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WASHINGTON UNIVERSITY IN ST. LOUIS
Department of Anthropology

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Ecole doctorale de sciences sociales
Anthropologie sociale et ethnologie

Dissertation Examination Committee:

Carolyn Sargent (Chair, WU)
John Bowen (Co-Chair, WU)
Didier Fassin (Co-Chair, EHESS)
Ahmet Karamustafa (WU)
Rebecca Lester (WU)
Richard Rechtman (EHESS)
Brad Stoner (WU)
Mahamet Timera (Paris VII)

CULTURAL ANXIETIES AND INSTITUTIONAL REGULATION

**“SPECIALIZED MENTAL HEALTHCARE
AND “IMMIGRANT SUFFERING” IN PARIS, FRANCE**

By

Stéphanie Larchanché

A dissertation presented to the
Graduate School of Arts and Sciences
of Washington University in
partial fulfillment of the
requirements for the degree
of Doctor of Philosophy

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Abstract

This dissertation looks at “specialized” mental healthcare expertise in France as a lens through which to address the institutional management and representations of cultural difference in France today. By “specialized” mental healthcare centers, I refer structures that provide culturally-sensitive mental health services to immigrants specifically. I identify and explore three contemporary expert approaches: namely, transcultural psychiatry, clinical medical anthropology, and ethnoclinical mediation.

By providing a genealogy of specialized mental healthcare institutions, and by construing them as “meta-discursive nodes”—that is, as points of encounter between state, institutional, and individual ideologies—I provide an analysis of the cultural anxieties, contradictions and double-binds that arise from the opposition between a regulative, universalist republican ideology, and a field of expertise which strives to promote culturally-sensitive mental healthcare for immigrants.

I argue that, as a product of the conflation of the “immigrant issue” (*la question immigrée*) and the “social issue” (*la question sociale*), “immigrant suffering” (Sayad, 2004) has become a medium that problematically couches immigrants’ “difficulties”—whether they relate to mental health pathology or structural problems—in terms of cultural difference. As a result, generic cultural representations of immigrants are uncritically reproduced, making it difficult to identify and address the structural inequalities that do engender suffering.

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Table of Contents

Abstract	ii
Acknowledgments	iii
Table of Contents	vii
CHAPTER 1: Introduction.....	1
The context: “Specialized” mental health at the intersections between social policies, immigration, and the discourse on national identity.....	1
The research and definition of concepts	5
Theoretical Framework	8
A genealogy of specialized mental healthcare and “immigrant suffering”	11
The structure of the specialized mental healthcare field	13
Culture in mental health:	
The language of “immigrant suffering” in and beyond the clinic	15
Methodology	19
Research population: Sub-Saharan African immigrants and their children	19
From social and health services to “specialized” mental healthcare	20
Framing Health Issues and Identifying Assistance Networks	23
Selecting “specialized” mental healthcare institutions	24
Gepela: an association and “ethnoclinical” mediation center	26
Minkowska: a community mental health institution and “clinical medical anthropology” center	28
Avicenne: a university hospital with a transcultural psychiatry consultation, affiliated with the Jean-Baptiste Carpeaux Center: a community mental health institution with an ethnopsychiatry consultation.....	30
Referrals and the circulation of immigrant patients	32
Ethnography of the Transcultural Psychiatry Program	34
Situated knowledge	35
Chapter Summary	39
<u>PART I: GENEALOGY</u>	
CHAPTER 2: French Colonialism and the “African Mind”.....	44

Race, Mental Difference, and Politics	46
The genesis of the race concept and its application in the nascent field of Anthropology.....	46
Racial prejudices and anthropological studies on the psychology of “primitives”	48
The political uses of racial theories	51
Colonial Psychiatry and the “African Mind”	53
The case of the Algiers School: Ethnopsychiatry in the French Colony	54
Other ethnopsychiatries	59
Post-Colonial Critique and the New Ethnopsychiatry	63
Fanon: Political Critique and “Sociotherapy”	63
Independences and Alternative Approaches to Culturally-Sensitive Psychiatric Care	66
George Devereux: Theorizing Ethnopsychanalysis	70
Conclusion	75
Synopsis of Chapter 2	76
CHAPTER 3: Immigrants in France —From Malingering Bodies to Deviant Families	78
A National Contradiction: Universalism and the Conditions of Belonging	79
Labor Migration and the Malingering Body	82
An overview of labor migration until the 1970s	82
Separate Care for Foreigners: The Creation of the Avicenne Hospital	86
The “illness of immigration”	89
Early “Specialized” Mental Healthcare Structures in France: A Focus on Trauma ..	92
“Immigration After the ‘End’ of Immigration” (Hargreaves, 1995:17): Towards the Management of Deviant Families	94
From Workers to Families	94
The “Immigration Issue” and the Cultural Politics of Health in France	98
“African AIDS”	100
African fertility	101
Lead-poisoning: a disease of African culture	102
Networking Healthcare: The Social Management of Immigrant Families and the Broadening of the Mental Healthcare Field	104
Cultural Mediation	105
Ethnopsychiatry	108
Conclusion	110
Synopsis of Chapter 3	112

PART II: INSTITUTIONAL DISCOURSE

CHAPTER 4: “Specialized” Mental Health – The Making of the *Field*114
**Medicalizing and discriminating – Testing the boundaries of republican ideology
and “scientific” discourse115**

Immigration politics in France and “The Universe of Possibilities”116
Nathan’s spin on ethnopsychiatry118
Pushing Cultural Relativism, Loosing Institutional Legitimacy120
Delegitimizing the dissenter125

Maintaining expertise – Re-labeling “specialized” mental healthcare129
The three “specialized” mental healthcare centers130
Coining scientific labels132

The transcultural psychiatry model and “hybridity”132
Clinical vignette: Performing Transcultural Psychiatry134
The clinical medical anthropology model and “explanatory models”138
Clinical vignette: Performing Clinical Medical Anthropology141
The ethnoclinical model and “bridging intentionalities”144
Clinical vignette: Performing the ethnoclinique146
Synthesizing the three new approaches151

Networking Expertise153
University diplomas and on-site/off-site professional training153
Competing in a field: scientific texts, multimedia, and international networks .157

Conclusion160
Synopsis of Chapter 4162

CHAPTER 5: Performing Expertise – A Reflexive Field165
Becoming an expert:
Internal deliberations on “specialized” mental healthcare167
The experts: Immigration, reflexivity, and the professional project168

Colonization, immigration, and cultural identity171
The universal and the particular173

The trainees: “self-disembedding” mechanisms and “adapted” responses to cultural
difference177

Encounters with difference: Discrimination and trauma narratives180
“Practiced” narratives of the self: Psychoanalysis and reflexivity185
Lessons learned:
Beyond “culture,” beyond immigrants, beyond specialized care188

Graduate Training in Transcultural Psychiatry: Institutional Reflexivity	191
“Decentering” and “counter-transference:” The relevance of culture in clinical care and beyond	193
Institutional positionality: Mediating between immigrants and institutions	198
Problematizing the patient’s “need” (<i>la demande</i>)	199
A reflexive case-study	200
Conclusion	203
Synopsis of Chapter 5	205
<u>PART III: CLINICAL NEGOTIATIONS</u>	
CHAPTER 6: Referring and Naming	207
Instruments: Filing without differentiating? (internal representations)	211
Minkowska: Adapting to French public healthcare guidelines	212
Jean-Baptiste Carpeaux and Avicenne: One filing for all?	217
Gepela Center: Mediating for “Africans”	222
Internal contradictions	223
Referring: Repertoires of representations and structural obstacles (external references)	224
Communicating cultural differences, locating pathology	226
Managing immigrant families	229
Conclusion	235
Synopsis of Chapter 6	237
CHAPTER 7: Circulating and Contesting	239
Specialized Mental Healthcare Practitioners: Between Legitimizing and Contesting	240
The double-bind	240
The double-bind in its clinical context	242
Activist roles	253
Immigrant “patients”: Between Contesting Institutional Circulation and Mobilizing Specialized Mental Healthcare Centers as a Resource	259
Contesting at the margins	259
Institutional Circulation as a Resource	270
Conclusion	275
Synopsis of Chapter 7	277
CHAPTER 8: School Referrals	279
Starting at School:	

Locating “Difficulties,” Naming Disorders and Disabilities	283
Immigrant descent as the basis of “difficulties”?	285
Disability Representations:	
The Conflicts between Schools and Immigrant Families	288
Behavioral Disorders: The Conflicts between Teachers and “Children of Immigrants”	297
Listening and Communicating: The Missing Link	303
 From Schools to Specialized Mental Healthcare Centers: Circulating and Contesting	 304
Pre-Consultation Meeting with Gepela: Communicating vs. Referring	304
School Referrals and the “Double-Bind:” Clinical Scenes	313
Case 1: Individual School Actor Referral	314
Case 2: Personalized School Project Referral	320
Case 3: Cultural Variations on the Concept of Disability	326
 Conclusion	 330
Synopsis of Chapter 8	332
 CONCLUSION	 335
Contributions to anthropology	345
 BIBLIOGRAPHY	 351
 APPENDICES	 376
Appendix A : Specialized Mental Healthcare Institutions Chart	376
Appendix B : Table of Referrals, Minkowska, 2007	378
Appendix C : Demographic Charts : Immigration flows to France	383
Appendix D : Interviews and Vignettes: Dates and Methodology	389
Appendix E : School Referrals Organizational Charts	391

I. The context: “Specialized” mental health at the intersections between social policies, immigration, and the discourse on national identity

In the early 1980s, French society gradually discovered the social consequences of the economic crisis that started in the previous decade, among them, high unemployment rates, and urban violence. This time of social insecurity brought about the “problem” of immigration, which at the time “euphemistically [signified] ‘the problem of North African Muslim immigrants and their children’” (Silverman, 1991:1). Today, I would argue, especially since the highly mediatized 1993 anti-polygamy law, the “problem” largely encompasses sub-Saharan African immigrants and their children. Immigration thus constituted a threat to a nation perceived—or rather, mythologized—as culturally-homogenous. In May 2007, the inauguration, under the new presidency of Nicolas Sarkozy, of a Ministry on Immigration, Integration, National Identity and Solidary Development (*Ministère de l'Immigration, de l'Intégration, de l'Identité nationale et du Développement solidaire*), attested to the persistence of a dualistic model of “the French” versus “the immigrants.”

In fact, as French historians only recently documented, France had long been a nation of immigration (Noiriel, 1988), concerned with its identity, and driving the inclusion or exclusion of “foreign” populations on the basis of their potential for “integration” (Weil, 2008). French philosopher Etienne Balibar (1991) argued that racism and nationalism are inextricably linked, and that racism is a total social phenomenon in modern societies. In France, nationalist discourses fed into racist ideologies, but the

process was consistently hidden behind the universalist claims of the republican discourse. In 1970s France, there was no use of the concept of “race.” Instead, “race” was semantically substituted by “cultural difference,” but, Guillaumin argues, “[the] syncretic core of racist ideology, [based on physical, mental, and cultural forms], remain[ed] intact” (1991:13). French political parties, both left-wing and right-wing, made marked attempts at distancing themselves from the concept of “race,” appropriating instead—albeit with different purposes—a discourse on “the right to difference” (*droit à la différence*). The right to difference was also used by 1970s and 1980s antiracist movements, especially to counter increasingly popular extreme-right National Front party’s charismatic leader, Jean-Marie Le Pen, and the differentialist ideology of the Club de l’Horloge’s New Right.¹ However, as French philosopher and historian Pierre-André Taguieff argued, “antiracism falls, better than racism—its continual invention and its condition of existence—under the general definition it gives to its designated enemy” (2001[1987]:14).

It is undeniable that, beyond issues of ethnic identity, racism in France also stems from the social and economic problems to which immigrants are particularly vulnerable. In the late 1970s and 1980s—as it persists until today—immigration was problematized in relation to “the sickness of the suburbs” (Champagne, 1999[1993]). As profits made by the French economy from migrant labor significantly eroded, the permanent settlement of non-European immigrants and their families in the suburbs of major French cities raised the issues of the social costs of immigration, namely housing, education, medicine, and

¹ The Club de l’Horloge is a political school of thought, founded on the works of Alain de Benoist and GRECE (Research and Study Group on European Civilization). It is concerned with preserving the “roots” of French identity, namely France’s republican values. See: Le Club de l’Horloge, 1985, *L’identité de la France*, Paris: Albin Michel.

welfare (Sayad, 1999[1993]). As a result, some municipalities practiced territorial exclusion based on population quotas,² and relocated immigrant populations to concentrated, low-income housing areas (MacMaster, 1991). In combination with rising unemployment, housing conditions in these low-income suburbs rapidly deteriorated, leading to urban violence, such as the riots that took place in the suburbs of Lyon in 1981 (Bachmann and Le Guennec, 1996). Media attention then focused on “young immigrants,” as they were called, at that time mainly referring to French-born youth of North African descent— “*les beurs*.”³ Their protests were alternatively interpreted as the result of culture shock, school failure, or delinquency.

The political response was almost immediate, as in May 1981 socialist candidate François Mitterrand was elected President on a pro-immigrant rights platform. Capturing the discourse on the “right to difference” as a universal right, Mitterrand advocated for “A Plural France” (*La France au pluriel*), commenting that “we profoundly believe that if France must be united, she must also be rich in her differences. Her unity has enabled our country; respecting her diversity will prevent her undoing. One and diverse, that is France” (in Silverstein, 2004:163). In addition to the implementation of pro-immigrant policies, such as the abrogation of deportation laws and the massive regularization of illegal immigrants, or the right for immigrants to form associations, Mitterrand’s socialist government launched a series of “social policies,” most of which focused on urban areas.

² Quotas were based on the theory of “*seuil de tolérance*,” which maintained that “when the percentage of foreign or immigrant people reaches a certain threshold within a given locality or institution (a housing estate, a ‘quartier,’ a school or hospital) there follows an almost automatic process of hostile rejection by the indigenous population” (MacMaster, 1991:14).

³ A slang term, coined by reversing the syllables of the word *arabe*, which means Arabic or Arab in French.

Public officials began to speak of “urban youth” (*jeunes des cités*), “precarious neighborhoods” (*quartiers en difficulté*), and “social exclusion” (*l’exclusion*) (Fassin et al., 2004). A number of reports—all resulting from the collective work of social science researchers, doctors, psychiatrists, psychologists, social workers, and administrators—pointed to new forms of psychic suffering, both for the socially excluded and for the social agents that work to assist them. The observation rapidly gave rise to public initiatives, qualified as “mental health” initiatives, and involving the collaboration between psychiatrists, psychologists, social workers, and educators. A new field started to take shape: a multidisciplinary field of mental health, with a cohort of experts crossing institutional affiliations and its language of “social suffering” (*la souffrance sociale*) (Renault, 2008).⁴ After the reform of the psychiatric hospital, this field of mental health extracted itself from the logics of district-based⁵ healthcare organization, so as to cater to disorders no longer relating to medical pathology, but to a wide array of “social problems.” As Fassin et al. contend (2004), this development followed two interdependent logics: the logics of caring (*logique d’assistance*)—caring for a population suffering from precarity (both socially and psychologically), and the logics of regulating (*logique d’encadrement*)—regulating the behavior of those, the youth in particular, who relieve their suffering through risk behavior such as violence or drug abuse.

⁴ I am referring to a field of mental health that moves beyond the boundaries of traditional mental health disciplines, namely psychiatry and psychology.

⁵ This term “district-based” (*sectorisé*) refers to the geographical organization of care provision in the French public health system, in which hospitals target populations within geographically demarcated limits, in contrast to those with no geographical restrictions on patients.

It is in this context that, what I refer to as “specialized” mental healthcare institutions—mental health structures catering specifically to immigrants—developed in France, starting with the creation of Tobie Nathan’s ethnopsychiatry consultation in 1980. In parallel to the popularization of the practice of “cultural mediation” for immigrant families in public institutions such as schools, hospitals, and justice courts, “specialized” mental healthcare received wide state financial support for the management of “immigrant suffering.”

II. The research⁶ and definition of concepts

This dissertation is about the articulation of what in the French context would be referred to as “cultural difference,” both in the institutional discourse of mental healthcare structures catering to immigrants in France, and in the interactions of the various social actors who meet there. It analyses the performance of being able to speak of cultural difference meaningfully, while minding the discriminating potential of its very utterance in the French republican context. This is about a cultural anxiety—the anxiety of multicultural France. This “difficulty with naming” (*la difficulté de dire*, to borrow Didier Fassin’s expression, 2006) in contemporary France has its history and its present justifications. At times, such difficulty hides racist intentions (Fassin, 2006)—a form of racism without race.

In my research, I refer to the notion of “immigrant suffering” (Sayad, 2004). This is not one that is used in everyday discourse in France. I borrow this notion from the work of French-Algerian sociologist Abdelmalek Sayad, who used it to refer to the

⁶ This research received funding from the National Science Foundation (Doctoral Dissertation Improvement Grant #0650072) and from the Wenner Gren Foundation (Dissertation Fieldwork Grant #7561), to both of whom I am infinitely grateful.

paradox of suffering from the immigrant condition while simultaneously dissimulating this experience so as to maintain the coherence of immigration as a total social phenomenon.⁷ Likewise, I use Sayad's notion of "immigrant suffering" to underline a paradox and, I hope, semantically capture the contradiction that mental health experts and referring social actors often face—albeit for different reasons—in referring to culturally-different population categories, without naming them. Indeed, on the one hand, the "immigrant" category is both arbitrary and imprisons the individual it refers to in his/her irreducible cultural difference—especially when it encompasses the French-born generation (Noiriel, 2001). On the other hand, the "suffering" category—purposefully in tune with the politicized language of "social suffering" born in the 1980s—refers to how vaguely social agents have come to define psychic suffering, without necessarily resorting to any clinical or medical nosology (Jacques, 2004).

I identify this notion of "immigrant suffering" as the product of the "specialized" mental healthcare movement in France, which developed at the end of the 1970s. Again, "specialized" mental healthcare is not a category that is used in the French public health jargon. It is another analytical construct I use to pragmatically regroup the various mental health institutions catering to immigrants specifically, whether or not they are identified distinctively according to their various clinical approaches.

My analysis bears on the *representations* of "immigrant suffering," rather than on its *experience*. Therefore, while it includes clinical interactions, the ethnography that follows focuses first and foremost on the institutional discourse of specialized mental

⁷ Sayad specifically refers to Algerian immigrant workers in France who suffer from being both displaced and excluded, while they simultaneously feel bound to downplay this experience of suffering, thereby encouraging the reproduction of the economic, social, and mental structures of immigration around a "collective lie" that paradoxically gives coherence to their experience.

healthcare, as well as on the rationales that inform the referral of immigrants to specialized mental healthcare institutions. It pays attention to how social agents name and interpret cultural difference through their identification of “immigrant suffering.”

In this dissertation, I argue that while racist thinking initially informed the relationship between culture and the expression of mental health disorders, contemporary “specialized” mental healthcare institutions are characterized by a non-stigmatizing, non-essentializing understanding of the concept of culture and of its relevance in the interpretation of mental health disorders and their treatment. Their challenge is specific to the cultural context of France, and shaped by a republican ideology in which references to culture are perceived as readily stigmatizing and anti-republican. In such a context, specialized mental health faces the dilemma of having to abide by structural logics which lead them to “positively” differentiate so as to precisely destigmatize their immigrant patients. As a result, the discourse of these institutions, as well as the interactions which take place *in* and *around* the clinic concerning the referral of immigrant “patients,” are fraught with contradictions and inconsistencies. “Specialized” mental healthcare experts thus routinely find themselves caught in “double-binds,” wherein they find it difficult to appropriately counter arbitrary or racist-informed referrals, or themselves create the stigmatizing situations they seek to avoid. In these dynamics, symbolic language strategies—especially the use of institutionalized euphemisms such as the concept of “difficulty”—prove to be powerful instruments of negotiation.

Ultimately, I argue that the analysis of interactions between a wide array of social agents in specialized mental healthcare is reflective of a broader tension in French society today, between an increasingly untenable republican philosophy of integration—which

actively reproduces populations hierarchies and discriminates against “visible” minorities, North and sub-Saharan Africans in particular—and the increasingly vocal denunciation of these discriminations in public discourse. This dissertation, then, unpacks the complex ways in which this structural tension plays out in everyday interactions, through the lens of specialized mental healthcare.

III. Theoretical Framework

Since the development of the political economy and critical paradigms in medical anthropology, most studies in the subdiscipline have focused their attention on how medicine constitutes a locus of power. This perspective draws from Foucault’s work, particularly his analysis of the emergence, in modern states, of “technologies of power” designed to regulate the population in various arenas such as health and sexuality (Foucault, 1990[1978], 1994[1973]). According to Foucault, starting in the 17th century, a new expression of power—“biopower” or the power over life—constituted itself along two poles: the first centered on “disciplines of the body” and the conceptualization of the body as a machine to be used at its optimal capabilities and extorted of its forces (Foucault, 1994[1973]); the second focusing on the “regulations of the population” and based on the control of biological processes such as birth and mortality, or life expectancy and longevity. “The old power of death that symbolized sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life” (1990[1978]:139-140).

It is in light of this epistemological problemization that public health institutions have been shown to reflect existing structures of inequality and to enforce state policies

by producing population hierarchies (Castro and Singer, 2004; Fassin and Dozon, 2001). Central to this understanding is the framing medicine as an institution of social control (Zola 1986; Conrad 1992), with tendencies to expand its expertise beyond the limits of its application (Lupton 1997). Using the concept of *medicalization*, critical medical anthropology commented on “the absorption of ever-widening social arenas and behaviors into the jurisdiction of biomedicine treatment through a constant extension of pathological nomenclature” (Singer and Baer, 1995:80; also Conrad, 2007).

This expansion has been particularly noticeable in psychiatry over the course of the twentieth century. New psychiatric practices have not only produced new diagnostic categories and clinical entities, but they have also extended their application and practice to nonclinical institutions, such as the legal and educational systems, or social services. This expansion of psychiatry in the social realm has itself become the object of anthropological studies that showed how psychiatry’s scientific discourse and biological theories of causation have depoliticized—and therefore naturalized—the social dimensions of distress (Castel et al., 1982; Ehrenberg, 1998; Fabrega, 1993; Fassin and Rechtman, 2009; Gaines and Hahn, 1985; Good, 1996; Kleinman, 1988a; Young, 1995).

The popularization of Foucauldian analyses in medical anthropology, along with their constructivist approach, has also been criticized as ceasing to be productive (Hacking, 1999), and as pushing anthropologists away from scientific objectivism (Béhague, 2009). Some have made a call to bring ethnography back to analyses that are more empirically complex and that refocus on individual accounts of experience and local meaning systems (Biehl et al., 2007). In my analysis of specialized mental healthcare institutions in France, I try to develop an approach that moves beyond this

analytical dualism (Browner and Sargent, in press). I argue that social theory and a constructivist approach remain necessary in situating and understanding the present dynamics of mental healthcare provision to immigrants—notably in delineating the mechanisms and contours of the cultural/racial hierarchization of populations in contemporary France. Such theoretical grounding does not preclude the analysis of contradictions and “counterdiscourses” that arise from institutional actors within mental healthcare, that are partly informed by the legacy of the antipsychiatry movement in particular, and by a critical and reflexive perspective on social order in general—namely the stigmatization of immigrant populations.

My attempt to ground social theory empirically draws partly from the ethnomethodology tradition (Garfinkel, 1967)—the study of how people make sense of the local social order *in situ* through social interactions, as well as from the practice theories of Bourdieu (1977) and Giddens (1979). By exploring the rationales that underlie the referral of immigrant individuals and their children to specialized mental healthcare centers in particular, or the ways specialized mental health experts respond to institutional constraints, I address the concept of “structure-in-action” (Zimmerman and Boden, 1991; Giddens, 1984). Based on this same “integrative” framework, I draw from Essed’s methodology for understanding the mechanisms of what she coins as “everyday racism” (1991).

Indeed, my ethnography suggests that social actors are often cognizant of the rules of the institutional game and that they dialogue with them, even though these rules exert powerful constraints on their agency. At least, this is the dynamic I attempt to capture in my use of the concept of the “double-bind.” On the one hand, my data reveals

the difficulties social actors experience in representing and vouching for immigrant populations; this is particularly true of mental health experts who also strive to convince institutional actors and policymakers of the relevance of *nuanced, non-essentializing* cultural expertise in mental healthcare provision (caring). On the other hand, it becomes obvious how the same actors simultaneously must navigate the institutional norms that frame both clinical practice and the referral system, and that ensure the reproduction of a stigmatizing social order (regulating). The “double-bind” is at once individual (Bateson, 1969) and institutional (Bourdieu et al., 1999).

A genealogy of specialized mental healthcare and “immigrant suffering”

Foucault (1970) argued that all periods of history have possessed specific underlying conditions of truth that constituted what was understood as socially acceptable, normal, or “natural.” He showed that that these conditions of discourse have changed over time, in major and relatively sudden shifts, from one period's episteme to another. He analyzed the discursive and practical conditions for the existence of truth and meaning (Foucault, 1972), and simultaneously unveiled the means by which people govern themselves and others. He described how, since the 17th century, the discourse of science, in particular, through institutions such as medicine and psychiatry, has produced technologies of governmentality based on expert knowledge, and disciplining bodies at the biological level (1978:139-140).

The psychological suffering of immigrants has been the object of increasing attention since the 1980s in France. I argue that the development of a “specialized” field of mental health expertise, which paralleled this interest, is reflective of a broader shift in

the contemporary moral economy (Fassin and Rechtman 2009), one in which the notion of suffering produced by sociopolitical conditions—alternatively defined as “structural violence” (Farmer, 1996) or “the violence of everyday life” (Scheper-Hughes, 1993)—has come to constitute a new ethical regime (Kleinman, Das, and Lock, 1997; Das et al., 2000, 2001). My research questions this new categorizing process which, as Rechtman observed,

consists in displacing, into the field of mental health, categories of social deviance which, paradoxically, borrow concepts of general psychopathology to legitimate a social etiology. Yet, rather than addressing relations of domination, social or educational inequalities, urban policies, etc. it is an etiology which only speaks to changes in values, authority figures, and family dynamics. (2004:132, my translation)

On the other hand, my findings illustrate that, rather than adhering to this process of legitimization through the medicalization of immigrants’ social ills, specialized mental healthcare centers constitute loci where relations of domination and inequalities are somewhat paradoxically contested, at times challenged.

Drawing from the Foucauldian concept of genealogy— as the history of the position of the subject which traces the development of people and society through history, accounts for the constitution of knowledge, discourses, and regimes of truth— one of this dissertation’s objectives is to analyze the production of a discourse on “immigrant suffering.” As I stated earlier, I define “immigrant suffering” as the discursive product of a separate mental healthcare field catering to immigrants specifically. I therefore approach “immigrant suffering” as a socially constructed concept. This does not imply that the concept refers to something unreal. The experience of exile, as well as the experience of stigmatization and social precarity to which many

immigrants are particularly vulnerable, *does* engender psychological suffering, and produces ill health in general. Rather, my goal is to understand why and when “immigrant suffering” became not only legitimate, but the object of “specialized” mental health initiatives sponsored by the State.

