital to demonstrate flexibility, and to adapt oneself to individuals' resources, needs, and difficulties. He also focuses on "*opening up to newcomers*" in the group, the challenge being to facilitate their integration without weakening the dynamics that are already at work. It is also a matter of intervening when needed and reminding people of the rules related to respect when speaking and respect for each other. For Gautier, facilitating the group consists in particular in "*defining the environment*" at the beginning of the session: members are required to respect others and adopt a neutral style of discussion, that is, one that does not involve telling others what to do. In addition, the facilitator's authoritative role requires him or her to structure the session and be responsible for timing.

Étienne also refers to the "parental" figure, which appears as an extension of this "authoritative" figure. He believes having at least two group leaders present at a session is vital, because this ensures a certain level of stability within the support group, in case one of the leaders is having a difficult time. In his eyes, it also facilitates the identification mentioned above and, more concretely, increases the chances of affinities forming between facilitators and participants. Thirdly, he believes that co-leadership by a male leader and a female leader means that the participants can be offered parental figures: "*I also think that this has the benefit that people can perhaps identify more with either one of us in discussions, and this shows in the way that they engage with one or the other of us. . . . We realized that there was maybe a maternal role with her sometimes and a slightly more paternal role on my side of things.*"

For those who have previously been participants, becoming an MSG facilitator allows them to embody the figure of recovery. Gautier believes that "*the groups can help [people] to regain stability, or even enter remission*." Maëlle, meanwhile, says that she regained "*a balance.*" Facilitators become models for members of the group, giving hope by showing that it is possible to make it through. As several scientific studies on the helper therapy principle emphasize, helping others proves to be therapeutic — some-

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times more so than receiving therapy oneself. Taking on a role that is rewarding is of even greater interest for people suffering with a mental health disorder, because they often have fewer opportunities than others to take on non-stigmatizing roles (Brown and Lucksted 2010). Étienne confides that supporting other people through the support group is, in a more general way, part of a desire to feel useful: "*The idea of contributing to the betterment of society and helping people with bipolar disorder is also something that motivates me.*"

Along the same lines as this figure of recovery, Maëlle brings to light the figure of "stable support": her role involves listening to the participants, being capable of receiving what they express, and being someone on whom they can rely in spite of the resonance of a shared suffering. Here, the idea is that the group leader is capable of accommodating the emotions of the group without breaking down. The stability of the group also comes into play. Étienne adds a point here, reminding us that facilitators do not need to be stable all the time; co-leadership allows for "low" moments without presenting a threat to the organization of the sessions. Far from calling the credibility of the facilitators into question, these periods can reassure the participants, who note that "relapses" are part of the recovery process. According to Maëlle, the other side of co-leadership is that it entails taking the time to coordinate and build strong bonds within the leadership team. The facilitators have to find ways to communicate with each other and to manage the potential conflicts, tensions, and disagreements that could arise in order to avoid the team imploding. Stability is also achieved by way of the group's rules and setup: the regularity of sessions, their punctuality, and so on. Pierre sums up these different facets, stating that he believes facilitators must be stable, have completed a training course on group leadership, and be punctual and proactive.

The different forms of mediation

As these testimonies show, the facilitator therefore carries out a mediation between the participants, in the sense of being a third party who can sometimes remain neutral, and sometimes take on a more active role. Gautier reports situations in which participants have had a poor command of French: the facilitator has then had to take on the role of interpreter, in addition to that of mediator, by ensuring that the exchanges between members are as accessible as they can be to everyone present.

Some groups, such as Étienne's, welcome both people suffering with bipolar disorder and those in their close circle. The repercussions of bipolar disorder are not limited to the individual alone, but also affect the individual's family, friends, and so on. They too can seek support and the opportunity to express themselves by means of a group. In

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addition, they sometimes play an important role in the sufferer's engagement process, particularly by going "prospecting" in the field and/or by providing encouragement about the process. For Étienne, those close to the person affected by bipolar disorder can be a real driving force for engaging participants. They can act as intermediaries between the group and the future participant. Thus, when the bipolar participants and those in their close circle mix with each other within the same group, facilitators may be required to carry out a mediation on two levels; between these two individuals and between this duo and the rest of the participants.

Mediation can also be practiced between the MSG and the outside world. This can be between the peers that make up the group and the professional contributors from institutions, or between the group and the general public.

Developing collaborations and/or partnerships with different actors in the mental health sector is one of the courses of action envisaged by the facilitators to increase attendance. Étienne believes that MSGs and individualized support are complementary practices, with the former constituting "*an opportunity to continue the therapeutic work.*" He hopes that professional caregivers might direct people diagnosed with bipolar disorder toward his support group. For Gautier, networking is essential, as it improves the visibility of MSGs, thereby leading to their greater recognition. For that to happen, positive relationships with professionals need to have been established beforehand. These professionals are expected to act as mediators between their patients and the group: they inform and reassure potential participants of the legitimacy of this type of practice — which the facilitators think remains too little understood and under-recognized at present. Gautier has already initiated some informal collaborations with doctors working within hospitals.

Collaboration with professional caregivers can also translate into interventions within groups themselves. Étienne wonders, for example, about the value of occasionally inviting a psychologist or a psychiatrist into the group — "*Would it be worthwhile to call upon a professional to get to the heart of the problem?*" — but he has no definitive answer to this question as he has not tried doing so.

Finally, a last role of the facilitators that is associated with the idea of mediation is that of a relay between the group and the general public. Gautier reminds us that widely disseminating information and using appropriate terms — "*I find the word 'psychiatry' outdated, it is a relic of another era and needs to be replaced by more suitable terms such as 'psychopathology' or 'mental health disorders'*" — contributes to combating the stigmatization associated with bipolar disorder. The participation of several facilitators

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in this study is also linked to this idea, as Gautier explicitly articulates: "*You too, through your profession and your dissertation in particular, you could contribute to increasing the visibility of associations like ours*." Étienne would like to keep a record of and disseminate the testimonies that are shared during sessions. This could help people suffering with bipolar disorder who might not wish, dare, or be able to join a group, while also helping to destigmatize this mood disorder.

A brief conclusion

Self-help or mutual support groups aim to facilitate mutual support among peers and are self-managed. However, this does not necessarily mean that interactions between professional caregivers and members of such groups are absent. The different figures embodied by the facilitators, as well as the forms of mediation that they practice inside and outside the group, bring to light a certain tension between professional expertise and lay expertise. Let us recall the case of Maëlle, which highlights the reluctance and ambivalence that can persist about the idea of being cared for by peers: at first, she turned toward a hybrid group, reassured by the fact that it was led by a psychologist. While experiential knowledge is valued and sought after as much by participants as by group leaders, the status of professional is associated with a certain capacity to take a step back, and with competencies that reassure participants. While being considered a peer — and not a professional caregiver — is an asset in Étienne's eyes, he also explains that he aims for a "*professional organization*" of the association within which MSGs for bipolar people and those in their close circle are set up. Training, which Pierre considers vital, raises questions related to the formalization of peers (Shaw 2014), which are often asked in the context of hiring peer supporters (Godrie 2014). After all, is a trained, or even professionalized, peer still truly a peer?

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PREVIOUS LIVES: THE MOBILIZATION OF EXPERIENTIAL KNOWLEDGE IN PEER WORK

Laws redefining the relationship between service users and the institutions that support them are leading peer support to gradually become institutionalized in several fields, including mental health, access to the law, job insecurity, housing, and disability. However, peer support still remains a nebulous, polymorphous practice that is difficult to define. The multitude of titles under which peers operate ("peer workers," "peer supporters," "peer mediators," and so on), along with the diversity of their activities, the organizational contexts in which they develop, their different statuses, and their working conditions do nothing to clarify the issue. This is because peer work, which is the paid (generally salaried)[1] version of peer support, is perceived as "not proper work," on the grounds that it is based on similarities of experience, background, and life trajectories between the professional and the individual that he or she is supporting. The issue here is that of a symbolic boundary, separating caregivers and patients, those with specialist knowledge and those without, and social workers and the individuals they support. Unlike the traditional recruitment process, which values qualifications and professional careers, it is the experiential knowledge that peer workers have gained from their "eventful" life courses that gives them this minimum qualification. This is underlined by a term used in Belgium to designate these workers: *experts du vécu* (experts by experience). In peer work, it is precisely what people usually omit from their CV that is taken into consideration and sought after: "experience of several forms of domination" (Demailly 2014),[2] or of a certain position in social relationships that has given rise to an experience of stigma — a stigma that being recruited as a peer worker ostensibly "reverses."

Peer work stems from peer support practices that have been collectively developed through mutual support groups (MSGs) and "self-help" groups that revolve around

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[1] Some peer workers work in community organizations as self-employed service providers, and are remunerated by means of universal employment service vouchers (*chèques emploi service universel*).

[2] Translator's note: Our translation. Unless otherwise stated, all translations of cited foreign language material in this article are our own.

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people's lived experience of illness, addiction, disability, mental health issues, or various painful conditions, whether real or symbolic. Indeed, the fact that both real and symbolic conditions are considered to have the same importance within these groups seems to operate as a powerful lever for the destigmatization process that supports and facilitates recovery. Furthermore, peer support can be perceived as a set of practices drawing on the ethics of a social relationship based on the "reaffiliation" of people who have experienced a "disaffiliation," who live as "supernumeraries" (Castel 1995). If institutions are now adopting the practice of peer support[3] and symbolically adopting the watchwords of the individuals they are supporting (participation, self-determination, non-judgment, and so on), it is because over the last few decades, an awareness of the real-life effects of peer support has been developing from the margins. Peer support's success is built on the relationship of specularity (or the mirror effect) between peers, which is a prerequisite for the peers' mutual trust and facilitates individuals' empowerment.

The realities of using peer support in medical and social services nonetheless demonstrate — if proof were needed — the importance of not simply accepting a positivist vision of peer work, a view that may itself produce some effect, in an absolute context devoid of all contingency or any situational features. The "added value" of peer work in medical and social interventions always depends on the organizational context, the room for maneuver granted to peers, their status, their potentially vulnerable condition, the clarity or vagueness of their objectives, the tools at their disposal, and the spaces that they use or are allowed to use. In other words, it depends on the space — both real and symbolic — that is accorded to them or that they make for each other in the given organizational structure.

The Plateforme de promotion et de développement du travail pair en région Auvergne Rhône-Alpes (Platform for the Promotion and Development of Peer Work in the Auvergne-Rhône-Alpes region), which I am responsible for managing, was set up three years ago with the specific aim of clarifying the issues involved in the institutionalization of peer work. It initially operated in the Grenoble area and then throughout the Auvergne-Rhône-Alpes region.[4] Together with a colleague, I provide "support for those who provide support" in community and institutional facilities. Working on peer work implementation projects, we raise awareness about the issues surrounding this type of mediation and help set up regional networks for those getting involved in projects, including peer workers. We are in a position to take an overview of peer work practices and observe the trends in this area, including the widespread development of peer support training and the distribution of peer workers in certain sectors depending on their location. For example, there is a greater emphasis on psychiatry in Lyon, while

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[3] For example, the "Un chez soi d'abord" (Housing First) program in France requires peer health mediators to be hired.

[4] Initially funded by the Délégation interministérielle à l'hébergement et à l'accès au logement (Dihal) (Inter-Ministerial Delegation for Accommodation and Access to Housing), the platform now receives support from the Agence régionale de santé (ARS) (French Regional Health Agency), the Direction régionale et départementale de la jeunesse, des sports et de la cohésion sociale (DRDJSCS) (Departmental Directorate for Youth, Sport, and Social Cohesion), Metropolitan Grenoble, and Metropolitan Lyon.

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housing and access to the law are more predominant issues in Grenoble. Furthermore, our activities effectively align us with the organizational side: we mainly work alongside peer workers and their teams, their employers, and a number of institutional and private funders. This involves taking a situated perspective, where we cannot afford to fall behind with new developments, which could create blind spots. We do not, therefore, have the capacity to observe how peer work is being developed among service users (as we might be able to do with ethnographic methods or work clinics) beyond what we are told about it. The tight timescales on which we operate in response to the requests that we receive from around the region do not leave us with sufficient time to carry out observation work or to keep ourselves up to date with the specific practices that peer workers are adopting with the individuals they support. Therefore, our experience of what they do comes through the filter of what they tell us.[5]

Resolving the asymmetry of social relationships

Peer work is based on a principle of taking into consideration the overall condition of individuals who are receiving support. Its mission is to become the cornerstone of an overhaul of medical and social intervention practices. This is what is suggested by the reflection currently underway in working groups. In each region, these groups are made up of providers of medical and social interventions (including peer workers), and individuals being supported as part of an anti-poverty plan. Their aim is to rethink, "hybridize," and "blend" training for future medical and social workers, taking the views of service users into account. In this sense, peer workers, whose experiential knowledge gives them a basis for casting a critical eye over the traditional practices of medical and social workers, are viewed as being key to the decompartmentalization of disciplines and the horizontalization of relationships between service users and professionals, in settings in which there is an asymmetry in the respective positions of these two groups.

In the conversations on peer work that my colleague and I hear in the teams in which we are involved, there is often confusion between peer work and the participation of individuals who are receiving support. Peer workers are, by implication, the representatives of these individuals and, on the grounds of parity, they give them a voice before the bodies that coordinate their medical and social support. However, peer workers are no substitute for participation schemes, and this confusion places them in a paradoxical position, where they are simultaneously viewed as being on the side of the professionals and on the side of the service users.

> *"You get a bit lost. You don't really know who's who, it's as if there wasn't any difference between us and the people who come in for support."*

[5] The extracts cited in this article in italics and quotation marks are from salaried peer workers in various institutions and organizations in the Auvergne-Rhône-Alpes region. They are taken from individual interviews, public statements given by peer workers, team meetings, and meetings between peer workers that took place in 2018 and 2019.

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In any event, it is now a matter of jointly building systems of support for individuals as they recover, their condition stabilizes, and they gain autonomy — and therefore breaking away from the prevailing normativity of traditional forms of support, making way for less prescriptive and more flexible, cross-cutting modes of intervention. Above all, this entails offers of support focused on individuals' needs as they express them, rather than as they are diagnosed or stated on their behalf from a situated perspective that often does not know about or misunderstands their lived reality.

> *"It's true that social workers can seem all powerful. I've seen that a lot."*

> *"We don't judge. We don't say, 'You need to do this, you need to do that.'"*

> *"I try and ask questions that lead the person to think, 'How did you feel, do you want to go there?' I try to lead the person to having a proper opinion, based on what they want."*

In one team meeting, a social worker described the following "effects" of the presence of peer workers on the support provided to individuals at the facility: *"Their presence greatly facilitated the links with the families. Their presence makes it possible to understand things more quickly. It also speeds up the process of* [the supported individuals] *finding work. We're the ones who do the referrals, but he's the one who sees most of the families. The way I think of it today, I co-refer with him. That happened by itself."* At a different facility, a counselor commented, *"The peer worker lets us enter into a relationship with the residents. It's not the same rapport that we have with them."* The distinction between "relationship" and "rapport" is an interesting one. It appears to emphasize how peer work functions, forging a particular interpersonal bond, working on the social rapport built up by institutions and getting rid of the notions of "us" and "them." For instance, peer workers adopt a kind of bilingualism, which makes them a sort of courier between the two sides: they often talk about translating the institutional language to make it intelligible to the service users; they act as interpreters or translators, in a role that allows the two parties to understand each other.

> "*If you can use simple words, that's like gold dust for therapists, who can get stuck in a jargon that others don't understand. We're a bit like health care interpreters. We're completely complementary to the medical staff."*

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A hybrid approach based on the ethics of communication and cooperation

If peer work serves to facilitate communication and interventions with individuals, at least when carried out in favorable conditions, this is because it shakes up normal practice and reinvents its processes. Peer workers share a professional ethics that is connected to their personal ethics. By questioning their positioning ("the right distance") and the registers of action of "traditional" interventions, these ethics engage their morality as subjects, imposing symmetry as a condition for the establishment of relationships with people. This is even more true for peer work than it is for social work, because it is exclusively based on the experiential knowledge of those who undertake it — for peer workers, it is part of who they are. Everyone talks about commitment, using a variety of terms, but in a way that conveys considerable investment in a job that engages them fully. However, this investment must be treated with due care and attention, as those who make it are more vulnerable in terms of their mental health, and they may suffer if their work no longer makes sense to them (Schweitzer 2008).

> "*I created a relationship based on trust. For me, the important thing is to respect that trust. Looking at it from the outside, my way of doing things must look quite pally, but with the residents, they know we're professionals, and you can't just do anything you feel like.*"
>
> "*We don't give up, that's the difference. We keep going till the end.*"
>
> "*For me, it's a passion, a vocation.*"

There are certain ways of doing things, or "*arts de faire"* (De Certeau 1980 [English translation 1984]), that peer workers have developed for themselves based on their own experience, which they may then use for and with the individuals they support. These stem from "hacks" or "tricks of the trade" that they have learned — pieces of theoretical and operational knowledge that contribute to an understanding of the scenarios one may encounter, an understanding that takes into account the uniqueness of these scenarios and makes it possible to adapt to real-life situations. Experiential knowledge is highly plastic by nature: whereas academic knowledge leads to prescriptive work, always with a gap between the theory and reality, peer workers' experiential knowledge has been developed in personal and social settings. This makes it possible to bridge this gap between reality and the representations conveyed by traditional modes of support, drawing on a range of lived situations and tried and tested ways of doing things — resources that have been empirically constructed for the various critical situations that may be encountered. There will be some who have detailed knowledge

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of the "territory" covered by their own particular missions, whereas others might arrive with nothing more than a "map" at the outset.

> "*The educated people, they've got their degrees, but not a past.*"
>
> "*It's the way they look at things, that's what's different. It's time as well. Trying to do things in a hurry doesn't work. At the MSG I can really see how people change over time. Some people never used to talk, but if you look at them now, they could start a revolution.*"
>
> "*When you're a peer, you can accept someone who's failed in life, and why it is they've failed. You just can.*"

When they describe what they do and how they do it, peer workers emphasize the primacy that they give in all circumstances to their feelings, their emotions, and their sensations, so that they can position themselves and interact with the other members of their teams and the individuals they support. With empathy and "*deep listening*," availability, and a concern for contingency that they display in the way they relate to those they support, peer workers can convey a morality of shared action, based on the relational characteristics that they evaluate in the light of the "*palpable*" recognition and trust that the individuals receiving support show them. In peer work, more than elsewhere, "the validation of the work through the recognition given by others makes a major contribution to building up a sense of meaning for that work" (Dejours and Gernet 2009, 31).

> "*If I get the sense he's ready to hear what I have to say, then I say it. But if he's not ready for it, I save my words.*"
>
> "*It's a big job of listening, of being available, it's quite testing.*"
>
> "*You know when it's working, you can tell how people are getting on, you can sense the recognition as well.*"

Knowledge based on experience of stigma

The experiential knowledge on which peer support is based involves a "practical sense" (Bourdieu 1990 [1980]) stemming from having experienced violence and repeated stigmatizing situations. "The originality and precious nature of their life experience lies in the fact that it is an experience of a situation of domination, and of the

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forms of resistance, difference, subjectivation, and potential empowerment that can appear in relation to this situation" (Demailly 2014). Subjects will develop theoretical, practical, and technical knowledge from this experience, displaying their social skills by engaging in role play in particular. It is "central to understanding the specific structure of their professionalism" (Demailly 2014). The experiential knowledge developed by peers stems from an autodidactic praxis that they have had to build up from situations they have had to endure in their dominated position, where they have been constrained, infantilized, incapacitated, stigmatized, ostracized, and abused in their social relationships.

> "*I'm familiar with accommodation and social reintegration centers* [centres d'hébergement et de réinsertion sociale (CHRS)]*. When I got put in a CHRS, it was a sort of internment. When I came back in, they'd breathalyze me, and if I tested positive, I'd have to sleep outside*."

> "*There's a lot of violence at the hospital. You need to have been in hospital under duress. You just want to die*."

> *"The thing you have in common with the service users is that you've been, you're subjected to the same forms of support. You're subjected to it, that's the thing.*"

Knowledge based on experience of mental illness, for instance, concerns the experience of the illness itself and that of "*taming"* it, but also experience of the way in which the stigma of the illness has an impact on social relationships. Similarly, peer workers who have come "*from the streets"* display their knowledge of how to "*muddle through"* in the daily "*grind*," and of social relationships as viewed through the lens of the discrimination that they suffer. Some sorts of visible stigma act as a type of "gateway stigma" that can make it possible to understand the experiences of other stigmatized individuals, as their manifest nature so fully determines the degrading treatment to which the individuals have been subjected. This is clear in the comments of peer workers who have experienced racism, for instance.

> "*You know, I've always experienced racism, people's looks. I see the way they look at me, how they talk to me* [...]*. I know all too well what it's like to be in a vulnerable position. It's just miserable. It helps having the people from the program. The number of times I've experienced humiliation* ... *Unacceptable behavior, demeaning, insulting. I can see how we're not allowed to speak to people."*

> "*I'm an Arab woman, I know about poverty and addiction* ..."

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We could theorize that the experiential knowledge of individuals in a dominated position primarily derives from an “expertise with regard to others” (Dorlin 2017), which needs to be obtained in order to survive. Dependency on others and the fact of being at their mercy in social relationships and of having to endure one’s situation seems to encourage the adoption of a particular disposition, willingly or otherwise: a “concern for the other,” which generates knowledge and skills with regard to the other, because one does not have a choice whether or not to pay heed; one needs to engage with the other and to protect oneself if necessary. “One has to be almost permanently on alert, but this gives rise to a level of exhaustion that precludes any level of care of oneself … References to ‘dirty care’ refer to the type of care that is given to oneself, or rather that is given to one’s ability to act, such that one becomes an expert on other individuals out of self-preservation” (Dorlin 2017, 177).

> “*When I was on the streets I was always pretty paranoid. On the lookout the whole time, watching everything, wondering what was going to happen to me. The streets make you paranoid, especially if you’re a woman. I still feel it: it doesn’t go away, it’s exhausting. I don’t trust anyone, I can’t relax, can’t stop anticipating everything that might happen. I can’t help it… At the same time, though, being alert like this means I see lots of stuff coming.*”

As peer workers describe it, it is their experience of an urgent need to “*regain control”* at some point in their life that makes them aware that a certain free “*play*” is possible, a room for maneuver in relation to institutions, others, and themselves. When they describe “*what* [they] *have gone through*,” how they have managed to “*turn shit into fertilizer*,” and the pride they have taken from achieving that, peer workers often express a dialectical consciousness of the social relationships they have endured and of the relationship they maintain with themselves. This relationship with themselves has the capacity to perpetuate the effects of their social relationship by depriving them of their empowerment, or it could allow them to feel like they are “*actors in* [their] *own lives*.” They talk about how they have viewed themselves for a long time, which is connected to how others see them. They discuss this “*judgment,*” and how they have tried to free themselves from it and to “reverse the stigma.” They mostly offer a dialectical vision of their own condition, set out according to a structural and individual framework, where re-establishing or consolidating a favorable situation depends on a certain relationship with the world, with others, and with themselves. The empowerment that they give themselves is often also based on the “*consciousness*” that they say they have. This “expertise with regard to others,” produced by experience and the situated perspective of peers, is often connected to an “expertise with regard to oneself,” which is to some extent essential for re-establishing or im-

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proving the conditions in which they live. The fieldwork that my colleague and I carry out with peers shows that, for most of them, their work leads them to continually re-examine their reactions, behaviors, positions, views, diagnoses, and ways of doing things in light of the realities that they encounter. In doing so, they appear to adopt a critical view of themselves, improving their "self-knowledge" through the situations that they experience.

> "*I need to analyze what I feel, I need to note it down. There're things like your ego, but you need to understand what it is you're feeling. I've worked out my own little tricks for doing the job, resolving conflicts, and making sure that I don't lose my cool, and that I don't try and take everything on myself. Not letting it get to me . . . I think I know myself well.*"

Whereas peer work can help to "*support people's recovery*," it also works in both directions owing to the critical spirit that peers invest in their work and the specularity of the underlying relationships. For the supported individuals, the peers represent "*the people who've pulled through (more or less),*" thereby offering the hope of some degree of "recovery." In return, supported individuals, whether deliberately or otherwise, may turn out to be "*caregivers*" for the peers, whose identity is worked on through the daily activities in which they are "*100 percent invested*," as "subjects" or "actors" rather than as "agents" (Schweitzer 2008).

> "*When I'm in front of people, I understand things; but at the same time, it triggers a sort of internal rebellion, where I can't get away from myself. It's a mirror effect, when I see them doing their work, I see myself. It's a job where I can't be running away from myself. The peer work really helps.*"
>
> "*Helping people is magic; it helps to help, you know.*"
>
> "*With this work, my experience makes sense, it's part of my identity. I never had my existence made legitimate before.*"

A legitimacy that is hard to master

The picture painted by the implementation of peer work in the region bears one particularly salient feature: most of the peer workers we encounter are experiencing difficulty or are actually suffering, in the sense, defined by Yves Clot, of an "amputation of empowerment" (1999), which affects their identity. One peer worker expressed it in those terms: "*I feel amputated from my work.*" Only rarely does peer work develop

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in conditions favorable to efficiency and recognition: factors may include job insecurity, low pay, strong resistance among teams to the appearance of new but unqualified professionals (who are perceived, in a context of tight budgeting, as a threat to the qualified staff whom they could potentially replace), vague mission frameworks, and conflicting instructions down the chain, with recognition made conditional on demonstrating a professionalism modeled on that of traditional practitioners. Many factors are left unconsidered, and there are frequent demands for training that maintains "the right distance" and professional orthodoxy, although this risks standardizing the practices of peers in a rigid "format" and thereby taking away the very things that are unique about their form of intervention.