Therefore, part of my analysis of the social construction of “immigrant suffering” is temporal. I address the evolution of the scientific discourse in the management of racial/cultural difference in mental healthcare initiatives, in the French colonies and in France, consecutively. By approaching the bodies of immigrants as political bodies—that is, as sites of power and control (Lock and Scheper-Hughes, 1996; but also Comaroff, 1985,1993; Hunt, 1999)— my goal is to unveil the dialectical interaction between political strategies of control and the creation of scientific categories that stigmatize the Other in a morally-sanctioned way. These “disciplines of the body” that guarantee social relations of dominance and sustain “sovereign power,” become normative social structures, which knowledge, in turn, becomes embodied in mental structures (Durkheim and Mauss, 1963; Durkheim, 1973; Bourdieu, 1996). The arbitrariness of such knowledge is thus misrecognized, creating a habitus of perception on racial/cultural difference and its meanings (Bourdieu, 1977), along with a powerful symbolic system that articulates in everyday language (Bourdieu, 1991). My goal then, is also to analyze the culturally differential construction of subjectivities and the mechanisms that underlie it, and how these subjectivities travel through time, become reproduced, contested, or negotiated through the scientific discourse of specialized mental health.

The structure of the specialized mental healthcare field

Bourdieu's (1971) concept of "the field" provided the analytical frame for my analysis of the institutionalization of specialized mental health expertise. Approaching specialized mental healthcare as a social space in which social actors compete for the monopoly on a new form of scientific knowledge (Bourdieu, 1971), also enables me to trace the contours of a structure that is at once structured and structuring. On the one hand, it is structured by a socioeconomic context in which social inequalities have increased and in which immigration—at least the immigration of poor, "visible" populations—has become undesirable and actively restricted. This context is also dominated by a political ideology—French republicanism—which strives to impose a perception of the social order based on universalistic and egalitarian principles, while simultaneously sanctioning the unequal application of these principles, thereby naturalizing divisions between socially constructed groups—namely, the French and immigrants. On the other hand, the field is structuring since, its existence and legitimacy being contingent upon serving the interests of the dominant group and of the political ideology in place, it "contributes to the (dissimulated) imposition of the structuring principles of the perception and consideration of the world and in particular the social world" (Bourdieu, 1971:300, my translation).

Following the same analytical framework, I analyze the structured dimension of the field—that is, the processes which allowed for specialized mental healthcare to become an autonomous field, in a public health landscape shaped by the republican mandate of universal healthcare access. I show how the use of a homologous, universalizing scientific discourse provided the means for the field to establish its legitimacy and for its particularizing healthcare services to be institutionally sanctioned.

Within the field, I describe different groups of specialists—whom I call experts—and follow how expertise is constructed and disseminated, by identifying technologies and networks that control the circulation of expert knowledge (Latour, 1987). Again, drawing from Bourdieu's (1991) theory on the acquisition of legitimate language competence, I attempt to show how specialized mental healthcare centers maneuver “communicable circuits” (Briggs 2005) and acquire institutional capital. I argue that, ultimately, by adopting a legitimizing discourse which simultaneously emphasizes the politics of “universalism” through republican values and “scientific” discourse, “specialized” mental healthcare centers limit their practical challenge to the structural misrecognition (Taylor 1994) of immigrants in France.

**Culture in mental health:
The language of “immigrant suffering” in and beyond the clinic**

As it relates to the mental health of immigrants, anthropologists have shown that one way to depoliticize distress, and to avoid addressing the socioeconomic inequalities to which this group is particularly vulnerable, is through the use of culture as all-determining in the expression of mental disorders and its treatment (Andoche, 2001; Fassin, 1999, 2000b; Ong, 1995; Rechtman, 1995; Santiago-Irrizarry, 2001; Watters, 2001). It is not to say that anthropologists do not recognize the relevance of culture in the experience and treatment of mental illness. In fact, the anthropological literature has been instrumental in documenting the importance of this relation, underscoring cross-cultural variations in constructions of the self and of emotions (Csordas, 1994; Desjarlais, 1992; Jenkins, 1991, 1996; Lutz and White, 1986; Shweder and Levine, 1984; Shweder, 1991, 2003). Anthropology has also been a strong advocate for culturally-sensitive therapeutic

care (Kleiman, 1980; Kleinman and Good, 1985; Jenkins and Barrett, 2004). However, the popularization of the notion of “cultural competency” in mental health initiatives, and in public healthcare in general, has led to essentializing understandings of the “culture” concept, along with its conflation with the concepts of “race” and “ethnicity” (Santiago-Irrizary, 2001). As a result, anthropologists have also been critical of some of the drifts that emerged in the application of some cultural competence models.

The critique has concentrated on the following issues (Carpenter-Song et al., 2007): the tendency to present culture as fixed and static (Shaw, 2005; Taylor, 2003), thereby reifying it or reducing it to a variable (Jenkins and Barrett, 2004); the related inability to conceive of culture and self-identity as fluid and changing (Santiago-Irrizary, 1996), thereby reifying existing racial categories (Santiago-Irrizary, 2001; Shaw, 2005); the risk to perceive cultural difference as a form of social deviance, distinguished from the white, middle-class norm (Lambert and Sevak, 1996), as well as the risk of underemphasizing class difference (Ortner, 1998); the unintended blaming of the patient’s culture as a barrier to effective treatment when transforming culturally normative behavior into psychopathology (Kleinman, 1988; Santiago-Irrizary, 2001); the failure of taking into account important structural features that may negatively impact care, such as power imbalances in patient-physicians interactions (Mishler, 1984) which may be exacerbated with minority groups (DelVecchio Good et. al, 2003; Kleinman, 1980); and finally, the inability of recognizing biomedicine—and psychiatry in particular—as a culturally constructed and historically evolving system (Good and Good, 1993; Gaines, 1982; Luhmann, 2000). This last critique has led to important objections to alleged universal psychiatric disease categories as classified by the Diagnostic and

Statistical Manual of Mental Disorders (Gaines, 1992), as well as its categorization of “culture-bound syndromes” (Guarnaccia, 2003; Guarnaccia and Rogler, 1999; Hughes, 1998; Mezzich et al. 1999, 2009). However, less often have anthropologists moved beyond the confines of academia to propose clinically relevant and practical recommendations, with the exception of psychiatry (Carpenter-Song et al., 2007; notable exceptions include: Guarnaccia, 2003; Kirmayer, 1997; Kleinman, 1988b; Kleinman and Benson, 2006).

Critical evaluations of the relevance of cultural difference in the diagnosis, expression and treatment of mental disorders thus generally focus on clinical interactions. In that respect, they problematize the use of the “culture” concept in relation to healthcare policy, healthcare provision, and the definition of psychiatric disease categories. They also frame their critique around the patient-therapist interaction. In this dissertation, I demonstrate that this problematization should *also* encompass extra-clinical settings, and problematize lay representations of the relevance of culture in relation to mental health suffering. I argue that the analysis of social agents’ rationales for referring immigrant individuals to “specialized” mental healthcare institutions is as critical as the assessment of how the latter make use of the concept of “culture” in mental healthcare provision, because culturally stigmatizing referrals severely constrain both clinical interactions and their therapeutic outcome.

The analysis of the language used in specialized mental health discourse, as well as in related institutional interactions, is central to my analysis. My genealogy of specialized mental healthcare provides an account for how representations of “cultural difference” (preceded by the use of the notion of “racial difference” and gradually

euphemized in scientific discourse) is “the product of a historical dialectic of cumulative differentiation” (Bourdieu, 1991:286). In present discourse, the conceptualization of otherness in relation to suffering is at stake. On the one hand, it is at stake in the representation that mental healthcare structures disseminate and in the discourse of experts which strives at respecting the republican status quo while avoiding essentialist understanding of otherness and at unveiling the tangible mental health consequences of social inequalities. The discourse of referring actors, on the other hand, reveals unscripted perspectives, which in turn offer a mirror into a collective reflection on identity, cultural difference, and the differential treatment deemed necessary for certain populations. This discourse reveals a perspective in which cultural difference is perceived as creating social “difficulties,” which in turn produce pathological situations. Such discourse is not necessarily articulated as being stigmatizing, but rather as translating a benevolent attitude towards immigrants, a desire to help with their “difficulties.”

Observation of referrals and pre-clinical or clinical interactions thus provide an analytical window into observing the symbolic dialogue between scientific formulations of the relevance of cultural difference in mental health and psychological suffering on the one hand, and lay representations of the same relation on the other. I am particularly interested in the strategic manipulation of euphemisms that dissimulate direct references to cultural differences behind the register of suffering. Bourdieu (1991) argued that substituting a word for another equated to changing the vision of the social order, hence the “illocutionary force” of speech. Through my ethnographic analysis I show, however, that the relations of power inherent in discursive exchanges are actively negotiated—and at times contested, by social actors. The latter are aware of what philosopher Ian Hacking

refers to as socially constructed “kinds,” or categories (1999). Embedded in the practices and institutions that categorize them, social actors interact with classifications, and “struggle [them] out” (Rhodes, 2004).

In that context, I aim at evaluating some situational mechanisms of cultural differentialism in contemporary France, based on Essed’s definition of “everyday racism” as

“a process in which (a) socialized racist notions are integrated into meanings that make practices immediately definable and manageable, (b) practices with racist implications become in themselves familiar and repetitive, and (c) underlying racial and ethnic relations are actualized and reinforced through these routine or familiar practices in everyday situation” (1991:52).

In this way, as I stated earlier, more broadly, this dissertation also addresses what Michele Lamont calls “boundary work” (2000:3) and the identification of “cultural repertoires” (Lamont, 2000:243), that is, repertoires of evaluation used to make judgments about various social domains such as politics, economics, morals and aesthetics.

IV. Methodology

Research population: Sub-Saharan African immigrants and their children

I chose to focus my research on Sub-Saharan African immigrants and their children mainly because, as I will argue in greater details in Chapter 3, they have received particular attention from state institutions and, as a result, have constituted a large proportion of “specialized” mental healthcare institutions’ clientele. I suggest that attention to this population in particular is related to multiple concerns, from its growing

visibility in the aftermath of family reunification policies and through the *sans-papiers* movement in particular,⁸ to their political mobilization today against racial discrimination.⁹ Until very recently, social science studies of discrimination in France have largely focused on North African immigrants and their descendants as the primary targets of racism in France, putting forth “a decoupling of racism and blackness” (Lamont, 2000:192) that reveals less negative feeling towards blacks than toward North Africans. While I do not dispute this observation, I argue that the “blackening” of immigration (Lamont, 2000:193)—especially among the undocumented—together with the politically-fed sensationalization, in the French media, of cultural practices such as polygamy and female genital mutilation, have increased the salience of racism among “blacks.” Also, in relation to my earlier discussion of the arbitrary nature of the “immigrant” and “children of immigrants” categories, I want to point out here that the term “blacks” is equally problematic, as it likely encompasses French citizens from the French Caribbean (Ndiaye, 2008).

Outside of clinical settings—in the context of which I could not select the patient population—I therefore framed my research around participants from sub-Saharan Africa, or their French-born children.

From social and health services to “specialized” mental healthcare

⁸ A movement of undocumented sub-Saharan asylum-seekers and undocumented immigrants. In August 1996, the *Sans-Papiers* (literally, those without papers) became internationally known when 300 undocumented African women, children and men were violently evicted by police from the St Bernard Church in Paris, where they had taken sanctuary for several months.

⁹ I am particularly referring to the recent creation of the CRAN (National Representative Council for Black Associations of France) in 2006, as well as to the “Indigenous of the Republic” Movement initiated in 2005.

The idea of conducting research on “specialized” mental healthcare in France came to me progressively as I had the chance to conduct exploratory research for four consecutive summers between 2003 and 2006. I became familiar with the management of cultural difference in the French public health system through collaborating on Carolyn Sargent’s NSF-funded research on reproductive strategies among Malian women in Paris.¹⁰ That research – which took me to clinical settings, to immigrants’ homes, and to migrant association meetings – revealed the coercive nature of family planning interventions in the hospital setting as reflecting state strategies to control local immigrant populations (Sargent, 2005).

In particular, I was struck with the variety of state agents—affiliated with the medical realm or not—that assisted immigrant women in virtually every domain of their life. For example, one of my Malian friends, Hawa—a mother of three whom I had met through Carolyn Sargent, would receive as many as four visits from such agents every day. A few months after I started fieldwork, she had delivered her last baby boy. She had one assistant come every morning to help with the children as well as with household chores. She had another one who would come and do the same every afternoon. Hawa’s social worker—who organized those services for her in liaison with the city hall services of the *arrondissement* she lived in— would come and chat with Hawa about various issues, from marital relations, to children’s school progress or administrative mail. For a couple of months, a midwife would come once a week to check on Hawa and her baby’s health. She would weigh the baby and keep a health progress book for Hawa to bring to

¹⁰ NSF Research Grant #105192, “Reproduction and Representations of Family Among Malian Migrants in Paris, France.” I also want to express my appreciation for the three NSF Research Experience for Graduates (REG) Awards I received consecutively in 2003, 2004, and 2005, as well as for the Mary Moore Free Departmental Award received from Southern Methodist University in 2005.

her maternal care center visits. Hawa also had a history of depression. Since her second childbirth, she had been seen by a psychiatrist at the hospital where she delivered. Now the psychiatrist comes to her house for therapy sessions. Hawa also saw an ethnopsychiatrist with whom she had been put in touch with by her oldest daughter Fatou's child psychiatrist.

Hawa's experience, as well as the experience of many other immigrants I met prior to and during fieldwork, led me to reflect on the extent to which such institutional assistance took place in other state-mandated institutions. My interest began to shift to "specialized" mental health care institutions in particular after I attended a few family mediation sessions at an ethnoclinical center, called Gepela. Prof. Ismael Maiga, Gepela's director, had been a long-term collaborator on Carolyn Sargent's research, first as an ethnolinguist, but also as a trained ethnoclinician at the George Devereux ethnopsychiatry center. He had created the Gepela in collaboration with school psychologists interested in sub-Saharan African cultures, partly out of personal interest, but also because they worked with a great number of children of immigrants families from West Africa. At that point I was familiar with the debate on ethnopsychiatry which had sparked in France in the early 1990s. I had read about ethnopsychiatrist Tobie Nathan, his theories on culture as a closed system (Nathan, 1986), and on the necessity of preserving immigrants in an hermetic cultural environment for the sake of their mental health well-being. In addition to obvious issues related to the cultural stigmatization of immigrant populations, the extensive state sponsorship and financial support of ethnopsychiatry initiatives, in collaboration with criminal justice and educational institutions, had raised questions about the clinical management of migrant patients. The intervention, within those centers,

of a variety of state-sponsored institutional actors assisting migrant families – from school psychologists and social workers, to “cultural mediators” and other interpreters— had raised questions concerning political agendas that may shape these institutional interventions (Fassin et al. 1997). This led me to question whether other mental healthcare institutions providing culturally-sensitive care existed in France, and to what extent they were similar to Nathan’s ethnopsychiatry. Moreover, focusing on specialized mental health centers enabled me to analyze the interactions between migrant households and the range of state-sponsored institutional actors identified above, as well as to investigate the structures and policies that have generated the proliferation of professionals targeting immigrant health and welfare.

Framing Health Issues and Identifying Assistance Networks

I carried out fieldwork in Paris from March 2007 to June 2008. During the first part of my fieldwork (the first six months), I both volunteered and carried out participant observation at two associations catering to immigrants, and offering services facilitating healthcare access to that population. At one local grassroots association catering specifically to sub-Saharan African immigrants (Afrique Partenaires Services), I worked during walk-in hours and helped the undocumented fill out applications to obtain State Medical Help. I also worked in two different offices of one national umbrella organization called La Cimade. At the first office, I worked during walk-in hours to offer legal support and information to migrant women victims of domestic violence. At the second office, I assisted migrants seeking a visa status for medical reasons. These activities enabled me to generally assess the impact of political restrictions to healthcare

access for immigrants on the work of social workers, health professionals, and legal advisors. Semi-structured interviews with representatives of each institutional category were carried out. This first part of fieldwork enabled me to observe the constraints as they are experienced by these key institutional actors. I have observed, among other things, that migrants were often accused of instrumentalizing their own health vulnerability towards administrative ends. The context of suspicion towards immigrants, fostered by a political agenda that imposed quotas on entering immigrants and circulated an image of distrust towards migrants, affected even those institutional actors whose work is to help migrants.

Moreover, in a context of extremely restrictive immigration policies, I became witness to a fact that had already been analyzed elsewhere (Fassin, 2004)—that the right to healthcare could constitute a last resort for residence legitimacy. I often heard immigrants at the associations I worked at, say things like: “I do not know what else I can do, outside of getting sick,” or “I have high blood pressure, is this serious enough a condition?”, and so forth. A survey I carried out among 50 immigrants on access to social and healthcare services indicated that, overall, whether they were documented immigrants or not (the majority were undocumented), the problems related to accessing such services were not due to a lack of information on how the system works. Rather, obstacles stemmed from their powerlessness in obtaining legal status, as well as from their related context of social and economic precarity.

Selecting “specialized” mental healthcare institutions (Appendix A)

I selected three mental healthcare institutions on the basis that they represent the main theoretical approaches to specialized mental healthcare in France today: namely, clinical medical anthropology (Minkowska), transcultural psychiatry / ethnopschoanalysis (Avicenne / JB Carpeaux)¹¹, and ethnoclinical mediation (Gepela). Thus, while theoretically speaking, the three selected institutions propose distinct approaches to mental healthcare provision, in practice, they resemble one another by sharing a similar perspective on the impact of culture in the field of mental health for immigrant patients.

More importantly, these institutions represent, in the French public health jargon, “second-intention” centers: they receive foreign “patients” with whom a broad array of state institutional actors (from education, justice, police and public health) feel helpless or consider that the problems facing such individuals are culturally-framed, and therefore out of their professional capacity. During my observations, I have noted that such institutional referrals can be arbitrary (even before any institutional measures were taken or whether the concerned institution was failing in its task), which raises questions concerning the way such “specialized” centers are used as centers to deal with cultural difference in a way “mainstream” institutions cannot. It is on that basis that I found the comparison between these different institutions to be analytically relevant. Moreover, these institutions are representative of the different structural grades in the public health spectrum: one is an association¹² (Gepela), two are community mental healthcare

¹¹ I count both Avicenne and JB Carpeaux as one institution, on the basis that they are institutionally linked (transcultural psychiatry students from Avicenne are given access to JB Carpeaux for their clinical internship, as in my case) and that they practice the same clinical approach to specialized mental healthcare (ethnopschoanalysis) in an identical clinical setting (group consultations).

¹² In France, the Waldek-Rousseau law of 1901 allows citizens to form voluntary associations. Depending on the nature of their projects and activities, associations may receive funding from one to several sources at the State, regional, or local level. The 1905 law on the separation of Church and State allowed religions to organize as private associations as well (see Bowen, 2007). Associations recognized by the State as

centers¹³—one is non-district-based (Minkowska) while the other is (JB Carpeaux), and finally one is non-district hospital-based (Avicenne).

- **Gepela: an association and “ethnoclinical” mediation center**

As I stated above, Gepela is an association, based on the law of 1901. As such, it receives partial, but limited financial support from the State. Up to very recently, it received support from the northern suburban town of St. Denis, which let the association use a room in its cultural center. Initially, the Gepela used two offices and a meeting room which were rented out by the University of Paris 8.¹⁴ The Gepela now has relocated

being of “public utility” (*associations reconnues d’utilité publique*) may benefit from greater State funding. The creation of associations has grown in popularity throughout the 20th century in France, especially since the aftermath of the Second World War (see the case of Minkowska). More associations were created in the last thirty years than since 1901, and it has been estimated that approximately 70,000 associations are created each year. Today, France counts approximately one million active associations, most of which are related to cultural activities (15%), followed by health or social services (8%), and education, training, or housing services (7%) (Ministère de la Jeunesse et des Sports, 2010). Since 1981, foreign residents also have the right to form associations. This has led to a proliferation of immigrant associations, which most commonly sponsor development initiatives in sending communities (see Daum, 1998, on associations of Malians in France), organize cultural activities for immigrant communities in France, provide legal, social, and health services to both legal and undocumented immigrants, and, more recently, encourage citizenship participation for “children of immigrants” (see Ricardou and Yatera, 2007, on youth of sub-Saharan African origin).

¹³ Following the de-institutionalization of psychiatry in 1960, the dominant model in the organization of comprehensive psychiatric care in France has been the creation of geographically defined areas, known as sectors. Community-based (or sector-based) mental health care was born out of concerns with the continuity of care, the development of partnerships with patients and families, and the involvement of the local community. In this system, psychiatry has become one among other mental health therapeutic options, such as psychotherapy, art therapy or occupational therapy. Community-based mental healthcare has also sought the integration of mental healthcare into primary health care, along with the provision of social services such as employment and housing. In the French public health jargon, a community mental healthcare institution is referred to as a *centre medico-psychologique* or *CMP* (literally, “medico-psychological center”). In Paris, each *arrondissement* is thus divided into several geographic sectors, each of which as a CMP.

¹⁴ In 1970, the University of Paris, often referred to as La Sorbonne, was reorganized as 13 autonomous universities. Only the first four universities have a physical presence in the historical Sorbonne building. They are commonly referred to by their number (“Paris 1,” “Paris 2,” and so forth), rather than by their name (in this case, “Paris 8” is more formally named the “University of Vincennes in St. Denis”).

to another location in St-Denis, close-by the University Paris 8, where it rents a meeting room and an office.

While Gepela cannot be considered a public healthcare structure as such, it does indirectly provide public health services in the form of ethnoclinical mediation sessions to local institutional actors.¹⁵ In fact, the official brochure (undated) presents Gepela as an association “which goal is to provide information or training on the knowledge of Africa.” Through research and training, it offers to discuss such themes as “the knowledge of peoples and cultures of Africa” or “the impact of cultural contact.” Its targeted audience are “migrants, institutional services (municipal services, hospital centers, schools, justice courts...), professionals (social workers, teachers, psychologists, etc.) who work with them, NGOs, students, and other researchers.” Among the center’s other activities, Gepela provides “intercultural mediation,” a service offered for “the resolution of differences and the understanding of cultural, social, and linguistic issues. The service offers advice and plans of action.”

The brochure also describes the team as being composed of a group of university researchers from various institutions such as the University of Paris 8, the National Institute for Scientific Research (CNRS), and INSERM the National Institute for Health and Medical Research (INSERM), as well as clinical psychologists, social workers, and master students in psychology from Paris 8. Regarding researchers, the brochure specifies that they are “of African origin, specialists of their cultures, or experts who work in that field. They are anthropologists, linguists, psychologists, or sociologists.” While I carried out fieldwork, the team essentially consisted of two researchers from Paris 8, including

¹⁵ Referrals typically come from the city of St.Denis’s social services, and from the city of Cergy’s schools, with which Gepela psychologists are affiliated.

Pf. Maiga, the director, three school psychologists working in the same district of Cergy—a northwest suburb of Paris, and a varying number of psychology students (four at most). Except for psychology students, for whom meetings at Gepela are part of their Master’s training, all other professionals’ participation is voluntary and unpaid.

The Gepela group meets once to twice a month.¹⁶ Meetings—usually attended by the whole team—alternate between research seminars on “ethnoclinical” issues, presentations by member school psychologists of current problematic “cases,” and ethnoclinical sessions with a child, his/her accompanying parent(s), and in some instance, external referring institutional actor(s). Ethnoclinical sessions are led by Pf. Maiga, the director, but all team members typically sit in a circle around the family, and are encouraged to participate. These sessions are indeed modeled after ethnopsychiatry’s group consultations and the “circulation of speech” therapy.¹⁷ “Cases” generally concern children of West African immigrants, many of these families residing in the suburbs of St.Denis and Cergy. I only encountered one exception, with the case of the child of Sri Lankan parents. However, there was no actual ethnoclinical session with the family, and the case was only discussed. With an average of one to two ethnoclinical sessions per month, the Gepela provides services to approximately 15 families per year.¹⁸ I attended all the meetings, during which I took comprehensive fieldnotes of the interactions. I was never under the impression that my taking notes raised concerns or disrupted the sessions.

¹⁶ Meetings are typically scheduled late afternoons or early evenings, considering Gepela team members hold a regular day job, or attend day psychology classes at the university.

¹⁷ This will be described in greater details in Chapter 4.

¹⁸ This is an approximated average for on-site mediations. I do not have official figures for off-site interventions.

- **Minkowska: a community mental health institution and “clinical medical anthropology” center**

Originally founded as an association providing psychotherapy to post-war refugees in their native language, Minkowska recently became accredited as a formal public health structure, catering more broadly to immigrants and asylum-seekers, and proposing a clinical medical anthropology model of mental healthcare. Minkowska is not district-based, which means it may receive migrants patients from anywhere in France, and it may provide services to both adults and children. Minkowska’s staff is composed of 11 psychiatrists, 11 psychologists, and 2 social workers. In 2008, the Center had a total of 1,999 patients, 861 of whom were new (Association Française et Eugène Minkowski, 2009). Thus, beyond clinical consultations, the center also offers other social services for immigrants and asylum seekers living in the greater Paris area. Therapeutic approaches vary according to therapists. Medical diagnoses (although they did not always appear on the files I looked at) are based on the ICD-10. Patients come from all continents, with a majority of patients from North and sub-Saharan Africa, Eastern Europe, and a rising number of patients from Southeast Asia. Until recently, patients were dispatched to different teams following their geo-linguistic origin (the Center had seven expert teams specializing in “Black Africa,” South and Southeast Asia, Maghreb, Portugal and Portuguese-speaking countries, Spain and Spanish-speaking countries, Central and Eastern Europe). The Center’s public health accreditation now precludes such form of patient triage, for reason which will be detailed later in this work.

There, I attended clinical consultations, orientation meetings, and staff meetings. Because Minkowska favored the training of Master psychology students and wished to limit outside attendance at consultations out of concern for the quality of the therapeutic

relation between psychotherapist and patient, I could not attend consultations systematically. Upon the agreement of the patient, I was invited whenever trainees were absent or unavailable, and when patients from sub-Saharan Africa were concerned. I was also granted access to sub-Saharan African patients' files. Very quickly, it became apparent to me that such fieldsite allowed me to observe all the dynamics I had planned on analyzing in my research project. The referral process, in particular, seemed most interesting. Patients were not necessarily referred from medical structures with identified mental health disorders. Many referrals came from a wide array of state-mandated institutions, from schools to social services and justice courts. In fact, the activity report of the Minkowska center for 2006 showed an increase in referrals from school and judicial administrations in particular.

- **Avicenne: a university hospital with a transcultural psychiatry consultation, affiliated with the Jean-Baptiste Carpeaux Center: a community mental health institution with an ethnopsychiatry consultation**

Avicenne is both a hospital and university structure, located in a northern suburb of Paris, Bobigny. Its transcultural clinic is linked to the child and adolescent psychiatry service led by internationally renowned Pr. Marie Rose Moro. As I will describe in greater details in Chapter 3, the Avicenne hospital has a unique history, as it was created in the interwar period to accommodate the needs of Muslim patients from North Africa. In part because Bobigny has continued hosting immigrant populations of various origins, the Avicenne hospital has maintained a particularly diverse patient community. In 1979 the child and adolescent psychiatry service, then led by Pf. Lebovici, invited psychologist Tobie Nathan to create the first ethnopsychiatry clinic in France, out of a concern with

improving psychiatric care to culturally-diverse local patients. In 1993, as ethnopsychiatry gained in popularity, Nathan left Avicenne to create an independent ethnopsychiatry clinic—the Georges Devereux Center—affiliated with the department of psychology at University of Paris 8, located in another northern suburb of Paris, in St. Denis.

Marie Rose Moro, who had trained with Nathan as a psychiatry resident, took over the direction of the clinic, and succeeded to Pf. Lebovici as the head of the child and adolescent psychopathology service. For reasons which will be detailed in Chapter 4, Moro's clinic changed its approach to transcultural psychiatry. It maintained the group setting of Nathan's ethnopsychiatry consultations, while eliminating a few clinical methods, most significantly the use of ritual objects and general enactment of healing rituals during therapy. Moro also created a graduate program in transcultural psychiatry at University of Paris 13, located in Bobigny as well.

By enrolling in the Transcultural Psychiatry program, I was allowed to attend four transcultural psychiatry group consultations with Pr. Moro. I wrote extensive fieldnotes immediately after each one of the consultations. I also obtained permission to attend ethnopsychiatry group consultations at a community health center in the 18th arrondissement of Paris—the Jean-Baptiste Carpeaux Center. There, I attended on average two consultations per week, from October 2007 through June 2008. Patients directed to this center mainly came from Sri Lanka, North and Sub-Saharan Africa. The ethnopsychiatry clinic was created in 1990, and directed by psychologist Kouakou Kouassi, who received his ethnopsychiatry training working as a co-therapist in Nathan's consultations at Avicenne, and continued his services at Avicenne in Moro's transcultural

psychiatry clinic, also as a co-therapist. At the Jean-Baptiste Carpeaux Center, Kouassi recreated the same group therapy setting as that of the transcultural psychiatry clinic, but receives the help of only one other co-therapist—also a psychologist trained in psychoanalysis. The rest of the clinical team consists of Master students in psychology (six on average) and students from the Transcultural Psychiatry program (there were two of us for the duration of my fieldwork). Jean-Baptiste Carpeaux is district-based, which means it only accepts referrals from institutions located in its district. As with Avicenne, I wrote extensive fieldnotes immediately following consultations.

Referrals and the circulation of immigrant patients

Specialized mental healthcare centers, I argue, represent points of encounter between various state-mandated voices and institutional ideologies, at the same time as they circulate individual ideologies. The referral process thus seemed to offer the best vantage point to observe the intersection between the medical and the social in the management of immigrant populations. The result of the encounter is the production of what I would call a meta-discourse on the management of cultural difference in France. This discourse is generative of dynamics of categorization, based on “cultural repertoires” (Lamont, 2000)—which are often intangible to the interactions themselves. Hence the importance accorded in my research to the language of patient referrals. The meetings between referring institutional actors and clinical staff, and mental healthcare delivery to immigrant patients thus became my main points of entry in carrying out fieldwork.

This led me to collect data on unexpected paths. I was taken to places outside of the clinic. Conversations about and around the clinic became as relevant to me as clinical interactions themselves. This entailed tracking diffuse and loose relations, not within medical institutions, but between a wide array of state-sponsored ones. It also implied mastering various institutional languages and a battery of specialized acronyms (see the school chapter in particular). The most challenging aspect of fieldwork was the tracing of referrals. It is evident that I was unable to witness the referring process for all the patients visiting the three fieldsites where I carried out fieldwork. At the same time, to better frame the rationale for referrals, I had to find a methodology to trace the circulation of these voices, and delineate institutional networks. I teased out three main domains: 1) the referral's origin (i.e. school, legal services, social services, etc.), 2) the official rationale for referrals (located in patients' files), and 3) pre-consultation meetings.

At Minkowska, where I had access to patients' files, I developed a table compiling information on referrals' origins and official rationales exclusively (Appendix B). As often as I could, I attended pre-consultation meetings, which were not a systematic feature of the management of patients in the association. Such meetings occurred when referring actors were in the decision-making process as to refer their "patient" to the center or not. These were most interesting as these exchanges offered the most direct and unmediated discourses on the relevance of cultural difference in the expression of mental health pathologies, or on the relations actors may draw between cultural difference and the ambiguous notion of "difficulty," a concept used relentlessly in conversations about immigrant patients' "problems." I must add that my reference to "cultural difference" is,

when relevant, analyzed as “euphemized racism” (Lamont, 2000), more than in reference to subtle and informed analyses on the relevance of cultural traits.

Ethnography of the Transcultural Psychiatry Program

In the context of my participation in the transcultural psychiatry program, I was expected to write a thesis on a theme related to the discipline. I opted for a reflexive approach and suggested I could write my thesis on the program and on participants themselves. I would interview students in the program, on a voluntary basis, and investigate the reasons that motivated them to seek training in transcultural psychiatry.

My research goals were threefold. First, I wished to tease out ways in which institutions apprehended working constraints with immigrants that encouraged them to fund transcultural training for their employees. This data would contribute to my analysis of the relation between institutional referrals to specialized mental healthcare centers and political discourse on the management of immigrants in France. Second, I sought to analyze how program participants approached cultural difference in their work, and what type of assistance/working tools they expected from their training. Interviews on this topic were conducted between January and April, which is well into the second half of the training, up to its end. Accordingly, participants had gained enough experience in the program to evaluate what its professional impact would be like. And third, I intended to gain insight into who participants were as individuals; what informed their personal reflections on cultural difference beyond the clinic and the context of their work. I anticipated the information would constitute an interesting parallel with the life and career paths of specialized mental healthcare practitioners themselves. Are the types of

recognition for the acknowledgement of cultural difference in healthcare provision different between experts and trainees? If so, on what basis? How does this, in turn, more broadly address the evolution of cultural difference representations in French discourse?

Situated knowledge

Being an anthropologist at these fieldsites was particularly challenging. I appreciate Lorna Rhodes's metaphorization of the anthropologist as "institutional analyst" (1986). As Rhodes observed, like the analyst, the anthropologist "is given unusual access to the 'parts' of the institution" (1986:208), with freedom of movement and lacking a clearly defined role, which either triggers feelings of safety or defiance. I believe the silent dimension of my observing/listening role led people to freely comment to me on their frustrations or "gossip" on the institution. On the other hand, the knowledge of my movement from one institution to another, in a relatively competitive field, led others to feel uneasy. A therapist, practicing at three of the institutions where I carried fieldwork, once shouted out to me in the hallway: "You? You're thirsty for consultations, or what?" He obviously seemed disconcerted by my observation activities in more than one institution, and I am unsure whether I should have interpreted his reaction as mundane or as negatively judgmental.

As the institutional analyst, I started fieldwork most anxious about being subject to negative processes of transference¹⁹ (Freud, 1989[1940]). As I will explain in greater details later in this dissertation, these sites were indirectly heirs to the ethnopsychiatry movement of the 1980s, which received severe public criticism from a variety of

¹⁹ Transference is a phenomenon in psychoanalysis characterized by unconscious redirection of feelings from one person to another. In a therapy context, it refers to redirection of a client's positive or negative feelings for a significant person (the father or the mother, according to Freud) to the therapist.

intellectuals, many of whom were anthropologists. In fact, there was a direct confrontation—via newspaper and journal articles—between the leader of ethnopsychiatry, Tobie Nathan, and Didier Fassin, anthropologist, *and* co-adviser of this dissertation. I was expecting, then, that my introduction to these various fieldsites, could raise a great deal of controversy. I never planned on dissimulating my association with Didier Fassin, and in fact, I did not feel that doing so hindered my research in any way. I did my best at reassuring the staff everywhere that I came with an unbiased perspective on their activities. In fact, it may have been that the warm welcome I received everywhere may have constituted—consciously or not—an effort at convincing me that none of those stigmatizing, culturally relativistic activities were going on at those places. I also think that my being primarily affiliated with an American university partly eased the suspicions. I had been trained in the American “school” of anthropology, which was perceived as being very different from the French—at least as being more open-minded in addressing the issue of the management of cultural difference and of stigmatizations.

I acknowledge that my professional identity as an anthropologist may have affected how people spoke of cultural representations in my presence, as some perceived me as the token specialist on the topic. To some extent, my very presence in the clinic was validating the scientific basis of its activities, especially at Minkowska, the clinical medical anthropology center. I conclude that there, while my professional identity as a medical anthropologist opened incredible opportunities, such as traveling to conferences and being invited to sit on institutional meetings, I was being instrumentalized into validating the scientific image of the Center. It was also tempting on my part to intervene on issues where I had expertise and at times I did just that. Minkowska was the fieldsite

where I had to make a conscious effort at maintaining research boundaries. For example, one condition for me to conduct participant observation at the Center was to officially become an affiliated researcher. As a result, this became a way for the Center to introduce me—both at the Center and at conferences—as such, rather than as an anthropologist. However, my interventions were only limited to participation in research seminars or to personal interactions. Regardless, more acutely than in the other field settings, I felt mindful of how I represented the discipline within the institution, and of how my very professional identity affected my data collection.

Being both a researcher and a student at the transcultural psychiatry program was never challenging, except on the day we were asked to articulate our thesis research plans in front of the class. At the beginning of the program, we were divided into research groups, each group being assigned a supervisor for the degree validating project. I was assigned to a group led by a clinical psychologist, trained in psychoanalysis at Paris 8, and now practicing at Avicenne.

On our first meeting, we went around the table to present our respective research projects. Everyone intended to write on one aspect of transcultural psychiatry, as it applied to immigrant individuals in the clinical context, or in the context of their work. Following each individual presentation, our supervisor would give input on related readings, or analytical possibilities. Then came my turn. My presentation was followed by an uncomfortable silence, after which the supervisor asked me to repeat what exactly my project was about: “I’m not sure I completely understand what your project is about,” he said, “or how transcultural psychiatry relates.” He was right. While I was genuinely interested in the training myself, my project was more about studying the trainees, and

the institutional ramifications of transcultural psychiatry, rather than a topic informed by the discipline itself. I replied that I thought it would be original to study the motivations of the trainees and their experience of the program, as informing the utility and uses of the discipline across institutions. I cautiously added that my training as an anthropologist, and my specific interest in how state institutions manage cultural difference in France, shaped my project. My supervisor nodded, without adding any comment, obviously unconvinced by my explanation. This made me feel very uneasy, even though many students came to talk to me after the meeting to let me know they were interested in my project, a few even volunteering to be interviewed. I decided to speak to the program coordinator, trained in both psychology and anthropology, in order to gauge whether this project was going to jeopardize my standing in the program. After listening to me carefully, she thought the idea was interesting, and volunteered to supervise my work on the side, while I continued to attend my regular group meetings. I also received Pf. Marie Rose Moro's full support and interest.

Finally, being raised in France, but having spent the past decade in the United States, gives me both proximity with and distance from my fieldwork. While I consider this positionality analytically helpful, I recently realized how it hindered my work to some extent, namely in approaching the issue of culturalism and differentiation in my analysis, partly, I think, because I was socialized in the same cultural repertoires as the social agents I refer to in my analysis. Evidently, I am aware of culturalism in France and of its contemporary guises. Regardless, the identification of differentiation—at times discriminatory—mechanisms in my research came to me somewhat unexpectedly. In a sense, considering actions as text (Ricoeur, 1991) was necessary in distancing myself

from a research object which is subjectively close, and simultaneously provided me with a new “consciousness of belonging” (Ricoeur, 1991:73).

V. Chapter Summary

This dissertation consists of three different parts. The first part offers a genealogy of “specialized” mental healthcare and “immigrant suffering” in France. I argue that, in order to understand the contemporary relevance of the use of culture in mental healthcare and the distinct shape that it took in the French context, it is necessary to 1) understand how the concept of “culture” (preceded by the concept of “race”) became relevant in mental healthcare provision, and 2) trace the evolution of the cultural representations of immigrants in France—notably their impact in the healthcare context—and what led to an interest in “immigrant suffering.” In chapter 2, I analyze colonial psychiatry, the collaboration between the scientific fields of psychiatry and anthropology, and how these were structured by the political context of French colonialism. Relying on biological racism, colonial psychiatry’s use of the concept of “race” in therapy contributed to the control of colonized populations. I then analyze how the transition to a different political context—that of decolonization and postwar internationalisms—positively impacted post-colonial psychiatry initiatives. I describe how a growing scientific interest in the cross-cultural variations in the expression of mental health disorders and their treatment inspired collaborations between Western psychiatrists and local healers. I show how these ultimately reify culture and depoliticize distress.

In chapter 3, I pursue the genealogy of “specialized” mental healthcare by tracing the mechanisms that eventually motivated an interest in “immigrant suffering.” I pay

particular attention to the evolution of the cultural representations of immigrants in relation to France's immigration policies. I analyze the reproduction of colonial representations of the "African Other" in the general field of public health in France at the turn of the nineteenth century. I look at the representations of distinct immigrant groups (North and sub-Saharan African successively), and how these impact their health and its management by French public health institutions. I focus on the naming of immigrants' health issues by medical officials and how these naming strategies depoliticize the socioeconomic inequalities to which immigrants are vulnerable. In particular, I draw attention to the rhetorical shift from an emphasis on the infectious and malingering body of African workers (especially north-Africans), to an emphasis on the management of socially deviant and psychologically distressed African families (especially West Africans), each corresponding to two general phases in the history of immigration: labor immigration and family reunification. Finally, I argue that this transition led to the first clinical ethnopsychiatry initiative for immigrants, and resulted from the need to institutionally manage immigrant families.

In the second part of the dissertation I analyze the institutional discourse of "specialized" mental healthcare in contemporary France. In chapter 4, I analyze how, in the aftermath of Nathan's ethnopsychiatry, the three specialized mental health approaches I have identified have respectively re-formulated an expert discourse on "specialized" mental healthcare delivery to immigrants in France. I suggest that these approaches have "softened" their discourse on the relevance of cultural difference in mental healthcare delivery, mainly with the aim of securing institutional capital. In particular, I argue that by uncritically amending the overlap between cultural difference and socio-economic

inequalities, and by developing technical lexicons that politically euphemize the relevance of culture in discourse, they indirectly participate in de-politicizing the issue of immigration and the management of cultural difference in France altogether.

In chapter 5, I nuance this conclusion by introducing the internal complexities that characterize “specialized” mental health institutions. After establishing the structural features of the field they inscribe themselves into (the macro-context of my institutional analysis)—namely the close interaction between political conjunctures, immigration policies and racial/cultural discourses in particular, and the evolution of mental healthcare provision to foreign populations—I want to introduce the individual figures who “perform the field.” Using the concept of reflexivity, I analyze how mental health experts and their trainees articulate their positionality in the field, where they identify institutional contradictions, and how they make sense of them.

The last part of this dissertation analyzes clinical interactions and cross-institutional referrals to “specialized” mental health centers, focusing on the identification and categorization of cultural difference. In chapter 6 (and in the third part of this dissertation more broadly), I thus move beyond institutional discourse, and analyze filing and referring practices (the management of patients prior to consultation). I identify the coding of cultural differences, and how it creates tensions for health practitioners and staff in daily practice and interactions. Similarly, I study how referring institutional actors resort to a shared use of the concept of “difficulty” in order to avoid references to cultural difference. However, I suggest that the representations they help disseminate through the concept of “difficulty” simultaneously call for a pragmatic acknowledgement of cultural differences and an affirmation of their relevance both in their relation to the structural

inequalities many immigrant families face, and to the expression of the mental suffering such inequalities produce. I argue that the aforementioned paradoxes echo France's long-standing anxieties with naming identifiable immigrant groups, at the same time as its struggling with the necessity to structurally acknowledge them.

Chapter 7 analyses the clinical impact of the discursive ambivalences described in the previous chapter. In a first part, I focus on how specialized mental healthcare practitioners manage the contradictions of their own institutional position, and alternatively find avenues to contest it; the second part focuses on patients, the ways they put the regulative system to the test by directly contesting it, or by becoming socialized in it and finding ways to mobilize it to their own advantage.

Finally, chapter 8 re-emphasizes the tensions teased out in the previous sections, around naming and referring practices as regulative strategies in the management of immigrant families on the one hand, and their contestation in "specialized" mental healthcare clinics on the other. The language of school referrals is particularly relevant as it most directly conveys definitions of what a "standard" socialization model and "normal" behavior are. By examining how definitions of "normal" behavior are articulated through school referrals, I argue once again that "specialized" mental healthcare centers represent loci where essentializing representations of immigrants' cultural differences are projected, and can be analyzed. Once again, I identify a language of "difficulty" – this time institutionalized by the national education jargon – in the identification of immigrant children's behavioral problems and/or learning disabilities.

Theoretically, this dissertation contributes to social theory by proposing an analytical frame that measures the extent to which political discourse and public

representations shape institutional practices by highlighting how social agents negotiate between the two. It thus contributes a model of institutional analysis that both delineates social frames and documents individual experience, through time and space. By doing so, it illustrates how anthropology may contribute to and praise the study of complexity of social life beyond the traditional structure/agency dyad.

CHAPTER 2: French Colonialism and the “African Mind”

In this chapter, and the following one, I analyze the genealogy of specialized mental healthcare in France. In other words, I trace the historical conditions that led to concerns with developing a discourse on “immigrant suffering,” and that made such discourse gradually be inscribed in schemes of thought, to become practice (Bourdieu, 1977). Through this analysis, it becomes readily evident that concerns with establishing expert knowledge on the mental health of the Other responded to political concerns with disciplining the Other. I show how this tension between caring and regulating – reiterated in my analysis of specialized mental healthcare today, was thus a “built-in” feature of early specialized mental healthcare initiatives, namely in colonial psychiatry and the development of scientific racism in the nineteenth century. More broadly, through these two chapters, I attract the reader’s attention to the “political subjectification” (Fassin 2008:533) of the colonized in the first place, and of immigrants in the second. That is, through the genealogy of specialized mental healthcare, I contextualize how these two groups successively came to be constructed and identified as such in the public arena, how this identification was legitimated through the language of science – particularly in the initial collaboration between anthropology and psychiatry. Finally, I show the evolution from a biologizing discourse on the relevance of “race” in mental healthcare provision to the colonized, to a post-colonial interest in the relevance of “culture” and cross-cultural variations in the expression of mental health disorders and its treatment.

The collaborations between the anthropology and psychiatry produced rich clinical material and contributed to the development of contemporary transcultural

psychiatry, or alternatively, ethnopsychiatry (Collignon, 2003). As Fassin (2000b) explains, the collaboration has taken two major directions: “psychoanalytic anthropology”, a perspective in which some concepts developed by psychoanalysis were thought to be useful in the analysis of common anthropological inquiries – such as myths, rituals, etc.; and “ethnopsychanalysis”, a perspective in which alternatively, anthropological notions are used to analyze the psychological specificities of various groups (through analyses of social organization or witchcraft for example). The first perspective, psychoanalytic anthropology, remained marginal within anthropology, and its development was confined to academia.²⁰ For analytical purposes, I will not address this perspective here. Ethnopsychanalysis – or more commonly referred to as ethnopsychiatry, on the other hand, refers to the use of anthropology and psychoanalysis as complementary frames of reference in a clinical context.²¹ However institutionally marginal, it found some resonance in the French public health realm, by offering a methodology for the therapeutic care of “non-traditional” mental disorders or “unusual” expressions of distress.

This chapter proposes to analyze how ideas of racial differences—put forth, in part, by anthropological theories—have informed racially biased theories of human behavior through colonial French psychiatric practice, and how, in turn, these have influenced contemporary representations of “foreign” populations, focusing on North and sub-Saharan Africans. It focuses specifically on how French colonial psychiatry has

²⁰ Anthropologists adhering to this perspective are commonly grouped under the Culture and Personality School of anthropology. Leading figures of the perspective include Ruth Benedict, Cora DuBois, Abram Kardiner, Ralph Linton, Margaret Mead, and Edward Sapir.

²¹ The use of the “ethnopsychiatry” label in reference to clinical psychoanalysis can be confusing, as it also refers to a perspective in American medical anthropology, one which addresses the cultural variations in behavioral disorders and their healing modalities (Hughes, 1996), as well as “the cultural construction of professional and folk psychiatries” (Gaines, 1992).

analyzed mental disorders in the context of cultural (or alternatively “racial”) difference. Through the lens of colonial psychiatry, it highlights the political uses that were made of racial theories as a form of social control in the colonial context. Finally, it traces the post-colonial collaborations between anthropology and psychiatry, their confrontation with early colonial biological racism, and their alternative approaches for culturally-sensitive psychiatric care.

I. Race, Mental Difference, and Politics

The genesis of the race concept and its application in the nascent field of anthropology²²

In his book on the genesis of the race concept, Brace (2005) argues that while race and the classification of allegedly biological categories emerged as early as the Renaissance in the 15th and 16th centuries, they only attained the status of accepted truth within the last 200 years, with the professionalization of natural and behavioral sciences.

The first attempt at classifying human species on a biological basis was provided by Swedish Botanist Carolus Linnaeus in *Systema Naturae* (1758). In this work, Linnaeus turned his attention to human biological variation, and distinguished four varieties: *Homo sapiens europaeus*, *Homo sapiens asiaticus*, *Homo sapiens americanus*, and *Homo sapiens afer* (Europe, Asia, America, and Africa). Already then, characteristics were given to those groups following the theory of humors: Europeans were “sanguine,” Asians “melancholic,” Americans “choleric,” and Africans “bilious” (Bock, 2005: 27).

²² In this part I provide a highly selective and simplified summary of ideas generated on the concept of “race”, as they best serve the purposes of this chapter. For further elaboration of the ideas presented here, see, among many others, Baker, L.D. (1998); Shanklin, E. (1994); Stocking, G. 1968 (a compilation of sources on the concept of “race” in anthropology have been gathered on the AAA website in the context of The Race Project, and are available online at: http://www.understandingrace.org/resources/pdf/annotated_bibliography.pdf).

At the time of Enlightenment, science and religion were inextricably linked. It was generally assumed that the world was hierarchically arranged, and that there existed a Great Chain of Being, which God had carefully crafted. Scientists' major dilemma with establishing human differences was to reconcile their findings with traditional Christian framework and the biblical accounts of human creation from an original pair, Adam and Eve. Debates thus took place between monogenists and polygenists around the concept of the "unity of mankind," put forth by American philosopher Samuel Stanhope Smith. The latter, an advocate of monogenism, staunchly opposed the racial classifications of his contemporary natural historians on this basis. On the other hand, proponents of polygenism, such as Paracelsus and Peyrère, sustained such classifications with claims for "non-Adamic Men" (Bock, 2005: 39).

Darwin's theory of evolution brought modifications to the concept of "race" (Darwin, 1985[1859]). His model described human beings as a whole within which "races" were identified as "subspecies." Mostly for geographical reasons, "races" had maintained their distinctiveness and reproduced within the group. Nonetheless, "Each race was seen as being subject to continual modification and development rather than to a static set of inherited characteristics. Although the Darwinian idea of race as a subspecies promoted the concept of geographical race, it did not exclude the view that races may become separate types: it was held that a subspecies may evolve to a point where it is no longer able to interbreed with other forms and hence become a species" (Fernando, 2002:21). But the racist ideological convictions dominating during Darwin's time eventually led him to modify his position. In *The Descent of Man* (1871), he thus

suggested that “savage races” were likely to become extinct as they appeared unable to change when brought into contact with “civilized races.”

Racial prejudices and anthropological studies on the psychology of “primitives”

Accordingly, early studies of perception, motivation, and cognition among “primitive” cultures were shaped by racially prejudiced assumptions. For example, it was believed that “primitives” had poor color vision because their languages contained only few color terms. “Another kind of stereotype involved the ‘sharp-eyed savage,’ who could supposedly detect objects (or hear sounds) that escape the civilized eye (or hear)” (Bock, 1988: 9). British anthropologist W.H.R. Rivers (1924), for example, compared Europeans to “native” groups in attempting to determine the degree to which individuals were affected by optical illusions. Testing the Muller-Lyer illusion on Melanesians, he found that the latter were less susceptible to the illusion than Europeans were. While such findings were analytically limited, it drew some to infer that such differences were racial, and that “some ‘natives must have some kind of sixth sense’ that allows them, for instance, to track game over barren ground, to find their way home ‘instinctively,’ or to navigate out of sight of land without a compass or other instruments” (Bock, 1988:12).

Early studies of motivation were subject to similar biases. “Native” peoples were almost uniformly depicted as showing brutish attributes, and as having limited objectives outside of satisfying their hunger and resting after physical activity. L.H. Morgan (1877), thus “wrote of the inferiority of savage man in the mental and moral scale, undeveloped, inexperienced, and held down by his low animal appetites and passions” (Bock, 1988:13). Natives were said to be overridden by passions, thus at times displaying violent

behavior, and unleashed sexual behavior. Such passions had to be restrained, it was conveniently argued, by European settlers and colonial officials. Again, racist theories attributed motivational differences to group inheritance and linked it to physical appearance, following Linnaeus's famous racial divisions. Others attributed differential motivation attributes to differences in activity and the influence of climate. For example, the intense heat that often characterized regions of colonial occupation were said to make people lazy, and henceforth less culturally accomplished.

According to Bock, "more has been written about primitive thought than about perception and motivation combined. (...) The characteristics of primitive thought were of great concern to early anthropologists and 'folk psychologists'" (1988:17-18). L.H. Morgan, for example, associated specific mental developments to each stage of the civilizing process – from barbarism to civilization (Morgan, 1878). Another famous scholar, E.B. Tylor (1858), contended that cultures evolved from simple to complex forms, and that "animistic thinking" characterized the earliest form of religious thought. German psychologist Wilhelm Wundt (1916), one of the founders of "folk psychology," similarly attempted to link particular thought processes to alleged stages of cultural evolution, based on ethnological reports. He was one of the first to assert that the intellectual capacities of "primitive man" were not inferior to those of "civilized man," but that they were rather narrowed from living in a more restricted environment. His ideas undoubtedly influenced some of his students such as Durkheim, Boas, and Malinowski.

Scottish anthropologist James Frazer, who studied religion as a cultural phenomenon, sought to analyze primitive belief systems. In his famous book *The Golden*

Bough (1890), adopting social Darwinism as his paradigm, he interpreted three rising stages of human progress: magic gives rise to religion, which then culminates in science. Although Frazer believed that “primitive” people could reason just as well as “civilized” people, he maintained that their reasoning was affected by false premises rooted in magical beliefs. According to him, variations in reasoning abilities only resulted from different assumptions underlying such reasoning. French philosopher Lévy-Bruhl, on the other hand, initially argued for a distinctive “prelogical” primitive mentality. He was actually the first anthropologist to address comparative cognition. In his work *How Natives Think* (1910), he differentiated between two basic mindsets of mankind, “primitive” and “Western.” The first does not differentiate the supernatural from reality, but rather uses “mystical participation” to manipulate the world. The Western mind, on the other hand, uses speculation and logic. Like many others, Lévy-Bruhl based his analysis within the perspective of evolutionary teleology, which looked at human evolution as a continuum leading from the primitive mind on one extreme, to the Western mind on the other.

While Lévy-Bruhl’s position was taken seriously, it was severely critiqued by American anthropologist Franz Boas, whom in *The Mind of Primitive Man* (1911) firmly established that mental processes were the same among all human beings, and that the existence of an evolutionary scale of mental organization could not be scientifically sustained. This did not entail that he disagreed with Darwinian evolutionism – he actually cultivated the notion of “cultural progress” –but the scientific method he proposed for academic anthropology could not verify differences in the functions of the human mind. Boas actually encouraged anthropologists to use their data to speak out on social issues,

such as against racial prejudices. In his famous 1906 address to Atlanta University, he argued against the alleged inferiority of the “Negro race,” celebrating the cultural achievement American “colored” people’s African ancestors, and criticizing the United States’ racist imperialist stance (Baker, 2004).

The political uses of racial theories

Merely a decade before Boas’s address, American physician and anthropologist Josiah Clark Nott published his *Types of Mankind* (1854), intending to show that the institution of slavery as it existed in the United States was “justified” by the findings of science. Such views were approved and supported by Swiss American naturalist Louis Agassiz (Brace, 2005:101). As the latter had claimed: “The indomitable, courageous, proud Indian – in how very different a light he stands by the side of the submissive, obsequious, imitative Negro, or by the side of the tricky, cunning, and cowardly Mongolian!! Are not these facts indications that the different races do not rank upon one level in nature?” (Brace, 2005: 101-102).