The amateur and individual nature of the experiential knowledge brought to bear by peers does not facilitate their legitimization in a field dominated by academic learning. The epistemic injustice done to peers manifests itself, in particular, in their being reduced to a status of providing "mere testimony," as they are asked to "talk about [their] life," and this minimizes their political significance ("*It's like we're performing monkeys*"; "*We're good examples, they want to show us off, make us talk*"). Many peers still feel stigmatized ("*We were being up front, but they still kept us out of sight*"). Contrary to what Lise Demailly (2014) noted, some of them experience their role as being "delegated to do the dirty work" ("*We're cannon fodder. We're like the infantry of social work, we're the ones who get sent up to the front line, but we never get acknowledged*"; "*They ask us to be the agents of their good conscience*"). Although most peers devote a huge amount of energy to demonstrating their abilities and do their best to make their work visible, they come up against the structural paradox that, in certain activities, their effectiveness depends on their invisibility. When institutions finally take over the "peer" role themselves by labeling workers as being peers of service users (rather than service users themselves declaring those workers to be their peers),[6] they are putting these workers in a conflicted position, which does not help them to feel legitimate, nor does it give them legitimacy either in the eyes of their professional colleagues (as the "peers" of service users, they are suspected of being "*on their side*"), or in the eyes of the service users ("*You always get the impression you're spying for one side or the other*"; "*You're caught sitting on the fence*").

In many cases, peers are "grafted on" to organizations with well-functioning, systematic operations, walking a tightrope between two different worlds (the "*pros*" and the service users). Occupying no position of their own, they are asked to fill "*the gaps*" between medical and social interventions, so it is up to them to build up their professional legitimacy as best they can: peer workers who build on the history of peer support situate their practices in a continuum that gives them a sense of belonging and an

[6] We can be a peer only with someone with whom we identify and who recognizes us as such.

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identity. “Professional circles” or peer collectives are emerging with the aim of building a community from the bottom up so as to constitute a new sort of “professional body,” that would be capable of engaging with existing professional institutions. These self-support and co-learning spaces serve to consolidate the position of peers and to ensure that the substance of peer work is not taken away through being institutionalized (“*Training is about power dynamics, which is really political. But who oversees peer support? That’s the question*”). Indeed, the growing number of training courses for peers, which points to a newly forming market, highlights one of the many paradoxes in which peer work is trapped: while this sort of work is expected to transform institutions by instilling new ways of seeing and doing things, the immediate result is the standardization of peer work itself. ◗

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THE INTERPRETER AS "TRANSLATION MACHINE" AND THE NEGOTIATION OF MEANING IN VERBAL INTERACTION: A CLASH OF APPROACHES TO INTERPRETING PRACTICE?

The involvement of a third party in a mental health consultation presents challenges for both the health professional and the patient, as well as for the third party in question. When the patient is a migrant, this third party's presence is especially significant if his or her role is to guarantee mutual comprehension between the other two parties so as to facilitate "successful" conduct of the consultation. In this article, we will look specifically at the practices implemented by one particular type of third party, an interpreter, in a patient consultation with a non-French speaking migrant.

Our work is part of the REMILAS ("RÉfugiés, MIgrants et leurs LAngues face aux services de Santé") (Refugees, Migrants and their Languages in Healthcare Encounters) project set up by the ICAR (Interactions, Corpus, Apprentissages, Représentations) (Interactions, Corpus, Learning, Representation) laboratory and the Orspere-Samdarra Mental Health, Vulnerabilities, and Societies Observatory.[1] Research carried out as part of this project focuses principally on the linguistic and cultural issues that emerge in interactions between medical staff and the migrant population, including in procedures linked to mental health care. Because the participants speak different languages, an interpreter/mediator may be present to facilitate communication. Here, we focus on the linguistic "fixes" used to overcome communication problems between migrants and health professionals.

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[1] http://www.icar.cnrs.fr/sites/projet-Remilas/.

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In our analysis, we will focus on one videoed interaction, recorded as part of the project. It concerns a mental health consultation between a psychiatrist and a Chechen patient who is seeking asylum; a nurse is also present. The patient does not have a sufficient level of French, so a Russian/French interpreter, who is a member of an interpreters' association, takes part in the interaction. Our analysis will illustrate how the interpreter navigates between two contrasting approaches: on one hand, he operates in line with the interpreting ideal of the "translation machine" (Bot 2005), and on the other, he takes up a position as a full participant, with a distinct voice and presence in the interaction. In fact, in his verbal contributions the interpreter perfectly preserves the sequence of exchanges between the psychiatrist and the patient, but on several occasions takes the initiative in order to clarify an element for translation. With this study, and in keeping with the tradition of interpreting studies, we will show that the notions of "invisibility" and "neutrality" are not applicable in dialogue interpreting (Wadensjö 1998). We also defend the position that the quality of interpreting is not solely the responsibility of the third party but is in fact the result of a joint endeavor involving all participants.

Interpreting: From theory to practice

The question of the "quality" of the renderings produced by interpreters is a central concern of interpreting. Quality can be expressed in terms of faithfulness to the original utterances, accuracy, neutrality, or the invisibility of the interpreter. Current research shows that the normative concept of the invisible, neutral interpreter, required to operate as a "translation machine," is not only impossible to achieve, but in fact rather controversial in that it takes no account of the complexity of the role the interpreter takes on (Ozolins 2016, quoted in Cirillo and Niemants 2017). In practice, during these interactions, interpreters find themselves having to manage the flow of turn-taking between at least two interlocutors. This involves them in the construction of meaning and mutual understanding through the use of, for instance, reformulations, explications, and repetitions, this because, above all, interpreters must understand and make themselves understood (Pöchhacker 2008). These linguistic actions necessarily impact on the sequential development of the interaction, in the sense that participants' turn-taking is necessarily modified by the interventions of the interpreter, who may for example exchange with a participant to request a clarification, to check his or her understanding of what has been said, or to correct the understanding of one of the interlocutors (Ticca and Traverso 2015; Pasquandrea 2011). Although the interpreter's impact is universally accepted among researchers, this is not always the case at the institutional level, particularly in the case of interpreters' associations. A glance at the codes of practice of interpreters' associations in France and Canada quickly reveals the degree to which interpreter behavior is tightly defined.[2]

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[2] In France: https://www.unaf.fr/IMG/pdf/charte-signee-scan19-12-2012.pdf; in Canada: https://www.ailia.ca/resources/Documents/National%20Standard%20Guide%20for%20Community%20Interpreting%20Services.pdf.

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It is important to note that in the field of medicine, care can take place in a fairly wide variety of situations. Clearly, speech is central to all consultations, but the role of discourse is not the same in general medicine as in mental health care contexts. Whereas in general medicine, participants who do not speak the same language can call on resources other than language in order to aid communication and to deal with problems, particularly those of a physical nature, things are a lot more complex in mental health care. In this kind of situation, words, formulations, and the images conveyed by the patient are a source of information that the care professionals may use to assess the mental state of the patient (Béal and Chambon 2015; Peräkylä et al. 2008). The role of the interpreter therefore becomes a very sensitive one from the point of view of the caregiver, who finds him- or herself having to depend on the translation of a third party in order to establish the psychological status of the patient. Indeed, it is not uncommon to find doctors working in mental health care who are reluctant to accept non-French-speaking patients with an interpreter present (Bischoff et al. 2003; Boivin, Leanza, and Rosenberg 2012; Graz, Vader, and Raynault 2002; Hudelson and Vilpert 2011; Weber and Molina 2003). Hanneke Bot (2005) addresses this issue by identifying two distinct models concerning the place of the interpreter in such consultations: the "translation machine" model, and the "interactive" model. In the first case, the interpreter has not received any briefing about the context or the situation in the proposed interaction, and he or she is expected to produce a faithful and equivalent translation of the conversation between the medical practitioner and the patient, relayed through direct reported speech. This model leaves the interpreter no room at all to use his or her own initiative and restricts him or her to providing a translation of each turn in the conversation between caregiver and patient. In the second model, the opposite is the case. The interpreter is considered a full participant in the exchange. He or she is briefed beforehand, his or her contribution can facilitate the doctor-patient relationship, and his or her spontaneous interventions are welcomed. This interactive model is similar to the procedures typically used in ethnopsychiatry or in transcultural clinical contexts (Devereux 1972; Moro 1998), where the interpreter takes part in group therapy sessions held with families and children from migrant populations, or with refugee families, and where the linguistic and cultural differences between participants are salient features. By virtue of the sociocultural experience he or she has in common with the patient(s), the interpreter has a degree of insight when interpreting patients' utterances, and acts as a co-therapist, co-constructing the therapeutic activity.

In the following section, we will draw on the theoretical and methodological framework of conversational analysis (Sidnell and Stivers 2013) in order to describe the details of a case of interpreting practice that combines both models. By paying particular attention to how the exchange in a mental health consultation unfolds turn by turn, we

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hope to illustrate the way in which the interpreter deals with the interactional challenges when problems arise in the exchange. It is in these moments in particular that he or she must manage the balance of the "double role" — as both a "translation machine," the guarantor of the faithfulness of the translation, and a full participant, guarantor of mutual comprehension between participants who do not speak the same language.

An illustration of third-party involvement in an interaction in a mental health care setting

With the two conversational extracts presented below, we illustrate how the interpreter (referred to as IPC) takes up the position of a full participant in the interaction between the psychiatrist (PAH) and the patient (MAL), while maintaining the (apparent) role of "translation machine."[3] This "double role" is particularly noticeable in passages of repair or correction (Schegloff, Jefferson, and Sacks 1977), moments when the progress of the interaction is blocked by the presence of an interactional issue. This kind of conversational sequence allows the observer to see up close how the meaning of the words is co-constructed and negotiated during the exchange, and is therefore an ideal place to study the emergence of meaning constitutions and interpretations made by participants "on the spot" (Chernyshova 2018). Analysis of these sequences is therefore of great interest in studying interactions in mental health care contexts, where the patient's verbal expression is at the heart of the consultation. This first extract illustrates the interpreting practices referred to:[4]

Extract 1 – "People"

01 PAH bon (.) c'est trop difficile d` parler de ça
ok (.) it's too difficult to talk about that
02 (0.7)
03 IPC sliškom složna gavarit' ab etam
too difficult to talk about that
04 (5.1)
05 MAL mne očen' bol'no kagda (.) pra svaju semju gavar'at ((sniffs))
it pains me when (.) one talks about one's family
06 IPC vous savez ce ça me fait très mal hein quand j'aborde le sujet :
you know it hurts me eh when I talk about the subject
07 euh de vie de ma famille
of my family's life
08 (0.7)
09 MAL °ja° očen' t'až'oluju ž'izn' perež'ila

---

[3] The names of the participants have been replaced with pseudonyms in order to preserve their anonymity.

[4] These extracts have been transcribed using the ICOR transcription convention (http://icar.cnrs.fr/projets/corinte/documents/2013_Conv_ICOR_250313.pdf), the main elements of which are detailed at the end of this note. The Russian interventions are rendered phonetically, taking into account the particular manners of articulation of the two Russian speakers, as well as of the non-standard grammatical constructions (which are preceded by an asterisk). [Translator's note: a translation in English appears in italics underneath all Russian and French interventions. Those underneath the Russian interventions are based on the literal French translations provided by the authors, while those underneath the French interventions are our own translation.]

Elements of the transcription convention used:
[] : overlap
/ : rising intonation
\ : falling intonation
(()) : comment by transcriber
°voilà° : segment spoken in a low voice
& : (indicates the) continuation of a turn
(0.4) : pause, measured in seconds
(.) : micropause (< 0.2 second).

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°I°'ve had a very difficult life
10 IPC vous savez j'ai vécu une vie tellement dure
you know I've had such a hard life
11 (4.9)
12 MAL ((crying))j- jesli men'a ne tak ponimajut h : ja ne magu
if I'm not understood properly I can't
13 et` (.) [terpet']
take it
14 IPC [et si] les gens ne me comprennent pas même avec tout
[and if] people don't understand me even with all
15 c` que j'ai vécu hein
I've lived through PRT
16 MAL ((sniffs))
17 IPC j'en peux plus\
I can't take any more
18 (2.1)
19 PAH les gens c'est qui °madame Nagaeva°
who are people °Mrs Nagaeva°
20 ⇒ IPC KTO ne panimaet (.) l'udi kto/ (.) kakie l'udi
WHO doesn't understand (.) the people who (.) which people
21 (1.0)
22 MAL deti moi rodnɨje de[ti]
children my own children
23 IPC [ah] je parle de mes:: z- en- [fruits de mes] &
[oh] I'm talking about my [fruits of my] &
24 PAH [vos enfants]
[your children]
25 IPC & entrailles mes enfants[5]
& gut my children
26 (0.4)
27 PAH hm
28 (3.5)
29 ((MAL sighs))

Following the observation of the psychiatrist (01), the patient produces several complaints (05, 09, 12), which are translated, respectively, by the interpreter (06–07, 10, 14–15), in accordance with the "translation machine" model. Responding to the last complaint produced by the patient, or rather its translation ("*if people don't understand me even with all I've lived through*," 14–15), the psychiatrist formulates a question after

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[5] A detailed analysis of the translations provided by the interpreter cannot be given in this study due to considerations of space.

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a long pause: "*who are people*" (19). Faced with this question, the interpreter is in a delicate situation: the term "people" (in Russian, *l'udi*) has not been used by the patient in her complaint, it was how the interpreter chose to translate the impersonal grammatical construction used by the patient. She said, specifically, "*men'a ne tak ponimajut*" (12), literally: "they don't understand me properly." This impersonal expression designates "the others" as the subject of incomprehension, a non-specific subject that is translated by the interpreter not by the indefinite French pronoun, "on" [English: "one/they"], but by the paraphrase "les gens" [English: "(the) people"].

Given this interactional problem, the interpreter reformulates the question put to the patient by the psychiatrist: "*WHO doesn't understand the people who/ which people*" (20). He at first articulates the point of the question put by the psychiatrist, who wants to identify a definite subject, then gives a faithful translation of the question. This is the exact moment in which the interpreter shows his participation to be not just that of a "machine," but also that of a full participant, one whose role is to guarantee mutual understanding between the principal participants despite any vagaries his participation may cause. By prefacing turn 20 with "WHO doesn't understand/," he provides the patient with the information necessary to make the link between what she has just said and the subsequent request for a more specific answer, put to her by the psychiatrist.

The same practice is found again later in the conversation, when the interpreter once more takes the initiative. He prefaces a translation of a question from the psychiatrist with a supplementary question that is not a translation of the preceding turn. The turn-by-turn model of translation is preserved in this instance, also.

Extract 2 – "Reproaches"

01	IPC	ses insultes\ her insults
02		(1.3)
03		((MAL sniffs))
04	MAL	patom mne kanfe:tɨšto-nibud' tak prin'es'ot što b' (.) after she brings me (chocolates; candy) like that so that
05		[et` vs'o prašlo] everything goes away
06	IPC	[après euh:::] apporte quelques chocola:ts quelques [after] brings some chocolates some
07		bonb[ons:] voilà: pour faire passer [la chose hein] candy there to make go away [the thing PRT]

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08	PAH	[hm]
09	PAH	[c'est c'est des rep]
		[is it is it a rep]
10		roches/ (.) c'est des reproches qu'elle vous fait/
		roach (.) is it a reproach that she's making toward you
11	IPC	i protiv *vam gavarit što-nibud'/ inagda//
		and against *you does she say something sometimes
12	MAL	((sigh)) °naš'ët čevo
		about what
13		(0.4)
14	IPC	par rapport
		about
15		(0.4)
16	PAH	.tsk je sais pas
		I don't know
17		(0.3)
18	IPC	[n'e znaju]
		I don't know
19	PAH	[par rapport au.] passé: par rapport à
		[about the] past about
20 ⇒	IPC	°euh° pačemu askorbl'ajet vas naš'ët prošlava/ što-nibud'
		why does she insult you about the past something
21		[proizašlo/ ili kakie pričinɨ]
		happened or what reasons
22	MAL	[ne::t prosta] kavo-nibud' jesli kto-nibud' je-
		no just someone if someone
23		(.) ja dumaju š'to j- (0.3) s kem-ta ana passo[rilas'/]
		I think that (0.3) she's had an argument with someone
24	IPC	[moi je pense] que
		[me I think] that
25		bon\ quand elle s'engueule avec quelqu'un (.) dans la vie
		well when she has a shouting match with someone (.) in
26		*quotidienne*
		daily life
27	MAL	prišla kakuju-ta mal'en'kuju pričinu
		she turns up and any little reason
28		(0.5)
29	IPC	et la: le [moindre prétexte inexistant fait que.] ça y est\ elle&
		and then the [slightest non-existent pretext means] that's it she&

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30 MAL [i *načala *za eta što-ta gavarit']
*and *starts to say things *about that*
31 IPC &s'emballe .h elle commence à sortir des mots
&she gets carried away she starts coming out with comments

Here, the patient is complaining about the insults she receives from her daughter. The psychiatrist questions her about the nature of the insults and asks if these are reproaches (09–10). This question is translated as "*and against you does she say something sometimes*" (11), which does not convey the term "reproach" in Russian (*upr'ok*). The patient replies to this translation with a request for more precision ("*about what*") (12). The psychiatrist responds in turn with the hypothesis that it may be about reproaches regarding the past in particular (19). Reacting to this exchange that requires a clarification of the psychiatrist's initial question, the interpreter's translation additionally includes a reformulation of the psychiatrist's question: "*why does she insult you about the past/ did something happen/ or what reasons*" (20–21). By reformulating in this way, making the psychiatrist's question more precise, the interpreter takes a step toward resolving the lack of understanding that he has contributed to cause. After this, the patient responds to the psychiatrist's question and the interaction follows its course.

As we saw in the previous extract, here, the interpreter corrects a non-faithful translation of the original that seems to be the cause of a lack of understanding between patient and caregiver. The way in which this problem is resolved does not alter the structure of the translation process as conceived by the "translation machine" model.

To summarize, through the analysis of these two extracts we have shown a particular practice of the interpreter. After having identified the trouble-source, the interpreter produces a rendering of a question put by the psychiatrist to the patient, which unfolds in two phases. First, the interpreter formulates a question that is not a translation of the psychiatrist's turn, thus providing the patient with the information necessary for understanding. Second, the interpreter produces a faithful translation of the psychiatrist's question. Thanks to this maneuver, the interpreter ensures mutual understanding between the patient and the psychiatrist, while simultaneously anticipating, and even repairing, an understanding problem caused by his own original rendering. By dealing with the informational and interactional content in this way, the interpreter combines elements of the two models of interpreting under discussion: the turn-taking sequence from the "translation machine" model is respected, yet at the same time the content of the translation is not strictly faithful to the original utterance, but is modified to aid understanding, which is a practice from the "interactive" model.

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Conclusions

The provided analysis of a situated doctor–patient interaction has shed light on a particular practice of an interpreter in a mental health consultation with a non-French-speaking patient. The starting point of our study was the observation of the dichotomy presented by the models that prescribe how interpreting should be done: the model that imagines the interpreter's behavior as being akin to that of a "translation machine"; and the format that allows him or her a greater degree of freedom, known as the "interactive model." Based on the analysis of these two extracts, we have tried to demonstrate that these two models are not only compatible, but that they are actually complementary, and can both be called upon when an interpreter encounters a "problem" of meaning in the course of an interaction. Indeed, in the two extracts studied, the interpreter has blended the two models, using the tools offered by both to (re-)establish mutual understanding between psychiatrist and patient as the twists and turns of the interaction unfold.

Earlier REMILAS project studies (Ticca and Traverso 2015; 2017), and others (Pasquandrea 2012), show that interpreters can opt for other methods when dealing with cases of incomprehension, such as dyadic sequences with one of the other interlocutors. These are fairly frequent in the health context and allow the negotiation of meaning of particular words or content; their purpose is to ensure the mutual understanding of participants.

The unpredictable nature of a medical consultation, particularly in the mental health care context, brings challenges for the interpreter. The meaning and the negotiation of the meaning of words and formulations can lead to moments of tension, and it is in these moments that the role of the interpreter becomes crucial: it is the interpreter's understanding of the speech of the caregiver or the patient that provides the other with what they need in order to respond, reformulate, or explain. That is why we have tried to show that interpretation in such cases is the result of a joint endeavor involving every participant in the interaction. The interpreter has just as much of a voice as the other participants, and that voice is essential to making the most of the resources available.

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WHICH WORDS SHOULD BE USED TO SPEAK THE WORDS OF THE OTHER? THE NAMES OF EMOTIONS AND THEIR TRANSLATION IN MENTAL HEALTH INTERACTIONS

Like any interaction, mental health consultations (in psychotherapy and psychiatry) depend upon speech and exchange in all their forms, from the most language-based (the choice of words, for example) to the most embodied (gestures or facial expressions). What is particular to these situations, however, is the role played by speech in the clinical aspects of the interview, which can be seen as the very essence of care. In this article, we approach the mental health consultation as linguists, focusing on the question of the choice of words used to articulate one's problem, state of mind, and emotions in cases where speech is being conveyed through an interpreter.

Introduction: Speaking, finding the right word, reformulating, translating

It is not easy to articulate how you feel, even in your own language. In addition, it has often been observed that there is a link between the situation of expressing emotions and various types of destructuring of discourse, including hesitation, incompleteness, searching for words, and repetition (Plantin, Doury, and Traverso 2000). These phenomena can be observed in the short excerpts from interviews given below.[1] In the first, the patient answers the question "*How are you?*" asked by the psychologist.

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[1] Transcription notation:

(0.4) indicates a pause of 0.4 seconds;
( ) indicates a very brief pause;
: denotes lengthening of a vowel;
[indicates overlapping speech;
/ and \ indicate rising and falling intonations respectively;
<((slowly))… > means that the words inside the chevrons are spoken with the characteristic indicated in brackets;
In all excerpts, participants are referred to as PAT: patient; PSY: psychologist or psychiatrist; NUR: nurse; INT: interpreter.

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Excerpt 1

PAT well (0.4) I'm I'm not not very very good but I'm okay I'm a little tired there's (0.7)
there's <((puts her hand on her chest)) something that that>'s stuck inside and
I can't manage to say: (0.4) I don't understand what it is.

Here we see the patient's attempt at formulating her emotions, as she brings into play a variety of verbal and multimodal communicative resources to express her state of mind.

Reformulation is an essential resource in the therapist's practice, which has been the subject of numerous studies. Denis Apothéloz and Michèle Grossen consider that reformulation allows the therapist to "maintain a balance between interventions that are continuous with the patient's interventions (as otherwise the dialogue risks being interrupted), and interventions that aim to introduce a certain discontinuity (without which any therapeutic process would be impossible)" (Apothéloz and Grossen 1996, 117).[2] Many of the roles played by this practice have been highlighted (Vehviläinen 2003; Antaki 2008; Peräkylä et al. 2008), which Charles Antaki summarizes in terms of turns at talk "formatted as: *challenges; corrections; extensions;* and *reinterpretative statements*" which allow therapists to "understand their clients and to offer them new ways of thinking" (2008, 27).

In Excerpt 2, the patient talks at length about the fact that she is taking Seresta, an anxiolytic drug, and then recounts an occasion when her husband called her crazy. After this she expresses her feelings ("*To me, it's not nice what he said*") and the psychologist reformulates her statements:

Excerpt 2

PAT but in your face he says to you (0.2) you're crazy/ it's not fair it's not it's not nice
(0.4) to me it's [not] nice what he (0.3) [said]
PSY [yes] [it's] hurtful\ (0.4)
[it] hurt you\
PAT [it's true]

However, when the consultation is carried out via an interpreter, neither caregiver nor patient has access to their interlocutor's own lexical choices. The interpreter then has the very delicate task of providing access to meaning through his or her own lexical choices, which have a complex relationship to the original words spoken, something Jean Margaret Davis expresses very clearly:

[The translator] does not simply reproduce the patient's words and expressions. He or she also tries to analyze and explain the tone, and to say whether this or that expression

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[2] Translator's note: Our translation. Unless otherwise stated, all translations of cited foreign language material in this article are our own.

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is usual in the country of origin. He or she tries to work out which expression would be used in France to describe the same kind of pain, for example, and the meaning that this type of suffering might have for the patient. When an Algerian woman says that her head is getting hot, a Chechen woman that her blood has cooled, an Uzbek woman that her dead father is giving her advice through her dreams, linguistic and cultural insight can help in better understanding the meaning of these perceptions in the patient. (Davis 2009, 169)

As this passage illustrates, in their translation, interpreters are torn between different requirements bearing upon the lexical choices they make. The ideal might be for them to translate words into perfect equivalents in the target language, but this is more the exception than the rule (because of the use of metaphor and figurative expressions and the cultural dimension of the words used). In practice, interpreters are in fact engaged in a continual process of negotiation. They employ various different ways of rendering words or expressions, and sometimes use them successively within the same sequence. They may try to translate them literally, as in Excerpt 3:[3]

Excerpt 3

PAT nga ta kthesh shume keq eshte\
it's bad every way around (n.b. "*it doesn't matter how you look at it, it's still bad*")
(.)
INT even if you go around it it's bad ((laughs))

They may use a formulation in the target language that is close to the initial idea, as in Excerpt 4.

Excerpt 4

PAT uh: sikur nje njeri po me merr frymen avash avash ndjehem
uh: as if someone were slowly taking away my breath I felt
(0.7)
INT I felt as if <((hand on throat)) someone: he is trying to strangle me (0.9)> little by little

Finally, they may introduce a metalexical sequence to comment on the patient's lexical choice, in terms of the difficulty of translating it, its specificity, or simply to add emphasis.

It is the use of this last procedure in the translation of patients' descriptions of their emotional feelings that we address in this article, through the study of a corpus of health consultations filmed during 2016 and 2017 as part of the project "RÉfugiés, MI-

[3] In the transcript, turns in the original language are translated in italics on the following line.

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grants et leurs LAngues face aux services de Santé" (REMILAS) (Refugees, Migrants and their Languages in Healthcare Encounters).[4]

Metalexical sequences[5]

Metalexical sequences may concern cases where a speaker makes a comment about his or her own speech, as in the following excerpt where the psychologist asks a question about one of the languages spoken by the patient (Lingala):

Excerpt 5

PSY *is it a uh: a language like those from from (0.6) rural areas/* let's call them that / *and that's spoken less in the city/*

The psychologist adds a metalinguistic comment ("let's call them that") regarding her choice of the term "rural areas." This is what Jacqueline Authier-Revuz calls the "autonymic modality" (1993).[6]

It is another case that interests us here though, that of dialogical metalexical sequences (co-constructed among the participants) that emerge over several turns at talk between different speakers, and take the following form:

- the patient uses a certain word or expression to talk about his or her emotional feelings;
- in the next turn, the interpreter makes a meta-comment in which he or she points out the difficulty of translating the word, explains its connotations, or simply underlines its use, thus endowing it with particular importance;
- the sequence may continue with the intervention of the caregiver, who participates in the negotiation of meaning by proposing reformulations.

We looked for such sequences in the fourteen consultations between a mental health professional, an asylum seeker, and a professional interpreter in the REMILAS corpus (six interactions with a psychologist, five with a psychiatrist, three with a nurse as part of psychotherapeutic follow-up), representing approximately eleven hours of consultation in total. Perhaps surprisingly, if we compare this result with the abundance of word searches and the incessant work of reformulation on the part of the speakers, which testify to their dedication to "saying it right, finding the right word," or in any case demonstrate lexical work, such metalexical sequences are extremely rare in the data. We found only five in total and they appear in only two consultations. We therefore see that either the interpreter does not resort to this practice at all (as is usually the case), or that he or she resorts to it several times over the course of the interaction.

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[4] See the project website: http://www.icar.cnrs.fr/sites/projet-Remilas/.

[5] We distinguish these from "metadiscursive" sequences, in which the comment focuses not on lexical choices but on other discursive phenomena. For example, when the interpreter translates the patient's words and adds a comment on the organization of his speech: "That's where I last saw my father and my paternal grandfather (.) and he told me again what he said before: I didn't know where I was going to go."

[6] According to Authier-Revuz, "[t]he doubled mode of speech proper to the enunciative configuration of the autonymic modality [. . .] is always a suspension of self-evidence and naturalness, of the obviousness of a nomination: its forms appear as the enunciator's responses to their encounter, within their own speech, with the non-coincidences that constitutively affect that speech – that of the interlocutory relationship, that of the relationship of words to things, that of the discourse traversed by other discourse, that of words that contain the play of other words – when, locally, these non-coincidences present themselves to them" (1993, 88).

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Several hypotheses can be put forward to account for this rarity of the use of metalexical sequences.

One of them, interactional in nature, is that these sequences interrupt the flow of discourse, whereas interaction is generally governed by a principle of progressivity (Sacks and Schegloff 1973; Mondada 2012). Another may be linked to the bad reputation of such practices, which could be likened to the "translator's note" for the written word, described by Pascale Sardin as follows:

> The translator's note is probably so decried because, by breaking the unity of the text and decentralizing it, it exerts violence upon it, manifesting a crisis of translation's capacity to be homological, identical to itself, self-contained. The note signals a hiatus, the differential play that affects any translated text. As the place where the translator's own voice emerges, it betrays, as close as can be to the text itself, the dialogical nature of translation and the conflict of authority that is woven into it. The note is scandalous because it reveals in broad daylight that the "illocutionary disappearance of the translator" (Ladmiral 1994, 230) is only a delusion, that the translator never fades behind the author, but rather imprints the text with his or her subjectivity and the presuppositions of his or her own socio-cultural context. (Sardin 2007, 121)

For the same reasons, using a metalexical sequence may be seen as a practice damaging to the image of the interpreter's competence, making it seem as if he or she is not skilled enough to be able to translate everything — in the background here is also the model of the "translation machine," as denounced by researchers in interpreting studies (Wadensjö 1998; Baraldi and Gavioli 2012).

Reviewing the sequences reveals the recurrence of certain forms of statements that accompany them. They may concern an explicit description of the lexical usage made by the patient, of the type "She/he uses the word/expression"; "These are the terms she uses,"[7] or a distancing of the word chosen in the translation, as in "it's not exactly the word *x*" (Authier-Revuz 1993).

Metalexical sequences vary in length. A comment might be a single turn at talk following the use of a certain word or expression and highlighting its usage:

Excerpt 6

PAT hm (.) veç njate (.) domethene ky ankthi qe kam per (.) n'ofpra (.) euh (.) per te tjerat

---

[7] It is not the use of the terms "he" or "she" that should be noted here, but the whole of the statement that describes what has been said.

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hm (.) just that one (.) that is to say this anguish I have in relation to (.) ofpra[8] *(.) uh (.) as for the rest*

INT [just the

PAT [t'ja leme kohes
I leave it to time

INT just the::: how to say (.) for the str- not stress but ANGUISH/ (.) she used the word anguish in relation to Ofpra

NUR yeah\

In some cases, more complex sequences may also occur, as in the sequence below that we have chosen to analyze in detail.

Case analysis

This sequence (Excerpt 7) is taken from a consultation between the psychologist, Lucie, the Albanian asylum seeker, Annik, and the professional interpreter, Ilyana. It lasts about 2 minutes and 15 seconds and is the longest in the collection. The consultation, which began 45 minutes earlier, is almost over. The interaction was especially rich in metadiscursive comments: around minute 30, in fact, the psychologist made a comment on a French idiomatic expression ("*le courant passe* [things are really going well]"), which the interpreter explained to the patient. Then, within the space of fifteen minutes, the interpreter used three metalexical sequences to explain or highlight the words that the patient had chosen to describe the dramas she had experienced. In this sense, it can be hypothesized that, in paying particular attention to the nuances of language, the psychologist encouraged the interpreter to do the same.

Excerpt 7

PAT kam përjetu shum rand
i felt it very painfully

PSY well

INT cos I've (1.0) lived I've: (1.5) some very difficult things
(2.9)

INT it's not the word lived it's another word that I can't quite find
(8.2)

INT we don't use the word lived it's not really the verb to live

PSY to feel (0.8) to go through

The metalexical sequence is triggered by the patient's use of the Albanian word *përjetoj,* composed of the verb *jetoj* (to live) and the prefix *për*. The interpreter begins

[8] Ofpra stands for Office français de protection des réfugiés et apatrides (French Office for the Protection of Refugees and Stateless People). It handles applications for asylum.

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to translate, then she pauses and starts to search for the word, which she manifests with various signals (pauses, vocal lengthening, looking up) (Goodwin and Goodwin 1986). During the search, she uses the word "lived," and then — finding no other more appropriate term — completes the sentence. She could therefore have finished her translation there. However, after a fairly long pause (2.9), she initiates a self-repair (Schegloff 2007), i.e., she goes back to the word she used ("lived"), explaining that it is not the one she is looking for. Another long pause follows (8.2), while the psychologist takes notes in her notebook, and then the interpreter reformulates her comment on the inadequacy of the verb "to live," thus pointing out the impasse. At this point, the psychologist looks up from her notebook and suggests two verbs ("to feel" and "to go through"), thus collaborating in the interpreter's search for the right word.

(0.4)
INT hm no not even that you could say it's a play on words in Albanian
PSY hm hm
INT it's a (0.5) you add a (1.5) you add (1.4) uh be- before the ver- `basically the verb is to live and with it uh if you add a: a a prefix (0.8) it becomes
(1.7)
PSY to survive or °something°
INT not only it's not to survive (1.2) it's (3.2) to incarnate it it it it (0.2) something like to in- (0.4) incarnate

The psychologist's suggestion is rejected by the interpreter, who, after a pause (0.4), begins an explanatory sequence on the composition of the Albanian word *përjetoj*. At the end of this explanation, the search for the word remains open (as indicated by the unfinished sentence "It becomes" and the pause that follows), and the psychologist makes a new lexical suggestion ("*survivre*" [survive]) that reproduces in French the same composition process (a prefix meaning "over" + the verb "to live"). However, this suggestion is again rejected by the interpreter, who continues her search for the correct word and ends up proposing a new candidate, "incarnate"). However, this word is not indicated as being entirely satisfactory: it is not a perfect equivalent, but rather a term belonging to the same semantic field ("something like").

PSY something in the flesh
INT exactly (0.6) but what's the the prefix for it it it's it's the equivalent we have well in French I can't think of it right now (0.5) a: a: word that's like (0.5) but it's in the sense of incarnate
(3.2)

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PSY it's uh imprint (0.5) like a like a trace something
(1.3)
INT yes as if it left uh there you go (0.7) uh as i- uh
[if you like it's not] just th- live
PSY [leave an indelible trace]

In reformulating the interpreter's suggestion of the verb "to incarnate," the psychologist highlights the notion of "flesh" as the core of the expression. The interpreter aligns herself with the psychologist's formulation ("exactly"), then expands further on the meaning of the prefix and the difficulty of translating it into French. In the meantime, during the pause (3.2) the psychologist takes notes in her notebook and then intervenes with a new proposition centered on the notion of the "trace," which is accepted by the interpreter, but does not seem sufficient to bring the metalexical sequence to a definitive close. Immediately after this excerpt, the interpreter launches into a new explanation of the meaning of the expression, emphasizing the double status of the subject of this verb: the person in question is both agent and victim of the action in question. The psychologist shows her understanding of the explanation through head movements and verbal feedback, then takes notes in her notebook. She then announces that the consultation has come to an end. This information immediately triggers apologies from the interpreter — addressed first to the psychologist and then to the asylum seeker — for the length of the digression. In response, the psychologist reassures the interpreter of the importance of her explanations, and tells her that she has taken notes on the subject.

Considerations for application

This case analysis shows in detail the functioning of an especially complex metalexical sequence. The search for the "right word" initiated by the interpreter quickly turns into a collaborative activity in which the psychologist participates by making numerous suggestions. During this sequence, the participants dedicate more than two minutes to the translation of a single word used by the applicant to define her psycho-affective state, as they seem to consider that this word has a particular connotation that could be of interest for the interaction and the process of psychotherapeutic care. This interest is further confirmed by the fact that on several occasions during the sequence the psychologist takes notes.

This joint work on a translation problem, then, allows the psychologist access to nuances of meaning that would be lost in a more straightforward interpreting process. In this sense, the use of metalexical sequences may be considered as a practice to be

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encouraged in the context of psychotherapeutic consultations involving an interpreter. However, our research shows that the practice remains quite rare, probably for the reasons discussed above. Encouraging the use of metalexical sequences would first and foremost make it necessary to present the advantages of such a practice as part of the professional training of interpreters. In addition, interpreters could be encouraged to use metalexical sequences by the health professionals themselves. Indeed, it is worthwhile for healthcare providers to negotiate directly with interpreters as to the methods of translation they consider most appropriate for their needs — including the possible use of metadiscursive comments. Naturally, excessive use of these sequences would threaten the progressivity of the interaction. For this reason, healthcare professionals could also assist interpreters in the delicate task of determining which words or phrases "merit" special attention, based on the requirements of the care process. ◗

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A THREE-WAY DIALOGUE: THERAPIST, PATIENT, AND NTERPRETER

In this article, I will present the thought processes that a French interpreter may be called upon to go through in the context of a psychotherapy session with a non-French-speaking patient. To do so, I will recount an episode from my professional practice.

Mr. Lopez[1] has been a refugee in France for five years. His papers are in order, and after a very difficult and disruptive first year he succeeded in obtaining refugee status for himself and his family without too much difficulty. Their housing is adequate, and the children are in school and seem to be well integrated as far as I can see. This is my point of view when I compare the family's situation with that of many other families I know. Mr. Lopez, on the other hand, has a far more negative view of the time he has spent in France.

Neither Mr. nor Mrs. Lopez are in steady employment. They do not seem to have any friends in France and there is a great deal of tension between the couple. Mr. Lopez has requested mental health care. Following a review of his file and an assessment carried out by the care team, it was decided that he would benefit from psychotherapy with a psychologist accompanied by a professional interpreter. It was in this capacity that I became involved. The two professionals must always be the same, which can sometimes make the appointment process complex.

Mr. Lopez expresses himself very well in his own language, Spanish, but speaks almost no French. He has a university education and had a brilliant career for about ten years. He was of high social status, but all of this collapsed when he had to leave his country to escape threats against himself and his family. One of his relatives was also murdered.

We have known each other for a few months now, meeting every two weeks or so for a session that is supposed to last for one hour, but which frequently goes on for longer. Mr. Lopez was highly suspicious during the initial sessions: he would explain later on that, since arriving in France, he no longer trusts anyone, and is suspicious of everyone and everything.

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[1] Not his real name.

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Mr. Lopez talks a lot, speaks clearly, and is analytical. I find that he understands the language of his host country quite well, especially when I translate: he keeps an eye on me and at times makes sure that I am faithfully translating his words into French. He has even corrected me once, because he thought I had mistranslated a sentence, which occasioned a brief explanation about false friends in our respective languages. I occasionally check with him on the meaning of some of his expressions with which I am not necessarily familiar, since I speak the patient's language "European-style" rather than as it is spoken in his home country. On this subject, I think it is important to point out that we never entirely speak the same language as someone else, even when we come from the same country or region. Sometimes I also give brief explanations to the psychologist or patient of certain cultural differences when I feel it is necessary to understand the context. My interventions — apart from the strict interpretation of everything that is said by both parties — are brief and relatively infrequent, and I pay particular attention to make sure they do not hinder the fluidity of communication between psychologist and patient. While Mr. Lopez sometimes closely monitors the way I translate his words, I notice that when the psychologist speaks, he waits for me to translate rather than trying to understand her directly.

In the eighth session, the three of us — therapist, patient, and interpreter — began to work well together. During this session the psychologist asked the patient to talk about one of the most traumatic episodes experienced in his country. At first his words were very clear and translation was easy, but then he began to talk about the present, his current state of mind, and started to speak very softly and indistinctly: it was a highly emotional moment for him. He described his state of mind during this very hard period of his past life, but it blended with his present state of mind and he spoke about death.[2]

The patient then whispered a sentence in which I recognized only the words *fear* and *die*, but I could not hear the rest. I decided not to ask him to repeat this barely audible sentence because I thought it would interrupt what was becoming unblocked in him. So I had to guess what he meant. I had to make a quick decision: What am I going to do with these few words? It may be the present or it may be the past, it might mean "*I'm afraid of dying*" or "*I'm not afraid of dying*," and I felt like there was another nuance that I couldn't hear: "*I want to die*" or *"I don't want to die.*" I chose the solution: "*I was afraid of dying*." Then, during the course of the session, I realized what he had meant: now living in France, far from his home country, he is paradoxically afraid of dying, whereas the idea did not frighten him when he was confronted with very real danger back home, but when he had a task to accomplish and saw this danger as a risk inherent to his profession, something that simply had to be assumed. It was only a few minutes later that I understood my translation error, based on the context of other comments. I decided that I should not correct myself in front of the patient,

[2] In fact, this patient often goes back and forth in his story between past and present, in a way that is sometimes difficult to decipher. When it is really unclear, I believe that the very fact that past and present are merging is information that might be helpful to the therapist. I then specify, in the course of my translation, that here it seems that the patient has returned to the present, or that here he is plunging back into the past, or I sometimes specify that I have no idea where we are at all. All of this needs to be communicated very quickly and has to blend in with my other words without hindering the flow, but during these exchanges back and forth, the therapist also needs to be able to distinguish unambiguously which of the two voices are the patient's words and which are comments from the interpreter.

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since that could interrupt his story and shake his confidence in me, which it seemed to me was now well established, but had been difficult to gain and still felt fragile. So we continued until the end of the hour — or rather an hour and a half, because it was a long session. I hung around a while after the customary goodbyes were exchanged at the end of the session, and very quickly explained my misinterpretation to the psychologist. I knew that if I did it discreetly right away, she would be able to review any conclusions she may have drawn, and correct her notes.

Although my explanations above constitute long written sentences, at the time these processes lasted only a few milliseconds. On the way home I thought about what had just happened and I replayed the film: the monologue into which this patient entered, the thoughts that were in my head, and my intervention. I realized that during the course of a session I am constantly analyzing everything that happens — not only the words themselves strictly speaking, but also what may be behind them — but without ever overstepping my role, which is that of a simple messenger from one language to another. It is a little like when you have almost had an accident, and afterwards you go over what happened in your head and realize how complex the decision-making process is and what it implies in terms of your experience. It is only after having performed this or that maneuver thousands of times, having been confronted several times with this or that situation, that we become able to react in the best possible way. It is because I have been interpreting for a long time and have experienced this kind of situation in simultaneous interpreting many times that I can react so quickly. In simultaneous interpreting, when the interpreter does not understand exactly what the speaker means, they cannot interrupt the flow of speech. If they hesitate between different versions, they must quickly choose one of them so as not to leave any blanks, even if they later correct themselves if they realize a mistake has been made that could distort the general understanding. If it is an inconsequential error, one can let it go; if not, one makes up for it as soon as possible by adding a few words — which, with experience, often goes unnoticed by the listeners following the translation. In this case, I was not translating simultaneously and had plenty of time to make amends a few minutes later, but I chose not to do so for the reasons mentioned above.

One might think that the type of interpretation required for psychotherapy is quite simple, since most of the time it is consecutive (the speaker speaks one or more sentences in one language, the interpreter listens and then repeats this speech in the other language) rather than simultaneous (the interpreter listens and speaks at the same time, with a time lag of only a few seconds, which is deemed to be more difficult and, above all, requires a great deal of training). Most assignments that need to be fulfilled by a professional interpreter involve learning a whole range of specialized vocabulary, whereas in this context the vocabulary is very often that of everyday life, which may seem easy. On the contrary, I think that many things are hidden behind

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speech that seems simple on the surface but is obscured by the emotional context, and that the many choices the interpreter has to make during a session can lead the therapist down the wrong path. I also think that great agility is needed to avoid these pitfalls without affecting the fluidity of exchanges within the therapist–patient dyad. Indeed, we might ask ourselves the following question: Is it still a dyad, or should we call it a triad?

Conclusion

This article recounts a fairly common, even banal, episode that took place during a psychotherapy session in the presence of an interpreter, but it seems to me that it illustrates the importance within this field of calling upon professional facilitators capable of bringing into play skills that go far beyond the simple mastery of two languages, so as to give the patient–therapist–interpreter triad the best chance of functioning well.

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TRUSTING (EACH OTHER): COLLABORATION AND A RENEWED CLINICAL FRAMEWORK IN PEDIATRIC PSYCHIATRY

Establishing a patient-focused health care approach with an emphasis on recovery requires fluid communication in the appropriate language. From this perspective, interpreters occupy a central role in exploring how individuals use particular words or expressions, and thus make sense of their experience of suffering. Without professional interpreters, mental health care professionals cannot truly learn about the feelings, needs, and resources of their patients (Hanssen and Alpers 2010). Interpreters are not only translators of the verbalized world (Leanza 2005). They enable the integration of different models of care present in the professional–patient relationship, particularly by facilitating understanding of the cultural, social, and contextual variables of the patient's difficulties, and his or her personal circumstances — all vital information for clinicians.

Several studies underline that, despite all these advantages, a majority of health care professionals report numerous difficulties in working with patients who do not speak the same language as them and the interpreters accompanying these patients (Kotobi, Larchanché, and Kessar 2013; Raval and Smith 2003; Favereau 2010). Among other challenges, they identify loss of information, lack of time, ethical questions posed by the presence of a third party, the fact that the translation process draws out the length of the consultation (Rosenberg, Leanza, and Seller 2007), and difficulties moving from a dyadic to a triadic relationship — experienced as disrupting the encounter and the connection between patient and caregiver (Tribe and Morrissey 2004). In the context of mental health care in particular, the impartiality of the interpreter is often subject to debate, with professionals underlining the risk of the words spoken in the interaction becoming distorted (Leanza et al. 2014). They also mention feeling excluded from

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the exchange between the patient and the interpreter, and a loss of control over the dynamics of the formal interaction (Rosenberg, Leanza, and Seller 2007; Tremblay 2011). It is true that working with an interpreter affects the dynamics of the clinical consultation. Through his or her presence, the interpreter influences the relationship with the patient and, as a result, the quality of care. The triadic relationship thus calls for some adjustments to how the clinical consultation is conducted, which for the health care professional involves being able to challenge the dominant model of practice (Leanza et al. 2014).

To better understand and situate the issues and struggles around the presence of an interpreter in the clinical system, this article draws on the "TCP triangle" (Trust-Control-Power) model created by Camille Brisset, Yvan Leanza, and Karine Laforest (2013). This model treats the consultation space as a "social space" in which patients, interpreters, and health care professionals deal with the relationship issues that affect their interactions. The triangle schematizes this relational dynamic, which oscillates between trust, control, and power. First of all, establishing a relationship of trust is a key issue when working with an interpreter. Health care professionals understand that an alliance with the interpreter is necessary, but the latter's presence can introduce a sense of loss of intimacy with the patient. Interpreters, from their perspective, can be faced with ethical dilemmas when patients tell them information that is new to the health care professionals. As for the patients, the notion of "trust" can involve a shared identity with the interpreter — but this cultural proximity can sometimes provoke suspicion. Second, the notion of "control" relates to the need felt by health care professionals to be able to guide the proceedings of a consultation and verify the accuracy of translated speech. In the presence of an interpreter, the fear of losing control of the consultation leads health care professionals to implement various strategies, such as suddenly stopping exchanges or simply no longer employing the services of an interpreter. Finally, the "power" dimension can be connected to factors outside of the consultation, such as institutional constraints — time restrictions on the consultation, budget, or the rest time granted to interpreters.

The model's authors (Brisset, Leanza, and Laforest 2013) underline that if these various active relational dynamics (trust, control, and power) are not regulated, the connection with the patient risks becoming weakened, as does the capacity for collaboration between the health care professional and the interpreter. From our research experience, we can also connect these issues to a lack of practice and training for health care professionals around working with an interpreter. The absence of such training prevents health care professionals from putting their trust in the interpreter and from acquiring the tools enabling them to structure an interview in their presence. We suggest that the

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move from a position of suspicion to one of trust requires the interpreter and the health care professional to receive training or support *simultaneously*. The recommendations of health care consultative bodies regarding the necessity of using interpreters (HAS 2017), and the numerous publications on strategies for working effectively with an interpreter (Björn 2005; Hays 2008) are not enough to enable health care professionals to overcome the obstacles they encounter in the field. As Yvan Leanza et al. (2014) underline, these directives are limited to “a list of technical tools”[1] that do not make the connection with the context in which health care professionals and interpreters are applying them. This suggests the potential of training where interpreters and clinicians interact directly and modify their collaboration — such as training in the field (Davis et al. 1995; 1999). Ideally, this training would form part of the initial training of health care professionals, or at least be part of the continuous professional development on offer (Brisset, Leanza, and Laforest 2013). As of today, this field training is rare and its impact little documented.

The research context

Faced with these challenges and struggles, the Centre Minkowska[2] developed an action-oriented research project aimed at improving the collaboration between mental health care professionals and professional interpreters. This research was undertaken in collaboration with the department of psychology at the Université Laval in Quebec[3] with the financial support of the Fondation de France.[4] Five CMPs (centres médico-psychologiques, see note 3) took part in the research, with each receiving funding for two interpreter follow-up studies, which involved one intervention a month for eighteen months. Training was offered to each CMP halfway through the research period. Beyond theoretical content on working with an interpreter in mental health, the training also offered a space for analyzing practice and for role-play. None of the health care professionals had received specific prior training on working with an interpreter. On the other hand, all the interpreters had received training on interpreting in health care.

Trust as a prerequisite for trying new methods of care in the clinical context

The French verb “confier” (which can be translated into English as “to trust”) comes from the Latin *confidere* (*con* is from *cum*, which means “with,” and *fidere* means “[to] trust”). It signifies an acceptance of giving something precious to someone, putting one’s trust in them, and to a degree surrendering oneself to their kindness and good faith. To trust, one must be able to trust others and accept the risk of dependence and uncertainty on the basis of optimistic beliefs regarding the intentions or behavior of the

[1] Translator’s note: Our translation. Unless otherwise stated, all translations of cited foreign language material in this article are our own.

[2] The Centre Minkowska is a nonsectorized CMP (centre médico-psychologique) in Paris, offering person-centered transcultural psychiatry. CMPs are district-based mental health clinics that organize outpatient care.

[3] Yvan Leanza, Audrey Marcoux, and François René de Cotret at Université Laval, along with Daria Rostirolla at the Centre Minkowska, participated in the development of the project by collecting data and analyzing results.

[4] Project #00051304, “Humanisation des soins” (“Humanisation of treatment”).

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other. One must have had the experience of being understood very early in life in order to be able to understand. Our capacity to understand our subjective states is not innate, but is essentially intersubjective and built through relationships. For babies to develop this capacity for themselves and for others, their own behavior must be understood by their parents in terms of needs, emotions, and mental states. Children's mentalization capacities, sense of security, and ability to reflect all depend on the ability of their parents to reveal the world "in small doses" and to contain their children's affects. The trust that this sense of security engenders is essential for accessing all forms of learning (Fonagy, Steele, and Steele 1991).