Europe was not spared by such discourses. On the contrary, some of the most extreme racial theories developed in France and in Great Britain, justifying colonial repression and imperialism, as well as preparing for the rise of Nazism in Germany. In France, Comte de Gobineau, often referred to as “the father of racism,” wrote his *Essai sur l’inégalité des races humaines* (1853-1855), in which he declared that all civilizations derived from the white race, and that none can exist without its help. He also defended that the Aryans were the most “noble,” “intelligent,” and “vital” branch of the white race (Brace, 2005:120). In America, paleontologist Nathaniel Southgate Shaler (1904)

reiterated Gobineau's Aryan hypothesis, declaring that the progress of people of African origin depended "on the imitation of 'a mastering race' since biosocially they are innately inefficient. (...) Democracy could survive, he claimed, only where European superiority was recognized and maintained. He also noted the 'inferiority' of European peasant immigrants to the 'superior' Anglo-Saxon 'race' and advocated controls on immigration (Shaler, 1893)" (Brace, 2005: 161-162).

The break-out of the First World War perpetuated the concept of "race." British dilettante Galton's eugenics became popularized. His ideas were exported to America by Harvard biologist and zoologist Charles Benedict Davenport, who set up the Eugenics Record Office in 1910, where he hired Harry Hamilton Laughlin, a high school teacher interested in breeding, as its superintendent (Brace, 2005:183). The latter formulated the "model sterilization law," which was passed in Germany in 1927.

Collaboration with psychologists encouraged links to be drawn between "race" and "intelligence." Immigrants in particular were targeted, under the "assumption that "they" [were] less intellectually competent than "we" and the fear that "they" might dilute the mental caliber of the nation as a whole" (Brace, 2005: 204). In France, Sorbonne psychologist Alfred Binet (1905) developed a way of rating the "mental level." He noted that performance on assessment tests depended on learning as much as innate ability. His ideas were translated by American psychologist Henry H. Goddard, who applied Binet's methods of assessment to document class and "racial" distinctions which he claimed were genetically determined (Brace, 2005: 207). The ideas were used to limit educational opportunities for immigrants and African Americans, and to justify immigration quotas. The concept of "national minds," formulated at the beginning of the

twentieth century by McDougall (1908) in his textbook on social psychology perpetuated the stereotyping of allegedly homogenous racial groups, depicting the Nordics as good scientists, Mediterraneans as great architects or orators, and Negroes as submissive. Fernando also reports that in the 1920s, Carl Jung (1930) postulated that the Negro “has probably a whole historical layer less” in the brain: “Jung considered himself to be a specialist on ‘primitive’ people. In speculating on a supposed danger to white people of living in close proximity to black people, Jung deduced the theory of ‘racial infection’ as ‘a very serious mental and moral problem whenever a primitive race outnumbered the white man’” (1988:20)

In the United States, the IQ movement, led by Lewis M. Terman (1916) and Robert M. Yerkes (1921) generated more racist pseudo-scientific measurement of races’ intelligence levels. Although their theory triggered much debate in academia, it was revived later on in the century by Berkeley psychology Professor, Arthur R. Jensen (1969), who offered a genetic explanation for variations in IQ ratings between white and black Americans.

II. Colonial Psychiatry and the “African Mind”

Perhaps nowhere were the links among race, mind, behavior, and social regulation as both openly discussed and hotly debated as in the area of French colonial psychiatry (1870s-1950s). Colonial psychiatry generated discussion around the influence of “race” on mind and behavior, the question of cultural difference, the possibilities and limits of social transformation in the colonies, and the political evolution of colonial subjects. As historian, Vaughan notes about this time that colonial psychiatry provided a scientific

language with which to frame dilemmas encountered by colonial administrations (Vaughan, 2007). Alongside anthropology, psychiatrists were involved in elaborating theories of “acculturation,” “culture contact,” and of the “educability” of the African. Such theories were politically relevant, as they directly addressed “the question of whether and when increasingly ‘detribalized’ Africans would ever be ready to govern themselves” (Vaughan, 2007:8). Both anthropology, with its theories of systems breakdown, and psychiatry, with its language of “the disintegration of the African personality” provided negative answers to the question and encouraged the pursuit of colonial management (Vaughan, 2007:8).

In some colonial psychiatric theories, just like in anthropology at the time, “culture” (and sometimes religion) was merely a more acceptable term for “race”. While anthropologists concentrated on changes at the level of “tribal” entities, psychiatrists offered a distinct medico-psychological approach which located the detrimental effect of “culture contact” in the individual African’s personality and psyche. However, the basis for such discussions relied on the notion of biological difference and its influence on the relationship between race and psychopathology. Biological racism provided a scientific basis for the ideological opposition between “civilized” (European) and “primitive” mentalities (Vaughan, 2007:24).

The case of the Algiers School: Ethnopsychiatry in the French Colony

Psychiatrists in the French colonies were particularly fascinated with the relationship between psychology and culture. Many found in the so-called primitive mind of the colonized elements of a primordial, universal human subjectivity, proving the

existence of an essential psychic unity of mankind. Yet psychiatrists of the Algiers School sought to demonstrate a clear separation between the “civilized” mind of Europeans and the “primitive” mind of North Africans, based on bodies and traditions (Keller, 2007). The difference between these groups, they argued, was exacerbated by the colonial encounter which thrust primitive folks in an alienating modern environment. Their work drew on the legacy of the psychological anthropologists, physicians, and racial biologists of the time. They produced a new science of colonial psychiatry, with pragmatic applications in judicial, social, and military institutions. French psychiatrists have thus characterized North African Muslim populations as inferior to civilized Europeans, “by documenting the Maghrebians’ temperamental violence, fatalism, superstitions, and mental debilitation” (Keller, 2007:123).

Here it is important to emphasize that colonial psychiatry very much constituted a “military organism” (Keller, 2007: 123), articulated around the language of battle, and deployed in the service of colonial power to tame unruly indigenous populations, and later shape debates over law enforcement and immigration. According to Keller, the outbreak of the war in 1914 and the presence of colonial subjects in the infantry provided psychiatrists with the opportunity to study indigenous populations under stress and draw conclusions on racial and cultural influences on psychopathology. French psychiatrists Antoine Porot and Angelo Hesnard (1918) established a racial hierarchy of suitability for military service. North Africans were thus considered particularly fitted for acts of brutality and thus praised as first-line soldiers. However, their highlighted impulsivity was identified as also putting them at risk for hysteria, and it was recommended to supervise them closely as less controllable soldiers. But of all North Africans, only

Muslims were seen as posing particular problems, and this was linked to their alleged resistance to civilized modernity (notably technological order and military discipline). War threw these soldiers from “‘the hypnosis of brilliant sunlight’ into an ‘infernal’ but also ‘scientific’ cataclysm. As Porot (1918) argued, ‘Suddenly, we were able to measure the entire moral resistance of simple souls, the powerful force of certain primitive instincts as well as the misery of certain mental deprivations and the deviations imprinted through credulity and suggestibility’” (Keller, 2007: 132). North Africans were described as irremediably other.

This literature triggered an explosion of interest in primitivism in postwar France, and contributed to French philosopher Lévy-Bruhl’s famous work on *Primitive Mentality* (1923), mentioned earlier in this chapter. Rather than biological reasons, Lévy-Bruhl evoked cultural and environmental factors for primitive mentality. For those who accepted this theory, this meant that through “psychological and psychiatric instruction,” primitives’ mental lacunas could be reversed in “the fulfillment of France’s civilizing mission” (Keller, 2007: 133). Such interest in primitive mentality in the interwar period also “indicated that an ethnological sub-specialty was gaining steam within the French psychiatric profession” (Keller, 2007: 136). Psychiatrists practicing in North Africa insisted that close contact with colonial patients revealed the practical and political importance of specific ethnopsychiatric knowledge. Their works departed significantly from that of their metropolitan colleagues, in that their insistence on the biological nature of psychological constitution aimed at forging local, pro-colonial political advocacy (Keller, 2007).

The School disseminated appalling characterizations of *the* indigenous Algerian, claiming that observations of Algerian psychopaths in fact corresponded to an Arab normal mental state. In fact, generalizations from Algerians to Arabs, North Africans, and Muslims occurred recurrently.²³ Pathology was often ascribed to religious and racial factors, “linking Muslim cultural tendencies to heredity in a Lamarckian fashion” (Keller, 2007: 139). Again, Muslim individuals, especially men, were said to have inherited an impulsive behavior. They were blamed for neglecting and even murdering their wives too frequently, or for allegedly considering statutory rape as a sexual norm. This led to the conclusion that, considering this pathological heritage was believed to be biologically hereditary, Arabs could never assimilate. Porot and his student Don Côme Arrii (1932) proposed that French North Africa therefore “required intense policing, as ‘it is above all through...sanctions that we teach these thwarted and overly instinctive human beings that human life must be respected...a thankless, but necessary task in the general work of civilization’” (Keller, 2007: 140). The Algiers School’s increasing influence was sustained through its publishing extensively on a wide range of psychiatric topics that were foreign to practice in the colonial field (Keller, 2007).

With the outbreak of the independence movements in the 1950s, ethnopsychiatric knowledge caught the attention of a new group: the French army’s newly founded Fifth Bureau, which led psychological operations during the Algerian war. Keller argues that this initiative was actually inspired by American propaganda campaigns in the Pacific during the Second World War. In response to the Algerian *Front de Libération Nationale*

²³ And here I would like to point that such generalizations still hold in contemporary France today, where the reference to “Muslim” stands for “North Africans” as a group, and vice versa. Despite the fact that many sub-Saharan African immigrants in France also share the same religion, they are not subject to this arbitrary linguistic connection and related social representation.

(FLN – National Liberation Front) propaganda, this French army unit developed strategies designed to convince Algerians of the benefits of the French presence in their country. Such techniques as press censorship, loudspeaker announcements, and street flyers were aimed at influencing public opinion with this message. It was believed that in order to increase the pro-colonial propaganda's efficacy, the psychological characteristics of the "normal" North African needed to be taken into account. According to Keller, "A top-secret memorandum of 1959 indicates that the Fifth Bureau actively sought information about North African mentalities from key members of the Algiers School. (...) Officials hoped that (...) Porot and Sutter might adapt information extracted from their patients in order to design a psychological operations program to be implemented in internment camps for Algerian prisoners of war, and then more broadly throughout the population" (2007: 155). A chart was even created to shape psychological tactics according to Algerians' character traits. For example, it was understood that in order to sensitize such primitive individuals, arguments needed to be articulated that touched Algerians' emotions rather appealed to their limited intellectual capacities.

In France, the Algiers School's works were received enthusiastically, praised for advancing psychiatric knowledge with an unparalleled wealth of clinical experience. There were voices of dissent, however, especially among French psychiatrists who worked with immigrants, and who attributed the high prevalence of mental disorders to feelings of nostalgia and dislocation rather than to intrinsic fatalism, impulsivity, or general deviance as described by the Algiers School (Alliez and Descombes, 1952).

Unfortunately, the outbreak of the Algerian war in 1954 led some to shift their views radically, and the growing immigrant population instilled fears of instability which

in turn exacerbated scathing representations of immigrants both in medical and public spheres. North Africans' alleged "tribal ways" were linked to higher crime rates, which drew the attention of police authorities. Immigrants were generally deemed unable to assimilate. Religion, together with an innately criminal and deviant nature, prevented North Africans' acculturation.²⁴ In this context, "the Algiers School's constant reiteration of North Africans' difference brought scientific corroboration to this prejudice. (...) It provided a justification for the disparities of the *Code de l'Indigénat*, for the limiting of educational opportunities, and for the banning of Muslims from medical practice" (Keller, 2007: 150). In other words, the scientific racism of the Algiers school had the successful, practical policy impact it intended to make.

Other ethnopsychiatries

The Algiers School was but one example among others. Because I want to focus the genealogy of ethnopsychiatry to France and French colonies, I am deliberately omitting a number of other notable ethnopsychiatric experiments serving the political purposes of colonial empires elsewhere. I will briefly mention Dr. John Colin Carothers, who in 1954, was appointed by Great Britain to direct the Mathari Mental Hospital in Nairobi, Kenya. Without being an expert, the appointment nonetheless propelled him to become a preeminent figure of colonial ethnopsychiatry, and to be solicited in many other regions of Africa. He received much attention for his publication entitled "Frontal Lobe Function and the African" (1951), in which he resorted to physiology to explain mental

²⁴ Again, I want to underline how such racist representations of "North Africans" may have informed their representation in contemporary France's public imaginary, as religiously fanatic and violent, and also perpetuated in representations of North African youth as delinquent.

derangement as related to personality structure among Africans. Attesting to his growing fame and popularity, the World Health Organization commissioned him to write a monograph on mental health and disease among Africans (he was chosen over other eminent experts like social anthropologist Melville Herskovits) (McCulloch, 1995). Carothers published his report entitled *The African Mind in Health and Disease* (1953). This publication is notable as it is the first one formally subtitled as *A Study in Ethnopsychiatry*. In the report, Carothers presented his theory of African inferiority, expanding “his explanation of Africans’ deficiency to include culture, race, brain morphology, morality and intellectual endowment” (McCulloch, 1995:61). Such theory were intended to justify the colonization of Africa as a continent, and directly linked the study of mental health to colonial politics.

A year later, Carothers published *The Psychology of the Mau Mau* (1954), in which he reduced the indigenous political movement both to the personality of the Kikuyu, and to the psychological disruptions that the colonial encounter with Europeans triggered in that population. Specifically, he noted that the Kikuyu’s “forest mentality” predisposed them to suspicion and a propensity to respond violently to feelings of insecurity. Also, while the colonial situation deeply disturbed them in that sense, he concluded that it also instilled envy in terms of social promotion, which in turn produced hatred towards colonial authorities. Neither the nationalist ideology of the movement nor its claims over land ownership were anywhere acknowledged by Carothers. Accordingly, Carothers’ prescription consisted of socially reintegrating the Kikuyu by grouping them in small village units, away from the destructuring environment of cities, and by helping them rediscover traditional and moral ways of living. What in fact constituted a form of

political repression on the part of British colonizers was thus interpreted as a culturally-sensitive form of therapy. Ethnopsychiatry thus became “an official instrument to control colonized populations” (Fassin, 2000b).

There was another notable study of a colonial revolt that took place in the French colony of Madagascar in 1947. It was written by French ethnologist and psychiatrist Octave Mannoni, and entitled *Psychologie de la colonisation* (1949), which was later published in English under the title *Prospero and Caliban* (1950). It was the first study in ethnopsychiatry problematizing the colonial relationship itself. Mannoni considered the colonial situation as the encounter between two kinds of personality, which created a relation of dependence from the inferior personality (the colonized) to the superior one (the colonizer). According to him, the “dependency complex” among the Malagasy prefigured the arrival of the Europeans, and explained their unconscious compliance (McCulloch, 1995:100-101). The innovative element in Mannoni’s work was his psychology of the colonizer, as being dominated by the same “perverse and infantile needs” as the colonial subjects (McCulloch, 1995:102). He believed that, as such, they were illegitimate representatives of European civilization, and that they were the ones responsible for colonial racism. To Mannoni (1950), racism was an aberration. He argued that what the Malagasy “were seeking was not political rights but relief from fear of abandonment. They wanted to project their own shortcomings onto Europeans and so they behaved like impossible children who wanted one thing but demanded another. If they were granted self-government at the wrong time, they would simply regress” (McCulloch, 1995:103). In other words, he depoliticized distress by approaching

independence strictly as a psychological problem, and ignoring the economic and political demands made by the Malagasy during the riots.

Generally then, throughout the accounts of ethnopsychiatrists, colonized societies were characterized as diseased, mentally backward, or prone to mental illnesses. Even on the eve of independences and obvious social transitions, many ethnopsychiatrists maintained that the colonized –Africans in particular – lacked the ability to change and to adapt to the modern, urban environments introduced by Europeans. Their critique was also directed at the figure of the African intellectual who led the nationalist movement for independence. These men “were portrayed as having the worst possible qualities for political leadership, combining an inability to accept responsibility or to show initiative with a predisposition to mental illness” (McCulloch, 1995:120). In this way, ethnopsychiatry accounts also attempted to curtail potential political insurgence.

At this point, we may identify two generalizing, monolithic representations of North and sub-Saharan Africans, disseminated and *naturalized* through colonial psychiatry’s literature. These representations almost stand in opposition to one another: on the one hand, North Africans are depicted as religious fanatics, cunning, violent, and naturally subject to committing crimes; on the other, sub-Saharan Africans are infantilized, shown to be mentally and socially backwards, as well as irresponsible. Colonial psychiatry thus contributed to generate mechanisms for the production of a tacit knowledge that feeds today’s racist representations of the same populations in France, as they are still monolithically referred to, in the same binary opposition, as *les Arabes* (Arabs) (or alternatively *les musulmans* (Muslims)) or *les Africains* (Africans) (or alternatively *les Noirs* (Blacks)). Its derogatory images (“the fanatic Muslim” or “the lazy

African”) have certainly weakened with the delegitimizing of the notion of biological racism, but they are intermittently resurrected in both everyday and political discourse (Ndiaye, 2008:191-244).

III. Post-Colonial Critique and the New Ethnopsychiatry

In the context of colonial independences, ethnopsychiatry was gradually transformed. This transformation stemmed from two main factors: one was the professionalization of European psychiatry in Africa and the development of epidemiological studies of mental disorders in sub-Saharan Africa; the other was the passionate critique brought on by psychiatrist Frantz Fanon, who exposed “the political foundations upon which ethnopsychiatry rested” (1995:121).

Fanon: Political Critique and “Sociotherapy”

The most famous critique of colonial psychiatry is Frantz Fanon’s. Although Fanon did not directly work towards the elaboration of ethnopsychiatry as a discipline (at least it was never his goal), his passionate contribution on denouncing the political and human abuses of colonial psychiatry and, more importantly, his theorizing on the experience of racism and the impact of the sociopolitical environment on individuals’ mental health, must be underlined. In fact, some argue that “Fanon’s psychiatry was fundamentally socio-political” (Youssef and Fadl, 1996:527).

Born and raised in Martinique, Fanon had received his medical education and degree in psychiatry in France. During this time, he encountered a large number of North African men who had migrated to France as labor force. He found these men to be treated

with utmost contempt in public hospitals, where they often presented themselves with vague complaints, categorized by physicians as the “North African Syndrome.” Patients would be sent home with treatments with which they would fail to comply, and would soon return to the hospital with the same complaints. Hospital staff perceived them as “malingerers,” using their fictitious ailments as a way to escape work. This perception persisted for decades, and was known in France as *sinistrose*, the colloquial translation for “malingering.”²⁵ Of course, such perception reflected the image of North African migrant workers in the public imagination as illegitimate residents. In that respect, while *sinistrose* –or “The North African Syndrome” (Fanon, 1952)— pointed to an illness that resulted from the structural conditions of expatriation and racism, it could not be recognized as such by medicine, for such recognition would admit the relationship between suffering and the precarious social conditions endured by immigrant workers lived (McCulloch, 1995:124).

After obtaining his degree in France, Fanon left for Algeria, where he served as a *chef de service* at the Blida-Joinville Psychiatric Hospital until 1957, before moving to Tunisia (he was deported after he participated to the FLN activities), where he died shortly thereafter. At Blida, he observed the provision of care to Muslim patients. “He also wrote a brief review of the ethnopsychiatric literature from British and Francophone Africa (Fanon, 1955). Each of these articles was addressed to the problem of effective care for inmates of colonial asylums and replacing ethnopsychiatric theory with what he conceived to be an authentic scientific perspective” (McCulloch, 1995:124). What distinguished Fanon’s work from his peers at the time, according to McCulloch (1995),

²⁵ The following chapter on immigration and health in France will provide further detail on this issue.

was his sensitivity to the sociocultural origins of his patients, and to the historical and political situations in which they lived. To fully decolonize psychiatry as it was practiced until then, Fanon argued that a program of what he called “socio-therapy” had to be implemented. However, he quickly ran into a series of difficulties which led his program to fail.

In an essay written with psychiatrist Jacques Azoulay (1954), he described these difficulties. Among these, he emphasized the methodological difficulties that language and cultural barriers raised for proper therapeutic work. But more importantly, he considered the practice of psychiatry as self-defeating. As Françoise Vergès notes, summarizing Fanon’s observations:

How could the psychiatrist perform his role, ‘to enable man no longer to be a stranger to his environment,’ when the colonized was condemned ‘permanently [to be] alien in his own country’ and psychiatric institutions could not in such situations properly fulfill their goal of ‘serving man’s need.’ Since ‘madness was one of the means man has of losing his freedom’ and colonialism was the systematic organization of the deprivation of freedom, therapy was impossible except if the psychiatrist entered the service of the struggle for decolonization (1996:93).

In other words, practicing psychiatry in the colonial context in itself constituted a pointless political act: how could psychiatrists work towards freeing patients from their psychological distress, when they were alienated from their own environment?

Surprisingly, Fanon and Azoulay revealed little of the actual structural conditions that oppressed patients outside of the asylum’s walls. In *The Wretched of the Earth* (1973), looking back on his experience at the psychiatric hospital in Blida, Fanon theorized the psychological consequences of colonial rule and oppression. In *Black Skin, White Masks* (1964), he deconstructed colonial psychiatry’s pseudo-scientific racism. In

the end, however, as McCulloch comments, Fanon “abandoned his commitment to science in a favor of a commitment to political action” (1995:131). But, more problematically, his critiques of ethnopsychiatry eventually endorsed the same theory “that all colonial people were the same. That idea, reinforced by his encounter with Negritude, which subordinated class and nationality to race, was an idea he never managed to transcend” (McCulloch, 1995: 134). In the end, Fanon thus opposed racism with a form of racist anti-racism.

Independences and Alternative Approaches to Culturally-Sensitive Psychiatric Care

It is in the context of independences that an interest in the relevance of the concept of “culture” in mental healthcare developed, and that studies on the cross-cultural variations of the experience of mental distress and its treatment flourished. In his brief historical review of mental health initiatives in Africa, Collignon (2003) underlines that a call for a better management of “native” populations’ mental health was articulated as early as 1912 (Reboul and Regis, 1912). Franck Cazanove, a French physician, had then called for the protection of the insane as sick, rather than dangerous individuals (Collignon, 2003). Interested in the local representations of illnesses and in the practices of traditional healers, Cazanove documented the family management of the insane in Africa, and recommended colonial public health authorities to replicate such a system in the building of its asylums (Cazanove, 1927). He also put forth the idea of “an encounter between psychiatry and ethnology susceptible to produce the most brilliant and more fruitful results” (my translation, 1912:897). In the aftermath of World War II, when international aid developed through United Nations organisms, such collaborations found

a favorable political context, which in turn increased the collection of anthropological and sociological data on the local dimensions of mental health problems and their local treatments (Collignon, 2003:109).

According to Collignon, there were two pioneers in postcolonial African psychiatry: Nigerian psychiatrist T. Adeayo Lambo, and French psychiatrist Henri Collomb (2003:110). Both psychiatrists developed original initiatives for the management of mental health, in collaboration with local healers and local populations. Lambo is actually the first Nigerian psychiatrist who marked “the magisterial entrance of Africans endowed with an intimate knowledge of the language and culture of their patients” (Collignon, 2006:91-92). Inspired by his training in England, Lambo innovated from previous psychiatric practices in West Africa by creating a program exclusively based on outpatient care and open hospitalization.

Moreover, convinced that chances for cure increase with family/community support, Lambo developed the idea of “village housing” – through which he housed patients seen at the hospital in nearby villages in cases when their families live far away. This practice,

which uses as its main therapeutic technique the dynamic resources proper to the social environment, was made possible by a preliminary dialogue with the chiefs of several major neighboring villages, as well as with traditional healers, and the representatives of traditional cults, all of whom agreed to participate in the project. (Collignon, 2006:92)

The project became known as the “Aro village system.” Lambo progressively cumulated tremendous data on the local expressions of disorders, and particularly on the effects of the process of acculturation initiated by colonialism. In collaboration with Cornell University, he led a vast epidemiological study on the issue, known as the Cornell-Aro

project. The project involved the collaboration between Nigerian and American psychiatrists, as well as American sociologists and anthropologists (Leighton, Lambo, et al. 1963). Later, in the 1970s, Henri Collomb developed his idea of “therapeutic villages,” inspired from his experience with therapeutic communities as they were organized by local healers (Collignon, 2003:110).

Throughout the 1960s and on, there was an effervescence of local epidemiological studies which allowed for such creative responses to mental health disorders in the region. Henri Collomb institutionalized such efforts with the creation of the Fann Dakar School of Psychiatry. At the Fann Hospital, Collomb gathered around himself a team of collaborators from various disciplines: psychiatrists, psychologists, and local healers, but also sociologists, ethnologists, both European and African.

As evident in the previous sections of this chapter, ethnopsychiatry has, throughout the colonial period, occupied “a small and uncomfortable niche between the disciplines of psychiatry and anthropology” (McCulloch, 1995:1), never really achieving the status of an independent discipline in its own right. Some argue that the contours of contemporary ethnopsychiatry (or alternatively, transcultural psychiatry) as a science, and of a formally articulated collaboration between psychiatry and anthropology, were elaborated by Collomb and his collaborators at the Fann Hospital (Collignon, 2006). In 1962, he Collomb formalized his collaborative work group, providing a training program for local resident psychiatrists. He also created a clinical psychology consultation specifically responding to the needs of children and adolescents failing at school.

Such initiatives led to elaborate analyzes on work in transcultural situations. For example, in their book *African Oedipus* (1966), Marie-Cécile (psychologist) and Edmond

Ortigue (philosopher) offer a testimony of the important methodological innovations and research observations that the Fann School brought together, exploring the meaning of the Oedipus complex among Islamic tribal Senegalese. This edited work marks the beginning of a formalization of the incorporation of cultural representations in psychoanalysis, even though, as Collignon (2003) points out, at the time the practice of what could be called “ethnopsychanalysis” was still very limited, for lack of trained practitioners.

An important study led by French ethnologist Andras Zempléni (1968), member of the Fann Hospital team, also explicitly articulated the limits of psychoanalysis, and analyzed the conditions for the incorporation of local representations of disorders, based on a study of the Wolof and the Lébou of Senegal. Zempléni’s work called attention to the importance of the group in an African setting, and to the fact that “the individual is not always the sole place holding the truth about his/her illness” (quoted in Collignon, 2006:97). The importance of the patient’s family discourse and of his/her family environment is highlighted, and the mobilization of the patient’s broader entourage is recommended in therapy. Zempléni also described local etiologies in the understanding of disorders, often perceived as resulting from the intervention of outside maleficent forces. He distinguishes four types of such aggression: 1) witchcraft, 2) divining rituals (*maraboutage*), 3) the actions of *jinn*s or *seytaan*, in the context of coranic practices, 4) ancestors’ spirits (Collignon, 2006:98).

At the Fann Dakar Hospital, novel clinical techniques that incorporate the participation of healer and patients’ families are thus implemented. These initiatives present a complementary approach between clinical psychology and ethnology, described

by Ortigues, Martino and Collomb (1967) as incompatible if used simultaneously, and as dangerous if using the knowledge of local traditions as all determining in the expression of illness. Besides the “therapeutic village” experiment mentioned earlier, Collomb organized therapeutic discussion groups, called *pénc*, which aimed at reconstituting discussions in traditional African village assemblies. All patients and their relatives would gather, and exchanges would take place in the local vernacular, with the aim of forming “therapeutic communities.” Collignon (2006) notes that if the Fann School practices could be characterized as social psychiatry, they strongly differed from ethnopsychiatry. He quotes Edmond Ortigues, who recently wrote that

Ethnopsychiatry is a technique of psychotherapy which is strongly prescriptive: ethnicity and an ethnic typology are both prescribed, whereas the relationship between an individual and his/her traditions can be extremely variable. It is a constant characteristic of culturalism to imprison people in their traditions. When cultural norms or traditional beliefs are introduced in a voluntary and artificial manner in the context of the consultation, they become desocialized, they are ideological. (Ortigues, 1993:21-22; quoted in Collomb, 2006:101-102)

Lambo and Collomb’s psychiatry initiatives constituted novel attempts at incorporating local understandings of disorders that were not solely concerned with the regulation of local populations in mainstream psychiatric structures, but rather were sensitive to apprehend mental healthcare provision beyond the conventional biomedical framework. While in the end, as Ortigues argued, such initiatives proved strongly prescriptive and conceived of “culture” in static, essentializing terms, they put forth a strong concern with caring rather than regulating.