In a foreign country, following an immigration process that is often traumatic, parents find themselves in a situation of insecurity. In addition, their mentalization capacities are reduced — for themselves, and even more so for their children. The patients that we encounter have very often been repeatedly misinterpreted and have often felt unable to make themselves understood. They often feel persecuted and that they are in a hostile environment (Martin 2015). How can we support these parents to enable them to help their child when the latter is displaying behavioral problems and learning difficulties in the context of immigration and resettlement? Can we heal without understanding?[5] We have often asked ourselves this question at our CMPP (centre médico-psycho-pédagogique)[6] in Massy, where the families of three quarters of the children treated speak a wide range of languages.

Stéphanie Larchanché trusted us to participate in this research, as did Djamel Khouas, whose work went much further than that of interpreter, and who accepted the task of working in therapeutic family consultations. Stéphanie Blondel, our psychologist colleague, agreed to take the child into therapy and to participate in group consultations. The family accepted this collective endeavor. We all put our trust in one another, and we all felt stronger together.

Ismaël, the tornado child

It was the daycare psychologist who referred Ismaël, a "tornado child" tearing through the daycare space and taking with him everything in his path. This was in 2015, when he was three years old but only spoke a few words, either in French or Arabic. His parents, originally from a country in the east of Africa, had arrived in France three years earlier. The mother, an undocumented migrant, hid at home for more than a year, in a state of loneliness, anguish, depression, and hypervigilance about her surroundings. It was in this context that she found out she was pregnant with Ismaël. Pregnancy and childbirth were synonymous with the hope for a new life, but also revived past trau-

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[5] ISM-Minkowska symposium, April 8, 2019, Ministry of Solidarity and Health.

[6] Centres médico-psycho-pédagogiques (CMPPs) are similar to CMPs, but specifically look after children and teenagers with complex mental health needs, with close collaboration between psychiatrists, pediatricians, and other health care professionals.

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mas; both parents had lost their mothers when they were teenagers, both dying in childbirth.

Ismaël started attending daycare at the age of two and a half, when his younger sister was born. For him this was a triple separation: from his mother, from the family environment, and from the Arabic he spoke at home. When Ismaël witnessed or experienced separations, he had fits of tears and anger. He was particularly distressed by the cries of other children, by noises, frustrations, and the least display of authority by adults. To calm himself down, he would grab a telephone or a notebook to jot down notes in the manner of adults. The daycare team could not be at any distance from him, even behind a glass door. The team had little interaction with his father, who was very busy with his work, and even less with his mother, who did not speak French. We decided, therefore, to offer them therapeutic family consultations with an interpreter, as part of the joint research project run by ISM Interprétariat and the Centre Minkowska. This work was an essential prerequisite for the establishment of a "classic" care system and continued after the end of Ismaël's individual care.

Ismaël underwent a neuropediatric exam, a psychomotor assessment, and a psychometric test that confirmed our clinical diagnosis of reactive attachment disorder (RAD) (Guédeney et al. 2012). Our social worker helped the family to apply for a special needs teaching assistant so that his integration into a school could, at the very least, be conceivable, in very close collaboration with the school. Ismaël then joined a small "nursery rhymes" group and received individual psychotherapy at the CMPP. Family consultations with the psychologist and the interpreter have taken place for the last three years. It would be impossible to summarize the complexity of this undertaking in this article, but we can still try and illustrate it in terms of self-representation.[7]

It is worth pointing out that mark-making did not interest Ismaël at all and that it was extremely difficult to get him to "leave traces," even more so to get him to color in or to talk about his drawings. His final "self-portrait" also illustrates the work we did together on recognizing the emotions of others, which gave rise to wonderful discussions on how to name and express emotions in French and Arabic.

At the beginning of our sessions, Ismaël would pick up a telephone and despair when he could not find a speaker on the other end of the line. He asked to turn on the computer or to be given his father's cell phone. This showed us that the family lived in almost permanent contact with their relatives back home and that they sometimes celebrated "together" over Skype or FaceTime. The parents said that our sessions evoked these situations for Ismaël, who thus sought to re-establish the link with his family.

[7] A series of four drawings, chronologically ordered, show an overall evolution of Ismaël's self-representation: the first two drawings show undefined forms (in the lines as much as in the shapes), while the next two drawings represent "little guys" (self-portraits), whose more precise lines reveal distinct emotions ("happy").

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Gradually, as the tale of his parents' immigration progressed, the repetitive games with the telephone were replaced with a representation of their migration in a game using toy cars, a toy house, and toy people. In this traumatic and unchanging game, he threw all the people and furniture into the house in a state of haste and anguish. He then hooked a tractor trailer to a fire engine, which was to tow the house. We often moved around the office observing the collapse of the ensemble and Ismaël's powerless fury.

Bit by bit, as the game was repeated, the house survived better and for a longer time, but on arrival, the people had to fight and ward off those inside, who were seen as threatening: "*Get out of the way, this is our house!*" These scenes were reminiscent of the fights he waged relentlessly in the schoolyard. It took some time for Ismaël to accept, with his sister's help, that the people could get down from the truck without fear and share a meal with "the hosts." The perception and representation of his family also evolved, nicely illustrated by his pictures of "the family in a boat."[8] In a third picture, his father has fallen in the water and climbs back up with the help of a ladder, while in the last drawing in the series, his parents drive the boat together and "we can go to Africa and England, because we are French" (the flag drawn by Ismaël uses the colors of the French flag).

The benefits of working with an interpreter

From the first consultation with the interpreter present, the family's perceptions changed. The interpreter's presence led them to feel sufficiently confident to challenge us and invite us to imagine ourselves in a similar situation, in a foreign country, unable to properly explain the illness of a loved one or to understand the explanations of health care workers.

Throughout this work, the interpreter's presence enabled them to re-establish bonds of trust with their environment, and to have a mediator to translate words, gestures, and codes. The quality of the interpreter's presence facilitated the identification of the parents with the nursing staff and gave us all the opportunity to notice Ismaël's identification with the interpreter.

The interpreter helped us to understand the importance of setting up meetings with the parents alone and of having a symmetrical relationship with them. He also helped us to understand how much they wanted to protect their children from their traumatic past and help them give it a communicable form. Once the parents recognized themselves in the way the therapists understood them, we saw that the children in turn were able to recognize themselves in the way their parents understood them.

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[8] The illustration shows Ismaël's father drives the boat to go to Paris, but he is in the water under a very hot sun. Ismaël clings to the mast, split in two, between his mother and his sister. In the second drawing, the boat is on the water but "we are going to the pool in the sea" (following their first family holiday in Normandy).

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For this to happen, the interpreter had to be given a place of his own. In contrast to interpreting in other fields, interpreters in mental health care contexts cannot be beholden to the famous “neutrality” that is often recommended and even required in their work. Neutrality, in general, remains a quest for the interpreter, and in mental health care contexts, it is more than a quest. It becomes a chimera. In their role, in mental health care contexts, interpreters can be allies for patients overwhelmed by the gears of the medical machine. They can be, in addition or at the same time, a valuable cultural expert for the “impressive” health care professionals. As such, the position of the interpreter in mental health care contexts is optimal when it is shifting. We can talk of impartiality in the place of neutrality. We can even dare to use the idea of multi-partiality, which well expresses this spirit of flexibility and itinerance, vital for interpreters working in medical-social contexts.

However, the positioning of the interpreter depends on the health care professional who requires his or her services. Beyond the trust between the caregiver and the interpreter, briefing and debriefing sessions were necessary so that real collaboration could take place. The interpreter, in this way, could become the custodian of the patient’s words: it is the patient who decides, without the caregiver having a say. From this moment on, the interpreter becomes a co-therapist.

While we, CMPP professionals, were nervous about working with the interpreter at first, we gradually came to find it very relaxing. It gave us time to reflect, to observe, to uncover the meaning of words in the language of another, and to welcome the interpreter’s confirmation. In the end, we played together in a space of potentiality, which allowed us to experience this work as a game — with all the seriousness and all the involvement that this represents for children.

A point common to all journeys, whether they are migrations for economic or political reasons, a way of life, adventurous expeditions, projects of knowledge or healing … is that they achieve completion through meeting others who transform the voyager. (Moro and Mestre 2011) ◗

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TRAINING INTERPRETERS FOR THEIR INVOLVEMENT IN MENTAL HEALTH INTERVENTIONS: THE DEVELOPMENT OF A TEACHING KIT

In Western European countries, mental health institutions are caring for an increasing number of migrant patients who have little or no ability to speak the local language. In order to avoid language discrimination when it comes to care quality and accessibility, these institutions usually have no choice but to use third-party interpreters. In terms of the profile of these third parties, the literature highlights the importance of entrusting linguistic and cultural mediation to trained professionals, even more so in psychiatry than elsewhere (Bauer and Alegría 2010).

In other French-speaking countries, interpreting professionals working in the health sector tend to be called "public service interpreters." However, in French-speaking Switzerland, where our project is based, the official designation is "community interpreter" ("interprète communautaire"). Thanks to various federal authorities and associations, these interpreters working in our country are able to acquire a certificate and a qualification recognized at the federal level.[1] In interpreter training courses, work in the field of mental health is the subject of specialized teaching. Clinicians working in mental health also have access to a growing number of training opportunities to learn or improve their skills in working with interpreters.

Training courses preparing health professionals and interpreters for their joint interventions generally aim to provide the knowledge, skills, and attitudes that promote functional practices in line with the goals of clinical consultations. In mental health care, one of the main challenges for clinicians and community interpreters is the ongoing

[1] Information on community interpreting and intercultural mediation in Switzerland can be found at www.inter-pret.ch.

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need to adapt and adjust their respective practices (Bot 2005; Delizée and De Ridder 2016). The wide range of settings and activities that make up contemporary psychiatry confront the triad of patients, interpreters, and clinicians with a variety of challenges. In order to contribute to a better understanding of these challenges, the research team of our transcultural psychiatry unit (consisting of a linguist, two psychiatrists, and a psychologist) decided to study the difficulties that predominate in psychiatric or psychological investigations. From the outset, the aim was to contribute, on this basis, to the training of interpreters and clinicians.

Psychiatric investigations are important for enabling migrants to access health care. But the literature (Farooq et al. 1997; Guex and Singy 2003; Brisset et al. 2013), as well as our initial observations in the field (Weber et al. 2017) show that they are particularly challenging for professionals who have to work in triads. Several observational studies have questioned the quality of the practices of professionals — especially interpreters — involved in triadic investigations (Farooq et al. 1997). These investigative processes also appear to be particularly tricky in terms of relationships. People involved in these encounters must often get to know and trust each other in a context where clinicians are afraid of missing essential diagnostic clues owing to insufficiently rigorous linguistic mediation. As a result, there are still major concerns and uncertainties among professionals, as well as tensions related to issues of control and power (Guex and Singy 2003; Brisset et al. 2013).

With the aim of promoting practices and strategies useful to interpreters, clinicians, and patients interacting in psychiatric investigations, we filmed and analyzed several clinical consultations. In accordance with the principles of action research (Nikodemus and Swabey 2015), we then designed and tested teaching interventions, and produced and put online a teaching kit for trainers and self-taught interpreters.[2] A similar kit to be used as part of training courses for clinicians is in preparation.

The aim of this article is to introduce and showcase the main outcome of our project — the teaching kit we produced — with the hope of thereby encouraging its dissemination. First, we shall briefly relate the scientific and didactic process that led to its creation. Additional methodological details and information about the procedural side of our investigation are available in a previous publication (Weber et al. 2017).

Multidisciplinary analysis of consultations

Our analysis of consultations was focused on understanding how inter-professional collaboration and interpreter involvement in interventions could be improved in triadic

[2] The dossier can be consulted here: www.hospitals4equity.ch.

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psychiatric investigations (i.e., those involving a patient, clinician, and interpreter). Given the composition of the team in our unit, we opted for an interdisciplinary study combining a clinical and a discursive approach. The research is based on video recordings of triadic psychiatric investigations, transcribed and translated by another interpreter. The videos were then subjected to a clinical analysis listing all the clips in which the interpreter's renderings or the collaboration between interpreter and clinician complicated or limited the investigative work. These clips were then subjected to a linguistic analysis focusing mainly on:

- turn-taking, interruptions, non-verbal assignment of the following turn, and so on;
- actions aimed at preventing and repairing misunderstandings;
- coherence and relevance in the original statements and the interpreter's renderings; and
- the way in which participants in the triad manage potential relational tensions in exchanges (known as "face-work").

This double analysis led us to formulate hypotheses linking the clinical and linguistic observations, which will be the subject of a more extensive publication. These hypotheses relate mainly to six challenges, some of which concern both health professionals and interpreters, and some of which concern interpreters alone. These challenges are summarized below in lay language and only from the perspective of the work of interpreters, as interpreters are the focus of the teaching material presented below. Our analysis shows that when faced with these challenges, professionals select certain options and discard others. These choices — often made unconsciously — may have consequences, some of which are less clinically desirable than others. These challenges can therefore be spoken of in terms of clinically sensitive interactional pathways, which is what makes them so interesting for training purposes.

Six challenges for interpreters

1. Language that is difficult to understand (confusing explanations or stories, off-topic answers, neologisms, and so on)

Interpreters are often confronted with speech whose internal logical connections, as well as its connections to the broader interactional context (for example, that of an answer to the previous question), are difficult to understand. Another difficulty stems from the use of neologisms. Interpreters can then render this type of speech, usually uttered by patients, in a way that is more easily understood by or useful for clinicians. Doing so, however, deprives psychiatrists/psychologists of decisive information, especially on a possible disorganization of speech and thought in the patient. As an alterna-

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tive, interpreters can meta-communicate about the comprehension and/or rendering difficulties they are experiencing, and then limit themselves to rendering elements or themes that they are sure they have understood. Another option is semi-simultaneous interpretation (whispering).

2. References to emotions and subjective perceptions

When the words exchanged contain references to emotions and subjective perceptions (for example, feeling that something is of concern to the other person), clinicians express a need for particularly precise renderings. This need for precision applies both to what patients say about themselves and to clinicians' interventions, particularly when they investigate patients' experiences or present their vision of the situation with reference to emotions or perceptions. Meta-communicative exchanges between professionals are particularly important if statements dealing with emotions or elements of subjective experience put the interpreters in difficulty (for example, if a word for an emotion has no direct equivalent in the other language, or if a subjective formulation by the clinician is very complicated and seems to be misunderstood by the patient).

3. Sensitive comments in relational terms

Certain comments made by clinicians and patients may be perceived by interpreters as likely to create or reinforce relational tension within the triad. Interpreters then have the option of either delivering renderings with a similar conflictual charge or of mitigating this charge through subtle changes in meaning. Clinicians view the second of these options as problematic, fearing that they will be deprived of important elements about both the patient's relational functioning and the evolution of the therapeutic relationship.

4. Clinicians' concluding interventions (statements not leading to a question-answer alternation)

Before asking a new question, clinicians who have just heard a patient's response or story often summarize very briefly what has been said. These concluding interventions, which are a kind of addition to the main question-answer pattern used in the consultations, comment on what has just been said or are a way for the clinician to make brief observations. These brief interventions are sometimes important both clinically and for the therapeutic relationship. Sometimes they are rendered by the interpreter, but on other occasions they are omitted.

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5. Interruptions while the interpreter is speaking

Interruptions by one of the other two parties often occur while the interpreters are still in the process of rendering what has been said previously. In such cases, it is important to remember all the new elements that have been said, as well as all the elements that have not yet been rendered. Some interpreters have impressive memory skills in these situations, but despite this, they often lead to significant loss of clinical information, as well as to the large-scale reorganization of speech, which can, for example, mean that problems of coherence in the original words of the patient are overlooked (cf. challenge one). Meta-communicative exchanges between clinician and interpreter may prove essential in such cases.

6. Non-verbal elements

Gestures within the communicative scope of patients and clinicians are sometimes understandable without translation, but certainly not always. Non-verbal codes also vary greatly from one language community to another. Interpreters therefore have the difficult task of identifying situations in which it is useful for them to intervene actively in the communicative gestures exchanged, and then to choose a method of rendering: either explaining the gesture verbally or substituting it with an equivalent gesture that the other party can understand.

Implementing the results in training

Alongside undertaking an analysis of the results, we began to use them and the consultation extracts in various training activities. In particular, Orest Weber was asked by the association Appartenances to contribute to the continuing education of community interpreters as part of the module “Interpreting in the field of mental health,” within classes focusing on interpreting techniques and the practical handling of particularly difficult speech. The lessons developed for this module last three and a half hours in total and have been delivered three times over the last four years, meaning that the feedback and ideas from the participants and the training organizer could be used to gradually adapt them. The high levels of interest in and satisfaction with the lessons led us to think that it would be appropriate to produce a teaching kit that could be used by other trainers.

A teaching kit for the training of interpreters

The teaching kit developed for interpreter training courses is a support for courses offering specialization or in-depth study in the field of mental health interpreting,

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particularly in a context of psychiatric investigation. It is primarily designed to be used in face-to-face teaching that combines reflective group discussions and moments of individual practical experimentation and note-taking. However, the material is also designed to allow for self-directed use.

The lessons in the teaching kit aim to:

- improve participants' awareness of some of the key challenges encountered in mental health interventions, particularly in psychiatric investigations;
- improve participants' ability to recognize aspects of speech that are important to clinicians and that require particular precision in their renderings, and to adapt their practice accordingly;
- improve participants' ability to recognize elements that warrant being addressed in a meta-communication, and to carry out this meta-communication.

The teaching kit is structured around four extracts, each of which addresses one or more of the above-mentioned challenges. For each extract, there are six documents:

- an introduction to the challenges present in the extract;
- background information about the extract, along with the starter question(s) for the reflective discussion;
- the extract itself;
- a list of probing questions to ask participants;
- a worksheet for learners to record their observations (lessons learned and potential strategies); and
- a commentary on the extract that also contains a list of lessons and strategies that can be suggested to participants.

As an example, below we present some of the documents accompanying the first of the teaching kit's four extracts. Alongside the extract itself are the starter questions, background information, and the commentary on the extract. Extract one focuses on challenges two, three, and four: references to emotions and subjective perceptions; sensitive comments in relational terms; and clinicians' concluding interventions (statements not leading to a question-answer alternation).

Extract One: Starter questions, background information, and transcription[3]

Starter questions for discussion/reflection

What are the challenges for the interpreter in this passage? How does she address them?

[3] In the transcription of extract one, words originally spoken in French are reproduced in Roman characters, while words spoken in the patient's language (Dari Persian) are in italics. "°"= low volume (as in line 4); "[ ]" = simultaneous (overlapping) speech (as in line 3); "C" = clinician; "I" = interpreter; "P" = patient.

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What good strategies are used or could be used?

Background

This extract is taken from the patient's third consultation with this clinician. The beginning outlines of the evolution of the situation and symptoms since the last consultation. The patient's divorce is the first major topic that is introduced by the clinician and will be the subject of a large part of the consultation. The patient had previously mentioned this divorce, but had never discussed it in detail with the clinician. This passage shows how the topic is introduced and what discussion this introduction triggers among the participants:

1. C: Mhm. In any case, I get the feeling that this is something that concerns you a lot, because
2. you've often mentioned it, without going into more detail. So I'm thinking [maybe]
3. I: [*She says*]
4. C: °That concerns you a lot°
5. I: *Anyway, I see that you're very concerned about this, every time you talk about it*
6. *You're sad, without further explanation.*
7. P: *Well, if no one asks you the question*
8. I: [Yeah]
9. P: [*You can't*] *respond like that right off the bat.*
10. I: When I'm not asked the question, I can't answer uh without question
11. C: Mhm, of course… Were you married for a long time?
12. I: *How long ago did you get married?*

Extract One: Commentary on the extract

The terms used to talk about subjective experience

Here we have an example of investigation of the patient's emotions. The clinician begins the discussion by explaining, on line 1, that she senses the patient's concern about the divorce. This element is taken up by the interpreter (line 5), but the interpreter also makes an addition (line 6) that the clinician did not say and that expresses a specific emotion: sadness.

The interpreter may have added this element so that the patient can better understand that the clinician is interested in his emotions. But this way of translating can have a problematic consequence (which is not observable here): if the patient speaks of sad-

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ness, the clinician will think that he does so spontaneously, when in reality it is the interpreter who has put this word in his mouth. Both parties using the precise terms for emotions is often key to effective work in psychiatry and psychotherapy.

Another challenge for the interpreter is related to the terms used by the clinician to talk about her own subjective experience in relation to the patient's situation: "*I get the feeling*" on line 1 and "*I'm thinking [maybe]*" on line 2.

Our observations are that these elements are often conveyed to the patient in a less nuanced manner (here: "*Anyway, I see that*," on line 5), which does not allow the patient access to the hypothetical nature of what the clinician is saying. Such elements, which can easily go unnoticed, require special attention from the interpreters in order to be translated. However, for clinicians, these elements generally seem less important than the words that are used when talking about patients' emotions.

Lessons learned

- Mental health clinicians need the most accurate information possible about patients' emotions and subjective experiences.
- When rendering clinicians' questions, it is very important to be precise so that clinicians know exactly what patients are responding to.

Potential strategies

- Focus particularly on memorizing terms and expressions related to emotions.
- Meta-communicate with the clinician if questions are too long or complex to allow precise translation and, if necessary, ask him or her to rephrase the question more simply.

Statements outside the question-answer alternation that are relevant to the therapeutic relationship

In this situation, there is a kind of negotiation of responsibilities between the clinician and the patient. It is triggered by the clinician telling the patient that he has barely discussed with her the subject of his divorce. The patient's reaction suggests that he interpreted this remark as a criticism. The patient undertakes to explain why this topic has not been discussed in any depth in previous encounters: the clinician has not asked him the question. So here we find ourselves in a difficult relational moment of the type "*it's not my fault, it's yours.*"

In this context, it is particularly important that the clinician responds by saying "*of course*" (line 11), thereby signaling that she is validating the patient's point of view. This

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feedback is not repeated by the interpreter (line 12), who simply translates the question put to the patient. In general, it can be observed that the elements of the questions and answers are often given priority in translation over the rest of the content of the speech. Questions and answers are essential elements of the content of exchanges, but the work of translation cannot be reduced to these elements, especially in a clinical context where the discourse as a whole is of prime importance for the relationship and therapeutic work. Interjections outside the question-answer alternation are elements that can easily go unnoticed, but can be of great importance in certain situations.

Lessons learned

- Statements that are not part of a question or answer are particularly likely to be overlooked in translation.
- Sometimes these words may seem insignificant, but are important, for example, because they play a role in delicate relational moments.

Potential strategies

- Pay attention to speech that is not part of a question or answer.
- Observe whether tensions arise and pay particular attention to precisely translating words that reinforce or dissipate the tension.
- Translate short concluding remarks immediately, before the clinician asks the next question.
- Meta-communicate with the clinician to request agreement for a semi-simultaneous whispered interpretation (chucotage) of short concluding remarks if time for consecutive translation is lacking, and then practice in this way.

Conclusion

Our experience in interpreter training shows that discussions triggered by extracts such as the one presented here are lively and rich. It is usually possible to help participants formulate for themselves many of the ideas, lessons, and strategies contained in the commentary above. It is striking that interpreters often begin the training with some ideas about what is expected of them in mental health, including renderings that reproduce the original words as closely as possible without trying to make them more understandable to the recipient. They find it all the more useful to look closely at real-life exchanges and to reflect, on this basis, on how one can practice one's profession with professional conscientiousness, but without undue guilt in the face of such a horizon of expectations.

To support the effective impact of the reflections on practice — and consequently on the quality of the interpreters' work and their well-being — we offer as many practical

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exercises as possible in the lessons (strategy tests, role-play). Participants also leave the lesson with the task of using what they have learned in subsequent psychiatric interventions and discussing it with their colleagues in future lessons.

In conclusion, it should be noted that one of the main strengths of our training — its clear focus on precisely rendering speech in areas that are key in the context of mental health clinical practice — is also its main limitation. The focus of our lessons remains largely on the most central and consensual mission of interpreters: the mediation of language (and physical gestures). The only other activity we focus on is meta-communication, which allows interpreters to talk about their difficulties in order to inform the clinician and/or to discuss possible solutions with him or her (e.g., semi-simultaneous interpretation). However, it is now well established that the activities of interpreters in the mental health field are much more diverse in practice (Bot 2005; Delizée and De Ridder 2016), going far beyond these two activities. Training such as ours is therefore by no means sufficient to prepare interpreters for their work in psychiatry, and other contributions are essential. We are thinking, for example, of exchanges of information between clinicians and interpreters about potential relational, emotional, and cultural challenges with certain types of patients (for example, patients with decompensated psychosis, suicidal individuals, and so on), but also of reflective work about the whole broad spectrum of tasks and missions that interpreters can perform in psychiatry (support in social services settings, contribution to diagnosis, general provision of contextual and cultural information, and so on).[4] ◗

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WHAT MEDIATION IS USED IN INTERPRETING PRACTICE?

Speaking another language involves carrying within oneself all the systems of signifiers that are encompassed by that language. Interpreting beyond language suggests that one can grasp words and weave meaning from another linguistic system. The profession of interpreter, which differs from that of translator[1] by the degree of presence, and therefore of involvement, is far from being so simple. What part of oneself is involved when one takes the risk of grasping, through words, the psychic universe of an individual in order to transcribe his or her words? Having worked as an interpreter in the social setting[2] for many years, I have been confronted with a wide variety of situations and difficulties. I have thus developed different ways of looking at interpreting — sometimes critical, sometimes amused, sometimes astonished — especially in view of the situations we interpreters encounter, which do not correspond closely to the expectations or the idea that people have of this profession.