George Devereux: Theorizing Ethnopsyoanalysis

It is not until the work of George Devereux that a methodology for a complementarity between psychiatry and anthropology in the clinical context was formally articulated as “an autonomous science” (Devereux, 1980:3). The “key concern” of ethnopsychiatry, according to Devereux, is the redefinition of normality and abnormality “in terms of the key *concept* of anthropology, which is Culture, and the key *problem* of psychiatry, which is the boundary between normality and abnormality” (emphases in text, 1980:5). It was argued that Devereux provided “a vast synthesizing effort between Freudian theories, American anthropology’s debate on the relationship between individual and society / psyche and culture, and finally the French school (Durkheim, Mauss, Levi-Strauss)’s dialogue with psychoanalysis” (Andoche 2001:283).

Devereux argued that it is impossible to dissociate the study of culture from that of the psyche, because both are concepts which—although distinct—are complementary to one another. Culture and psyche should be considered as two facets of the same reality, presupposing one another reciprocally, both functionally and methodologically. Hence the need for a complementarity between psychoanalysis and ethnology (Devereux 1980). This complementarity is only possible because Devereux made a careful distinction between a universal expression of “Culture in itself” (or *metaculture*) and local expressions of culture. Like psychiatrists, Devereux adhered to the principle of a universal psyche, to which the concept of Culture relates: “Indeed, regardless of the variety of cultures,” he wrote, “the simple fact of having a culture is a genuinely universal experience, and man functions as a ‘creator, creature, manipulator, and transmitter of culture’ (Simmons 1942) everywhere and in the same way” (1980:69). This

made it possible for psychiatrists to also engage with the practice of ethnopsychiatry. In fact, Devereux added, it

does more than palliate the psychiatrist's technical inability to become a universal ethnographer. In fact, the approach that views psychiatric problems in terms of Culture rather than cultures is also more effective in a practical sense—that is, therapeutically—and is theoretically far superior to any other cultural approach; for it affords a deeper insight into psychodynamics, and this, in turn, leads to deeper ethnological insight into the nature of Culture. (...) [As far as the ethnologist, he] cannot make a real contribution to psychiatric knowledge if he simply assimilates its jargon and, for the rest, is content to trot out his little ethnographic collection of esoteric 'curios.' He can make a real contribution to psychiatry only if he remains an ethnologist: a specialist of Culture, defined as a patterned way of experiencing both extrasocial and social reality. This, I feel, adequately answers Kroeber's (1948) claim that ethnopsychiatry is not part of real ethnology because it does not study Culture. Yet it is only the ethnopsychiatrist who studies both Culture and the manner in which the individual experiences his culture who completes and rounds out—precisely as it should be completed and rounded out—the science of Culture. (1980:70)

The distinction between Culture and cultures also lead him to distinguish two types of unconscious: the “unconscious segment of the ethnic personality” (which Devereux carefully differentiates from Jung's “racial unconscious”) or “the portion of the total unconscious segment of the individual's psyche that he shares with most members of his given cultural community;” and the “idiosyncratic unconscious,” which is “composed of the elements that the unique and specific stresses of the individual has experienced” (1980:6-7). From there, he establishes an ethnopsychiatric typology of personality disorders: “1. 'Type' disorders, relating to the type of social structure; 2. 'Ethnic' disorders, relating to the specific culture pattern of the group; 3. 'Sacred' disorders, of the shamanistic type; 4. 'Idiosyncratic' disorders” (1980:13).

In 1970, Devereux published a collection of essays, under the title *Essais d'ethnopsychiatrie générale* (translated in English in 1980 as *Basic Problems in Ethnopsychiatry*). In these sixteen essays, written between 1939 and 1965, Devereux argued that the understanding of all human behavior requires the application of both psychological and sociocultural methods of explanation. This unique approach, which differentiates sanity and insanity from social adjustment and maladjustment, provided a rigorous foundation for a general theory of psychoanalytic ethnopsychiatry. He discussed crime, sexual delinquency, dreams in non-Western cultures, and cannibalistic drives of parents. He frequently cited case material from his extensive field work with the Mahave Indians of Arizona and the Sedang Moi of Vietnam, and from his clinical work with non-Western patients. He argued that the use of cultural material in psychotherapy could be used as a transitory therapeutic lever, but warned that the use of such cultural levers should not constitute a therapeutic object in itself (Moro, 2006: 162). Devereux also noted that in fact, the use of culture could potentially become an obstacle to therapy, and therefore be used cautiously (Moro, 2006:164).

Thus, according to Devereux, the therapist must cease to perceive his/her patient as the “site of an illness” – providing him/her with investigations and all sorts of benefits – but instead must accept him/her as a person belonging to the human condition, trying to give meaning to his/her suffering and a sense to his/her life. In this perspective, the knowledge of his/her original cultural milieu can be used towards therapeutic ends. But it must neither be employed as a possible means of readaptation to that milieu, nor as a conditioning method to the healer’s culture (Andoche 2001). Cultural decoding must not constitute an objective in itself. The role of the therapist is to accompany the patient in

his/her self-reflections and questioning of their fate, while respecting their choices in how they express themselves. In fact, Devereux distinguished between three types of therapy in ethnopsychiatry:

1. *Intracultural*: the therapist and his patient belong to the same culture, but the therapist takes into account the sociocultural dimensions of both the patient's disorders and of the therapeutic situation. 2. *Intercultural*: although the patient and the therapist do not belong to the same culture, the therapist is well-informed about the culture of his patient's ethnic group and uses it as a therapeutic lever. 3. *Metacultural*: the therapist and the patient belong to two different cultures. The therapist does not know the culture of the patient's ethnic group; however, he perfectly understands the concept of 'culture' and uses it as he establishes a diagnosis and decides of a treatment. (Devereux,1978:11-12)

It is on the basis of this classification that English-speaking countries make a distinction between *cross-cultural psychiatry* (intercultural) and *transcultural psychiatry* (metacultural).

Devereux's seminar in Paris influenced the creation of transcultural psychiatric care sites, and the development of psychoanalysis along with a clinic of migration and exile (Mouchenick 2006). Devereux's ethnopsychiatry was also later re-interpreted in a radical manner by one of his students, Tobie Nathan, who, departing from Devereux's careful distinction between Culture and cultures, only retained cultures as all-determining in the expression of foreign patients' disorders (Nathan, 1994).²⁶ Therefore, it is following a heated intellectual struggle against colonialism and scientific racism that, in another sociopolitical context – that of restrictive immigration policies and racial discriminations in France – the collaboration between anthropology and psychiatry took yet another problematic turn.

²⁶ These distinctions are important as they inform contemporary modes of psychiatric treatment in France.

Conclusion

Colonial and post-colonial psychiatric initiatives were respectively shaped by distinct political contexts. During the colonial period, the dominance of the biological racism paradigm—fed by physical anthropological theories of the time—negatively shaped colonial psychiatry. The use of the concept of “race” in mental healthcare provision to the colonized served political purposes in the regulation of the population, more than it sought to improve care and alleviate suffering. In a sense, caring for the colonized could be perceived as a political act.

The struggle for independence, along with the process of decolonization and the international development programs that developed in the aftermath of war atrocities, together brought about the debunking of biological racism, and a renewed interest in the concept of “culture.” Based on anthropological studies of the cross-cultural variations in the expression of mental disorders and its treatment, as well as on the clinical work of psychiatrists from the *Métropole* and from the newly independent nations, creative mental health initiatives that integrated local healing methods to psychiatry began to develop. While such initiatives emphasize caring over regulating, their reification of the concept of “culture” eventually depoliticized local expressions of distress, along with continuing unequal relations between Western doctors and local patients. Because of the intertwining nature of political conjunctures, representations of the “Other,” and uses of “culture” in therapy, this tension between caring and regulating, then, subsisted.

Synopsis of Chapter 2

In this chapter, I analyzed the context in which the concept of “culture”—or initially, the concept of “race”—was deemed relevant to mental healthcare provision. By tracing the evolution of psychiatric initiatives in French colonies, in North- and sub-Saharan Africa, I showed how, through the collaboration between anthropology and psychiatry, the dominant theory of biological racism provided a rationale for the regulation of colonized populations. This collaboration resulted in the elaboration of scales of intelligence and cognitive development, at the bottom of which were the colonized. I illustrated this through two examples. In the first example, I focused on one of the most “famous” colonial psychiatry initiatives: the School of Algiers. I relied mostly on historians’ reports, which reflect the political subjectification of local North-African populations as violent, superstitious, and mentally debilitated. Second, also relying on historical data, I summarized other initiatives in British Kenya and French Madagascar, this time focusing on the political subjectification of sub-Saharan African as insecure, dependent and irresponsible, with perverse and infantile needs (a “forest mentality”).

With the emergence of struggles for independence and the beginning of decolonization, together with the evolution of anthropological theory on “culture” and its relation to personality, I analyzed how theories of biological racism were disputed in the context of psychiatry. First, I briefly summarized the basis for Frantz Fanon’s model of social psychiatry, and his critique of colonial racism. However I showed that, because Fanon’s critique itself relied on the concept of “race,” it was unsuccessful at debunking racism. Second, I focused on what became identified as the first clinical

“ethnopsychiatry” initiative: the Fann Dakar School of Psychiatry. I showed how the school’s efforts at being sensitive to local representations of mental disorders and its treatment were no longer based on biological racism, but rather on carefully documented, local representations of culture that took into account transcultural situations, and above all acknowledged the limits of psychoanalysis. This School implemented the first clinical collaboration between anthropology and psychiatry, but also psychology. Ultimately, the clinic was critiqued for remaining strongly prescriptive in its application of culture, and for reducing all symptomatology to cultural explanations. I ended this section with Devereux’s formal theorizing of the collaboration between the discipline of anthropology and psychiatry, which he named ethnopsychiatry. I detailed Devereux’s careful distinction between universal Culture (the human psyche) and particular cultures (varying cross-cultural representations of the normal and the pathological). I emphasized that for Devereux, the knowledge of local cultural representations should not be used as treatment, but rather as a therapeutic lever, and as reflexive tool for the therapist.

I concluded that, while colonial and post-colonial psychiatric initiatives were respectively shaped by distinct political contexts and evolved in their use of the relevance of “culture” in mental health, they both displayed a similar tension between caring and regulating—even if the “regulating” part was more obvious during the colonial period. The focus on racial determinism in colonial psychiatry, followed by cultural reductionism (or “culturalism”) in post-colonial regions, both depoliticized the nature of distress in their respective contexts.

CHAPTER 3: Immigrants in France

—From Malingering Bodies to Deviant Families

In this chapter, I analyze how the social construction of distinct immigrant groups (North and sub-Saharan African successively) impacts both immigrants' health and its management by French public health institutions. As in chapter 2, my goal is to trace the historical conditions that led to concerns with developing a field of expertise on "immigrant suffering." I do not intend to provide an exhaustive history of immigration in France, nor a detailed description of the organization of the country's healthcare system. Rather, I sketch these themes as they provide background to my efforts to document how perceptions of the immigrant body and suffering have evolved in France, following different stages in the "political subjectification" of the immigrant throughout the twentieth and the beginning of this twenty-first century. I focus on the performative effect of language (Austin, 1975) in the naming of immigrants' difficulties. In particular, I draw attention to the rhetorical shift from an emphasis on the infectious and malingering body of African *workers* (especially north-Africans), to an emphasis on the management of socially deviant and psychologically distressed African *families* (especially West Africans), each corresponding to two general phases in the history of immigration: labor immigration and family reunification.

Incidentally, this rhetorical shift parallels a transition in the field of mental healthcare, from the deinstitutionalization of psychiatry and the development of community psychiatry, to the blossoming of mental healthcare initiatives encompassing various institutional fields, both medical and non-medical. Both transitions—in the

rhetoric on immigrant health and in the transformations of mental healthcare—are rooted in specific political contexts, and obey similar rationales, namely, the disciplining of populations in the face of social distress. Therefore, here I reiterate the previous chapter’s thematic tension between caring and regulating, showing how the management of foreign populations in public health services translates a concern with both finding alternative solutions to socioeconomic inequalities and the ill health they may engender (caring), while keeping the social unrest these inequalities may cause at bay (regulating). Simultaneously, I show how the culturally-stigmatizing discourse of French public health produces discriminatory practices that negatively impact the health of immigrants, particularly from sub-Saharan Africa. Ultimately, this second genealogy chapter sets the background for the development of specialized mental healthcare initiatives catering to immigrants specifically.²⁷

A National Contradiction: Universalism and the Conditions of Belonging

Before launching into the genealogy of immigrant health in France, I want to briefly describe the ideological discourse against which immigration policies in France are recurrently framed. Since the Revolution of 1789, France has proclaimed a model of universalism to guide the nation as a Republic, and ensure the equal protection of all its citizens. However, this ideal was recurrently challenged by changing sociopolitical

²⁷ It is beyond the scope of this dissertation to address in detail the demographic, sociological, and geographic dimensions of immigration in France. Tables in Appendix C illustrate some of the recent demographic evolutions in immigration flows to France, as well as the geographic distribution of the foreign population in the country. For further references see Tavan, 2005, Thierry, 2004, Tribalat, 1995 and Tribalat 2010 on the demographic evolution of immigration in general; see Lessault and Beauchemin, 2009a, 2009b, on immigration from sub-Saharan Africa in particular. On the sociology of immigration in France, see De Rudder, Poiret and Vourc’h, 2000, Dewitte, 1999, Rea and Tripier, 2008, Rea, 2000; on the sociology of immigration from sub-Saharan Africa in particular see Poiret, 1998, Quiminal, 1991, and Timera, 1996.

contexts. This analysis of the management of immigrants and their descendants in the French public health system demonstrates how the application of this “republican idea” (Nicolet, 1982) and its appending universalist mandate to the healthcare system must be apprehended as a rhetoric, which arguments change to serve varying political conjunctures.

Indeed, on the one hand, the privileging of human rights over citizens’ rights was quickly challenged in practice as foreigners were excluded from fully participating in political life (Noiriel, 1988). The exclusion of the category of immigrants developed at the end of the 19th century, as France— then in its Third Republic—transitioned to an industrialized society, and became “threatened” by the influx of foreign workers in combination with declining national fertility rates (Noiriel, 1988). Immigration rapidly became perceived as a problem, threatening the idea of the nation, then determined by race and heredity—as described in the previous chapter. The creation of a Code on Nationality, and subsequently of the identity card and residence visas, contributed to limit the conditions of belonging to the nation. Those conditions were articulated against the notion of integration and its ideal of a homogeneous nation (Schnapper, 1991).

Immediately then, the republican model entered in a contradiction between the universality of rights and the differentiation of its application, which appeared most blatantly in its “civilizing mission” and the treatment of its colonies (Conklin, 1997). Today, as “immigrant” populations have settled and as the demographic landscape of France has become decidedly multicultural, political discourse more than ever insists on integration and cultural homogeneity—calling for the nation to reflect on the meaning of

its “national identity” (Le Monde, 2009a; Weil, 2008), and to preserve the universalist exception of the French nation (Renan, 1882).

However, the constant opposition, in political rhetoric, between republican universalism on the one hand, and ethnic differentialism (*communautarisme*) on the other, has become increasingly untenable for two main reasons: one is the contribution of French historians and sociologists in unveiling the identity of France as a nation of immigration (i.e. Noiriel, 1988; Schnapper, 1991; Weil, 2008) with the emergence of minority politics in this first decade of the 21st century—even though these have been defined in terms of discrimination rather than in terms of identity (Fassin, 2009 [2006]:134). What could only be articulated a decade ago as “the social issue”—universalist principles forbidding the mention that social inequalities and discrimination in France particularly affect ethnic minorities—has been directly challenged by the 2005 and 2007 urban riots in Paris, the reports on racial and ethnic discrimination they generated, and the current debates on ethnic statistics or on “the politics of memory” (Weil, 2008). Some scholars in fact have argued that public discourse in France has transitioned from acknowledging “the social issue” to articulating the “the racial issue” (Fassin and Fassin, 2009 [2006]). This does not mean that the “racial issue” was substituted for the “social issue,” but that both are now acknowledged as being interconnected (Fassin and Fassin, 2009 [2006]: 6).

It is interesting, then, to observe how the tension between universalism and particularism—along with the shift from acknowledging social inequalities to addressing ethnic and racial discrimination—plays out in the French healthcare system’s management of its “immigrant” populations. First of all, this tension is inherent to the

definition of the immigrants in France—as they are both considered in their humanity following universalist ideals, as well as radically foreign in terms of national and legal rights. Second, being particularly vulnerable to social inequalities and discrimination, immigrants embody the overlap between the “social issue” and “the racial issue.”

I. Labor Migration and the Malingering Body

An overview of labor migration until the 1970s

Labor migration started in France early in the 19th century, with the expanding industrialization of the country. Initially, there was considerable internal migration, from rural to urban areas, as in many other European nations undergoing the same transition. However, this proved rapidly insufficient, and foreign workers were brought in increasing numbers. Hargreaves (1995) reports that the foreign population in France grew steadily until World War I, and continued to increase until the economic slump of the 1930s. It achieved strong growth rates during the *trente glorieuses* (the three economically flourishing decades following World War II), until it stabilized at a rate of over 6 per cent of the population “where it has remained since the mid-1970s despite the much weaker economic growth and higher rates of unemployment which have prevailed since then” (Hargreaves, 1995:9). Until the 1960s, most laborers came from neighboring European countries. Earlier immigrants came from Belgium and Italy to work in the coal, steel and textile industries in the northeast of France. Italians also worked in the south of France of seasonal, agricultural laborers, where they were joined by Spanish workers. Between the wars, a large number of workers came from Poland and Portugal, and concentrated in the mining industry. In the aftermath of the two World Wars, there were

also a growing number of political refugees from Italy, Spain and Russia. With the rise of Fascism during the 1930s, Jews fled from Germany and other parts of Eastern Europe.

It is in between the World Wars, French historian and political scientist Patrick Weil argues, that France started elaborating a politics of immigration, calling on population experts to elaborate on laws that would regulate the influx of immigrants and redefine access to French citizenship (Weil, 2008). The experts' reports were tainted with the models of racial differentialism and hierarchization widely circulating at that time period (and supported by the "scientific racism" described in the previous chapter), and were concerned with establishing "degrees of possible assimilation" (Weil, 2008: 24-26). Among these experts, Georges Mauco, argued in 1937 that

among the diversity of foreign races in France, there are elements for which assimilation is not possible. There are also those who belong to races that are too different: Asians, Africans, Middle Easterners even, whose assimilation is impossible and, also, very often physically and morally impossible. The failure of numerous mixed marriages verifies this assertion. Those immigrants carry in them, in their customs, in their frame of mind, tastes, passions, and the weight of secular habits which enter in profound contradiction with the orientation of our civilization.²⁸ (quoted in Weil, 2008: 33)

Mauco's conclusions were "supported" by a small-size survey carried out among heads of staff at an automobile factory, employing 17,000 workers, 5,075 of whom were foreigners. Workers were ranked according to their nationality, and assessed on their physical appearance, their regularity, production, and discipline at work, as well as their understanding of the French language. The results ranked "Arabs" at the bottom of the scale, preceded, in order, by Greeks, Armenians, Polish, Spaniards, Italians, Swiss, and

²⁸ Text number 3, published from a conference organized by *Hautes études internationales*, on the assimilation of foreigners in France, Paris, SDN editions, April 1937, p.115.

Belgians. Arabs were described as fatalist and gullible (Weil, 2008: 33-34). It is important to underline that Jews were also identified as racially undesirable. A policy of immigration for refugees was strongly discouraged by population experts for those reasons. Instead, they encouraged an immigration policy based on “ethnic quality,” rather than numbers (Weil, 2008: 54). Some went as far as proposing eugenic policies (Weil, 2008: 60).

In the aftermath of World War II, labor migration continued to be encouraged to compensate for the country’s weak demographic growth and thus remedy labor shortages. Weil also notes that “the climate evolves. This evolution is well represented by the impact that Levi-Strauss’s plea in favor of the equality of cultures had. Progressively, the realization of the holocaust, the emergence of third world nations contribute to make the expression of racial prejudice—based on a hierarchy of ethnicities or nations—illegitimate” (2008:86). On November 2, 1945, the National Office of Immigration was created, granting the State the monopoly to introduce a foreign workforce on its territory. Three types of residence visas were created (1,3, or 10 years—automatically renewable, in principle), and family reunification was favored—as a demographic impetus and humanitarian gesture. While there were no quotas in the post-war immigration policy (Weil 1991), “successive governments sought as far as possible to encourage European rather than African or Asian immigrants” (Hargreaves, 1995:11). Labor migration originating in the Maghreb (Algeria, Morocco, Tunisia), however, became fast-growing. In fact, many had come earlier during the First World War, enlisting in the French armed forces, or filling labor shortages. However, although almost a million of them came at the

time, “there was a deliberate policy of repatriation [and] as soon as the conflict ended only about 6,000 remained by 1920” (Hargreaves, 1995:15).

Unlike most European immigrants who settled in France with their families, most North African workers came alone and returned after a few years, replaced by others in their village on a rotation system basis. At the time of Algeria’s independence, the Evian agreements gave Algerians residing in France the same rights as French nationals’, except for the right to vote. This gave them the right to travel freely between France and Algeria, and significantly increased the Algerian population in France. In face of the permanent settlement of North African families, political authorities felt the necessity to control this new phenomenon, notably through the implementation of social policies for the “management” of foreign populations (Noiriel, 1988:123-124). Immigrant workers concentrated in the centers of industrial urban areas since as early as during the Second Empire (Noiriel, 1988).

In 1956, a National Society for the Construction of Housing for Algerian Workers and their Families (*SONACOTRA*) was created, to solve issues of insalubrious housing conditions. Male workers stayed in hostels (*foyers*). But for families, Noiriel notes, employers encouraged the formation of “ghettos,” which had local residents flee: “regrouping on an ‘ethnic’ basis by neighborhood or zone is a strategy explicitly defined by the employer seeking to reinforce the homogeneity and stability of the workforce” (Noiriel, 1988: 172). The assimilationist strategy of political officials, who sought to avoid the dangers of such ghettoization, was thus defeated by economic interests, which created the exact reverse scenario. With the urban renovation plan of the 1960s, immigrant families were pushed to the suburbs, in low-income housing projects (the

emergence of Priority Urban Zones or *ZUP*). In 1958, a Fund for Social Action (*FAS*) was created for Muslim Algerian workers. In 1966, an office of the Direction of Population and Migrations (*DPM*) was created within an umbrella ministry concentrating the former departments of Work, Public Health, and Population. On July 3, 1974, immigration was temporarily suspended (except for members of the European Union). With the economic recession, France unsuccessfully launched a politics of voluntary return, shortly followed by a politics of forced return, targeting North African families, Algerians in particular.

Separate Care for Foreigners: The Creation of the Avicenne Hospital

Between the world wars, France thus had the fastest-growing immigrant population in the world (Rosenberg, 2004:637). French authorities were fearful of the threats they imagined these immigrants posed, namely political unrest and crime. They were especially weary of North African colonial subjects (Rosenberg, 2004:637). Many of them had settled in the northeastern outskirts of Paris. In 1926, a Mosque was inaugurated in Paris to honor the North African countries that had helped France during the War. Shortly after, a French doctor practicing in Algeria, Professor Amédée Laffont, made a suggestion for the creation of a hospital adapted to the needs of Muslim patients from North Africa. In fact, underlying a medical concern with responding to the special needs of foreign patients, the project reflected a political concern with controlling colonized indigenous populations (Rosenberg, 2004). The project was thus linked to the Surveillance and Protection Services for North African Indigenous People (*Service de Surveillance et de Protection des Indigènes Nord-Africains* (*SSPINA*)), also founded in

1926, at a time when first nationalist movements emerged. The felt need for surveillance of this particular fringe of the immigrant population thus won over concerns for the costs this project involved. The relation between caring for and regulating North African populations was therefore articulated as clearly as it was in the colonies at the same moment.

The hospital's architects decided to include some elements of North African architecture to the hospital structure. They built a monumental Moorish style entrance, very evocative of North African culture. Shortly after the completion of the hospital, in 1935, a project for a Muslim cemetery was initiated. Indeed, North African workers, who often came alone, in conditions of poverty and isolation, often died in France without the possibility of being offered a proper Muslim ritual, or of their families being able to afford the repatriation of their body. The Seine Regional Council thus offered the hospital an adjacent four-acre land, and the Muslim cemetery was inaugurated in 1937. All these initiatives – the building of a Mosque, a Franco-Muslim hospital, and a Muslim cemetery – aimed at polishing the image of France as a benevolent and powerful Empire (Musée de l'Assistance Publique – Hôpitaux de Paris, 2005).

By 1930, as many as a 100,000 North African workers had crossed the Mediterranean to come to France. Many lived in crowded, insalubrious conditions, in small rentals or in hostels. Most worked in the metallurgical and mining industries, where they took on the most physically enduring, least qualified positions. Partly because of such unsanitary living conditions and of work risks (also exposure to chemical elements in metallurgy), this immigrant population presented a high prevalence of diseases, notably tuberculosis. Prior to the creation of the hospital, scientific reports filled national

newspapers, blaming immigrants for invading the territory with their germs, failing to acknowledge that in reality, “most of the immigrants in local hospitals had contracted their diseases, notably tuberculosis and syphilis, after they arrived in France. If foreigners were more likely to suffer from tuberculosis, as was generally believed, it had far more to do with the conditions in France than in their homelands” (Rosenberg, 2006:176). Thus one can easily imagine a hygienist and political decision to build a hospital far from the city centre: North African immigrants not only constituted a political threat, but also a public health threat in the eye of officials.

Additionally, the administration strove to recreate an environment which would be familiar to North African patients. Arabic- and Kabyle-speaking specifically-trained staff was recruited. For example, hospital nurses not only took language classes, but were taught about the history and geography of North Africa. Other major accommodations reflected a desire to adapt to the patient population. For example, a prayer room was established for Muslim patients and staff, along with observance of dietary restrictions.

But more than respect for difference, the building of a separate hospital fit with the biological racism of the time. Pierre Godin, then head of the North African brigade unit, argued that the hospital would “cleanse” (*blanchir*) foreigners (Rosenberg, 2004:652). The hiring of staff was also questionable, as the hospital attracted uncertified Muslim medical students from the Maghreb, and largely overlooked public health standards (Rosenberg, 2004:660). To make matters worse, the hospital was located in an isolated area of a working-class suburb, next to a waste-treatment plant, and away from public transportation. Most Muslim patients in fact avoided going to that hospital. Rosenberg notes that very few came for outpatient treatment, and that “the overwhelming

majority (...) arrived in police vans” (2004:661). They felt they were segregated from the rest of the population.

The “illness of immigration”(Sayad, 2004)

In his analysis of French discourse on North African immigrant workers, Sayad articulates how public representations of the immigrant affected the immigrant’s relationship with his own body – “the body as representation and presentation of the self, the body as the seat of affect and of the intellect (for the body is inhabited by the entire group that lives inside us), the body as an instrument of labor and as site and expression of illness” (2004:179). Here I want to point to the reader that Sayad offers one particular point of view that I largely agree with, and which supports my argument about the relationship between immigration policies, cultural representations of immigrants, and its impact on both healthcare provision and health outcomes. Nevertheless, this is an interpretation which could be disputed differently.

Illness, according to Sayad, provides us with the best insight into the contradictions that constitute the immigrant condition itself: “Because the immigrant has no meaning, in either his own eyes or those of others, and because, ultimately, he has no existence except through his work, illness, perhaps even more so than the idleness it brings, is inevitably experienced as the negation of the immigrant” (2004: 180). Such contradictions initially stem from the fact that the conditions that originally generated *emigration*, and subsequently produced the *immigration* living conditions North African

workers faced in France, were largely ignored in the discourse on immigrants.²⁹ Instead, the onus always was on the “problems” they caused for French institutions.

Discursive references to “immigrants’ problems,” rather than France’s problem with immigrants, highlight the importance of the naming and labeling practices in public discourse, as well as its practical impact on the health of immigrants and its management by institutional actors. Sayad asks to what extent these “problems” are posed by the permanent presence of immigrants, who are equated with foreign bodies in French society. For example, public discourse on immigration deliberately overlooks the genesis of immigrants’ “problems” for two main reasons, according to Sayad: “First, it regulates a phenomenon that threatens to disturb public order (the social, political, moral order and so on); second, and paradoxically, it masks the essential paradox of immigration, and removes or neutralizes the question of what an immigrant is and what immigration is” (2004: 179).

The more the immigrant struggles to recover his health, and therefore his life equilibrium, Sayad explains, the more he tends to expect from medicine. This is precisely because his illness is bound up in his immigrant condition. He makes claims (*revendications*) to be cured. But eventually, the immigrant patient can only be cured from his illness in terms of accepting that he has been cured, but not necessarily in terms of what generated the illness in the first place. Meanwhile, the medical establishment is willing to resort to interpreters in their hospitals, or “tolerate the services of their ‘strange colleagues’ like marabouts. They will even make syncretic reinterpretation of phenomena (see “*djinnophobia*”)” (Sayad, 2004: 184). But they continue to refuse to take into

²⁹ I emphasized the concepts of “emigration” and “immigration” to underline Sayad’s efforts at showing how the distinction between the two is overlooked in public discourse on immigrants and their living conditions.

account the social circumstances that generate these illnesses. Instead, Sayad shows, they create an index of pathology.

Perhaps the best illustration of this pathologization of social circumstances is provided by the epidemic of “*sinistrose*” (or malingering in English) among North African workers. The term was coined by French physician Edouard Brissaud (1908), to describe

a pathological attitude on the part of the patient who refuses to recognize that he has been cured because he believes, in all good faith, that he has not obtained the due recompense for the injury he has suffered provided by the law; he is basically a claimant [*revendicateur*] whose claim [*revendications*] has at its starting point an exaggerated overestimation of his right to compensation. (quoted in Sayad, 184)

For Brissaud then, patients suffering from *sinistrosis* had no legitimacy for compensation, as the very act of making a claim was a deforming result of the pathology.

In the previous chapter on colonial psychiatry, I already made a reference to *sinistrose*, also known as the “North African syndrome,” and criticized by Fanon (1952). This diagnosis continues to be used – alternatively with the label “compensation neurosis,” and has since generated a large literature on the issue (see Bennegadi and Bourdillon 1990, for references in France). The use of the label with North African immigrant workers in particular illustrates how physicians often limit their diagnosis to physical phenomena, rather than the condition of the immigrant as a whole. There is no questioning of institutional prejudices. Rather, to use Reid and Reynolds’ expression in their description of the “politics of explanations” surrounding the Repetition Strain Injury epidemic in Australia, one might argue that *sinistrose* becomes “a polysemic metaphor,”

not only for what “ailed” North African immigrant workers, but for what “ailed” French society as a whole (Reid and Reynolds, 1990:185). As Sayad points out,

It is the system that decides which claim is legitimate and which is so ‘excessive’ as to be suspected as being ‘pathological’. No questions are asked about the preconditions for the formation of that system of justifications or, in the case of immigrants, about the preconditions for their involvement, other than as victims or as bad patients, in a system which, as they now learn to their cost, demands ‘rationality’, or a system that is abstract and is assumed to be universal (whereas it has, in reality, its economic, social, and cultural conditions of possibility). (2004: 185)

In fact, it seems odd to identify as “unnatural” immigrant workers asking for compensation, as there exists a whole system of medical, legal and social agencies that work specifically to assess such claims. Interestingly, however, Sayad shows that the establishment takes offense at immigrants’ claims for precisely not having therapeutic purposes, but rather social ones.

As foreigners, immigrants are thus likely to experience suspicion everywhere, and find themselves permanently under surveillance. This, in turn, gives rise to many discourses, which are not unlike the discourses that circulated on colonized populations earlier in the century, beginning with that of the psychiatrists.

Early “Specialized” Mental Healthcare Structures in France: A Focus on Trauma

A “specialized” form of mental healthcare support developed in France in the aftermath of World War II, with the constitution of a psychiatry of immigration. Fassin and Rechtman argue that the genesis of this mental healthcare approach thus occurred at the transition between two historical stages, each characterized by singular representations of cultural difference: the colonial era, with its image of the indigenous

colonized Other, and the postcolonial world, with the figure of the immigrant foreigner, seeking employment or asylum (Fassin and Rechtman, 2009:226). Mental healthcare practitioners who first became interested in the mental health of immigrants simultaneously found themselves between two psychopathological paradigms: the culturalist model of colonial psychiatry described in the previous chapter, imbued by racist interpretations of cultural personality types – and ultimately more concerned about political order than local psychopathology (Collignon, 2002; Keller, 2007; Mahone and Vaughan, 2007; McCulloch 1995), and the universalist model of the French healthcare system, readily rejecting the idea that immigrants would require “specialized” treatment (Fassin and Rechtman, 2005).

Meanwhile, French psychiatry was going through a profound reform, sparked by the demise of the asylum, and leading to a system of district-based, outpatient psychiatric care in the 1960s (Petitjean and Leguay, 2002). This left for an ambiguous space, in which various clinical initiatives took shape. The earlier ones focused on asylum seekers and the psychopathology of trauma (the Minkowska Center in 1951, the COMEDE – Center for Medical Advice to Asylum Seekers in 1979, the Avre Association in 1984, the Primo Levi Center in 1995). Although these centers’ approaches to trauma varied, they were all based on the notion of a common psychic world and therefore a universalist experience of trauma, with culturally varying expressions of symptoms and representations of suffering (Fassin and Rechtman, 2009).

Initially then, the focus was on post-war refugees and political asylum seekers. This may in part be explained by the favorable legal context accorded to refugees in the aftermath of WWII, crystallized by the Geneva Convention of July 1951 and the law of

July 25 1952 leading the creation of the French Office for the Protection of Refugees and Stateless Individuals (*OFPPRA*). The coding of a human rights discourse which emerged in this context likely shaped the universalist clinical approach to mental healthcare for refugees. Immigrants were excluded from this positive transition. Instead, they continued to be the victims of the same prejudices, albeit in a different guise (Weil, 2008:90). Little attention was paid by psychiatrists to immigrants, outside of *sinistrosis* cases, as described earlier.

II. “Immigration After the ‘End’ of Immigration” (Hargreaves, 1995:17): Towards the Management of Deviant Families

From Workers to Families

As I mentioned earlier, following World War II, France experienced a period of economic growth and practiced an open door policy for labor migrants. Most non-European workers came from North Africa—especially Algeria, as well as from Turkey. In the 1960s, however, workers increasingly came from West Africa, from the Sahel region in particular (Mali, Mauritania, Senegal). These migrants were usually grouped in hostels (*foyers*) and were mainly employed as low-skill labor in the industry, public services (i.e. as street sweepers and garbage collectors), and construction (Quiminal, 1999). Only a minority came as skilled workers, professionals, or as students. However, migration dynamics shifted with a legislation, in 1976, regulating family reunification (Barou 2002; La Documentation Française 2006). This legislation articulated the conditions under which male immigrants residing in France could legally bring spouses,

children, and other relatives to France. Family reunification policies were a response to the suspension of labor migration in 1974, which in turn limited the possibility of circulatory migration between France and Africa and its corollary, the separation of work and family.

Since the early 1980s, then, this influx of “foreign” families has translated into feelings of threat to French national identity, negative stereotyping, and discrimination. Although some would argue that individuals of North African origin are more vulnerable to racism and discrimination in France today (Lamont, 2000), in my analysis I choose to focus on sub-Saharan Africans for, I argue, they have been the “priority target” of public health initiatives designed to manage “culturally different” immigrant families. This can be explained partly by the fact that, in terms of immigration control, sub-Saharan African are a greater concern to political authorities than are North Africans. The fact that, together with “Asians,” they constitute the fastest growing immigrant population in ³⁰France (INSEE 2006, see tables Appendix C) is disputed (Lessault and Beauchemin, 2009a, 2009b). More importantly, they are perceived as epitomizing the phenomenon of illegal immigration, which has become a growing problem since the suspension of labor immigration in the 1970s. In 2004, 570 000 immigrants come from sub-Saharan Africa, which represents a 45% increase since 1999. Among them, seven out of ten come from French-speaking West Africa (INSEE, 2006). Between 1990 and 1999, growing numbers of migrants arrived in Paris from the Senegal River Valley region (Poiret, 1998; Quiminal, 1991; Timera, 1996). The percentage of Malians, for example, increased by 21.2% while the Senegalese population increased by 28.3% (Portas 2004). Estimates

³⁰ See also French sociodemographer Michele Tribalat’s (2009) recent critique of *Le Monde*’s Special Edition (2009b) on “The New Face of France, Land of Immigration,” which criticizes the media’s wrongful use of statistics on immigration flows.

from the Ministry of the Interior approximate the Malian population in France alone at 120,000, two-thirds of whom are undocumented.

The settling of African households in Paris and its suburbs “generated public awareness of large families living in inadequate lodgings (...). In conjunction with the pronatalist family allocation system, the perceived costs to the state of high fertility among sub-Saharan African women emerged as an increasingly controversial public issue” (Sargent, 2005:148). Beyond the economic issue, this presence of large families also provided material for France’s most vocal anti-immigrant party, the National Front, to target the practice of polygamy and Islam as moral threats to the nation. The practice of polygamy was implicitly tolerated by the French government until 1993 and the passage of the Pasqua law. The legislation threatened all men who remained in polygamous unions and their wives—with the exception of the first wife—with the loss of their residence and work permits, and subsequent deportation.

In a context of economic instability and high unemployment rates, they have continued to be accused of living “off the largesse of welfare payments” (Wieviorka 2002). The government has also pursued the restriction of immigration flows, moving towards a policy of “zero immigration” (Viet 1998). A series of laws and amendments addressing gender, marital status, and family composition thus successively threatened African migrants (Sargent, 2005). More recently, entire immigrant families – including French raised and educated children (Le Monde, 2006) – have been targeted for deportation. Such restrictive policies have increased the number of undocumented immigrants, which in turn has increased economic precarity in the migrant population. Fassin et al. (1997) analyzed how France’s restrictive immigration laws, discriminative

practices and xenophobia have created inhumane life conditions for migrants in France, and how the latter were epitomized by the “sans-papiers” movement (the movement started in 1996) (Ticktin, 2002).

Meanwhile, France has continued to promote a republican model of integration based on a logic of universal rights that denies the relevance of ethnic differences (Favell, 1998; Hollifield, 1994). However, the November 2005 immigrant uprisings demonstrated the failure of the longstanding state model of migrant “integration” amidst widespread protests against discrimination among immigrant populations (Fassin, 2001b; Weil and Crowley, 1994; Wieworka 2002). The government’s response to this crisis is emblematic of a profound philosophical contradiction as, despite the collective protest against social inequalities, state officials depicted the uprising as the product of unassimilated immigrant families breeding delinquent and psychologically distressed youth (Le Goaziou and Muchielli 2006).

Hence immigrants, especially those of West and North African origin, are perceived as a marked threat to the social order. Certain “cultural practices” were identified as especially problematic. Thus the Minister of Employment denounced polygamy as a possible cause of urban violence (Le Monde, 2005) and the Minister of Interior proposed a medical plan to treat the “psychological and psychiatric disorders” causing delinquency among immigrant children (Ministère de l’Interieur, 2005). The term “delinquency of exclusion” was coined, linking “the foreign or immigrant delinquent to inherited cultural pathologies and dangerous social milieus” (Terrio, 2009:13). Meanwhile, the media’s coverage of youth crime in the *banlieues* popularized the theme

of insecurity, which constituted the major political issue during the last presidential election in 2007.

Yet, there exists a substantial body of research that documents the complex economic difficulties confronted by sub-Saharan African migrants such as housing (Rezkallah 2000, Simon 2003, Barou 1999, Péchu 1999), the intractable issue of educational segregation (Ott 2006, Durpaire 2006), and unemployment rates twice as high as the rest of the population (Meurs, Pailhé and Simon 2005). Both in the industrial and service sectors, West African migrants were (and are) discriminated against in such areas as job training, promotion, or bonuses. One study reported that more than 30% of migrants from the Senegal River Valley are unemployed, or participating in the black market. In terms of housing, many are segregated in suburban high-rise housing projects on the basis of their African origin (Quiminal and Timera 2002:23). These issues moved to the forefront of public debate during the immigrant uprisings, and they continue to feed the debate on the use of ethnic statistics in France.³¹

The “Immigration Issue” and the Cultural Politics of Health in France

While legally, undocumented immigrants are entitled to healthcare in France, the consequences of their social stigmatization, of their precarious living conditions, and the climate of fear and suspicion generated by increasingly restrictive immigration policies in practice hinder many from being, or feeling, entitled to that right (Fassin, 2004). Indeed, one might argue that social stigmatization and xenophobia in fact affect all immigrants’ state of health, whether they are undocumented or not. In this section, I want to focus on

³¹ The use of ethnic statistics in France was deemed anti-constitutional by France’s Constitutional Council on November 15, 2007. It had been proposed in the context of the adoption of a new law on immigration (Loi Hortefeux).

sub-Saharan African immigrants in particular, and show how the construction of their “political subjectification” as socially deviant and psychologically distressed families has negatively affected their state of health, as well as their healthcare access and treatment.

Fassin explains that, traditionally, medical institutions in France distinguish between three types of afflictions among immigrants: the “pathology of importation,” which corresponds to the diseases brought from the country of origin; the “pathology of acquisition,” which reflect the impact of the new environmental conditions in which the migrant lives and which affect his health negatively; and finally the “pathology of adaptation,” which translates the psychological disorders resulting from the difficulties to adapt to the new society (Fassin, 2000c:5). This model is problematic because it represents the migrant’s body as a passive vector and receptor of diseases, and ends up representing immigrants collectively as a “risk group.” Therefore, immigrants suffer a “double logic of discrimination” (Fassin, 2000c:5). What Fassin denounces as “culturalism” relates to what “deprives [immigrants] of their universal prerogatives [and] avoids alternative explanations, such as material conditions, juridical statuses, etc.” (Fassin, 2000c:8-9).

Thus, biomedical institutions have perceived “cultural” dilemmas among their African patients, such as the widespread refusal of West African immigrants to accept cesarean deliveries, high fertility levels among West African women, perceptions that Muslim women are incapable of independent decision making, and are unduly submissive. Some “cultural” practices defined as extreme, such as female genital cutting and polygamy, have been criminalized. Correspondingly, biomedical personnel often respond to immigrant patients drawing on essentialized notions of their cultural

background. Solutions to dilemmas that affect particular hospitals targeting migrant populations are established at the national level, since public health and social assistance are primarily regulated by the state. For the public hospital system, immigration generates tension between the migrant as universal sufferer and the migrant identified in ethnic and cultural terms (Fassin, 2000c:9).

“African AIDS”

This tension appeared most clearly in the public health policies on AIDS that particularly targeted sub-Saharan African immigrants in France. Out of concern with discrimination, epidemiological data in France cannot use the category of nationality of origin. However, out of concern with risk for the public good, it makes it mandatory for medical practitioners to declare the “origin” of their HIV+ patients for the “transmittable diseases’ system of surveillance.” Such contradictory logics, Gilloire (2000) argues, not only produces a hierarchization of populations, but also methodological biases, considering that the use of the category of “origin” in the declaration form does not mention any relation to categories of nationality, birthplace, or filiation. This, in turn, has led to over-representing individuals of sub-Saharan African origin, and to framing African identity as a risk factor in itself (Gilloire, 2000).

In her study of the management of hospitalized African immigrants patients, French anthropologist Laurence Kotobi shows how health professionals, who deal with what they call “this type of patients,” always emphasize culture in explaining their patients’ medical history, rather than any other aspects, such as socioeconomic conditions, the model of French integration policy, the legal status of individuals. This

“culturalist” perspective leads to the emergence of a dominant representation—that of an “African AIDS” phenomenon—in the medical profession. The consequence of this representation is that “it imprisons the patient in an image of cultural otherness that keeps him at distance” (Kotobi, 2000:63). In this scheme, AIDS becomes characterized by a mode of contamination which is essentially heterosexual, and similarly referring to an African sexuality which is “either polygamous or very sexually active” (Kotobi, 2000:64).

Kotobi denounces the fact that this idea of sexual promiscuity was spread notably by anthropologists or demographers: “indeed, by not questioning the reductionist and culturalist character of this description, they also participated to the elaboration of a new risk factor for AIDS,” for which “being African means potentially carrying the HIV virus” (Kotobi, 2000:64). Thus the difficulties of immigrant patients to communicate, understand, accept the disease and its treatment are explained by the patient’s cultural background, which is usually considered as an obstacle. Also, the will to “know these patients better” by showing an interest in their culture, in order to improve healthcare and treatment, may reflect once again a culturalist strategy, for which the cultural explanation is considered as self-sufficient.

African fertility

Sargent’s (2005) research on the provision of maternal healthcare to Malian immigrant women in Paris documents the impact of similar stigmatizing judgments related to immigrant fertility. Her research shows how French public discourse surrounding immigration and the role of the state in regulating population has influenced

healthcare decisions in the public health system, particularly in maternities, public family planning and maternal health centers, and maternal and child health clinics. In particular, she shows how state pronatalism, which has influenced French national health and welfare policies since World War I, has been promoted more ambivalently with Malian patients. Indeed, she observes that while some public health practitioners at research sites mentioned earlier are sensitive to Malian women's cultural and socioeconomic context and adapt their family planning consultations accordingly, others have displayed an implicit philosophy opposing immigrant births by strongly encouraging contraception, sometimes without even discussing the topic with their Malian clients. Some directly expressed their frustration at the high fertility common among West African mothers, and provided a prescription for the birth control pill without explanation to their clients.

Sargent reported disparaging comments from some clinic and hospital staff, such as referring to African women as "laying hens," or directly addressing their migrant patients with such expressions as "not another baby!" (2005:152). She also found that even interpreters, who are occasionally called by midwives to discuss the topic with non-French speakers, "have their own agendas regarding contraception, and may see themselves as representing the requirements of 'modernity' to a less educated and more 'traditional' population (2005:151). Overall, maternity staff argued that they approached contraception as a tool to empower African migrant women, but some midwives' delivery of the prescription without any explanation questions their underlying motives.

Lead-poisoning: a disease of African culture

Also reflecting the negative impact of culturalism on public healthcare provision is Fassin and Naudé's (2004) examination of lead-poisoning in France, which describes medical authorities' resistance to recognize that the disease affected mostly children of immigrant African families living in dilapidated apartments with lead-painted walls (see also Rezkallah and Epelboin, 1997). Their study reveals how culturalism influenced policymakers and public health authorities' understanding of what had become an epidemic. Indeed, after initial investigations had established that lead-poisoning affected mostly young immigrant children from sub-Saharan Africa (85% of the severe cases in Paris), public health authorities tried to mask the evidence by suggesting possible biases in the population samples (Fassin and Naudé, 2004).

Also, while wall and woodwork paints were clearly identified as the source of lead, other propositions were made, including the fact that local African ritual specialists' treatments or African women's make-up potentially contained lead (Fassin and Naudé, 2004:1859). Again, when these other potential causes were ruled out, and lead paint remained the sole source of poisoning, pica behavior—defined as a taste for mineral substances—was used to explain the ingestion of paint, and linked to geophagy practices, reported to be common in Africa. African mothers specifically, who were said to eat clay when pregnant, were blamed for causing their children to imitate them. As Fassin and Naudé point out, “this search for cultural causes went so far as to call on ethnologists for assistance to study African family practices. (...) [Their] interpretation suggested that African families were not to blame but rather that their cultural differences needed to be understood” (Fassin and Naudé, 2004:1859). In the end, the authors identify “practical culturalism”—“a common sense theory that essentializes culture and overemphasizes the

understanding of social reality by its cultural aspects”—as providing an explanation for institutional resistance to link lead-poisoning to immigrants’ poor living conditions (Fassin and Naudé, 2004:1859).

These three examples illustrate how France’s immigration policies and stigmatizing political discourse on subSaharan African families have resulted in generic definitions of “African” culture as pathological. In each case, such essentializing uses of culture were related to the regulation of sub-Saharan Africans as 1) a risk population, 2) a rapidly growing population, 3) a population maladapted to its new environment. Against the background of republican universalism and the related philosophy of healthcare access for all, such cultural stigmatization was pragmatically un-acknowledged. Of course, it would be wrong to assume that concerns with the relevance of “culture” in care were underlied by discriminatory, regulating logics. For numerous institutional actors, it became clear that culturally-diverse understandings of care and of other services accessed by immigrants required culturally-sensitive forms of intervention, such as that of trained interpreters, who could not only translate language but translate ideas. Such intervention was paramount to improving not only care, but interactions between immigrant families and public institutions.

Networking Healthcare: The Social Management of Immigrant Families and the Broadening of the Mental Healthcare Field

Since the enactment of 1975 legislation allowing family reunification, a stream of women from the rural Senegal River Valley region, many with little formal education,

urban experience, or French language skills, joined their husbands in Paris (Nicollet, 1992). For these women, social workers and biomedical practitioners serve as principle sources of initiation into everyday life in France. Prenatal clinics, maternity hospitals and child health clinics all serve as links between West African mothers and central French institutions.

Cultural Mediation

Family reunification policies quickly led to a profusion of social, economic and legal issues that had been less prevalent in the era of male migrant workers in residence without families. Many of the women from the rural Senegal River Valley region who came to France to join their husbands, had little formal education, urban experience, or French language skills (Nicollet, 1992). For these women, social workers and biomedical practitioners served as principle sources of initiation into everyday life in France. They came with concerns about housing, documentation, employment, childrearing, the educational system, and marital disputes. These dilemmas, then, were associated with numerous state institutions—schools, hospitals, local government, criminal justice system, and so forth. Because they were challenging for institutions to manage—whether because dilemmas were perceived as cultural in origin, or because of the language barrier—increasingly frequent resort to interpreters and subsequently to “cultural mediators” was made in an effort to effectively communicate with non French-speaking migrants. Initially, these efforts were directed especially at women, who were in frequent contact with state institutions in the context of maternal and child health concerns (Quiminal and Timera 2002; Charte MCS 2006).

Cultural mediation as a formal profession emerged from this post-1976 phase of exploratory approaches to public health interventions with West African migrants. Anthropologists, sociologists, and psychologists helped to shape the concept of “mediator”, as distinct from that of “interpreter” (Rachid Bennegadi, Director, medical Board, Centre Minkowska, personal communication, 6/11/07). By the mid 1980’s, cultural mediators, principally women originally from the migrant societies of origin, were solicited by maternity hospitals, child health clinics, and similar institutions. The mediator’s function was literally to translate, on the one hand, but also (and perhaps more significantly) to bridge social worlds. Thus his/her role was to translate conceptually the discourse of state institutions to migrants while conveying to biomedical and social work personnel the local meanings and practices of migrant clients (Association Geza Roheim 2006). Mediators are intended to sustain client autonomy but assist social workers and other practitioners in carrying out public health, educational and other institutional objectives (Charte MCS 2006).

In the present institutional landscape, mediators are engaged by the public health, education, and judicial systems, among others. In addition to local and state government reliance on mediators, mediation is a primary service provided by the proliferation of associations generated in accordance with the laws of 1901 and 1981, which produced the association movement (*mouvement associatif*). A 2002 Guide to Intercultural Mediation lists over 150 resources categorized by type of activity and mission.

The popularization of mediation must also be considered in light of the “social policies” that developed in the 1990s in France, around the theme of “social exclusion.” During the 1980s, France experienced “the social consequences of what was then

commonly referred to as ‘the crisis’ (*la crise*)” (Fassin et al., 2004:22), which inspired a new language in political discourse, to interpret new forms of poverty characterized by long-term unemployment, and new forms of urban violence in “sensitive neighborhoods” (*quartiers en difficulté*)³². Social policies thus took the form of stipends for the unemployed,³³ and of youth programs to prevent delinquency and facilitate social insertion. Thus, what is progressively referred to as “the social issue” (*la question sociale*) in public discourse shapes politics throughout the 1990s, around the theme of “social exclusion,” as it is formally coined in a series of government-mandated reports.³⁴

More significantly, this ambiguous notion of exclusion marks a change of perspective onto the poor and the excluded. As Fassin et al. note, “Until the 1970s, the first were perceived as maladapted, while the second were seen as delinquents” (2004:25). However, the language of exclusion, and the social policies that developed around it, characterized both categories as *victims* who *suffered* from social inequalities. This in turn popularized the term suffering as categorizing a wide array of social problems, from “the suffering of the unemployed, the suffering of drug users, the students suffering from failing at school, the immigrants suffering from exile, foreign-born youth suffering from discrimination” (2004:26).

Fassin et al. contend that one way suffering became legitimized was through the institutionalization of the practice of counseling, engaging a wide array of institutional actors, especially in the public health and mental health sectors. Meanwhile, the onus

³² Riots in the suburbs of Lyon in 1981.

³³ Creation of the income support allowance (*RMI – Revenu Minimum d’Insertion*) in 1988.

³⁴ Fassin et al. (2004 :24) point to two reports in particular: “Exclus et exclusion” (1991) by Philippe Nasse, and “Cohesion sociale et prevention de l’exclusion” by Bertrand Fragonard.

shifted from speaking of social inequalities to speaking of individual suffering. Moreover, this new form of therapeutic listening—situated somewhere between social services and psychiatry, extended the boundaries of mental health outside of traditional psychiatry and psychology services. Fassin et al. analyze how the institutionalization of therapeutic listening results as much from a concern with *caring* about the excluded as a concern with *regulating* them (2004:33-34). I argue that this dual logic underlined the popularization and flourishing of mediation structures for immigrants in the 1980s and 1990s, especially those addressing sub-Saharan African immigrants.

Ethnopsychiatry

The professionalizing of cultural mediation as a strategy to address issues of immigrant “integration” paralleled the emergence of the field of ethnopsychiatry. Ethnopsychiatry had its origins in the colonial period, as I described in the previous chapter. Its emphasis on the “paradigmatic other” generated considerable interest in the “African mind” and in states of normality and abnormality in African populations in relation to racial features (Fassin and Rechtman, 2007:336), notably through the fruitful “encounter” between psychiatry and ethnology. Although proponents would argue that the evolution of ethnopsychiatry in France can bring no comparison to the racist initiatives of its founding figures (Latour and Stengers 1997), others have strongly critiqued the cultural essentialism inherent in some current ethnopsychiatry approaches (Fassin 2000b; Fassin and Rechtman 2007).