In health care and mental health care contexts, the issue of the reception and follow-up care of patients who speak other languages is a central concern for caregivers. The geopolitical situation and the reality of the precarious situation of patients who are either "economic" or "political" migrants, or who have come to be in France as a result of human trafficking, poses a challenge for professionals, who must therefore adapt their practices. When caregivers need to understand people who do not speak their language, using an interpreter is an obvious solution, yet one that remains controversial.

In France, very few specific training courses for interpreters exist in the mental health, social, and other fields for which they are required. Thus, for several years now, "do-it-yourself" forms have been developed among professionals and interpreters, creating almost exclusively empirical knowledge to compensate for their lack of resources. Although multidisciplinary arrangements for monitoring patients who speak other languages have existed for many years, very few interpreters have been integrated into

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[1] The terms translator and interpreter are often confused. As far as the term translator is concerned, the most common definition would be a person who translates, who transposes a text from one language to another. An interpreter would be defined as a person who orally transposes from one language to another or acts as an intermediary in a conversation between people speaking different languages.

[2] An "interprète en milieu social" (interpreter in the social setting) is the term most commonly used in France to refer to interpreters working for public services.

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these as professionals in their own right. It can therefore be seen that the use of an interpreter is based on a need for linguistic understanding rather than a real desire to provide a multidisciplinary approach or support. However, language and language comprehension are central, as they enable health professionals to establish an "analysis" and set up a therapeutic framework, particularly in the field of mental health care, for example. Therefore, when language is lacking, it is often the whole system that is called into question. Some health professionals may be resistant to using interpreters, and will in particular be opposed to changing their approach and working methodology in the interpreter's presence. These professionals want the interpreter to provide a "literal" translation and maintain an unfailing "neutrality" when dealing with people with psychological disorders and pathologies that increasingly question the specific characteristics of the migrant population (Pestre 2019). Indeed, the presence of a third party can modify the dynamics and issues within the therapeutic process, creating difficulties for certain professionals. Interpreters may then be perceived as hindrances, and sometimes rightly so, particularly when they do not understand the place they occupy and the issues at stake in the consultation.

There is a certain amount of confusion, even tension, around the figure of the interpreter and the definition of his or her role. Many of the difficulties faced by interpreters when practicing their profession show the extent to which their presence has a revealing function, as it highlights dysfunctions in the way some professionals conceive of working with a third party. In the case of the interpreter, this third party is neither a colleague, nor a patient, nor a collaborating professional. It also reveals existing problems in the way of conceiving reception, relationships, and otherness in care, and these are also issues that are raised when it comes to caring for patients from a migrant background.

Interpreters also represent the possibility of dealing with elements other than that of language alone. Questions surrounding the concepts of "neutrality," the "cultural," and "language," among others, have put to the test the role, the place, and some of the working methods of interpreters in the field of care. Because of the role interpreters play in the care process, but also because of the place they occupy in follow-up care and the contributions they can suggest thanks to their way of understanding various situations, questions arise about their role as "mediators." However, the term "mediator" or interpreters' mediation practices raise questions far beyond what one might imagine.

"Interpreter in the social setting, "interpreter in the social and medical setting," "mediator interpreter," "intercultural mediator interpreter," "cultural mediator," "linguistic and

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cultural mediator," "intercultural mediator" . . . : new terms are emerging and it can be noted that proposals for defining the role of the interpreter can differ greatly, particularly in view of the training courses commonly offered in Europe. I propose here to question the element of mediation in the activity of interpreting. To do so, I will reflect on the positioning generally expected of interpreters and the necessary mediations that take place during the activity itself, as well as drawing on my own practice.

Reflections on the interpreter's positioning: Expectations, questions, and realities in the field

Is the interpreter neutral?

Some health professionals still consider the ideal positioning of the interpreter to be one in which he or she remains neutral, translates literally, and does not interfere in the care process, despite the contradictions arising from this positioning. However, this injunction of neutrality suggests that health professionals expect interpreters to position themselves "outside of the field of action." They would therefore be expected to fade away visually, physically, and as individuals, leaving only a "pure" and "literal" transcription, which would be considered ideal. As François René de Cotret and his colleagues point out: "A majority of researchers, but also practitioners and other institutional actors, see the interpreter as a conduit, remaining invisible in the interaction" (de Cotret et al. 2017, 289).[3] Yet this invisibility deprives interpreters of essential elements — their senses, experiential knowledge, and individuality — that enable them to adjust their positioning, particularly in view of the incredible variety of situations with which they are confronted in the course of their practice. The reality is that, as individuals, interpreters also call upon their own particularities, their "interpretation" and affects, and effectively occupy a particular place. The difficulty is in understanding what this place is and how it fits into the processes of care and follow-up, or into a therapeutic framework. Certain questions arise: Why can the space occupied by interpreters be experienced as a hindrance by health professionals? Why should interpreters have to fade away in order to carry out their job "correctly" or to "meet the expectations" of the professionals who call upon them? Moreover, this self-effacement would not only be physical, but also psychological. Indeed, it would be expected that the presence and even the voice of the interpreter, already too marked by a personality of its own, would ideally leave room only for words, thus erasing everything that would enable the interpreter to grasp not only the meaning, but also all the subtlety of the different levels of language that come into play during an interpretation. In the context of interpreting, the sensory experience would therefore not be perceived as an essential element, which would allow one to orient one-

[3] Translator's note: Our translation. Unless otherwise stated, all translations of cited foreign language material in this article are our own.

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self in the construction of the meaning of the patient's expressions. This would lead one to believe, quite wrongly, that the linguistic code and linguistic expression are positioned at the same level within social practices. This point is notably raised by Cécile Canut: "Neither an object nor something transparent, linguistic expression is a complex activity, a praxis that conditions actions of a social, political, ideological, psychological, etc. type. For all these reasons, it is at the center of a permanent production of discourse, of which the reduction to the object 'language' is the oldest and most fruitful. It is time, however, to get rid of the idea that it is through language that the subject is constructed: no, it is through linguistic expression, or what others also prefer to call discourse" (Canut et al. 2018, 2). Yet we often hear the same concern, both from professionals and from interpreters themselves, about a certain inability that exists in this profession to balance the involvement of one's own self with one's professional practice. The idea would therefore be that any personal involvement of the interpreter would represent a risk of excess, even though it may seem logical that each professional acts and constructs his or her practice with the involvement of his or her own identity, without this being seen as problematic.

Interpreting beyond words

Interpreting beyond words requires firstly accepting the simultaneity of different behaviors and correspondences between several "worlds" (Bastide 1955). It then becomes difficult to conceive that there would not be a dialog between different forms of representation, taking place on several levels. Interpreting involves running the risk of being enveloped by the other, and without this risk, the transcription of words may prove to be inaccurate. It is a process of constant dialog, adjustment, echoing, an encounter, sometimes a struggle between two psychic environments, for which words provide directions, forms, nuances, and sensations. Therefore, as an interpreter, I cannot translate without engaging a part of myself, which by definition is also a principle of interpretation, making the boundaries of this multidisciplinary practice very porous. We can cite Piera Aulagnier's work, *The Violence of Interpretation*, which while not dealing with the same field addresses several aspects that are very close to the issues raised by interpreters: "The peculiarity of the living being is its situation of continuous encounter with the physico-psychical milieu" (Aulagnier 2003 [1975], xxx). The positioning maintained by interpreters can be disturbing and questioning, since their function as spokespeople also requires them to occupy other functions (Kaës 2005). It is from this questioning that the issue of interpreters' mediation arises, since it again includes interpreters in the field of action, allowing them not only to occupy a space in a positively assumed way, but also to allow a space for a part of themselves.

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What place is there for mediation in interpreting practice?

The issue of mediation practices within interpreting seemed to be resolved in most of the definitions and guidelines on social interpreting proposed from the 1990s onward, aimed at providing a framework for the profession of interpreting.[4] However, this issue has once again come to the fore. For example, most institutions in Europe providing interpreting services have accepted that the term "mediator" cannot not be applied to the mandate of interpreters (Delizée 2015). The term "interpreter in a social or community setting" has then became the most commonly used. One example is Belgium, highlighted by Anne Delizée's research (2015, 17) on community interpreting, where one of the institutions offering interpreting services clearly states in its code of ethics: "Interpreters are not cultural facilitators in the sense that they do not intervene at the request of the beneficiary and they are neither the beneficiary's lawyer nor defender; nor do they act as an intercultural mediator, as they do not have to manage conflicts of linguistic and/or cultural origin between beneficiaries and users. Interpreters intervene only as part of a group of three, translating the statements of the primary speakers without expressing themselves." Despite the range of positionings defended by researchers and attempts to set standards for interpreting activity, it is the interpreters themselves, in the reality of their practice, who are questioning the limits of these positionings, putting issues about their role back on the agenda and reintroducing the notion of mediation.

Questions of interpreting and mediation bring to light a parameter — already highlighted by some researchers (Moro and Abdelhak 2004; Delizée 2015; de Cotret et al. 2017; Collazos Sánchez and Qureshi-Burckhardt 2010) — that is still difficult to grasp for those interested in these issues. In fact, experiencing the situation from the interpreter's point of view, rather than as an observer, and confronting realities on the ground, helps to underline the variable, spontaneous, and improvised nature of the interpreter's practice. This element characterizes it far beyond what one might imagine, as it is a practice that is constructed in constant movement and which is sometimes analyzed in too fixed a manner. Each interaction has a unique and exceptional character. The repetition of words, which in itself is a transcription, is often confused with a repetition of the action (of interpreting) and situations; this can lead one to believe, wrongly, that the action of transcription (of interpreting) takes place in a mechanical, automatic, formal way, and is therefore easily transposable from one situation to another.

When interpreters are involved, the exchanges normally take place without preparation, adjustments, or any agreed-upon protocol, just like most of the interactions we have in our daily lives. Very often the adjustment is made during the exchange and is completely dependent on the uniqueness of the situation. Returning to the problems

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[4] The "Charte de l'interprétariat médical et social professionnel en France" (Charter for Medical and Social Professional Interpreting in France) was signed in Strasbourg by various associations in 2012.

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of mediation practices, these could also be considered as having an element of arrangement, which is necessary throughout each intervention. Mediation could be seen as the opening of a space containing different possibilities, which would go hand in hand with the rhythm that characterizes the specificity of each situation of interpretation. This would allow and include all the necessary modulations at several levels — including those of language, positioning, understanding, and interculturality — without limiting it to a simple function.

In my practice, I have noticed a dysfunction in the way interpreters are allowed to construct and practice their profession. It is implied that interpreters working in social settings should acquire a certain expertise in the fields of health, mental health, social work, public services, asylum procedures, and justice — to name but the main ones. This expertise should be in addition to any other skills acquired, needed, or expected. The introduction of new training courses in recent years raises not only the question of the interpreter's position as a mediator, but also the lack of recognition of the profession of interpreter, as well as the reluctance that some professionals may have when using an interpreter.

There are two main currents in the new proposals for defining the interpreter's mandate and role as mediator. One defines mediation as one of the competencies of the interpreter and the other defines interpreting as one of the roles of the mediator. This new attempt to define the role of the interpreter also responds to new requirements on the ground, which have gradually forced all professionals who receive migrant populations to adapt their practice. The prevalence of emergency situations and the conditions of reception have also challenged researchers, since this field is largely made up of interpreters who have not followed the standard training pathway, and sometimes have migration backgrounds similar to those of the people who are receiving care. Furthermore, the precariousness of working conditions, constant mobility, the diversity of the fields in which they are called upon to work, and the need to draw on resources other than just linguistic skills, are among the other parameters that have also contributed to this questioning. If we look more closely at the areas of health care and mental health care, however, the issue of mediation becomes obvious. There are many examples that demonstrate that "simple translation" is not enough.

As interpreters, we are in most cases confronted with situations that are out of the ordinary, on account of the conditions of departure, reception, and residence of migrants, who are often embroiled in complex procedures. These are mostly caused by situations of distress linked to the political, economic, and social problems faced by the populations we work with, forcing us to consider translation beyond the "norms." We

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encounter difficulties when patients consider the (often ill-defined) role we play to be beneficial in helping them get what they want, or when they greet our role with mistrust due to the representations of the professionals we work for sometimes being difficult to grasp. Language can be either a reassuring form of connection or alternatively a threat. The interpreter is unfortunately the object of projections that often tend to fall on the side of mistrust. In my practice, I have been forced to observe that within this triangularity — that brought about by the patient–caregiver–interpreter situation — everyone feels extremely powerless, equally so, mistakenly thinking that the interpreter holds all the keys or "power," as is often heard. This triangularity then frequently takes on a pyramidal form, in constant tension or negotiation, changing axis according to the configurations, and thus allowing very little free circulation of each person's knowledge and skills. However, this may contribute to creating other issues that add complexity to care work with an interpreter. The possibility of constructing together, and in a non-homogenized way, our practices and care is rarely considered. For this to happen, it would obviously be necessary for everyone's place to be respected, while pooling our different skills. Patients also hold one of the main keys in this configuration and should be just as much actors in their care. However, they too are rarely included and invited to be part of this triangularity in their own right.

In the case of asylum seekers, the question of language is related to other issues of great importance. Here linguistic expression becomes a question of psychological, social, and administrative survival, as the future of these individuals unfortunately depends on their past victimization. The formation of their asylum application narrative becomes a key to their survival. In an emergency situation that does not allow them the time that would be needed to recount their trauma, the interpreter is one of the only means that they have to succeed. However, the conflicts recounted may be exacerbated by the origin of the interpreter. In addition, the interpreter may speak a language that can be identified as that of the oppressor. I can cite here the example of one of my Russian-speaking interpreter colleagues, who has difficulties translating for people of Chechen origin, as this places interpreters in a very complex situation. My Serbo-Croatian-speaking colleagues encounter the same difficulty when translating for Serbs, Croatians, or Bosnians, despite the context of the conflict no longer being relevant. The stigma remains and the mistrust is difficult to overcome.

Sometimes the interpreter has to formulate or speak in the place of the patient, without that person being able to make the choice of words themselves, or without having the necessary time, with all the consequences that this has professionally and emotionally for both the interpreter and the patient. I remember an Angolan patient who, on arriving at a psychologist's office, and tired of telling his story, asked me to tell it for him. Faced

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with my refusal to do so, dialog with the therapist could not be established and therapy could not begin. Moreover, the majority of the women for whom I act as interpreter in a situation of asylum have been victims of sexual violence and often turns of phrase that they use to describe this violence, chosen with a concern for modesty, lose all meaning when translated. During a telephone consultation, I once had to translate these words spoken by a female patient: "*Then I went outside with . . . .*" I understood from the context of her story, the intonation, and other details of the narrative that it was an assault. However, I had to translate what she had said. How could I relate what she herself could not name? How could I imply what she had meant over the phone?

It is often forgotten that the interpreter is the first listener, that he or she always carries out a double transcription (i.e., transcribing for the patient *and* for the therapist), and that this intermediary role is not simple, because in the end, the interpreter takes on — both literally and figuratively — the "words" of each of the other interlocutors. The sentences that practitioners routinely ask us to translate, particularly so that, through us, they can give patients a diagnosis, are a good illustration of this difficulty. I will quote a health professional who told one of my fellow interpreters: "*Tell him that he'll have several operations and I think it'll be difficult for him to make it through, and while you're doing that I'll go and get a coffee.*"[5] Often, in these types of circumstances, there is little room for discussion about the situations that place us in difficulty. Moreover, without shared construction or agreement, we often remain suspended between confusions of meaning and place, among other possible confusions. The confusion of this place is not only at the origin of the lack of definition or framework, but also of the incomprehension of different levels that overlap and come into play during an interpretation.

Behind the word "mediation" lies a great deal of confusion and fear about going beyond the proper place of the interpreter, as mentioned earlier. One might wonder whether it is not the way we envisage mediation within interpreting practice that needs to be questioned. Should we then conceive of it as a function in itself, or as a means, a tool, a resource, or simply a framework? Or is it all of these? Why do we find it so difficult to conceive of the interpreter's skills as going far beyond mere linguistic issues? Making the link between two languages is a mediation practice in itself, and as most interpreters find, in most situations it is rarely the only function we are asked to perform.

As far as interpreters are concerned, and despite the desire to implement more professional practices and to build reflective and adapted training courses, difficulties still exist in the field. One might think that the lack of training for interpreters is leading to excesses in their practice. Nevertheless, this expectation of neutrality and this injunction to stand on the edge or "outside of the field of action" of the consultation, as well as

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[5] This episode was experienced by one of my colleagues during an interpreting assignment in a hospital. It was the source of a lengthy discussion and sharing of similar experiences during one of our practice analysis sessions.

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the fact that they are not able to take on the role of mediator, have real consequences for interpreters. I was very strongly influenced by the various comments made by my colleagues about their positioning. Many of them say that these remarks can have a direct impact on their self-confidence and their confidence in their own professionalism, as illustrated by the following extracts: "*I sit still and look at the floor*"; "*I try to look away as much as possible so as not to disturb anyone, to make myself invisible*"; "*But finally, after seventeen years of practice, I would like to know what is expected of me once and for all.*"

On the subject of this erasure, some of my colleagues explain that they find it difficult to maintain this position of remoteness since they are regularly called upon to create a connection. They relate how this can be a source of abuse and isolation. However, they testify to the fact that it is ultimately this connection that allows them to feel better and to approach their practice from a more accurate positioning, also allowing them to use their own resources, without having to constantly question them. Among the many misunderstandings and confusions that arise in our practice, it is very often implied that interpreters must have a positioning that is fixed and detached from what characterizes them as an individual. The idea of a positioning also introduces a bodily notion of rigidity. This rigidity is amalgamated with the field of action and then with the field of interpreting, making the interpreter an "interpreter-object" rather than an "interpreter-subject."

Talking about mediation within interpreting practices raises the question of the interpreter's status, but also the concepts of connections, openness, and the space of circulation which, consequently, would make a real difference in our profession and could be perceived as a means of giving interpreters a place of their own in their interventions as professionals. And perhaps one of the most important challenges is to specify and recognize this activity of mediation in the interpreting profession, particularly through training and the formalization of the profession, in which interpreters must take part.

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ELEMENTS TOWARD AN ECOLOGICAL APPROACH TO THE WORK OF INTERPRETERS WITH MIGRANTS: THINKING THROUGH THE RISKS INVOLVED IN THIS PRACTICE

"Bad translation!" was one of the first exclamations heard at the showing of a video excerpt of a medical consultation between a psychologist, an interpreter, and an Angolan patient, made by a Portuguese-speaking interpreter who was participating in a training course on "interpreting in health care."

"It's scary!" was the reaction of one doctor who, during one of these training sessions, discovered the gap that exists between what the psychologist says in French and what is translated into Portuguese for the patient.[1]

Such gaps have long been identified by all those interested in translation, however. They lie at the very heart of the art of translation and, as such, have been the subject of numerous theoretical explorations, such as Barbara Cassin's work on the "barbarity" of the "untranslatable," which aims to "complicate the universal" and to resist the reduction of the pluralism of languages (2016). Does this mean that there is another kind of gap here? That the interpreters and caregivers I meet, on the contrary, adhere to a conception (both impoverished and politically problematic) of translation as identification and sameness, which must overcome differences and produce the same discourse in another language? Is there a different way of treating translation depending on wheth-

[1] During these training sessions organized by Orspere-Samdarra, we provide a rather literal translation of what was said in the other language, meaning that anyone can compare the statements with each other, even if he or she does not speak the language in question.

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er one is situated within a poetic and literary framework that is open to creativity and even allows the translator his or her share of authorship, or within a social or medical framework attached to literal meanings, where interpretation is all that is required?

This separation between the two scenes is rather suspect. Just consider the role played by interpreters in ethnopsychiatry. During consultations in ethnopsychiatry, translation difficulties and misunderstandings are discussed collectively and openly by therapists, interpreters — who are so entirely integrated into the therapeutic system that they are renamed "ethnoclinical translators or mediators" — and patients, who are also transformed by the fact that their own expertise is recognized, in that the elucidation of the choice of words is just as much their business as that of the professionals (de Pury Toumi 2005). To call these interpreters "mediators" is to argue that they are not mere intermediaries, but that they make a difference to the situation and those people involved in it (Hennion 2015).

However, it must be noted that, compared with the consultations that I focus on here — those of the mobile mental health outreach team for vulnerable individuals (*Équipe mobile psychiatrie précarité*, EMPP) of the Centre hospitalier spécialisé (CHS) in the *département* of Savoie[2] — the practice of ethnopsychiatry is exceptional in many ways. While the latter tends to concern people who come to these consultations having exhausted other more traditional social and medical avenues, the EMPP is a common-law mechanism, and its consultations are intended for those who are in a situation of precarity. Interpreters are attached not to the EMPP, but to an association dedicated to "action to help the integration of immigrants and their families, along with access to rights and equality of opportunity."[3] They have not been trained in any particular clinical specialty. Finally, when they are called upon, it is always to support non-French-speaking migrants, often in emergency situations.

The disquiet that grips some caregivers when they watch the videos of these consultations may primarily be due to what they quite understandably see as a lack of expertise. While the ethnopsychiatric system internalizes the problems of translation, there is nothing like this in the consultations I have observed.

As for the criticisms made by some interpreters when watching these videos, they no doubt testify above all to the rather functional and instrumental conception of communication and translation that prevails in the situations I observe. The same thing is indicated by the expression used by one of the filmed interpreters I met: "*I'm a little cassette*." However, even if one talks about one's work in this way, this does not necessarily mean that there is a reduction in the gaps between the statements enunciated in

[2] This survey is part of the "RÉfugiés, MIgrants et leurs LAngues face aux services de Santé" [(REMILAS) (Refugees, Migrants and their Languages in Healthcare Encounters)]" project funded by the ANR (16-Fasi-0003).

[3] Extract from the website of the Association départementale pour le développement et la coordination des actions auprès des étrangers de la Savoie [(ADDCAES) (Savoie Departmental Association for the Development and Coordination of Action For Foreigners)]: https://www.addcaes.org/qui-sommes-nous/.

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one language and those translated into another, as if there were a mechanical solution that would finally make literal translation possible. It testifies both to the modesty of the work of these interpreters, and to the felicity conditions in a role which, for those who practice it, consists in doing everything possible to erase themselves. Immediacy is not synonymous with the disappearance of mediators. On the contrary, it must be thought of as an effect of their optimal alignment (Hennion 2015). If a mediator is knocked off balance — for example, if an interpreter stumbles over the translation of a term, fumbles, or trips over his or her words a little too much — these stammerings and his or her attempts to negotiate them become more visible than the translated statement itself.

In this article, therefore, I will not try to reassure either of those worried viewers, nor will I raise the concerns generated by the existence of such discrepancies. Rather than highlighting what constitutes the specific art of these interpreters and emphasizing their mastery and virtuosity, for example by celebrating their bricolage skills, I would like to describe their activity in its very vulnerability — that is, in so far as it is always like walking a tightrope. In doing so, I seek to reflect both upon their art and upon the possibility of its failure. I will thus show how certain solutions that have been found to negotiate the difficulties encountered invariably run the risk of creating new problems. In other words, I will show that these eminently complex situations do not necessarily have a happy outcome, *a fortiori* one that is sustainable, but that the discomfort they cause should not be considered as a problem. My contribution as a researcher in this world of practices consists ultimately in thinking about this trouble — that is, exploring ways of "staying with it."[4]

In order to do so, I will draw upon a methodological device that I have put in place: I returned to see the interpreters and caregivers filmed as part of the "RÉfugiés, MIgrants et leurs LAngues face aux services de Santé" (REMILAS) (Refugees, Migrants and their Languages in Healthcare Encounters) project and asked them to comment on the "traces of their activity" (Cahour and Licoppe 2010). More specifically, in the space allotted to me here, I will make use of an excerpt from a filmed consultation, and the discussions I had with the interpreter while viewing it.

The eminently composite nature of the interpreter's job

The consultation brings together a psychiatrist, a Serbian couple who came with their child, and an interpreter of North Macedonian origin who speaks no less than seven different languages, including Serbian. The consultation lasts about thirty minutes. Although the interpreter and the psychiatrist already know each other and are used to working together, this is only the third time they have met this family.

[4] As such, I place my work in continuity with that of Donna Haraway (2016).

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After the consultation has been underway for three or four minutes, and before addressing issues of health more specifically, the psychiatrist runs through the "*material*" aspects of the couple's situation (accommodation and "*paperwork*").

The couple answers, the interpreter translates. She says that they are still housed in a reception center for asylum seekers (*centre d'accueil pour demandeurs d'asile*, Cada), and that they are awaiting a notification from the Office français de protection des réfugiés et apatrides (Ofpra) (French Office for the Protection of Refugees and Stateless Persons).

The psychiatrist then asks the child: "And you, do you go to school?"

> The child does not answer, perhaps because he does not have time to do so, since the woman intervenes immediately: "*I wanted to ask you something else, can she give me a paper to give personally to Ofpra so that they don't ask us too much, so they don't question us too much, you know how it is when you go there* [silence]. *Surely you can write . . .* "[5]
>
> At first the interpreter does not translate the request. She questions the couple in return: "*She* [the psychiatrist] *did it for the file, didn't she? The papers?*"
>
> The woman responds, "[inaudible] *She* [probably meaning the social worker at Cada] *received a, I mean, a file . . . We received a file at Cada, but I don't understand what's written in it.*"

The interpreter addresses the psychiatrist: "She wants to know if she can get a paper from you for the day she's going to go there, to give, I think you have, I . . . "

The psychiatrist interrupts the interpreter: "Well, it's already done."

Interpreter: "It's already done, exactly, that's why I took the liberty . . . "

Psychiatrist: "Yes, yes."

---

[5] So as not to make reading the text too cumbersome, I have not included the Serbian transcription of the couple's or the interpreter's words, but only the French (re) translation made by Amandine Potelle, a translator recruited as part of the REMILAS project. I use italics and a left margin to indicate what was said in Serbian. Translator's note: the translation of the text into English was made on the basis of that translation into French.

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Without waiting for the interpreter's translation, the man intervenes: "*I'm sorry, I'm all over the place, I don't remember everything, I have absences, you understand. Since this . . .* "

His wife interrupts him: "*He often gets lost during the conversation and doesn't know what we're talking about, and sometimes even . . .* "

The interpreter asks before translating: "*Is this new or did it happen before?*"

The woman says, "*It used to happen before, but now it's really often.*"

The interpreter comes back to the psychiatrist: "Yes, she means that now, lately, when we're talking he gets lost, he doesn't know what the subject is."

The psychiatrist nods while the interpreter speaks: "Yes, okay." She then adds, "Then we'll, okay, we'll see about that."

Without waiting for the psychiatrist to finish, the woman speaks again: "*Not always, but sometimes, you know, sometimes his head gets stuck.*"

The interpreter translates: "It doesn't last long, but it happens."

The psychiatrist sets out the problems: "Okay. So there are two different things."

Taking advantage of a brief silence, the interpreter translates: "*Two different things, she says.*"

The psychiatrist continues: "As for the Ofpra file, the papers to be provided, [. . .] I already made out a certificate on [date] which I sent to [the Cada social worker]."

The woman nods. Perhaps she recognized the name.

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Psychiatrist: “For the Ofpra file. It’s on the side of the papers we’re going to say eh. So it’s… ”

The interpreter translates : “*She says, as for the papers, not what you were asking about, she’ll tell us afterwards. For the papers you asked for, she says she sent everything. I issued a certificate* [potvrda].”

She adds in French: *“certificate.”*

The psychiatrist continues: “This is where I emphasized, to sum it up simply, the seriousness of your husband’s condition.”

At this point in the consultation, the wife and husband speak one after the other, without answering a question asked by the interpreter or psychiatrist as is the case the rest of the time. When the woman makes her request, the psychiatrist has just asked their child a question. When the husband mentions his health problems, the interpreter has not yet had time to translate the exchange she has just had with the psychiatrist about his wife’s request.

When they both speak successively without waiting their turn, it is to ask that the psychiatrist indicate in her certificate that the husband presents cognitive disorders likely to hinder the answers that he will have to give to the Ofpra officer. They make their request in two voices: even though what the husband says is not explicitly linked with what his wife said, it is like a justification of the request that she has made.

However, this request is not really heard by either the interpreter or the psychiatrist. Indeed, the question asked by the woman is quite embarrassing for the interpreter. When we viewed this excerpt together, she immediately exclaimed:

“She wants a paper for Dr. Gekiere [the psychiatrist] to send over there [she snorts]. They are… some families… It’s bogus! So that they won’t ask [them] too many questions. No, but really! [She speaks in an offended tone]*.”*

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When I question her further as to what she finds problematic, she reports that it is "*embarrassing*" for her to relay the woman's request to the psychiatrist. Her reticence is moral in nature, not because she suspects this woman of trying to get a free ride but because, by translating her request, she would above all show her ignorance of the administrative procedures and would risk placing the psychiatrist in a difficult position. Because, to her knowledge, there is no such "*paper so that* [they don't] *ask* [me] *questions*" in administrative existence. Only the "*medical certificate*" counts. In our interview the interpreter emphasized how she had taken great care to translate "*certificate*" using the exact term: *potvrda*.

As for the psychiatrist, she does not quite give the interpreter time to finish her translation. Considering that "*paper*" is just a vulgarized or approximate form of the term "*certificate*" and wasting no further time on it, she proves both her efficiency and knowledge in the field of certification ("*It's already done!*"). In doing so, she only confirms the interpreter's impression that her various anticipations were justified: the efficiency and knowledge of the psychiatrist, the inappropriateness of the woman's request, and the administrative non-existence of this supposed "*paper,*" the term simply not being part of the psychiatrist's vocabulary.

If neither the interpreter nor the psychiatrist really hears the couple's request, it is also because it is obvious to them that, by mentioning his "*absences*," the husband is changing the subject. Their difficulty in seeing that the husband's words are continuous with those of his wife is no doubt due to the fact that, first, by speaking without waiting their turn, the man and the woman contribute somewhat to desynchronizing the exchange, and second, that at the very beginning of the consultation, the husband has already been taken up on this point by the psychiatrist. When the psychiatrist began her consultation, as she always does, by asking "*How are you doing?*," the husband started to talk about his fears. The psychiatrist immediately proposed to organize the consultation in a significantly different order, starting with the "*paperwork*" — which then presents the wife with an opportunity to ask for the "*paper* [papir] [*so*] *they don't question us too much*" — before talking about those "*thoughts*" that haunt the husband and have brought him to this consultation. Therefore, when the husband begins to speak about his health problems, it can only be understood as a repetition, or even as a kind of insistent dwelling on the subject that renders him incapable of grasping the correct order in which the consultation should proceed.

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By insisting, a little awkwardly, on discussing with the interpreter these remainders that she had not really translated, I force her to unfold certain other elements upon which she focuses her attention and which I had not really seen. Rather than list them all here, I will only mention her concern to make sure the psychiatrist was aware of the brief aside she had had with the wife and to elicit the husband's expression — hence, once again, the reminder given to the husband, before giving any translation to the psychiatrist.[6] Indeed, she knows that the husband finds it difficult to express himself and that his wife, on the contrary, is quick to "*always speak for him.*"

From a critical point of view, one might certainly consider that the interpreter is somewhat mistaken here — it is indeed possible to state in a medical certificate that an asylum seeker is not able to coherently answer questions put to him or her. It could also be argued that, by intervening as she does, the interpreter is interfering in matters that are not really her business.

But on the one hand, that would be to fail to see that she is well aware of this risk and seeks to avoid it. When she deciphers the embarrassment caused by the woman's request, she tells me that, if she could have, she would have taken this up further to let her know that her request was improper. If she held back from doing so, it was precisely in order to remain in her place as interpreter: "*I can't say to her 'But Madame . . . ,' I'm just* [there] *to translate.*" On the other hand, it would be to fail to see that the capacity or otherwise of each person to speak depends on the positioning of the interpreter.

What I would like to point out here is that these criticisms of the interpreter or limitations that might be pointed out are always made from an outside perspective, and as such always run the risk of failing to see that the interpreter's work involves not only the semiotic aspects of an interaction, but also its epistemic, relational, moral, organizational, etc. dimensions. Like all the other protagonists in this consultation, the interpreter must come to terms with these heterogeneous entities, and it is this heterogeneity that risks tripping her up at every step.

Perceiving linguistic affordances

The psychiatrist concludes this first part of the consultation devoted to the progress of the administrative process by summarizing what she has written in the certificate. She then moves on to health issues. Before following her, I would like to come back to the way the interpreter negotiates a difficulty in translation: the term "seriousness [*gravité*]" used by the psychiatrist escapes her.

[6] The same concern is again manifested in the third excerpt from this consultation (see below).

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Psychiatrist: "This is where I emphasized, to sum it up simply, the seriousness of your husband's health condition."

Interpreter: "*I put again… How do you say in Serbian? … That it is bad for him what happened, what you said, that he has absences* [izgubi]. *That's it.*"

The interpreter hesitates, wonders aloud, and shares her difficulties with the couple, as if she were asking for their help. Although this request for help may seem incongruous since the wife and her husband do not speak French, it is nevertheless thanks to them that the interpreter will find a solution to her problem.

After having tried a very approximate first translation ("*it is bad for him what happened*") which obviously does not satisfy her, she resorts to a deictic ("what *you said*"*),* pointing out the fact that "*gravité*" is being used to translate a term used by the couple. All that remains for her then is to make the reference explicit: "*What you said* [is that he has] *absences* [izgubi]".

Izgubi is certainly not a translation of the French term "*gravité.*" On the other hand, it does have the immense advantage of already being available in Serbian, whereas "*gravité"* is not (yet). In fact, it was used two minutes earlier by the husband, who was supporting his wife's request to the psychiatrist, pointing out that he had "*absences* [izgubi]" (see above).

The effect produced (the identity of the couple's and the psychiatrist's words) is certainly reassuring for the couple: namely, that "*what you said*" is indeed to be found in the certificate the psychiatrist wrote.

In showing how these things transpire, I am not trying to reveal or denounce something that is just an artifact or a fraud, by saying that "*gravité*" is not exactly *izgubi*. The interpreter knows this all too well. Rather, I intend to show how, on the one hand, to translate is to perceive linguistic "affordances." This notion, coined by the American psychologist James Gibson (2015 [1979]), refers to the possibilities of action offered by an environment. Affordances are not only subjective or mental (present in the mind of the person who perceives them) nor are they only objective, physical, or material (present in the objects and things in this environment). To use one of Gibson's own examples, the mailbox "affords letter-mailing to a letter-writing human in a community

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with a postal system." But the affordance of the mailbox "does *not change* as the need of the observer changes" (Gibson 2015 [1979], 138–39, emphasis in original). Just because I do not have a letter to mail does not mean that the mailbox around the corner ceases to invite me to mail letters. On the other hand, because I do not have a letter to mail, I may not perceive this affordance, I may not be attentive to it.

In proposing the idea of linguistic affordances, I understand language as an "environment" with which the interpreter and the other protagonists are "transacting" (Dewey 1938). Some elements are grasped as footholds for orientation, as with the term *izgubi*. Others are not perceived and may then risk being written off. This is the case when the interpreter, like the psychiatrist after her, decides that the husband's mention of his "*absences*" belongs to another subject entirely.

The advantage of this ecological approach is that it shows how affordances, even though they are objective and do indeed exist, may remain unperceived. Every engagement in the world leaves behind it an irrevocable remainder.

Hauntings: Resistant remainders

The psychiatrist then turns to health issues. She begins by saying that she has a "very specific question" to ask, probably so as to make sure of the interpreter's full attention and precision, and then says, "When we last saw each other, I suggested that you try a medication that might help a little with the nightmares. So I wanted to know if there was even a small difference, or no difference at all. How are you doing with this medication, since there are drops and a tablet?"

> Interpreter: "*The last time she gave you drops.*"
>
> Husband nods, wife says: "*Yes.*"
>
> Interpreter: "*And a drug to take, is there, she says, a difference: a little, more than that, or nothing?*"
>
> Husband: "*No, a small difference, there really isn't any difference.*"

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Interpreter: "*Just a little?*"

Husband: "*A little, not much, because I have these nightmares and I don't sleep much.*"

Interpreter: "*And for the nightmares, she gave it.*"

Husband: "*Yes, that's what I'm saying.*"

Interpreter: "*It didn't reduce them at all*?"

Husband: "*No, it has reduced them a little bit, but not that much.*"

Interpreter: "*That's what she said a little earlier, she said that she put that your condition is getting more serious* [inaudible]*.*"

The man nods. His wife intervenes: "*I noticed that too.*"

Interpreter: "*And she put that on this paper that went to Paris.*"

The interpreter then starts her translation for the psychiatrist.

I do not have the space here to dwell on the way in which, during our interview, the interpreter emphasized how much her translations and reminders to the husband aimed to respond to the need for precision, a need that she shares with psychiatrist.[7]

I will note only one aspect of this sequence: the fact that, if not the term "seriousness [*gravité*]," then at least the verb "to get worse [*s'aggraver*]" here comes back to the interpreter. The interpreter then allows herself to make an interpolation and to go backward, signaling this temporal rupture with the help of ad hoc markers: use of the past tense ("*she said*"), explicit anteriority of the psychiatrist's words ("*a little earlier*"). What the interpreter had stumbled over does not really disappear: these are all remainders that haunt her and are likely to return to the forefront — when a better translation solu-

[7] But it should be mentioned that, just because the interpreter and the psychiatrist share and divide up this same need, it does not mean that they necessarily agree. Having this in common is what unites and divides them at the same time.

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tion occurs to her, for example. Above all, it should be noted that the translation of the term she had been blocked on up to that point carries with it the context in which it was originally said. In doing so, it may also contribute to making the order of the consultation less legible. Whereas the psychiatrist has finished with the administrative procedure, the interpreter now comes back to it. The return of these remainders may allow the interpreter to create continuities, but it is just as likely to generate new discontinuities. What the interpreter finds at this point in the consultation is indeed a solution, but it may create another problem.

The ecological approach employed here invites us to depart from a finalist conception of the interpreter's work. The suggestion is not that it eventually turns out that the interpreter misses very little and that it is therefore possible to overlook the countless discontinuities and disconnections that distort these interactions. Rather, the above sequences show how much they are constitutive of the interpreter's work, and there is no longer any need to be afraid of the gaps and losses inherent in any translation. However, it is important to consider the risky nature of the interpreter's interventions. The interpreter always stands in a precarious balance. The footholds she manages to find in a given situation may slip away, and the solutions she sees may not be quite solutions. Every perspective on the situation necessarily leaves a remainder.

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TRANSLATION AS CREATIVE MEDIATION IN MAYOTTE: A SPACE FOR REFLECTION

This work was carried out in collaboration with the translator-orderlies Hachimia Abdallah, Sitti Demassi, Zaliffa Gue, and Moinamaoulida Kassim.

Operating according to the model of the psychiatric sector[1] since 2001, the mental health unit at Mayotte hospital[2] receives an unusually large number of non-French-speaking patients who speak local languages (Shimaore, Shibushi, and other dialects of Comorian). The majority of caregivers who deal with them only speak French. The situation of translation is therefore a part of daily practice, something that "goes without saying," having always existed by necessity, but perhaps for this very reason there is not much inclination to address the questions that emerge from these types of mediation. At the medical-psychological treatment center (centre médico-psychologique, CMP), translation is provided by Mahoran professionals who work as hospital orderlies. They have received no specific official training in interpreting, nor is their competence as interpreters institutionally recognized.

In light of this observation, a desire to think about this space of mediation resulted in the formation of a working group — composed of the unit's four translator-orderlies, a psychologist, and a psychiatrist — which adopted a qualitative approach, using the technique of focus groups along with a thematic analysis. In this article, we seek to highlight a common, multidisciplinary, and multicultural approach to our work in mental health through the lens of languages and translation. After briefly presenting the linguistic context and care provision in Mayotte, we look at translation as a linguistic and cultural "pro-active" tool that is the province of these translator-orderlies. We then reflect on the upheavals brought about in the mental health care space by the creation of the caregiver–patient–translator-orderly triad. Finally, we examine

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[1] Circular of March 15, 1960 on "Sectorization in Psychiatry" states that psychiatric care should be organized by the same team, delivering its services in the community and in the hospital. The sector is therefore based on internal–external continuity, adapted to the needs of patients.

[2] Mayotte is a 374 km^2 archipelago in the Indian Ocean, located between Comoros and Madagascar and made up of two main islands. In 2011 it became the newest of the French *départements et régions d'outre-mer* (DROM) (overseas departments and regions).

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the issues of professional recognition related to the translator's role in this French overseas *département*.

The context of Mayotte: Which languages, what kind of care?

The *département* of Mayotte has a distinct linguistic context, being officially French-speaking[3] owing to the annexing of the territory to France, but effectively multilingual because of its rich and tumultuous history.[4] For the sake of readability, we will focus more narrowly on the two languages that are most often translated by translator-orderlies at the CMP: Shimaore and Shibushi. Shimaore, a language of Bantu origin, is the first language of the vast majority of the population, with 70 percent of the *département's* inhabitants using it in daily oral communication. Shibushi, a Malagasy dialect specific to Mayotte, is spoken by 20 percent of the population living in certain localities of the *département*. The other languages spoken are those of the populations having immigrated mainly from the neighboring islands of the Comoros — Shinzuani, Shimwali, and Shingazidja, which have common roots with Shimaore — and from Madagascar, but also from East African countries and India, to a lesser extent.

The mental health care offering in the territory reflects major inequalities compared to mainland France, as well as inequalities between the *département's* different geographical areas. In the entire *département* there is only one adult psychiatry unit for more than 300,000 inhabitants (compared with one for every 70,000 inhabitants in mainland France), situated at the Centre hospitalier de Mayotte (CHM) (Mayotte Hospital Center). Its outpatient provision comprises a network of facilities, including a CMP on the site of the central hospital in Mamoudzou (the *département's* capital) where daily consultations are held in the presence of a full multidisciplinary team; four intervention sites in outlying clinics, spread across the *département* and with a more limited presence in terms of time and personnel (psychiatrist/nurse/translator-orderly two days a week and psychologist one day a week); a second smaller CMP in the south of the *département*; and a mobile crisis team responsible for managing psychiatric patients in emergencies. As for its inpatient provision, there are ten short-term beds (compared with thirty inpatient beds per 70,000 inhabitants in mainland France), without any long-term downstream structure.

In Mayotte, translation in the context of care is both ubiquitous and a challenge. How can all these elements be taken into account in an attempt to provide mental health care that is coherent and relevant to the needs of the community? In questioning the

[3] French has been present in Mayotte since 1841. It is the official language, and is the language of administration and public education.

[4] Mayotte used to be a French colony and was formerly part of the Union of the Comoros. Today it is undergoing rapid social change and is experiencing strong demographic growth and a boom in migration.

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role of translation in the care relationship at the CMP, our gaze logically turned to those who have embodied it since the establishment of the unit: the translator-orderlies.

Translation and translator-orderlies: What and who are they?

Etymologically speaking, translation, from the Latin *traducere*, means "to pass from one bank to the other." The function of the translator-orderly cannot be reduced to translation in its "instrumental" aspect, but brings about a transformation and an active participation in the relationship. According to Claire Mestre (2015, 38), "to engage in the activity of translation is to take the risk of being modified oneself as much as that of modifying what one translates. Translating means building a shared meaning with others, co-constructing."[5]

Next comes the questioning of the notion of the "cultural": Should we speak of "cultural interpretation" in the role of the translator-orderly? According to Joseph Ondongo (1987, 12), the cultural interpreter is "a person whose work — or role — consists not only in resolving linguistic mediations (translation) but above all in resolving cultural mediations (allowing the understanding of the hidden dimension in communication) between natives and their institutions, and migrants." The specificity of Mahoran means that the places are reversed here, the indigenous person being the patient, and the symbolic foreigner the caregiver originating from mainland France. In the postcolonial context of Mayotte, many professionals originating from mainland France are thus forced to work with a cultural otherness: "*The other* is *us*, the *wazungu*" (metropolitans, i.e., those originating from mainland France), forming a social category with its own system of values and representations. Moreover, how can we speak of "the" Mahoran culture (or indeed any other "culture") as unique and immutable? Are translator-orderlies supposed to know and define "their" culture and "the" culture of the patient homogeneously? From where do they speak? How can this supposedly general "knowledge" be separated from the unique relationship that each person has with his or her culture and from all the transformations and reinterpretations that occur?

Within the unit, the role seems close to being one of "cultural competence" (Kleinman and Benson 2006),[6] which allows professionals to avoid stigmatizing patients and locking them into cultural stereotypes, and instead accommodate their unique requirements. The translator-orderly must therefore be able to translate taking into account the cultural representations and metaphors used by the patient to express his or her psychological suffering, while avoiding imposing any simplistic cultural label on that patient. However, we have chosen to retain the term "translation" in this article, given the

[5] Translator's note: Our translation. Unless otherwise stated, all translations of cited foreign language material in this article are our own.

[6] A competence in decentering, in understanding the patient's cultural references in the context of transfer and the necessary confrontation of explanatory models of suffering and care between therapist and patient (Kleinman and Benson 2006).

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current lack of institutional formalization of the translator-orderly's role, as well as the recurrent use of the word in our daily practice.

While mediation is an integral part of translator-orderlies' mission, they are not mediators as such, only the system is a mediator. Indeed, the task of mediation cannot rest on a single person, it relies "on the stance of the interpreter and the professional as to the importance of the status accorded to language and the translation of meaning, which takes complex and diverse paths. It is based on different ingredients such as the therapeutic alliance, the explanation of implicit notions, the questioning of the institutional order and of our knowledge, and the evaluation of the power relations at work without our knowledge" (Mestre 2015, 44). Thus, rather than considering translation as mediation between patient and caregiver, we preferred to see the creation of the caregiver–patient–translator-orderly triad as a space for mediation between the suffering that gives rise to the request for care and the clinical universe — a mosaic representative of Mayotte's cultural richness.

The caregiver–patient–translator-orderly triad: A space of care that is singular… and plural!

How does the presence of a translator-orderly alter the therapeutic setting? If "psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist" (Winnicott 1991, 38), how will a translator-orderly find his or her place within this co-construction? In Mayotte, patients could be forced to stop using their first language and replace it with the official language, at the cost of a significant expenditure of mental energy. Indeed, as Julia Kristeva (1991) testifies in her work, "[l]iving with resonances and reasoning that are cut off from the body's nocturnal memory" is like carrying a secret vault within oneself. To bring back the mother tongue[7] into the consultation as "possible" in this way is then to bring back the original signifier that constituted original identity. From this perspective, the translator's "linguistic hospitality" (Ricœur 2006) allows access through language to a "cultural system," as described by Tobie Nathan (1994), which encloses, envelops the social group, contains its soul, its dynamics, its creativity. It is the place from which a sense of identity is continually diffused. These theoretical observations indicate the importance of the subject's first language in his or her psychic construction. The language conveyed by the translator-orderly becomes a "hyphen language," reassuring and unifying, and so allows access to the field of the innermost subject. However, when the patient is bilingual, it can also constitute a threat to the subject and in certain cases amplify a potentially traumatic reliving of the past. In his analysis of polyglotism, Daniel Lagache (1956, see Lagache 2010), considers that it is sometimes outside

[7] The phrase "mother tongue" does not refer to the language spoken by one's mother, but to the language one first acquires as a child (De Pury 1994).

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the mother tongue that psychological conflict can develop, when distanced from signifiers that are overly invested with affects. An individual can use an elected language or a language of education to aid resistance, leaving in the shadows the traces of the infantile contained in his or her childhood language.

When use of the mother tongue is possible, the next step is to understand how the patient sees the presence of the pairing of translator-orderly and therapist originating from mainland France. "It is necessary to ensure that the subject is not immediately placed in the position of a cultural witness who could represent the threatening order or before whom the revelation of violence would accentuate feelings of shame" (Wolmark, Nguyen, and Cossart 2015, 62). In one session, a rape survivor emphasized *the importance of having a mzungu*[8] *therapist and a translator-orderly from the east of the island*, wanting to avoid using a translator-orderly from her own village or community. This example highlights the potential threat to intimacy and confidentiality.

In other situations, the mere presence of a Mahoran translator-orderly is an invitation to shift the gaze: the pairing of caregivers implies that the therapist originating from mainland France is not all-powerful, that he or she does not know everything. This creates a feeling of great humility that unravels and reconstructs many therapeutic alliances. The position of the caregiver originating from mainland France may therefore initially be undermined by this displacement. It is a question of accepting this loss of power through the introduction of a third party into the therapeutic relationship, which calls into question the framework of face-to-face meetings, the so-called "special understanding" between doctor and patient. The dialogue then becomes a trialogue, which presupposes a shift in focus on the part of the professional, a stance that is not necessarily experienced in the practice of care but in the journey (Mestre 2008), and a confrontation with the unfamiliar. In a consultation, this is how a multi-transferential three-way relationship begins: "The simple circulation of exchanges shows that, once again, a link to the other, a relational dynamic, a circulation of emotions are possible. This created space is like a transitional area — a less overwhelming reality and a rediscovered place for the imagination and psychic play" (Wolmark, Nguyen, and Cossart 2015, 63). Moreover, the presence of this unfolded time of translation, apprehended as an opportunity, seems to facilitate the necessary space of reverie described by Wilfred Ruprecht Bion (1962) in psychotherapeutic work. This triangulation of the therapeutic relationship brings with it moments of pause conducive to reflection, and creates another temporality with breathing space and a rhythm of exchanges that bring together a secondarization of psychological processes. In this way, the triad makes it possible to co-construct a space for creative mediation — both for the patient and for the interprofessional relationship. But while the relational and cultural skills of the

[8] A Bantu term used in Mayotte to designate people of European descent.

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translator-orderlies seem to be well identified, their status within the health care team remains subject to various challenges.

The stakes of recognition and “scarring ambivalences”

During the focus groups, the attention paid to the career paths of translator-orderlies highlighted the diversity of their experiences, but also the similarities in terms of the ambivalence related to the translator’s function within the institution. Some of them were hired at the CMP directly into the psychiatry unit at the time of its creation, while others transferred from other units that were devoted to physical care. All of them said that they were recruited as translator-orderlies and assigned to translation work. The competition between the different tasks was never made explicit in their job descriptions. Thus, at the CMP, even if they are already busy with housekeeping work, they are tacitly required to make themselves available to caregivers originating from mainland France when their translation skills are “required,” which results in interruptions in work and uncomfortable multitasking. On the other hand, when they are assigned to “sectors” (consultations in clinics), they travel with a psychiatrist-nurse pair and participate in all consultations as translators. Although research (Karliner et al. 2007; Bauer and Alegría 2010) has shown that the presence of a trained professional interpreter increases the quality of care for non-French speakers, no translator-orderly has received specific formal training in this duty, even when he or she has performed this role for years. All of them have informally acquired a series of skills related both to translation itself and to the care relationship: clinical notions, adjustments in vocabulary, positioning in the triangular relationship, qualities of welcome and empathy, and so on. Some of the older ones have also used their own free time to train in key concepts of mental health care and therapeutic education with a bilingual Mahoran psychologist who has worked in the unit for almost ten years.