Although I do not intend to provide a detailed description of ethnopsychiatry initiatives in France in this chapter, I want to situate ethnopsychiatry in the present

genealogy to show the social and political conditions that made its emergence and its functioning possible. More importantly, I call the reader's attention to the evolution—in the management of immigrant families—of networks of institutional actors across medical, social, and legal services, as well as of a discourse on ethnic identity that reinforces the articulation of culture with pathology and deviance.

Together with cultural mediation, which it incorporated into its practice, ethnopsychiatry participated in such networks by receiving referrals from social services, criminal justice and education institutions. In turn, it received the financial support of the state. Ethnopsychiatrists also intervene outside of their consultations. Susan Terrio's analysis of juvenile delinquency cases at a Parisian justice court provides us with several accounts of ethnopsychiatrists' interventions in court (2009). She observed that "Court personnel tended to be highly suspect of upbringing in homes where cultural norms differed radically from mainstream French society and deemed placing children in state institutions or in French families preferable than to keeping them in such setting" (Terrio, 2009:188). In this context, ethnopsychiatrists were called on to "neutralize" the negative effects of culture, and reestablish "proper" family norms (Terrio, 2009: 81).

The intervention of ethnopsychiatrists became particularly visible during the highly mediatized trials of West African families who had excised their daughters (Bourdin, 2006; Winter, 1994). The first legal judgment on excision in France was rendered in 1983, following the death of a three and a half month-old little girl excised in 1978, and the death of another little girl in 1982. Although the 1983 judgment was handed down in relation to the case of a mentally-ill French woman who had impulsively

excised her daughter, it was intended to serve as legal precedent for excision cases among immigrant communities.³⁵

Winter argues that the cases became “more of a political polemic than a legal trial” (1994:946). The publicity associated with the trials also meant that there was greater pressure on medical and social workers to report cases of excision, making it a legal obligation. Several discourses were engaged in the course of the trials, both on the nature of excision and on the rationale underlying its perpetuation among immigrant communities in France. One of the defense’s strategies was to put forth the idea that these immigrants who practiced excision in France were poor illiterate Africans, who barely spoke French, and who did not know that the practice was illegal in France. This strategy irritated feminists who deplored this image of “ignorant Africans,” blindly acting in accordance with their cultural tradition. This latter premise actually constituted another defense strategy: the notion that immigrant individuals had obligations to their cultural group, and were subjected to its authority. Ethnopsychiatrist Michel Erlich supported this rationale, commenting on the issue of sexual pleasure, and defending the argument that definitions of sexuality vary culturally. His position generated outrage among French feminists and leaders of African Women’s groups in France.

Conclusion

³⁵ Currently, excision is classified under the Penal Code under the article concerning violent acts committed against minors (Article 312, Alinea 3), reading as follows: “Whoever beats or otherwise voluntarily inflicts violence upon or assaults a child of under fifteen years of age, excluding minor violence, will be punished as follows:… By imprisonment of between ten and twenty years if there has been mutilation, loss of an eye, or other permanent disability or unintentional death” (Code Pénal, 1983-84, 184).

In this chapter, I attempted to articulate the close relation between political conjunctures, cultural representations of immigrants, and the problematization of “culture” in public health in general. I argued that the concern with “immigrant suffering,” which only emerged recently, was related to the intersection between the development of a mental health field partly designed to regulate “social suffering,” and subSaharan African immigrants’ political subjectification as psychologically-distressed and deviant families, which called for the management of culturally pathological behavior.

I would like to conclude this genealogy section by reasserting that, while I believe that the political subjectification of immigrants partly informed *the regulative basis* of “specialized” institutional interventions, one must not lose sight of the numerous, practical challenges that arise in the institutional management of immigrants (language barrier, conflicting representations of health and disease, or disagreements on the course of treatment; see, for a poignant illustration of all these issues: Fadiman, 1997). Such challenges, if un-acknowledged, may also negatively affect *the caring basis* of both social and healthcare services to immigrants. The tension I articulate throughout this work, between caring and regulating, is not intended to blame any institutional effort trying to address immigrants specifically. The macro-analysis adopted for this genealogy section, as well as the presentation of most works I rely on to shape my argument, may lead the reader to such a conclusion. Rather, my goal is to call attention to the complexity of the dilemmas raised in the everyday management of immigrant patients, and the resort to cultural mediation expertise in that respect. The ethnography that follows is intended to bring that nuance to the fore.

Synopsis of Chapter 3

In this chapter, I shifted the focus to the *Métropole*, France, and analyzed the interaction between France's immigration policies and the evolution of representations of cultural difference through healthcare provision to immigrants. I reiterated the tension between caring and regulating introduced in chapter 2, analyzing how stigmatizing representations of North and sub-Saharan African immigrants in healthcare reinforced regulative state policies, as well as depoliticized social inequalities and related suffering.

In the first part, focusing on labor migration, I showed how early twentieth century biological racism informed immigration policies in selecting which populations were desirable, and in measuring degrees of "integration" and "ethnic quality." Arabs were the focus of regulation policies, especially during the wars, a period of unrest and rising crime. North-Africans, affected by higher rates of tuberculosis, also became the focus of public health surveillance, and "benefited" from the first "specialized" care initiative in France, with the creation of the Avicenne hospital. As labor immigrants, suffering from unhealthy work environments, North African workers were categorized by psychiatrists as "malingerers," unworthy of financial—and moral—compensation. The political subjectification of North African immigrants as both dangerous criminals, contagious individuals, and undeserving malingerers led to their social circumstances being overlooked and pathologized. Meanwhile, I showed that early "specialized" mental health initiatives focused on trauma as a legitimate form of suffering, but excluded the suffering of immigrants from their framework.

In the second part, I focused on the flux of immigrants after the end of labor migration policies. I analyzed how the shift from North African workers to an increasing number of sub-Saharan African families and illegal workers establishing permanent residence in France shaped the emphasis in political discourse on the threat represented by these “visible” minorities. I showed how political scandals around the practice of excision and polygamy, together with the Paris suburban riots of 2005 and 2007, led to the political subjectification of sub-Saharan African immigrants and their descendants as deviant and psychologically distressed. I argue that, in the context of the popularization of theories of “social suffering” and the related blossoming of a multidisciplinary mental healthcare field, such characterization of immigrants’ “problems” created opportune structural conditions for the popularization of cultural mediation and the creation of the first ethnopsychiatry clinic catering to immigrants in France.

I concluded by acknowledging that such macro-analysis may overemphasize *the regulative basis* of institutional interventions catering to immigrants specifically, and that led to a concern with “immigrant suffering.” For analytical purposes, some of the studies I relied on tend to simplify both the rationale and the context of resorting to cultural understandings in social or healthcare services. A nuanced analysis should not lose sight of the complexity of those dilemmas which institutional actors face in improving *the caring basis* of their interventions. The ethnographic material on “specialized” mental healthcare is intended precisely to examine and underline the complexity of the tension between caring and regulating.

CHAPTER 4: “Specialized” Mental Health – The Making of the *Field*

In this chapter, I discuss the genesis of an expert discourse on “specialized” care for immigrants, twenty years after it sparked a controversy surrounding psychologist Nathan’s school of ethnopsychiatry. I look at why the institutional establishment of such expertise was so controversial at the onset. I analyze how the controversy affected the “specialized” mental healthcare institutions that were created (or remodeled, in the case of Minkowska) to address ethnopsychiatry’s patients. Indeed, while the activity and reputation of ethnopsychiatry greatly suffered from the controversy, it has not deterred the multiplication of similar initiatives in the French public health landscape. How were these initiatives possible? What transformations were involved in the discourse on “specialized” mental healthcare, so that they became institutionally legitimate? How is the authority of such institutions constructed? How has their institutional expertise expanded across institutional boundaries? What does it say about these institutions’ position within the broader political landscape? Such are the questions that guide my reflections on the making of “specialized” mental healthcare expertise for immigrants in France.

Here I approach “specialized” mental healthcare to immigrants as a “scientific field,” in Bourdieu’s sense of the term (1991). That is, I analyze it as a social space (Bourdieu, 1985) in which agents or institutions compete with one another to valorize their social and scientific capital. The very structure of their field, as well as the relations of power within it, are determined by the historical and social conditions that led to the emergence of the field on the one hand, and conditioned its claims to legitimacy on the

other (Bourdieu, 1991). In the process I follow Latour's (1987) network approach by identifying technologies that disseminate and control the circulation of expert knowledge, as well as Bourdieu's (1991) theory on the acquisition of legitimate language competence. I attempt to show how "specialized" mental healthcare centers maneuver "communicable circuits" (Briggs 2005) and acquire institutional capital. I debate whether, ultimately, by adopting a legitimizing discourse which simultaneously emphasizes the politics of "universalism" through republican values and "scientific" discourse through diagnostic language, "specialized" mental healthcare, as a field, limits its practical challenge to the structural misrecognition (Taylor 1994) of immigrants in France.

I. Medicalizing and discriminating – Testing the boundaries of republican ideology and "scientific" discourse

Bourdieu pointed out that social conditions constrain and enable the production of scientific fields. In earlier chapters, I delineated the historical conditions that led to the emergence of a psychiatry of colonization and of ethnopsychiatry consecutively. I showed the relations between evolving political contexts, representations of the Other (the colonized and the immigrant, consecutively), and the analysis of the impact of perceived racial or cultural—depending on the time and context—differences on the psyche and psychopathology. In this chapter, and in the remainder of this second part dedicated to the analysis of expertise, I carry on this "historicized epistemology" (Bourdieu, 1991:23) with an empirical investigation of the development of "specialized" mental healthcare in contemporary France.

Immigration politics in France and “The Universe of Possibilities” (Bourdieu, 1991:10)

When ethnopsychiatry was initially introduced in France at the end of the 1970s, the field of mental health was inviting to “specialized” institutional initiatives targeting immigrants. As I discussed earlier in Chapter 3, in the aftermath of World War II, as well as in the context of the reform of psychiatry in the 1960s, a psychopathology of trauma developed in France, through the creation of mental health structures that addressed post-war refugees and asylum-seekers (Fassin and Rechtman, 2009). I also argued that, initially, there was little attention paid to the mental health of immigrants, whom at the middle of the century were essentially represented by single male workers, a growing number of whom came from colonies in North- and sub-Saharan Africa. These workers only began to be identified by psychiatry with having mental pathologies, as an increasing number of them came for work-related injuries, and demanded financial compensation for their absence from work. “Sinistrosis” thus became a psychiatric label, pointing to the illegitimacy of the workers’ claims, and indirectly to their social illegitimacy at large (Sayad 2004).

While imbued with racial stereotypes, political discourse (and immigrant associative discourse alike: see Daum, 1998) on immigration was class-based rather than ethnic-based. I showed, at the end of chapter 3, the shift that operated in the development of “specialized” mental healthcare, and which coincided with the suspension of labor migration in 1975, and the subsequent family reunification legislation in 1976. In a context of economic crisis, the arrival of immigrants’ children and wives—most of whom came from poor rural areas in North and sub-Saharan West Africa, uneducated and non French-speaking – triggered a series of structural challenges (i.e. housing, documentation,

employment, childrearing, the educational system), which were accompanied by a growing anti-immigrant sentiment— a sentiment exploited and exacerbated by the xenophobic discourse of the extreme-right.

Many of immigrants’ structural dilemmas came to the attention of the social workers associated with numerous state institutions—schools, hospitals, local government, criminal justice system, and so forth. The public health system, in particular, turned to interpreters and subsequently to “cultural mediators” in an effort to effectively communicate with non French-speaking migrants (Quiminal and Timera 2002; Charte MCS 2006). Meanwhile, France promoted a republican model of integration based on a logic of universal rights that denies the relevance of ethnic differences (Favell, 1998; Hollifield, 1994). Recurrent protests against social inequalities were depicted by state officials as the product of “non-integrated” immigrant families breeding delinquent and psychologically distressed youth (Le Goaziou and Muchielli, 2006).³⁶

Altogether, I argue, these events produced a “universe of possibilities” (Bourdieu, 1991:10) for ethnopsychiatry to emerge on the French public health landscape. As Bourdieu pointed out, “agents are not pure creators, who invent in a vacuum, *ex nihilo*, but rather they are, so to speak, actualizers who translate into action socially instituted potentialities” (Bourdieu, 1991:10). As I articulated above, the sociopolitical context in France had already inaugurated a political language ideology in which ethnic difference is only acknowledged as being pathological (Urciuoli, 1996). I argue that ethnopsychiatry as a practice was only legitimized in the French public health care as its discourse,

³⁶ There is much more to be added here on the discursive weight of the French political concept of “integration,” as “the expression of a vague political will (...), not a discourse of truth, but a discourse designed to produced a *truth -effect*” (Sayad, 2004[1999]:217, emphasis in text).

initially at least, validated the political ideology in place. Not only could it validate it, but it could effectively produce the pathological subjectivities it labeled discursively.

Nathan's spin on ethnopsychiatry

The first ethnopsychiatry initiative was launched in France by charismatic psychologist Tobie Nathan. While claiming an intellectual affiliation to anthropologist and psychiatrist George Devereux (1970), Nathan's practice took a radical turn away from Devereux's careful theoretical model. In terms of scientific legitimacy, however, it is interesting to note that Nathan chose Devereux to frame the intellectual genealogy of his center. While this may be explained by the simple fact that Nathan indeed studied under Devereux' supervision, and most likely benefited in his entrance to the field from that scientific filiation, it may also be perceived as a deliberate strategy to remove ethnopsychiatry's racist colonial heritage, thereby disaffiliating French ethnopsychiatry from it.

As I described in chapter 2, Devereux accepted the notion of a psychic universality, while documenting cultural specificity in the expression of mental disorders. He foresaw a perfect complementarity between the disciplines anthropology and psychiatry. Devereux' s concept of complementarity was not theoretical, but rather methodological. It prescribed that references to anthropology and ethnopsychanalysis be considered distinctly, not simultaneously, so as to avoid confusion between their respective analyses (Mouchenick 2006). It postulated a distinction between Culture in itself (a universal human phenomenon – psychic universality) and individual expressions of culture (cultural specificity and human diversity). It argued that the use of cultural

material in psychotherapy could be used as a transitory therapeutic lever, but warned that the use of such cultural levers should not constitute a therapeutic object in itself.

Devereux also noted that in fact, the use of culture could potentially become an obstacle to therapy, and therefore should be used cautiously (Moro, 2006:164).

Thus, according to Devereux, the therapist must cease to perceive his/her patient as the “site of an illness”—providing him with investigations and all sorts of benefits—but instead as a person belonging to the human condition, trying to give meaning to his/her suffering and a sense to his/her life. In this perspective, the knowledge of the patient’s cultural milieu can be used towards therapeutic ends. But it must neither be employed as a possible means of readaptation to that milieu, nor as a conditioning method to the healer’s culture (Andoche 2001). Cultural investigation must not constitute an objective in itself. The role of the therapist is to accompany the patient in his/her self-reflections and questioning of their fate, while respecting their choices in how they express themselves.

Nathan started his first ethnopsychiatry consultation at a hospital in a northern suburb of Paris. The Avicenne hospital, in Bobigny, was itself a symbolically charged location, as it was built in 1935 to serve the needs of Muslim patients from North Africa—and unofficially, to control colonized indigenous populations on the territory (as I described in chapter 2). Today, the hospital still caters heavily to immigrant populations. The hospital’s head of child and adolescent psychiatry, Pf. Serge Lebovici, thus invited Nathan to help him better serve the needs of these populations. Together they created the first ethnopsychiatry consultation in France, in 1980.

Although greatly inspired by the teachings of his mentor, Georges Devereux, Nathan's clinical practice significantly deviated from Devereux's contention that anthropology and psychiatry might play complementary roles in the treatment of psychopathology. In fact, Nathan did not elicit the participation of anthropologists, but rather constituted a body of experts, called "ethno-clinical mediators," whose competence was evaluated on the basis of their belonging to a patient's ethnic group or on their knowledge of one or several languages of their cultural area. These ethno-clinical mediators played the role of the ethnologist's informant (Andoche, 2001:295).

Nathan broke away from Devereux's careful distinction between a universal expression of "culture in itself" and local expressions of culture. Instead, he substituted a concept of culture as a closed system, all-determining in the expression of mental disorders (Nathan, 1986). In this model, the psyche is subordinated to culture. His theory of "cultural closure" postulates that migrant patients can only be treated in their cultural system, and in reference to "traditional" typologies (Mestre 2006: 168-169). This leads Nathan to reconstitute the therapeutic discourse as an adaptation of African village assemblies (as Collomb experimented in Senegal). According to this model, ethno-clinicians together with patients re-enact the technique of a circulating discourse in which each co-therapist in turn speaks to the issues presented by the case, a method thought to represent "African" healing. The co-therapy team also may use ritual objects in therapy or other rituals such as divination (Andoche 2001: 301).

Pushing Cultural Relativism, Loosing Institutional Legitimacy

A decade later, in 1993, Nathan created the Georges Devereux Center as another consultation service, simultaneously part of the Psychology department of the University of Paris 8, where ethnopsychiatry as a discipline was provided a space for experimenting with the concept of “mediations.” Patients were referred to the consultation in “second intention”³⁷ by a medical (general practitioners, psychiatrists, and others), social (social workers), school, or justice (child protection services, juvenile courts) institution. It was therefore set up to work “in network” (*en réseau*) with referral institutions, to which it also offered diagnostic and therapeutic advice, workshops on working with immigrant families, training or information on ethnopsychiatry, and cultural expertise. This was how Nathan’s clinic built its institutional authority, becoming at once a site for therapy, research, and teaching, and simultaneously crossing institutional boundaries. The transition also announced a radical turn in Nathan’s discourse. His institution grew in fame and popularity throughout the 1980s. According to Fassin, the George Devereux center was reaching as many as 600 consultations a year, not counting outside interventions in social services, health-promoting associations, and justice tribunals (2000:7). Colleagues and students of Nathan, who reflected on this flourishing period of the George Devereux Center, often commented in public meetings that Nathan was worshipped like a guru, evoking strong reactions from the psychiatry and psychology community. He was reported to have the spellbinding aura of a sorcerer—and indeed he used that charisma to manipulate ritual objects in consultation and conduct rituals (Andoche, 2001).

³⁷ “Second intention” is a French public health term indicating that the patient does not come for a consultation on his own initiative. Rather, his/her pathology is first suspected by one institution (such as those mentioned in the text), which then contacts the deemed appropriate health structure for consultation.

Attempting to extend his authority and establish a scientific legitimacy for a French practice of ethnopsychiatry, he published a book in 1994, *A Healing Influence* (*L'influence qui guérit*), which marked a definitive rupture with the political ideology that allowed his meteoric rise in the first place. In addition, it is crucial to note that within a decade, between the early 1980s and the early 1990s, the political climate had significantly changed, and that attitudes toward immigration had hardened. Following the early 1980s pro-immigrant discourse of the Mitterrand socialist government and its attempt at encouraging “the right to difference,” conservative, anti-immigrant discourse gained in popularity, eventually leading to election of right-wing President Jacques Chirac in 1995. Once again, the republican model of “integration,” based on a logic of universal rights that denies the relevance of ethnic differences (Favell 1998, Hollifield 1999), was pushed to the fore. Ethnic difference was only referred to in the media in denigrating terms,³⁸ and cultural practices subject to be punishable by the law.³⁹ Recurrent protests against social inequalities were depicted by state officials as the

³⁸ See Chirac’s famous comment during a discussion, at his right-wing party meeting (then *RPR*), on the need to reframe immigration policies: “How do you want a French worker who works with his wife, earning together about 15,000 FF (about 2,300 euros), and who sees on the floor of his low-income high-rise (*HLM*), all piled-up, a family with a father, three or four spouses and twenty children earning 50,000 FF (almost 8,000 euros) only from social benefits, and naturally without working... If you add to that the noise and the smell, well the French worker, he goes mad. And it is not racist to say this. We no longer have the means of pursuing the family reunification policy, and we need to finally tackle the essential debate in this country, as to whether it is moral and normal that foreigners should profit, to the same extent as French people, from a national solidarity to which they don't participate, as they pay no income taxes” (see the article in French newspaper *L'Humanité*, 1991)

³⁹ The trials against excision starting in 1983, the “Headscarf Affair” starting in 1989 (leading to a law in 2004), the anti-polygamy laws of 1993.

product of “non-integrated” immigrant families breeding delinquent and psychologically distressed youth (Le Goaziou and Muchielli 2006).⁴⁰

It is in this context that Nathan’s book denounced the inefficacy of usual psychiatric methods with immigrant patients, and presented a virulent assault on Western psychiatry. As Nathan wrote,

The most powerful resort of action for doctors, at least in psychiatry, is the prestige of medicine. ... Psychiatry practiced properly can truly be efficient for a patient who freely agreed to establish the therapeutic relation. But when it reigns as a master ideology in a service of psychiatry or in a medico-psychological consultation, it becomes, as with other presumed scientific theories, naïve gibberish (1994:12)

Rejecting all theory of psychic universality from psychoanalytical theory, Nathan then only retained Western medicine’s technique of influence as the mechanism leading to the modification of the subject. “In other words,” he added, “I am not far from thinking that psychology—as a science of the psychic apparatus, following Freud’s formula, ... would be a pure fiction. The only defensible scientific discipline would be, forgive the barbarism, an influence-ology, which object would be to analyze the different procedures to modify the other” (1994:21). More broadly, Nathan critically analyzed modern medicine’s claim to rationality and legitimacy from a reference to science and the theoretico-experimental model, which has continually allowed for a distinction between “doctors” and “charlatans” (Stengers and Nathan, 1995).

Not only then, was Nathan confronting the medical establishment, but he pursued a struggle to show how medicine served a specific political ideology, itself causing suffering for immigrants. In a personal political struggle against what he called “the

⁴⁰ There is much more to be added here on the discursive weight of the French political concept of “integration,” as “the expression of a vague political will (...), not a discourse of truth, but a discourse designed to produce a *truth-effect*” (Sayad, 2004[1999]:217, emphasis in text).

constraint of humanity” (1994:143), he showed that immigrants in France suffered from never being acknowledged in their cultural difference, and being forced to assimilate as “universal” beings. Such assimilation policies, he argued, were directly detrimental to immigrants’ well-being. He noted, for example, that in his consultations, an abnormal number of infantile autism cases among immigrants’ children were encountered; he linked these cases of autism to the experience of immigration and a family’s loss of its cultural environment (1994:145). He implied that assimilation policies as they were articulated in France, and its “machines of cultural abrasion” (medicine and schools) (1994:191), damaged the very psychological structure of immigrant individuals. This also led Nathan to make radical, passionate, but controversial declarations such as the following one:

What crazy demiurge, what delirious alchemist went to imagine that a family could, in the space of a few years, abandon a system which had been assuring its psychic homeostasis for generations, as one says, ‘adapt’ or ‘assimilate’? I know from experience that it is impossible! In societies with heavy emigration, one must encourage ghettos – yes, I say it loud and clear -- to encourage ghettos so as to never constrain a family to abandon its cultural system. (1994:190-191)

And further,

I claim it high and loud, the children of Soninkes, of Bambaras, of Fulanis, of Dioulas, of Edwoundous, of Dwalas, and of who else do I know?, all belong to their ancestors. To brainwash them in order to turn them into white people, republicans, rationalists and atheists, is simply an act of war. (1994: 296)

While I would argue that Nathan’s problematization of the higher incidence of mental health disorders, among immigrants and their children, as related to the experience of immigration and the loss of recognizable cultural markers seems highly relevant, I

believe the vehemence and extreme cultural relativistic nature of his accusations significantly undermined the cogence of his theory as well as the richness of his clinical experience.

Nathan's attempt at establishing scientific legitimacy thus rested on what Bourdieu interpreted as "a strategy of subversion," which calls into question the principles of the old scientific order, and with it, the social order with which this scientific order is bound up (1991:17). However, having limited autonomy, both within the scientific field and the political field, Nathan could not be conferred the specific legitimacy he called for. As I will show in the following section, he was cast as a heretic, refusing to circumscribe his speech to medical orthodoxy on the one hand, and to the rules of French republican universalism on the other. In reality, I would argue, Nathan's discourse meant to recontextualize what both ideologies had precisely sought to decontextualize through the sponsoring of ethnopsychiatry: namely, the relevance of culturally-sensitive care, not merely in improving mental healthcare provision to immigrants, but in unveiling the unhealthy consequences of the structural conditions of immigration and of the French "integration" model.

Delegitimizing the dissenter

Following the publication of Nathan's *A Healing Influence*, critiques rapidly followed. The delegitimization of Nathan's work and reputation took place through the circulation of scientific critique on the one hand (in scientific journals), and through lay discourse via the media on the other (in newspapers and magazines). I argue that lay critique bore more resonance in the debunking of Nathan than did the scientific critique,

because it added a moral dimension which most scientists would not allow. Moreover, while scientists attacked Nathan mainly on his essentialization of culture, they were also critical of the political ideology that had allowed for Nathan's practice to take shape. Both critiques, I argue, respectively legitimized the authoritatively competent languages of science and political ideology.

“Scientific” critiques came not only from social scientists, who disparaged Nathan's extreme cultural relativistic stance—but also from the medical realm, notably from psychiatrists who took offense at Nathan's deconstruction and re-appropriation of psychoanalysis. Rechtman, for example, a French psychiatrist and anthropologist, responsible for a national research project on psychiatric disorders among Cambodian refugees, argued that Nathan's work was not only based on “abusive simplifications of ethnopsychanalysis” (1995:120), but more dangerously, that Nathan's extreme relativism, by “suggesting the existence of fundamental differences between the functioning of the human psyche according to one individual's culture of origin risks not only to reactivate the concept of race, which paradoxically he claims to actively contest in his militancy, but also to inaugurate a theory of human species based on ethnic belonging” (1995:125).

In contrast, Bruno Latour, together with Belgian philosopher Isabelle Stengers, wrote a defense of Tobie Nathan's ethnopsychiatry initiative, showing how the backlash it suffered resulted from a specific ideological framework in which discussion about culture is always pitted between ethnic or group (*communautariste*) definitions on the one hand, and references to the Republic and citizenship on the other. As a result, they concluded, ethnopsychiatry was discursively characterized as an irrational science—even

charlatanism and sorcery, and as such opposed to republican-friendly universal science. It could no longer be, in fact, a legitimate, scientific discourse:

It is precisely on this theory of science, as always, that the integration, negotiation and invention of such clinical initiatives is discussed. Critics make it seem as if Tobie Nathan was preaching to the irrational by coming back on the Freudian discovery, on this 'scientific revolution,' this 'radical epistemological cut' which would have permanently disqualified older forms of psyche. From this great revolution, unfortunately, we have never seen the proof but the relentless reiteration of this assertion itself, that there was indeed a radical break between Science and charlatanism. ... Instead of pretending that there existed, out there, a natural and universal form of the human psyche which one could discover without fabricating it, the Centre Devereux 'laboratory' introduces to the fabrication not only of humans, but also of what psychoanalysts and philosophers designate under the noble term of 'subject.' It is not evident that this way of doing might not in fact provide one of the means to actually be scientific and to question the century-old practice of psychoanalysis again (1997; *my translation*).

I perceive Latour and Stengers's supportive comments as a valid attempt at re-establishing the scientific validity of Nathan's theoretical proposition, which his own radical claims had undermined.

Critiques came from both social science and medical circles. They circulated through scientific journals (Dahoun, 1992; Douville and Ottavi, 1995; Fassin, 1999). Some led to book publications (Ménéchal, 1999). These scientific critiques were also relayed by mainstream national newspapers such as *Le Monde* and *Libération* (Benslama, 1996; Policar, 1997; Sibony, 1997), and answered by Nathan in the same venues (Nathan 1997a, 1997b). Such critiques, as I mentioned earlier, were critical of ethnopsychiatry as supporting the political mis-recognition of structural violence affecting immigrants by sanctioning the pathologization of the political. Fassin, for example, noted that for Nathan, immigrants are Bambara or Fulani individuals first and foremost, and they need

to be treated as such. They are never portrayed as immigrants facing visa difficulties, encountering housing discrimination, confronting everyday racism. “Difference so construed,” Fassin argued, “can only lead to a construction of difference void of any social substance, and to a reassuring sublimation of conflict, which is the principle of politics” (2000b:19).