While it is clear that the hospital institution falls short in officially recognizing their status, their dedication to the activity of translation and care on a daily basis is no longer in doubt. Yet interprofessional relations within the unit remain tinged with ambivalence at various levels. In the therapeutic dyad or triad, for example, translator-orderlies report that they sometimes sense a climate of suspicion on the part of therapists originating from mainland France: an impression that their way of translating is being questioned, injunctions to translate certain words, or hesitations as to the use of the first or third person singular. They complain of the absence or insufficiency of time for exchanges after the consultations. Another point in question is the systematic rotation of translator-orderlies to the different clinics, which does not allow them to register as referents or co-referents of a given active patient file. This may imply a desire for control of the

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three-way relationship on the part of the health care providers originating from mainland France, with the translator-orderly perceived only as an "object of care" and not as an actor in the therapeutic alliance in his or her own right. These ambivalences seem to have been internalized by the translator-orderlies themselves. For example, they are stakeholders in this system of sector rotation, which perhaps protects them from overly powerful transferences. They have accompanied patients in the *département* for years, but on an intermittent basis, which makes it easier for them to place their own counter-transferential movements at a distance. Since they do not benefit from an analysis of the practice nor from training in mental health care, this strategy helps to support the insupportable via a diffuse, multifocal, and shared transference.

The focus groups revealed a wide variety of positions and issues on the part of the translator-orderlies, with nevertheless a "shared pride" in being "pro-active" for the patient and his or her family and in participating in the improvement of care. They boast various skills, particularly relational and cultural skills: they see translation as a part of "care," which begins "in the waiting room" when they speak with patients and reassure them that they will be able to express themselves in their language and be understood in their own culture. They boast qualities in therapeutic education such as being able to explain to patients and their families the purpose of a treatment or the ways in which treatment will be followed up. They are also aware of their role as a continuous memory of the therapeutic bond over the years, in a context of rapid turnover of health care personnel at the CMP. Finally, they emphasize their skills in multidisciplinary care by translating to the therapist the cultural and religious world of the patient, humorously naming this role "educating the doctor."

Paradoxically, they repeatedly stated that they were "not caregivers" in reaction to the tendency, by both caregivers and the institution, to make their role in care invisible. This hierarchy of professional status raises the question of the hierarchy of knowledge (Fanon 1986 [1952]). What type of knowledge is or is not valid? And what is the language[9] of knowledge? Here, while academic clinical knowledge, essentially held by French-speaking health care professionals, seems to have full legitimacy within the institution, experiential and cultural knowledge, conveyed by local languages, does not seem to receive the recognition it deserves. This implicit inferiority of the work of translation seemed to us to be underpinned by a process of memory erasure, pointed out in particular by one translator-orderly who deplored the fact that this work of legitimization had to be constantly redone as new professionals from mainland France arrived and left. She even derisively revealed to us that some had received a "diploma" as translators from a former psychiatrist in the department, but that this had in no way advanced the status of translator-orderlies in the hospital.

[9] "Languages do not have the same status and can bear witness to a diglossic state – that is, a state in which two linguistic varieties coexist in a given territory and have, for historical and political reasons, distinct statuses and social functions, one being represented as superior and the other as inferior within the population" (Madi 2016, 117).

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This questioning echoes the very topical contemporary interrogation of the traumatic traces of the colonial legacy, both for the descendants of the colonized populations and for those of the colonizing states. Indeed, the various languages spoken within French territory — within mainland France and overseas — are witness to France's colonial history, long held apart from the work of memory essential to the pacification of the present (Blanchard and Bancel 2011). It is in this sense that we suggest the term "scarring ambivalences" with regard to the recognition of the socio-professional status of Mahoran translator-orderlies in the unit, a status that is related to the language, the experiential knowledge, and the memory of a people formerly colonized by the French state. These ambivalences are all the more striking in that they are only rarely mentioned by the health care team, the subject being carefully circumvented, which bears witness to the contemporary difficulty of questioning our common heritage, even among professionals supposedly equipped to deal with the dimension of the unconscious. In this context, translator-orderlies have been able to develop forms of solidarity among themselves, such as gathering at the end of their day of translating to eat together and tell each other in the Shimaore language about their experiences at work …

Conclusion

In its multitransferential aspects, which sometimes protect and sometimes disrupt defenses, the mediation space delimited by the caregiver–patient–translator-orderly triad is a tool that generates clinical and cultural richness. The childhood imaginary can unfold in the mother tongue or, conversely, be folded into the elected language. The moment of translation allows a breathing space in the rhythm of the consultation, generating a new psychic temporality and a new clinical and cultural world. Finally, the enthusiasm and availability that the translator-orderlies of the unit have shown throughout this work, despite the difficulties encountered, testify to the creative potential of the mediation tool that translation represents within the health care setting, whether for patients and their families, within interprofessional dynamics, or in the process of exploring collective memory, and regardless of the language spoken or professional status occupied. This reflection on the assets and challenges related to translation within the health care context seems to us essential to pursue further, within health care teams and more broadly at institutional and political levels.

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"TAKING NOTICE" OF TRAUMA IN A MEDICAL ASSESSMENT OF ASYLUM SEEKERS

Assisting, caring for, and supporting migrants are activities that require conviction and commitment on the part of professionals and volunteers. Their desire to help migrants and their belief that their work is worthwhile are even more pronounced when the migrants they are assisting do not speak the same language as them. In such cases, they must join forces with a professional interpreter in order to understand complex personal circumstances, migration routes, and administrative procedures. Some migrants' life stories are horrifying, but they may need to be told. They are extraordinary, but sadly they end up seeming ordinary to those who care for, assist, and interpret for migrants. They are inexpressible, but they *must* be narrated and translated during the administrative proceedings. For those who do not speak the language of the country in which they are requesting asylum, translation is therefore essential. In order to request asylum, people have to describe their life story, the fear that motivated their departure, and the persecution they have suffered. They must then prove their victimhood, even if that means putting their private life on display. In this article, we focus on how what amounts to a "traumatic event" — in this case a rape — is described, objectivized, and translated during a medical assessment attended by a professional interpreter. We will use data from the "RÉfugiés, MIgrants et leurs LAngues face aux services de Santé" (REMILAS) (Refugees, Migrants and their Languages in Healthcare Encounters) project,[1] including filmed medical consultations and interviews with doctors who perform assessments of migrants.

Medicine and asylum law, mental health, and trauma

One of the main goals of the REMILAS research project was to understand the interpreter's activity and role in the medical consultation. Some of our research was car-

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[1] We recommend consulting the REMILAS project's website: http://www.icar.cnrs.fr/sites/projet-remilas/.

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ried out at Médecine et droit d'asile (Medicine and Asylum Law, Méda for short), an association based in Lyon.[2] The association's purpose is "to welcome asylum seekers who have been rejected by the Office français de protection des réfugiés et apatrides (French Office for the Protection of Refugees and Stateless Persons, Ofpra) with the aim of issuing a certificate specifying the principal instances of cruel, inhuman, or degrading treatment in the person's life."[3] The medical certificate, which is issued for the purpose of the appellant's appeal, is presented as supporting documentation to the Cour nationale du droit d'asile (National Court of Asylum, CNDA). Currently, the team consists of around fifteen doctors and four volunteer secretaries. Between 1988 and 2018, it carried out around twelve thousand consultations. In 2019, Méda issued just over one thousand free medical certificates. The level of commitment shown by its members is remarkable. They are determined to respond to all requests for help without turning anyone away. The doctors make sure that all certificates are of high quality. The association has a scientific committee that can call on experts in specific fields in order to enhance the knowledge and practices of the volunteer doctors. It also serves as a place for group discussions about the medical certificates produced by the association's doctors. In order to improve their practice, Méda's members also take part in training sessions on a wide range of topics, such as one on "sexual violence among refugees" run by the Primo Levi Centre. Méda members are careful to ensure that their certificates have credibility in the eyes of its partners, and their efforts are not in vain: the association's medical certificates are "well known" and "respected" for their high quality by those involved in the field of asylum. For example, a CNDA judge we met at the association's offices told us he valued the certificates for their thoroughness.

Appellants are mainly referred to Méda by its partners (Peugny 2019). Most of them only meet Méda's doctors once. The consultations last between forty-five minutes and two hours. If the appellant's lawyer thinks it would be useful, the medical certificate may be used during the appeal to the CNDA. In order to understand appellants who do not speak sufficient French or English (some consultations are conducted in English), an interpreter is often required. However, Méda does not pay the interpreters directly. They are either paid directly by the asylum seekers, or by the institutions housing the appellants (this is the most common scenario), or by the Auvergne-Rhône-Alpes regional health agency on the basis of a special protocol.[4] The interpreters enjoy working at Méda. According to an interpreter who works for the association regularly, the place where they normally work alongside the doctors is "welcoming."

Ideally, appellants should bring a number of documents to the Méda consultation, including a transcription of the account included in their asylum request submitted to Ofpra, their letter of rejection from OFPRA with its accompanying interview notes, their

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[2] The association replaced the Centre de droit et éthique de la santé (CDES, Center for Health Law and Ethics), which was founded in 1988 as a department of Hospices Civils de Lyon and was run by the teaching hospital's forensic service. Until March 2016, the CDES operated three days per week, with doctors providing consultations in two separate offices. Consultations now take place in one of two locations in Lyon.

[3] According to the association's statutes. Translator's note: Our translation from the French. Unless otherwise stated, all translations of cited foreign language material in this article are our own.

[4] After assessing the eligibility of the private practitioner or the association, the agency pays for the interpreter in accordance with an agreement with an association that provides interpreting services in Lyon.

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appeal to the CNDA, the contact details of their lawyer, and any medical documents issued in their country of origin — which must be translated by a certified translator — and/or in France. At the beginning of the consultation, the doctor reads the account sent to Ofpra and the appeal sent to the CNDA. The doctor then asks for clarification about aspects of the account and looks for "physical or psychological consequences." Some doctors photograph marks and other scars on the appellant's body during the clinical examination, but this practice is controversial within Méda.

The aim of the medical certificate is to establish that the appellant's account is consistent with what is observed during the clinical examination. To do so, Méda uses the Istanbul Protocol, published in 2005 by the Office of the United Nations High Commissioner for Human Rights (OHCHR). It establishes a sliding scale of compatibility between the account and the doctor's observations. It is essential that the medical report is accurate. The observations must be as "objective" as possible. This is relatively unproblematic for physical marks, especially burns and scars. Finding suitable ways to confirm suspected psychological problems is more difficult, however. Many consultations are focused on objectively documenting trauma. The doctors try to evaluate the relative significance of different psychological or psychopathological consequences, often using the classification system in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), which particularly describes post-traumatic stress disorder, for reference. All the doctors talk about the difficulties associated with their task. According to one doctor, "*for some asylum seekers, the medical aspect is not very strong*." The same doctor says of a specific person that "*she is certainly suffering from psychological trauma, but our certificate won't be able to add anything. There are no scars. It is not easy to establish connections between her account and what she feels. We can see … otherwise we'll destroy the credibility of all the other certificates*." Another doctor adds: "*Sometimes, it is hard to find anything to say except that they are suffering from post-traumatic stress disorder, but that doesn't really move the judges. The thing is they are all suffering from it …* " Another doctor adds, "*Rape is the most difficult, if there are no injuries it's difficult. That's the only way to see the consequences*." However, the doctors are not required to suggest any kind of medical or psychotherapeutic treatment. One says, "*We are not working in care at all*." Another adds, "*When there is too much emotion, we wait*." Their job is solely to confirm the account. But in contrast to Ofpra agents, they insist that they listen to everything appellants tell them without trying to find "*the absolute expression of truth*" and "*without casting doubt on their account*," in the words of one of the doctors, who nevertheless admits that his questions could seem "*intrusive and police-like*." The need to ensure the consultation conforms to the requirements of the asylum request is always present.

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Finding the right way to describe psychological suffering is one difficulty that doctors face; another is drawing the connection between this suffering and past events or even one specific incident. As one of the doctors says, "*trauma is everywhere*." And in contrast to interpreting in strictly legal situations, in this case it is the value of what is said that interpreters struggle with.

An example

Era is Albanian. She has asked Méda to issue a medical certificate for her. She is married and has four children, three of whom live in France. They are currently housed in a reception center for asylum seekers. In Albania, her son was the victim of a serious attack carried out by someone who intended to kill him "*because of his Romany background*." The family then received threats motivated by discrimination against their community. Era comes to the consultation accompanied by a professional interpreter who works for an interpreters association. The interpreter already knows her, having interpreted her account during the Ofpra proceedings and during her appeal to the CNDA. This sort of situation is not at all uncommon. The striking thing about the interview we are going to describe is that the interpreter "guides" the appellant, encourages her, advises her. She asks her to "*calm down*," to "*stop shaking*," to "*not worry about anything*." In French, she tells the doctor that "*she is trying to reassure her*," and adds: "*It's really important for her to concentrate, otherwise, it won't work*."

The appellant identifies two reasons why her asylum request was rejected by Ofpra. The first is that she was stressed on the day of the interview. She says that "*they* [the judges] *didn't really make the connection between the stories*." Second, a bad "translation" by the interpreter who was there on the interview day (a different interpreter) was partly responsible for the rejection. We heard these same claims repeated on multiple occasions by different people during our study.[5] When the doctor is satisfied that he understands the appellant's story, fifty minutes into the interview and before moving on to the clinical examination to assess traces of torture or violence on Era's body, the interpreter's intervention changes the course of the conversation.

Doctor: *Have we covered the main things? That's that, uh, so we don't . . .*
Interpreter: *Uh . . .*
Doctor: *I base it on what she tells me, which is the most important.*
Interpreter: *Yes, yes.*
Doctor: *What I'm looking for is if there is anything we haven't covered yet.*

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[5] We recommend reading the article by Gwen Le Goff and Natacha Carbonel in this issue.

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Interpreter: *Yes, yes. Right, but uh . . .*
Doctor: *Yes?*
Interpreter [laughs]: *It's, it's . . .*
Doctor: *Tell me.*
Interpreter: *It's not really my place, it's not my job but I want to say that this lady has forgotten the . . . the main purpose, why she's here.*
Doctor: *Which is?*
Interpreter: *Because actually . . . She was raped . . . So she was supposed to talk about her rape but I think she's waiting for you to ask her or I'm not sure what.*
Doctor: *Ah yes . . . But that means . . . hmm . . . I let people talk freely, uh . . .*
Interpreter: *Yes, yes, no, but . . .*
Doctor: *When did this happen to her?*
Interpreter: *Go ahead, or shall we just ask her the question?*

It is not uncommon for interviews to divert onto the topic of the person's mental health. Doctors try as best they can to document the nature of the person's problems in the certificate. In this conversation, it is clear how much importance the doctor gives to Era's statements in all their literalness. It is "her words" that he wants to transcribe. Some doctors actually transcribe appellants' speech directly onto the certificate.

It seems very important to note, in this extract, that it is the interpreter who draws the doctor's attention to the fact that the appellant was raped, although the interpreter feels uneasy about doing so and emphasizes that, in her view, "*it's not her place*." The information about the rape did not appear in the account given to Ofpra, but was included in the CNDA appeal, which the doctor had not read before the consultation. During a group discussion after watching the video of this consultation, the interpreter's stance provoked debate among the Méda doctors. Was it rather Era's responsibility to say that she had been raped? Was the doctor wrong to mention it at all? To be able to discuss the rape, should he have read the CNDA appeal before the consultation? To what extent did the doctor's actions, whether in his role as treatment provider or expert, fall into a gray area within Méda? One of the doctors said that "*in medical culture, you talk to the person*." The doctor involved in the consultation explained, "*When it comes to rape, I let people speak freely, but I can't just say to a woman: 'You've been raped.' We're not there to push people, that's not our job. Some people accept it. You ask a little question, and if you feel she wants to talk about it you go a little bit further. Now, that might have a therapeutic effect . . . . And for others, it's so painful that I don't insist, I respect their suffering.*"

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After watching the video of the consultation, the doctor involved did not criticize the interpreter's decision. He seemed to appreciate her intervention in a rather pragmatic way: "*She knew things that I didn't, she helped the patient . . . the asylum seeker.*" He admits that he "*was a bit surprised, that's true.*" One of his colleagues says that "*it takes effort to talk to the asylum seeker instead of the interpreter.*" A bit later on, he says that "*this sort of thing happens when the interpreter is familiar with the person's history.*" This ethical debate also arises within the interpreting community. Interpreters often encounter people in a range of different contexts and know about aspects of their life stories that those caring for them do not. Generally speaking, the Méda doctors say they like it when interpreters intervene actively, even though most of them think the interpreter's role is to translate and to do so well. Following the interpreter's intervention, the interview continues:

Doctor [to interpreter]: *In Albania, in Albania were you attacked? Does she talk about it in here or not?* [He reads the Ofpra account]
Interpreter [to doctor]: *Ask her. Not in there [the doctor is looking at the Ofpra document], but she does in the appeal.*
Doctor [to interpreter]: *OK.*
Interpreter [to appellant, in Albanian]: *Is that what you wanted to say about your story?*
Era [to interpreter, in Albanian]: *My story, that's something else.*
Doctor: *OK, good.*
Interpreter [to doctor]: *I have a different story.*

At first sight, the appellant does not seem to want to discuss the matter: when she says "*my story, that's something else,*" she is surely implying that her real story is different from the story she told in her asylum account, which had to meet certain requirements in order to "convince" the Ofpra officials. Her account was structured in a specific way that reflected the demands of the administrative procedure. The fact that her first request was refused forced her to review and revise her life story. She *has* other "stories" and she *is* "something else" besides that account. Does this "different story," which was concealed from Ofpra, belong in the supplementary account that she constructs with the help of Méda's doctors, with its specifically medicolegal language? Is there any actual value in mentioning the rape in the context of the legal proceedings? Could the fact that Era was raped make her worthy of asylum from the legal perspective? These are the questions facing Méda's doctors. As far as social workers and health workers are concerned, these questions should not be concealed, even if legally the answers are unfortunately often negative. In this example, the doctor tries to find out more from the appellant:

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Doctor [to interpreter]: *I need to ask her a few more things.*

Interpreter: *Hmm . . .*

Doctor [to appellant]: *Her son . . . She has one who was . . . How many children does he have, her son?*

Interpreter [to appellant, in Albanian]: *How many, how many sons . . . how many sons, how many children does your son have?*

Era [in Albanian]: *My son has three . . . has three boys.*

Doctor: *He had three sons . . . three boys.*

Era [in Albanian]: *He had four but one is gone.*

Interpreter [to doctor]: *He had four, he lost one . . . he has three left.*

Era [in Albanian]: *He has three left.*

Doctor [to interpreter]: *They said that they wouldn't have a vendetta, if I understood correctly.*

Interpreter: *Hmm.*

Doctor: *Hmm* [reading the appeal]

Doctor [to interpreter]: *OK . . . So it was Marsel's* [one of the two attackers] *father who came . . . May 15 . . . May 15, 2016 it was . . . It was Marsel's father, uh, who stayed there, uh, that's it.*

Interpreter [to appellant, in Albanian]: *On May 15, 2016, it was Marsel's father who came.*

Doctor: *Marsel's, who came to her house and attacked her . . .*

Interpreter [to appellant, in Albanian]: *And who attacked you . . .*

Doctor: *And who raped her, uh . . .*

Interpreter [to appellant, in Albanian]: *And who raped you . . .*

Era [in Albanian]: *Yes, OK . . .*

Interpreter [to doctor]: *Yes.*

Doctor: *So he injured your leg.*

Interpreter [to appellant, in Albanian]: *He hurt you, he injured your leg.*

Era [in Albanian]: *He should have killed me instead of doing that to me.*

Interpreter [to doctor]: *He bit me . . . Uh, I'd rather he'd killed me than done that to me.*

Era [in Albanian]: *A woman of sixty.*

Interpreter [to doctor]: *A woman of sixty.*

Doctor: *Hmm.*

Doctor [to appellant]: *Did you tell your family, that you'd been raped?*

Interpreter [to appellant, in Albanian]: *Did you tell your family?*

Era [in Albanian]: *No, I'm a sixty-year old woman, I didn't tell my husband, nobody.*

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None of Era's family members know that she was raped. At the end of the consultation, the social worker comes into the room and asks the doctor to send her the certificate. In fact, Era does not want her husband, with whom she is housed, to read it. The social worker, who helped her with her appeal, is aware of her wishes. Era has two versions of her account, one that includes her rape and another that does not mention it. A doctor at Méda told us that this sort of situation is not uncommon.

Knowledge and experience

During this consultation, Méda was made aware of a rape, an extremely violent and traumatic event. The appellant's suffering is exacerbated by the absence of any kind of follow-up care, whether therapeutic (Méda's doctors are appointed solely to carry out expert assessments) or socio-legal (the CNDA simply decides whether to accept or reject an appeal). What Era says is not listened to in all its complexity and does not receive appropriate social consideration. The rape is reported in the context of an administrative procedure. It is requested that this violent act be heard and considered by people whose job it is to evaluate the validity of asylum requests. What might happen if Era's asylum request is rejected now? In Era's experience, rejection could imply a lack of social recognition of her suffering and constitute another, institutional form of violence. As a Méda doctor says, "*There is the trauma of the rejection, and there is the trauma of the disqualification implied by this rejection*." The mechanisms of state action thus create a new form of trauma.

The social worker conveys the importance of the events in the person's life that are likely to bolster his or her file. The interpreter starts to put the event into words, not just by translating it, but also by deciding that it absolutely "must be said." The traumatic nature of the event is thus objectivized. Given that we now know how important it is to be able to deal with this sort of experience in suitable conditions, supported by a specific therapeutic approach (Salmona 2018), it is worth asking what effect this characterization for the purposes of administrative assessment has on the person concerned as well as on the other parties to the conversation (like the interpreter in this case).

When asylum seekers must talk about their experiences without being helped to work through and make sense of them, it exacerbates their impression of having to put their life on display without being socially heard. More importantly, psychological temporality does not coincide with the timing of administrative proceedings. We should, therefore, think seriously about the existence of a psychotherapeutic space. At the end of the consultation, the doctor tries to find out whether the appellant is receiving any kind of psychological or psychiatric care. When he learns that she is, he addresses the social worker, who has come back into the consultation room:

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Doctor [to social worker]: *Have you mentioned it to . . . Have you been able to talk about it to that psychologist?*
Social worker [to doctor, glancing at the appellant]: *Right, the psychiatrist, I tried to call her and talk to her because she* [Era] *gave me the authorization to do so, but she's on leave so I have to call her back and to get an appointment, I have to call her back.*
Doctor [to social worker]: *It's important because it takes time, it's not easy, uh.*
Social worker [to doctor]: *Because the interpreter was a man.*
Doctor: *Oh really?*
Social worker: *So, uh, she didn't talk about it in front of the psychiatrist but since I can give her all the information . . . she'll have all the information for the next appointment.*

Now it is the social worker playing the role of mediator between the doctor and the psychiatrist. The interpreter, who came to translate but with the desire to make sure the appellant talked about what was needed for the appeal, is joined by the social worker, who says she has notified the psychiatrist about this "new" element (Era's rape). None of those involved question the appropriateness of this relationship, particularly whether or not it is in Era's interests.

The accounts presented during the asylum and appeal proceedings are designed to conform to restrictive legal and administrative norms that reflect how our society works. According to Gérard Noiriel, the way the judicial process has developed means that "the essential feature of contemporary asylum claims is the personal identity of refugees" (Noiriel 2012, 273), while being part of a nation or social group is becoming less and less important. According to Estelle d'Halluin (2004, 32), it "is about personalizing the scene so that only the threat of individual persecution is recognized." In terms of rhetorical norms, the account must be "individualized," with experiences related to personal circumstances, and "accurate," with meticulous attention to detail; it must also avoid dwelling on economic difficulties, which could disqualify the claim based on the asylum assessment criteria.

This raises questions about the role of knowledge and about the involvement of the migrant, who in this example is partly deprived of the opportunity to speak for herself. It also raises questions about the role of the interpreter or the social worker, who, knowing what they do, feel ethically obliged to become mediators. Asylum seekers' own narrative capacities are effectively usurped (Chambon 2018) by those trying to support them, who standardize their accounts in line with norms imposed by the rhetorical

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demands of administrative procedures. Meanwhile, the forms of mediation depicted in this article, which may seem abrupt in many ways, reveal the limits of objectivity (particularly pathological). In contrast, they show the extent to which health and mental health issues are omnipresent, suggesting that it is important to recognize these types of mediation — in this case social and linguistic — and the role they might play from a therapeutic perspective. ◗

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BEING SUPPORTED BY AN INTERPRETER: BETWEEN THE NEED FOR RECOGNITION AND STRATEGIES OF RESISTANCE

While the promotion of interpreting and mediation activities was more of a militant stance in the late 1990s, today public authorities themselves are promoting the use of interpreters and mediators within care teams (Chambon, Zeroug-Vial, and Carbonel 2017).[1] We are currently witnessing the beginnings of the professionalization of interpreting, and this is being reflected in the establishment of new systems for training.[2] This development brings two groups into contact, and sometimes into tension: on the one hand, "professional" interpreters with academic and technical knowledge; on the other, so-called "community" interpreters or mediators, who act as the peers of individuals being supported, and whose skill base is built on their experiential knowledge. Many associations make use of these interpreters, who are often volunteers, trained on the job, and whose role is not very clearly defined (Pian 2017). In practice — and this was highlighted in particular by the consultations filmed as part of the ANR project "RÉfugiés, MIgrants et leurs LAngues face aux services de Santé" (REMILAS) (Refugees, Migrants and their Languages in Healthcare Encounters)[3] — practitioners act on a continuum between technical and experiential knowledge, regardless of their status. Indeed, some interpreters, whether professionals or volunteers, have first-hand experience of migration or even of the asylum process (Pian 2017).[4] This leads to a lack of clarity about the skills that are expected of interpreters. In the field of health care, their place is not determined in advance. Caregivers' expectations of interpreters vary. While some expect interpreters to limit their role to linguistic translation, others expect them to act as mediators and provide social and cultural insights (Wang 2016).

A great deal of research has focused on presenting the views of health professionals and interpreters, while the views of the individuals involved — those whose words are

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[1] Article 90 of Law no. 2016-41 of January 26, 2016 on the modernization of the health system specifies that: "Health mediation and linguistic interpretation aim to improve access to rights, prevention, and care for individuals who are disconnected from the prevention and care systems, taking into account their specificities." The same article of law provides for the publication of a reference framework of best practice drawn up by the Haute Autorité de santé (French National Health Authority). The aim of the implementing decree no. 2017-816 of 5 May 2017 is to clarify the definition of health mediation and linguistic interpretation in the health field. Translator's note: Quotation our translation. Unless otherwise stated, all translations of cited foreign language material in this article are our own.

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being translated — are poorly documented. We therefore felt it important to reflect on the expectations and experiences of migrants whose words were being translated, by conducting a study of them.

This study is based on twenty interviews conducted with individuals who did not speak French at the time of their arrival on French territory, but who subsequently acquired a sufficient command of the language, which meant we could conduct the interviews in French without an interpreter. These individuals all have in common that they have applied for asylum in France, and today have a range of different statuses. Various points were discussed during the interviews, such as their relationship to languages, their use of interpreters and translators, as well as how they learned French. The history of the individuals interviewed, the reasons that led them to seek asylum, and their migratory backgrounds were not discussed. The individuals we met were introduced to us by resource persons (professionals or volunteers from associations). We also met some of them in migrant reception associations. The interviews were recorded, transcribed, and anonymized. In addition to this study, this article draws on other fieldwork conducted as part of the REMILAS project, in particular the videos of consultations filmed in the various facilities for migrants in Auvergne-Rhône-Alpes (mobile psychiatric teams for individuals in precarious situations, health care access centers, clinics, and the association Médecine et droit d'asile) between migrant patients and care providers (general practitioners, psychiatrists, nurses). Finally, we also draw on a seminar on "Paroles, expériences et migrations" (Words, experiences, and migrations) that Orspere-Samdarra made available to exiled individuals in 2017.

The use of interpreting raises certain questions: What expectations do individuals being interpreted for have of the interpreter? How do individuals perceive the interpreter who accompanies them throughout their personal journey, within institutions, and with different professionals? Do individuals being interpreted for expect the interpreter to do only translation work? Or do they also want the interpreter to be able to provide cultural or social insights, or even to use his or her experiential knowledge — drawing on his or her personal history and background — in order to advise, support, or even act on their behalf?

This three-part article will show how the use of interpreting, while reducing the distance between health professionals and patients, can also produce a new form of assignation and dependency on the part of non-French speakers. The first part sets out what access to interpreters makes possible for non-French speakers. The second shows that,

[2] The training courses on "health interpreting" for interpreters and health professionals offered by Orspere-Samdarra since 2016 are an example of this. These courses should lead to enrollees gaining a university diploma in "interpreting and mediation" at the start of the 2020 academic year.

[3] The REMILAS project is carried out by the ICAR linguistics research group (École normale supérieure de Lyon), in partnership with Orspere-Samdarra, funded by the Agence nationale de la recherche (French National Research Agency) (2016–2020). For more information, see the project's website: http://www.icar.cnrs.fr/sites/projet-Remilas/.

[4] "Most of the volunteer interpreters we met have experience of exile and are, or have been, in the same precarious administrative situations as the foreigners supported by these associations. They often operate there in their mother tongue and use non-professional knowledge related to their own experience" (Pian 2017, 352).

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beyond what the presence of the interpreter makes possible, some individuals implement strategies to emancipate themselves from interpreters, which we will interpret as a form of resistance. Finally, the third part considers the importance that migrants give to experiential knowledge. From this perspective, the sharing of a common experience of the asylum application process seems to justify the fact of interpreting, accompanying, and supporting one's peers in turn.

Representations and issues around the figure of the interpreter

The interpreter often represents a figure that non-French-speakers feel close to, and with whom they generally want to create connections. However, establishing a relationship of trust cannot be taken for granted, and determines what the individual will be able to say, or not.

The least alien figure in an alien environment

When they arrive on French territory, asylum seekers have to find their way in an environment that is unfamiliar to them — places and geographical landmarks, administrative procedures, the language spoken, codes, culture. They may then be confronted with situations of major isolation (Einhorn, Tremblay, and Zeroug-Vial 2019), particularly when they do not speak French. Indeed, being unable to communicate in their own language, they find themselves "deprived of speech," unable to be understood and understand what they have been told. Beyond the feeling of powerlessness that this causes, this can also be a source of concern. Eshete, from Ethiopia, told us that, looking back on his first months in France, he seemed to be "*in a fog*." "*I was disoriented, distraught. It was a lonely time, I had no one to talk to. It was very hard*," he added. The isolation and the suffering that this can cause were also themes in the words of Ulrich, from Cameroon, and Tidiane, from Guinea, when they told us about their experience of crossing different countries on the African and European continent before their arrival in France. According to them, when you are in a country where you do not speak the language: "*You don't live, you don't exist. You're in a psychological prison, so you can't say anything, you can't communicate with anyone*," "*It's as if you're in prison. Even in prison you're better off*." Here, being a non-French speaker is compared to a place of confinement in which speech is eradicated.

This isolation, linked to the lack of mastery of the French language, also has consequences for the course and outcome of the asylum process and creates, in practice, inequality with French-speaking people. Asylum seekers are unequally provided with

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resources to get through the challenges of the asylum process (d'Halluin-Mabillot 2012). In fact, this linguistic isolation causes an additional vulnerability that can have an impact on the process.

In this context, the interpreter appears as an interlocutor who can overcome the isolation in which non-French speakers sometimes find themselves in the course of their journey. The interpreter gives them the opportunity to interact and communicate in a direct manner, without any other intermediaries. Sometimes, and this is particularly the case for individuals who speak only rare languages, the interpreter is the first interlocutor they meet who allows them to express themselves in their mother tongue, or in a language that they know well, when they have not been able to speak it for a long time. The complexity and duration of migration journeys exacerbates this situation. This is particularly the case for Eshete, who spent several months without being able to speak her mother tongue, Oromo, for lack of an interpreter in that language when she arrived in the country.

The characteristics that individuals share with the interpreter, beyond a common language, are seen as additional points of contact. For example, being from the same country, region, or city, sharing a culture or religion, or even a similar migratory background, are all elements that help to establish a connection between the non-French-speaking migrant and the interpreter. This inevitably creates a sense of complicity between the individual being interpreted for and the interpreter, thereby creating a special place for the latter. Some health consultations show the effects of the interpreter's presence. In a consultation between a doctor from the association Médecine et droit d'asile (Méda)[5] and a Nigerian patient, the English-language interpreter — who works for an association and does not know the patient — arrived late. The doctor, who is fluent in English, started the consultation without her. For the first fifteen minutes of the consultation, the interaction was laborious. The two interlocutors' conversation conducted in the same language revolved around basic questions,[6] but they seemed to have difficulty understanding each other. Sitting rigidly and extremely upright, the patient was strained and tense and appeared to be in a state of panic or alert.[7] The interpreter's arrival caused a radical change in the patient's posture. She seemed to relax bit by bit, speaking more calmly, while looking to the interpreter to translate her words and those of the doctor, even though, surprisingly, the doctor continued to interact in English with his interlocutors despite the presence of the interpreter. While many avenues of analysis and reflection emerged from this consultation, it is a perfect illustration of the mediation role that the interpreter can play and its undeniable effects on the course of interviews.

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[5] The mission of the association Médecine et droit d'asile (Méda), based in Lyon, is to receive asylum seekers whose application has been rejected by the Office français de protection des réfugiés et apatrides (Ofpra) (French Office for the Protection of Refugees and Stateless Persons) and to carry out a medical examination in search of significant objective traces of a history of cruel, inhuman, or degrading treatment (abuse suffered, the presence of psychological and physical after-effects) so that a certificate can be sent as part of the appeal process to the Cour nationale du droit d'asile (CNDA) (National Court of Asylum).

[6] Ascertaining the surname, first name, and date and place of birth of the patient and her children.

[7] This consultation took place because the patient was appealing to the CNDA following the refusal of her asylum application, and was held the day before the CNDA was convened. The doctor quickly noticed that the patient's file was not complete. He tried to question her about it by handing her the papers, but she could not read and did not recognize the documents. The doctor tried to contact the patient's social worker so that he could quickly pass on the missing document, but to no avail. This also made the patient more stressed.

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Between the desire and the need to create connections

During the asylum application process, in addition to his or her role in translating, the interpreter may be identified by migrants as a resource person, capable of helping and advising them in their administrative process, in the light of his or her own experience, background, and knowledge. Individuals therefore expect the interpreter to be able to use his or her experience to help them.

This can also place interpreters in complex situations, as one interpreter commented: "*They* [asylum seekers] *are so confused . . . I feel like they're begging me to help them personally, something that I can't do. They're looking for a special bond to improve their situation. Which seems to be a pretty good survival skill*." As we have seen, the interpreter can take on the role of helper voluntarily or reluctantly. Ilir, an Albanian-language interpreter with a background as an asylum seeker himself, explained to us that he was deeply affected by the stories that he translated. He often cried during the interviews and consistently suggested that they be extended over coffee so that he could support those for whom he was interpreting. In other cases, several interpreters testified that they had been confronted with difficult and intrusive situations, particularly when individuals asked them for their personal telephone numbers. These situations emphasize the need for interpreters to adopt a recognized position, linked to a defined professional role, enabling them to be close enough to the individuals for whom they are interpreting to establish a relationship of trust while at the same time maintaining sufficient distance.

The necessary trust in the interpreter

As with interpreters and professionals in the health sector, the trust that individuals have in interpreters is also crucial in the context of the asylum process. We observed that it can be difficult for the individuals being interpreted for to trust the interpreters to begin with, as Lena, from Armenia, puts it: "*I don't trust anyone. Because . . . it's complicated. It's difficult for me. It's my problem, it's my heart*." Being interpreted for puts individuals in a position where, firstly, they have to accept a level of dependence on someone who is a mere facilitator, rather than being the main person they came to meet — for example, the doctor, the social worker, an agent of the Office français de protection des réfugiés et apatrides (Ofpra) (the French Office for the Protection of Refugees and Stateless Persons) — , and secondly, they have to be able to talk about themselves. A lack of trust in this third party can prevent them from expressing themselves.

Besides these interviews, it is common for the same interpreters to provide their services to asylum seekers in different spaces.[8] By accompanying the individuals

[8] Including medical, administrative, legal, school, and association appointments.

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for whom they are interpreting through their various procedures, interpreters become closely acquainted with the course of their lives, get to know various types of information about them, and acquire a certain knowledge of their history. Strong relationships can also be created between interpreters and those for whom they are interpreting, which can encourage interpreters to go beyond their assignments and the framework of their job. This was noticeable when, a few minutes before the end of a consultation at Méda, the interpreter addressed the doctor and told him that the patient, an Albanian woman, had not told an important part of her story during the consultation. This had important stakes for the appeal, as it had never been stated before. The interpreter, who was following this woman's application process, was aware of it. Some individuals choose to rely on the interpreter accompanying them to tell their story directly, while others are much more reluctant to confide in a third person.

Forms of resistance to the relationship of dependence and strategies for emancipation from the interpreter

Although the interpreter has a central role in the reception of non-French-speaking migrants, we have heard expressions of reluctance and mistrust regarding the very principle of using an interpreter. Attitudes of resistance can be observed,[9] which can be manifested as different strategies to emancipate oneself from interpretation.

When one's words are interpreted, the spoken translation moves outside of the control of the first speaker, and places him or her in a position of dependence on a third person who "transfers, transports, translates, adjusts, adapts, attenuates, reinforces, summarizes, describes, explains" (Ticca and Traverso 2017, 305).

We observed that some non-French-speaking migrants were very determined not to use an interpreter. "*Translator?: never*" are two words that sum up the attitude of an individual who did not speak French when he arrived in France. These words reflect the fact that some individuals particularly resent this dependence on the interpreter, especially in the context of the asylum application process or clinical interviews. This is all the more marked for individuals who have had a traumatic experience linked to their exile or their migratory journey. In the context of an asylum application or when medical care is required, talking about oneself involves confiding in others, evoking traumatic events and intimate elements of one's history. The case of Petrit, from Kosovo, illustrates this perfectly when he shows us the card on which his appointments with the psychiatrist are noted. He tells us, smiling and visibly very pleased, that the next appointment will take place without an interpreter. We then ask him what will happen. "*I'll start telling my*

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[9] The concept of "resistance" is understood here as "a mode of action and reaction in a situation of social and identity assignation, or even objectivation through institutional treatment, in this case that of asylum seekers" (Felder 2009, 119).

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story," he answers. There are two possible interpretations of this confession. The first is that not everything has been said in the presence of the interpreter. The second is that this story will no longer be co-constructed and will therefore, as a result, become his own ("my story").

Migrants often have no knowledge about the professional framework in which interpreters work. This fuels their feelings of mistrust, which are connected in particular to the fear that the interpreter will not respect the confidentiality and impartiality of the interview, especially when he or she is from the same community as they individual. Certain other factors can also be problematic, such as the interpreter's origin,[10] but also his or her gender, social background, or religion. When asked about his freedom of expression in the presence of the interpreter during his consultations with a psychiatrist, Petrit replied: "*My problem is a little sensitive in Albania. And it continues to be so.*" His experience, considered problematic in his country, makes it difficult for him to express himself in the presence of an interpreter. The reasons for his exile are played out here in the host country.

The context of the asylum claim often assigns individuals to a status, a process, or even to a "negative identity" (Felder 2009). They maintain, sometimes in spite of themselves, relations of dependence throughout their migratory journey — dependence on their trafficker, their supporters, associations, but also on the professionals they meet. The use of an interpreter can therefore be seen as creating an additional relationship of dependence. The relationship can be experienced as a "humiliation and unbearable infantilization that removes them from their adult status and keeps them in a state of institutional dependence" (Gerbier-Aublanc 2017, 249). They must therefore rebuild their power to act and reappropriate their own life path.

Being able to ask for an interpreter in a particular language, or not wanting to use one, is a way of asserting oneself and positioning oneself as an actor in one's own journey. Joy, a Nigerian woman, spoke to us vehemently about the use of interpreters: "*It's your personal life. It's up to you if you want a translator, if you don't want one: basta!*" She therefore emphasizes the importance of the uniqueness of one's own journey, demanding the right to choose in the decisions that concern her. The fact that she does not speak French would not justify her being forced to have an interpreter present. Having the ability to act here is connected to the possibilities of overcoming the constraints and obstacles of exile, as well as the possibility of influencing one's environment according to one's needs. There are a number of different responses to this desire to resist.

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[10] If the interpreter is from the same region or country, or from a country or community in conflict with that of the individual for whom he or she is interpreting, this can be a source of concern for the latter. Individuals may fear that their speech will not be translated correctly, that their words will be changed, or that what they say will be used against them, exposing them to reprisals, or simply that their words might be repeated elsewhere.

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Creativity and emancipation strategies

The individuals we met shared with us the strategies they use to emancipate themselves from the interpreter, assert their desire to integrate into the host society, as well as reassert themselves as actors in their own story.

Learning French as quickly as possible

Learning the language of the host country is a major challenge for non-French-speaking migrants. However, it is not easy for individuals undergoing the asylum process to access French language courses that meet their needs and expectations.[11] In this context, learning the language of the host country was perceived by those we met as an individual initiative that necessarily entails significant personal investment. Finding out about the different associations that offer language courses, accessing them, while working out how to move around the city and organize one's time, are listed as skills that are required to achieve this objective. Mastering the French language is therefore proof of a personal effort, a strong motivation to learn, with the human qualities required to achieve it — courage, patience, and perseverance — cited in particular. Learning the language is also seen as a way of filling one's time and giving meaning to one's days.[12] These strategies have a psychological cost and require a certain amount of energy that can be undermined by the situation of precariousness and of awaiting news about one's application.

Various strategies have been adopted. In addition to attending courses offered by associations, individuals also told us about the different methods they used to learn the language or to improve their level, such as watching videos on the internet (on YouTube, for example), using free language-learning applications or software available on computers in municipal libraries, reading comic books, sitting at the back of buses in order to try to hear and understand conversations and learn words by repeating them, and so on. Spending less time with members of one's home community can also be a necessary condition. Arshad, from Afghanistan, justifies this distance as follows: "*I didn't spend much time with Afghans. I can't learn French there, that's why. I told them: 'I like you a lot but I can't stay much.' I told them we have to speak French, so we'll get used to it, we'll learn French, but they don't know how, that's why they don't speak it and I have to speak Pashtun with them.*"

Ensuring that translation is accurate and pushing back important deadlines

Individuals who are reluctant to use an interpreter but whose level of French is not yet sufficient to communicate without one implement other strategies to ensure the quali-

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[11] In France, access to French language learning for foreigners is determined by their administrative status. Since 1991, when the Rocard Law came into force, a distinction has been made between the rights granted to asylum seekers and those granted to statutory refugees. This marked the end of access to work and vocational training for asylum seekers in France, including access to language training. Asylum seekers, engaged in a waiting process that remains lengthy despite asylum procedures having sped up in France in recent years, must now obtain refugee status in order to have access to these rights. In the event of a positive response to their asylum application, French language courses are offered to them by the Office français de l'immigration et de l'intégration (Ofii) (French Office of Immigration and Integration). In the Lyon region, the language courses provided free of charge by associations are often oversubscribed, with a waiting list several months long. Associations rarely offer any courses that go above level B1, which is often insufficient.

[12] We feel it is important to point out that the people we met have the specific characteristic of having migrated alone for the most part. This undoubtedly had an impact on their linguistic experience in France, and we think it would be interesting for another research project to extend this part of the study to people who migrated with their families.

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ty of the interpreter's translation. They see interpreting as carrying risks — that of transforming their speech, changing their story, or translating inaccurately — which can have serious consequences for their future in France. This fear is accentuated during high-stakes interviews, where their words and story play a decisive role. Indeed, during the drafting of the asylum application statement, or interviews at Ofpra or at the Cour nationale du droit d'asile (CNDA) (National Court of Asylum), several individuals expressed the wish to verify what the interpreter had said. For example, Lida, from Afghanistan, explained that a friend asked her to translate his asylum story — written in French with the help of an interpreter — into Dari Persian to make sure that everything he had said had been transcribed and that there were no mistakes. Beginning to understand a few words in French can also be reassuring, as it allows individuals to ensure overall consistency between what is expressed and translated. Joy, meanwhile, uses a translation application on her phone to "*check if they* [the interpreters] *are talking rubbish*." She also tried to reschedule deadlines to give her as much time as possible to learn the language: "*If, for example, my appointment is for 22 October, I'll say: 'Can we put it off until 10 January?,' something like that. In the meantime, I'll try to [learn to] speak French*." Joy says that had her French not been good enough in time for her to attend her Ofpra interview, she would have preferred to postpone her appointment. This argument also applies to access to mental health care. Emna, from Iran, preferred to wait until she could express herself in French before consulting a mental health professional "*without someone else*," in order to "*explain myself what I have to say*." Her treatment was therefore postponed, even though she felt that she needed it.

In the context of the asylum application, claimants are expected to be able to "defend" their story, both by providing the details requested and also by embodying it, since they must succeed in convincing others that the story being told is indeed their own. Interviews at Ofpra can last several hours and the story must be striking and effective if the claimant is to be able to enter into the sort of discourse required to prove his or her eligibility for asylum (d'Halluin-Mabillot 2012). It is therefore clear why it is important to produce a clear, controlled, and embodied form of speech, especially since the stakes are so high. In this regard, we have collected a certain number of negative experiences of interpreting. For example, the individuals being interpreted for reported difficulties in being understood by the interpreter or in understanding them, the feeling that the interpreter was judgmental or lacked neutrality, or the impression that what was said was summarized or translated inaccurately. As the "facilitators" of asylum statements, interpreters have a role in the co-construction of these stories. By conveying asylum seekers' stories throughout the various stages of their process, they bear a special responsibility in asylum seekers' eyes. A link is established between the experience of being interpreted for and obtaining or being denied refugee status, as Joy illustrates:

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"*I think she didn't have a good translator. As a result, Ofpra rejected her asylum application.*" As we have heard on several occasions, if the application is rejected, the responsibility for the institutional decision is shifted back to the interpreter as an individual, as well as his or her translation skills.

Using experiential knowledge to help others

Some of the individuals we encountered highlighted the fact that they had already acted as interpreters, once they had mastered the French language, for non-French-speaking asylum seekers. They explained this by the fact that they themselves had gone through the ordeals of this procedure. There is a recognition of a similar life path, based on shared suffering and hardship. The simple fact of having gone through it and having a minimum level of French justifies the ability to help others, as Eshete expresses it: "*I do it voluntarily, because it makes me happy to be able to help someone. Because I've been there, I know what people are like, I know their situation. So if people need me, they call me.*" Ilir adds: "*I pass on knowledge to them, so they have more hope. I had the same experience as the asylum seekers, I understand them very well. I can understand them better and make them understand me. I share their pain and I share the difficulties they have, like the ones I went through.*" This is not just about linguistic translation but about mediation as a peer. Sharing a common experience, in this case the experience of the asylum process, is seen as reassuring. Yonas, from Eritrea, explains: "*When someone tells you their stories, if you also tell them what you've been through, it reassures them. They think that there's someone who understands them and who's gone through the same things they have, that reassures them. They'll think that they'll be able to do it too. It's encouraging, to have someone who has lived through it but … who has succeeded and survived.*" However, a bond can also be created by the fact of sharing the suffering related to the conditions of departure, the migratory journey, and also the precarious conditions of reception.

For those who have been granted protection, the end of the administrative process can also be an opportunity to support, assist, and affirm their solidarity with those who are still applying for asylum and are facing various difficulties.

We note here the importance of "peer support" for asylum seekers. This is particularly what Joy advocates, when she tells us that she translated a claimant's appeal. When asked about the difficulties in translating the claimant's personal story, she spontaneously answers that she did not translate everything, but "hid" what she felt to be too intimate: "*She tells me everything, her story. And when I translate, there are parts that I hide, because this is her personal life, she can't say that to everyone, but she doesn't*

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know it." Joy justifies this by explaining that the decision-maker (in this case the CNDA) needs proof and that it is therefore useless to bring up traumatic and personal elements that she will not be able to prove: "*This thing, you must not tell her, because this is your personal life. There are things you can say, there are things you can't say. You keep that to yourself. Even if it hurts you, it doesn't matter. I know a little bit about how it works here in France to get refugee status, it's not easy. There are stories you can tell that have nothing to do with it, they'll think it's not true. You need proof to get French papers. So when she told me about her story, I said, 'You mustn't say that, because if you say that they won't believe you.* They will think you're lying*. If they ask for proof,* you can't prove yourself.'"[13] For Joy, it is the very fact that she herself sought and was granted asylum in France that encourages her to help and guide another claimant's speech. Interpreters have power over what they hear, but above all over what they say, and this power is manifested in the ability to transform and shape that speech. This "power" is clearly revealed by the position Joy adopts, which she validates, moreover, by concluding: "I try to arrange everything the good way. *And I succeeded, she has her papers now*."[14] Here, Joy, sharing the same experience as the claimant, goes beyond the translation assignment for which she was engaged, by positioning herself as a peer mediator. In her view, her position is different from that of a professional interpreter, who, without sharing the same migratory journey or experiential knowledge, would not necessarily have been able to obtain a positive outcome for this claimant. In this sense, beyond the support that they can provide to individuals during the process, we note that for some, there is an interest in using their experiential knowledge to act in the interest of the other, and that this legitimizes their action as peer supporters.

Being able to use interpreters is seen as a fundamental requirement for non-French-speaking people, and essential for a dignified reception process. However, those we met, in the light of their experience, were determined in their desire to emancipate themselves from the interpreter at certain points in their journey. It came as a surprise in this study to discover the strategies that are used to manage without interpreters. Above all, this determination underscores these individuals' desire to assert their autonomy and independence in order to position themselves as actors in their own journey.

However, due to their lived experience — of migration, asylum, being supported — a number of individuals in turn position themselves to accompany and support migrants, in roles ranging from language interpreting to mediation. We suspect that the emergence of the profession of peer (health) mediator in the fields of health, mental health, and precariousness may also be followed by the emergence of a similar profession in the field of support and care for migrants. Training is one of the most important issues

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[13] The phrases in roman script in this quotation were spoken in English rather than French.

[14] The phrases in roman script in this quotation were spoken in English rather than French.

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in the definition and recognition of the professions of interpreter and mediator. The idea is not that they should be made experts in a geographical area or representatives of a community, but that they should be able to make use of their knowledge and experience for the benefit of the individuals concerned. ◗

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