Interestingly, discussions about Nathan’s position on the issue of genital cutting received most resonance in the media, and were most commonly relayed in lay discourse. The first accusation came from a small scientific journal, *Science et Nature*, which in 1995 (shortly following Nathan’s book publication) had interviewed Nathan to talk about initiation rituals in traditional societies, and made the claim that Nathan sanctioned excision. According to Nathan himself, in his own defense,

while I expressed my interrogations as to why some populations, in spite of the suffering entailed in those rituals, were so adamant on perpetuating their tradition. I claimed that it was absolutely necessary to understand the psychological function of such rituals. Nothing more. This interview was then written up by the same journalist, albeit with some exaggerations. I have, by the way, never written anything on excision phenomena. Nonetheless, an insidious press campaign spread the rumor⁴¹ according to which I would defend excision. Nothing is more wrong! To dismiss any ambiguity, I will claim once again that I do not defend excision—I am personally opposed to it and by encouraging the integration of immigrant families, I contribute to preventing it. (Nathan, 1999, my translation)⁴²

I believe this media episode to reflect on the sensationalism that was spread in the media around the critique of Nathan’s work, and which was void of any scientific basis.

⁴¹ The use of the term “rumor” is particularly interesting here, as an attempt to discredit this account of his own work—rumor corresponding to the circulation of non-authorized discourse.

⁴² This is my translation of Nathan’s response to the accusation, posted on the Devereux Center’s website, along with others of Nathan’s colleagues: <http://www.ethnopsychiatrie.net/actu/Mise%20au%20point.htm>.

A few years later, Nathan was the victim of another media hoax. An even more marginal journal, *Afrique Magazine*, claimed that in an interview attributed to Tobie Nathan, the latter seemed to justify excision and to understand its practice as a tool for educating, integrating, and protecting women in traditional societies. Few had heard about that comment, until it was used in an article published in *Politis*—a politically liberal weekly newspaper in which many politically-engaged social scientists publish (Jourde 1999). A few weeks later, the editor of *Afrique Magazine* published a “Mea Culpa” (Limam 1999) in which he revealed that “Nathan has never met with the journalists who signed the interview in AM. The responses that are attributed to him come from another interview, published in a French journal, and whose veracity Nathan has repeatedly contested.” Media language here appears clearly as one technique in the assessment of expertise and institutional authority. The circulation of media information focused on Nathan’s persona and allegedly culturally relativistic claims, without really discussing his scientific propositions. This media-relayed discourse resulted in a strong sense that Nathan was morally wrong (besides being unscientific, which scientific journals and some newspapers had already argued)—a dangerous neo-racist, and anti-republican above all. While it is undeniable that Nathan often adopted extreme positions, such as those cited earlier, the adoption of a critical discourse analysis of this debate shows how a certain political ideology imposed a structure of understanding on Nathan’s approach, which in turn shaped how people responded to him and on what grounds they were critical of him.

The terms of the debate, ultimately, demonstrated the precedence of power over scientific capital. If initially, at least, Nathan had managed to gain scientific capital, and

therefore, autonomy in the scientific world, by accumulating scientific texts and disseminating them through research and teaching, his discourse ultimately failed to support “the legitimate representations of the social world” (Bourdieu, 1991:15).

II. Maintaining expertise – Re-labeling “specialized” mental healthcare

Following the public critique of Nathan’s school of ethnopsychiatry, it may seem surprising that “specialized” mental healthcare institutions survived in the French public health landscape. Yet, a careful analysis of these institutions’ scientific discourse and the making of their scientific expertise shows that, by reappropriating a politically and scientifically authorized language in discussing the special mental health needs of immigrants in France, they have readily reasserted their institutional legitimacy, along with that of their field.

The three “specialized” mental healthcare centers

Although, theoretically speaking, Avicenne/JB Carpeaux, Minkowska, and Gepela propose different modes of mental healthcare provision – from transcultural psychiatry, to clinical medical anthropology and ethnoclinical care – I argue that, in practice, they all share a similar perspective on the relevance of cultural representations in the field of mental health for immigrant patients, and that, as “second intention” centers, they also share the same institutional functions. I also contend that, were it not for the political and scientific necessity of dissociating from Nathan’s legacy on the one hand, and to circulate their expertise independently of one another on the other, these

centers could identify with the same broader conceptual framework of specialized mental healthcare delivery.

All of them were thus forced to adapt their theoretical premises following the debate triggered by Nathan. With the exception of the Minkowska Center, which has a unique institutional history—and which was established long before Nathan’s ethnopsychiatry initiative, the other two centers’ clinicians (Avicenne/Carpeaux and Gepela) had been trained by Nathan, and therefore were closely inspired by his clinical model of healthcare provision for immigrants. Today, all of them acknowledge the negative implications of Nathan’s culturally essentialist position (Moro, De La Noe, and Mouchenick, 2006), and have become well aware of its sociopolitical stakes (as they were articulated by social scientists’ critiques). Also, while they acknowledge that the very concept of a separate, “specialized” model of mental healthcare provision for immigrants might end up stigmatizing such patients, they argue that it is a necessity in the French healthcare context which insists, for ethical reasons, on masking discrimination against immigrants (as one of the center’s director noted, in an ideal public health system, such “specialized” care would not be necessary⁴³). Theoretically, this more recent “specialized” healthcare model acknowledges social precarity as a core factor in mental suffering among many migrants and, as I argued earlier, partly inscribes itself within the movement of psychosocial medicine.

All three institutions continue to underline, in their respective terms, the importance of cultural expertise. Here, I analyze the labels they have chosen and the language they use in defining cultural expertise, as carefully molded discourses that strive

⁴³ Public intervention at a seminar on Mental Health and Immigration, Maison des Sciences de l’Homme, St.Denis, 9/01/08.

to remain within the boundaries of French public healthcare ideology of healthcare access for all, and that seek scientific (both medical and social science) sanctioning. I argue that the discourse of French republicanism, clothed with the language of science, imposes a “sphere of communicability” which creates

domains that seem to be unified (to varying degrees) by particular communicative ideologies, practices, and inequalities. Like epistemologies and social material networks, communicability is crucial for boundary work, for the creation and maintenance of boundaries, and for the regulation of membership (Briggs 2005:274).

In France, republicanism is the official state discourse—a set of normative institutional ideologies and practices—“against which all linguistic practices are objectively measured” and gain legitimacy (Bourdieu, 1991:44). The condition of the survival of “specialized” mental healthcare centers is, I argue, to remain within the limits of what Bourdieu called this “unified linguistic market” (1991:45).

Coining scientific labels

- **The transcultural psychiatry model and “hybridity”**

The transcultural psychiatry consultation at Avicenne opened in 1989, as Nathan stepped down to focus on the George Devereux Center. The Avicenne Center is therefore integrated in a hospital structure (Hopital Avicenne). It is the only university-hospital ethnopsychiatry consultation in France. It is integrated with other hospital services, is open to anyone, and consultations cost the same as any public psychiatry consultation fee.

Located in the child and adolescent psychopathology service, the transcultural clinic at Avicenne is currently directed by psychiatrist Marie-Rose Moro. Initially a student and

colleague of Nathan, Moro split from his clinical team over the question of the centrality and essentializing of culture in the treatment of mental illness. As a specialist of child and adolescent psychopathology, she naturally turned her attention to the second generation of migrants, and created a clinic for transcultural psychiatry. Just as for Nathan's use of ethnopsychiatry, Moro found in the label of transcultural psychiatry an already legitimately established scientific discipline, also the fruit of a collaboration between the discipline of anthropology and psychiatry.⁴⁴ She expressed her preference for the term transcultural psychiatry, rather than ethnopsychiatry—although they conceptually do not differ— because it has more applicability in international psychiatry (and also lacks the controversial history of the term ethnopsychiatry in France) (Moro, personal communication, 6/12/2007). “It makes it easier to establish a dialogue with other disciplines,” Moro added (personal communication, 6/12/2007). She notes that while Nathan's position on the construct of culture and on considering psychoanalysis as only one therapeutic technique among others was positive “in that it forces us to think of multiplicity ... [I]t also ignores the relationship between the technique and its context, which is necessary for it to remain coherent. In sum, it does not integrate *métissage*.” (Moro 2006:166).

Moro uses the concept of *métissage*, or hybridity, to refer both to the fact that the encounter between cultures, although complex and potentially destabilizing, can be harmonized, and that in response to this complexity, a repertoire of clinical techniques

⁴⁴ Transcultural psychiatry was established as a scientific discipline in 1955, by Drs. Eric Wittkower and Jack Fried, as a joint venture between the Departments of Psychiatry and Anthropology at McGill University in Montreal. “Its first achievement was to develop a newsletter to form a network of psychiatrists for the exchange of information about the then little known effects of culture on psychiatric disorders. The newsletter subsequently became *Transcultural Psychiatric Research Review*. In 1981, a Division of Social and Transcultural Psychiatry was inaugurated to integrate research and teaching in these fields.” (web source: <http://www.mcgill.ca/tcpsych/history/>)

must be offered to migrant patients (*clinique à géométrie variable*). Her understanding and use of culture in the clinical context is attuned to contemporary anthropological definitions of culture as flexible, dynamic, and contingent to history and power relations. “After Nathan,” Moro explains, the relationship of ethnopschoanalysis to anthropology had to be reinvented” (Moro, personal communication, 6/12/2007). Moreover, referring to Ricoeur’s concept of “narrative identity,”⁴⁵ Moro argues that a hybrid framework (*un cadre métisse*, that is a team of co-therapists with diverse ethnic origins) facilitates the unfolding of the subject’s narrative, because it respects and takes into account his/her representation of the world. However, in contrast to that approach at the Centre Devereux, she refuses to manipulate ritual objects in therapy, underlining once again that a psychotherapeutic/psychoanalytic context is not the appropriate site for “traditional” African healing methods.

Clinical vignette: Performing Transcultural Psychiatry

The transcultural psychiatry group consultation led by Marie-Rose Moro takes place once a week on Wednesday mornings, from 9am to 1pm. The group consultation is only one of many mental health therapy options in Moro’s transcultural clinic, and patients are offered the group consultation as one amongst other forms of therapy. The group usually receives two patients/families in the course of the morning, thus dividing time in two two-hour long sessions. The day of my first experience attending a group consultation, two patients were received, both second-generation children of North African parents. The first patient, whom I will call Sajid, is eighteen year-old and comes accompanied by his mother. His parents both come from Morocco, but he was born and raised in a suburb of Paris. He has just completed training in electronics (*CAP*) at a technical high-school. He was initially enrolled in an academic program also teaching technical skills (*BEP*), but did not like studying and therefore gave up in order to

⁴⁵ In *Oneself as Another* (1992), Ricoeur approaches the concept of “narrative identity” as the dialectic of sameness and selfhood. The identity of an individual or a character in a narrative is his or her narrative identity. A character in a narrative is an individual who may be reidentified as being the same. But the narrative identity of the character also reveals a form of selfhood. This notion also makes it possible for Ricoeur to distinguish two dimensions within the pseudo-unitarian notion of identity: identity as sameness (Latin: *idem*); and identity as selfhood (Latin: *ipse*). Finally, narrative identity defines a character or individual as being an agent of action.

obtain direct professional certification which would enable him to directly find a job in his area of expertise. Sajid first started therapy at Avicenne through the Home of Adolescents (*Maison des adolescents – CASITA*), another health structure integrated into the hospital and built in 2001 at the initiative of Moro's team. The structure is meant to facilitate adolescents' access to a health structure (this particular age population is usually reticent to frequent such institutions), and offer multidisciplinary services, from mental health to general medicine, but also social, education and justice counseling. If an adolescent pursues individual therapy at CASITA, depending on the nature of his suffering, he may be offered to participate in the group consultation.

That day, the room is full. All chairs have been arranged in a circle. Three of them are empty when I arrive: Pf. Moro's, the patient's, and the accompanying family member's. An intern sits at a small table by the window, where he prepares to take notes during the consultation. All exchanges must be transcribed and typed, for any consultation. I count twenty-two of us in the room. The atmosphere is very jovial and relaxed. Coffee is brewing on the small table assigned to take notes. Then Pf. Moro dynamically enters the room. Everyone hurries to their respective seats, and the room becomes drastically calmer. Pf. Moro always arrives after everyone else does, which makes her entrance into the room appear theatrical. Before the patient enters the room, she hears from the referring psychologist at CASITA, who informs her about Sajid's individual therapy and her weekly appointment with him. Sajid has been frequenting CASITA for over a year. She notes that Sajid has progressed a lot in the past months, even though he gave up on school. When he first arrived, he was delirious and suffered from dissociations. She believes it would be ideal for him to be accepted in a school structure which simultaneously provides healthcare (*classe soins-études*). However, it seems that such a possibility is only offered to students following the general curriculum, not the technical one. Pf. Moro then stands up to go meet the patients outside the room. She walks back into the room together with Sajid and his mother. She acts warmly and smiles. A co-therapist turns to me and tells me: "Marie Rose just has this unique skill: she can make patients feel comforted and at ease immediately. She radiates empathy."

Everyone is now seated, their eyes turned to Sajid and his mother. I wonder how intimidating it must feel for them to be the center of twenty-three inquisitive stares... While Sajid's mother appears shy, Sajid seems very relaxed. He obviously is not a novice in group therapy, and he comfortably meets everyone's attention. Moro goes around the room introducing only new faces to Sajid. She does, however, remind him co-therapists' names, their culture of origin, and their professional activity. Zinedine, one of the co-therapists, translates for Sajid's mother.

Moro first addresses Sajid and asks him how he has been feeling since the last time she saw him. Without an hesitation, he starts explaining to her how irritated he feels at people – especially people his own age –

asking him questions about how he feels or why he keeps his distance with others and does not want to speak to them. He says that in his head, he has already grown up, and that he feels mature. He says he feels older than his friends, that he already projects himself in the future. As he pauses, his mother intervenes, and addresses Pf. Moro, telling her that she is worried about Sajid's behavior at home. She says he "sticks too close" to her, is aggressive, and says strange things, things from the past. He even tells her he feels someone whispers in his ears, and that he sees things on the ceiling. Sajid relays his mother's comments. He says that he no longer wants to speak of those things. They belong to the past, and when they come back up to the surface, he feels nauseous. He says he has already experienced things. He does not want to be in the present either: it is not interesting. He is already passed that. He wants to project himself into the future. That is why people his age do not interest him. "Even my brothers and sisters are different from me," he adds.

Sajid's mother confesses that to help her son, the family has thought of sending him to stay with his maternal uncle in Morocco. "Perhaps they will find a solution there. There will be people who understand these things." Sitting next to her, Sajid nods enthusiastically: he fully agrees with his mother. He says he also believes a trip to his uncle in Morocco will help him feel better. "I cannot find my place here for now" he says. "I just don't know where I will feel well."

In the psychoanalytic tradition, Moro prompts Sajid to share one of his dreams with the consultation. Without hesitation, Sajid describes his most recent dream in which he found himself sitting on top of a cliff, dressed in a golden armor. He is surrounded by flowers, of the most beautiful and varied kinds. He picks one, which smells so good. "It is like paradise." There appears a beautiful young lady wearing a white dress. She approaches him, and he takes her into his arms. "Then all of a sudden, the scene stops, and I discover that I am on a movie set! There is a camera right above us, filming everything, at every angle, 360 degrees! I am holding a script describing me as the hero character, the strongest of all. But the script also mentions that in order to save the other one who wears the very same armor, I will have to die. I will have just enough time to pass on my powers to this other one before I die." He goes on to describe that after dying, he will reach "some kind of immortal status," because he will always be able to communicate with reality. "It is like a happy death, which solves a problem." Sajid's mother intervenes to comment on the fact that this death which his son speaks of, perhaps refers to the death of "this problem he has inside." This is what the trip to Morocco will help him accomplish, she thinks.

Following the description of the dream, Moro invites her co-therapists' to share their input. She wonders what people would say of the dream in their own culture, thus calling for different cultural etiologies of Sajid's "problem." The first therapist, of Vietnamese ethnicity, believes that where he comes from, ancestors or the elders not only have the

knowledge of things past, but also can foretell how events take shape in the future. They share this wisdom with people around them, just like Sajid does. Moro then addresses, another therapist, from Mauritania, suggests the theory of female jinns who come and inhabit young men. Moro appears quite unhappy with this last parallel, not only because it can be objected to, but especially because hearing that might add to the patient's anxiety, as well as to his mother's. A third co-therapist, of French ethnicity, explains that Sajid's story reminds him of Don Quichotte, who combats his ancestors as both real and imaginary enemies, and who is enamored of Dulcinée. A fourth co-therapist, from Tunisia, suggest that in his culture, one would analyze Sajid's tale as a quest for identity, and that people's related concerns with the transmission of family history or of local mores is likely to be underlying Sajid's self-questioning. The last co-therapist, of French ethnicity, offers no parallel but rather readily suggests that Sajid goes through an identity crisis in which he tries to define himself in relation to or in opposition to his father. Sajid and his mother complacently nod after each set of comments. While Sajid's mother's relatively neutral facial expression prevents me from detecting signs of either agreement or misunderstanding, Sajid's enthusiasm (he keeps smiling and nodding throughout comments) makes me suggest he genuinely appreciate the attention focused on him. Moro skillfully summarizes her co-therapists' comments to Sajid and his mother, and noting Sajid's active and enthusiastic involvement in the therapy, concludes that the group consultation fosters the perfect therapeutic alliance in this case. She hastily suggests Sajid and his mother to make another appointment.

After the family leaves the room, Moro engages in a very rapid synthesis of the consultation. She reiterates her dissatisfaction with the Mauritanian therapist's comments, and urges him to be more careful about making assertions that might trigger negative interrogations on behalf of the patient and his family members. There is no need to open new sources of anxiety. Sajid's referring psychologist from CASITA ends the first half of this group consultation by suggesting that Sajid's mention of a young lady in his dream is reflective of his concerns with his own sexuality which, she suspects, he has great difficulty expressing directly. She adds that Sajid's psychoactive treatment might increase his libido.

This clinical scene illustrates how strongly rooted in the psychoanalytic framework the transcultural consultation is. It also problematizes transcultural's psychiatry's interest with what Moro refers to as "Alterity in itself," making a parallel with Devereux's "Culture in itself" (Moro, 2006:168). Moro defines alterity as the characteristic of what is

being perceived as “other,” which nearly all immigrants or their children may experience “to the extent that there may not feel like there is any immediate, tangible, or logical coherence to reality, no systematic parallel between what was learned and what is experienced, between the inside and the outside” (Moro, 2006:168). Through the elicitation of his dream, Sajid’s reflection on his identity surfaces. While this reflection may be rooted in a culturally specific context linked to the family’s experience with immigration, the work of co-therapists is not to reconstitute the cultural envelope which, as Nathan’s theory of ethnopsychiatry framed it, is ineluctably ruptured by the experience of migration, and triggers psychological trauma (Nathan, 1986).

Moro’s transcultural psychiatry model, instead, further elaborates on the experience of alterity by attempting to harmonize the opposition between the inside and the outside. The physical presence of a culturally diverse group of co-therapist provides a protective envelope in which the patient may express his/her alterity-related anxieties. The elicitation of various cultural etiologies paralleling the patient’s experience is intended to reduce this anxiety, to celebrate hybridity, and reconstruct cultural difference as non-threatening, both existentially and socially. Eventually, the diagnosis is expressed in psychiatric terms, and treatment may involve the prescription of psychoactive drugs. The patient also pursues treatment in “mainstream” care.

- **The clinical medical anthropology model and “explanatory models”**

The Minkowska Center was founded in 1951 by a Polish psychiatrist, Eugene Minkowski. Minkowski, who, after fleeing to Paris during WWII, encountered a strong demand for psychological support, notably from Eastern European immigrants. He

launched a consultation which offered patients the possibility of receiving mental healthcare by taking into account their particular life histories and by offering services in their mother-tongue. Clinical expertise thus did not focus specifically on culture, but rather on life experience (such as exile and the violence it often entails). This approach to mental illness was based on universalistic models, rather than culturalist ones. The use of language responded specifically to facilitating the clinical encounter, especially since patients were referred to psychiatrists of the same geographic and linguistic origin, instead of using translators. Until very recently, then, “geographic and linguistic” affiliations officially defined the organization of the clinique at Minkowska. Cultural affiliation thus remained a primary frame of reference in therapy.

The orientation began to change in 1985, when the Centre received funding from the National Health Insurance Fund, and officially became part of the public hospital system (PSPH). Entering the national public health system meant that the institution had to reframe its clinical framework. Minkowska’s objective was to move beyond the use of culture as the only possible reference in therapy with migrants (Bennegadi, personal communication, 6/11/07). As a response, Rachid Bennegadi, psychiatrist and president of Minkowska’s medical commission, suggested the use of a clinical medical anthropology framework in therapy. This approach is intended to take into account the role of cultural representations in mental health disorders, and use the concepts of illness, disease, and sickness as adapted from Kleinman (1980). This clinic does not use the co-therapist/ethno-clinician approach of the Centre Georges Devereux or its adaptation as practiced by Marie-Rose Moro’s clinicians. The adoption of a clinical medical anthropology model was meant to avoid using an all-encompassing cultural framework in

mental healthcare, and to underline the relevance of cultural aspects “as one element of care, not as the main analytical grid” (Bennegadi, 1996). It does not expect from therapists to master anthropological knowledge on culture, but rather to be reflexive about their explanatory model of biomedical classification, which may overlook the cultural aspects of patients’ representations. Moreover, the clinical medical anthropology framework allows both general practitioners and therapists—regardless of their theoretical orientation (psychoanalysis, psychotherapy, etc.)—to focus on providing the most appropriate diagnosis or referral. As in Moro’s transcultural psychiatry framework and its concept of hybridity, the focus is no longer on being from the same origin as the patient, and to highlight “the issue of the universality of psychopathology” (Bennegadi, 1996). Finally, the fact that such perspective “respects the French public health system’s philosophy of healthcare access as a common/universal right (*droit commun*)” (Bennegadi, 2006), is articulated as a core value. This is not to say that the other approaches do not, but rather than clinical medical anthropology was specifically construed around that value.

Although it may not immediately be apparent why this approach is an example of a clinical medical anthropology, its practitioners have formalized their model and apply it in teaching at the university level as well as in clinical discourse among staff. In this model, the medical anthropological components of significance are the concepts of illness, disease and sickness, the recourse to the concept of culture (where relevant), and the reference to “universality” as encompassing peoples of all ethnic/national/religious origins. Following this model, therapists ideally engage in “intellectual gymnastics between anthropology and psychiatry” (Bennegadi, personal communication, 6/11/07).

The remaining problem lies in health professionals' willingness to broaden their theoretical and clinical framework, "not through a magical process, but through professional training" (Bennegadi, 1996).

In order to be consistent with this new model of mental healthcare provision, but also in order to obtain the accreditation of the Health Authority Administration (Haute Autorité de Santé) the organization of consultations at Minkowska had to be transformed. The accreditation started in 2005 and was obtained in 2007. Whereas, following the association's original model, patients were dispatched to therapists according to their spoken language and culture of origin, administrative secretaries can no longer elicit such information as a basis for therapy referral, and the division of consultations into "geographic zones" was removed from the Patient Information Form. First and foremost for pragmatic linguistic reasons, as well as out of concerns for close understanding of the patient's cultural representations (when possible), the internal organization of the Center has remained the same (a North African patient typically consults with the Center's therapist from North Africa, a sub-Saharan African patient consults with a psychiatrist from Senegal—first and foremost for pragmatic linguistic reasons), even if it has triggered tension among staff.⁴⁶

Clinical vignette: Performing Clinical Medical Anthropology

Mrs. Sangare comes to meet with psychiatrist Dr.X for the first time. She has met with a social worker at the center once before, who assessed her case for therapy. Before she comes into the room, Dr. X looks over the patient's file and becomes acquainted with the reasons that brought her in. The social worker, who had first received the patient, and myself attend the consultation.

⁴⁶ Although this cannot be detailed here, the modification of the Patient Information Form has indeed triggered numerous conflicts between Minkowska' administration and the "old" secretary staff – notably in terms of handling phone referrals and in organizing the "filing" of patients. This will be detailed in a later chapter.

When the patient comes in, Dr. X welcomes her and prompts her to tell her story, and the reasons why she needs help. Mrs. Sangare starts talking about her mother, whom she doesn't know. She was brought up by her father. Her mother was Congolese, and Mrs. Sangare herself was brought up in Congo until she was ten or eleven years-old. She was also told that in Congo, a mother easily abandons her daughter if she feels that she doesn't need her.

At that point, Dr. X interrupts her to ask her if she has any information on her mother. Mrs. Sangare replies that her birth is recorded on the Civil Registry, but that her mother's last name does not appear. Only her first name does. She says she has questioned her father about her mother's identity, but each time he gets upset and threatens her.

Dr. X asks her where her father is now. Mrs. Sangare tells us he has remarried in Bamako, Mali, which is where she went to live. She now has half-brothers and sisters with whom she isn't particularly close. She doesn't get along at all with her stepmother, who doesn't care about her either. She has studied marketing. She's been supported by her aunt, but the latter lives in a village further away (*au bled*) from Bamako. As a result, Mrs. Sangare says she has always felt alone, even when surrounded by company.

As Mrs. Sangare pauses, the social worker addresses Dr. X to let him know that Mrs. Sangare feels threatened and is scared. Turning to Mrs. Sangare, Dr. X asks her what it is that scares her. Mrs. Sangare replies that she's especially scared of *la sorcellerie* (generic term for "witchcraft" as coined in Catholic Europe) which her husband can resort to, to try and destroy her life. As if concerned that we would doubt her, she asserts that she believes in those things, that she has seen with her own eyes what could happen to people who are victims of witchcraft at home.

Dr. X asks the patient what she means by witchcraft. She replies: "Well, like when someone casts a spell on you (*jeter un sort*)!" Dr. X responds that in Senegal, people call that *maraboutage* (term of reference for "witchcraft" in Muslim, West Africa). Mrs. Sangare says that this is precisely what she means. Dr. X then asks her: "Well, would it work, even though you are in France?" Mrs. Sangare replies that wherever she may be in the world, it could reach her. She then proceeds to tell us that in fact, she did consult a *marabout* (ritual specialist) "at home" (*au pays*, meaning in Mali) before, but she has never done so in France, to ask about her husband. She hasn't sought protection yet, she tells us. She adds that she also goes to church, and that she believes in God, but that it doesn't prevent her from believing in witchcraft as well.

"What about your husband?" Dr. X asks. Mrs. Sangare responds that she attempted to commit suicide twice. The first time, her husband provoked her with a box of medication. She says he gave her the pills thinking she wouldn't dare swallow them all, but she did. She was sick all night long, and the following day, her husband took her to the hospital. The second time, she tried it on her own.

“Why do you try to hurt yourself?” Dr. X asks. Mrs. Sangare replies that she is tired, that she wants to die. She’s even ready to return to Mali, so that they stop tormenting her. The problem, she adds, is that she brings shame to her family. At that point, the social worker asks her whether she would be willing for her husband to participate in therapy. Mrs. Sangare says she could. They are separated now, because she is hiding from him, but she could ask his cousin, with whom she is in contact. That way, her husband may let her leave him and be at peace. Dr. X seizes this transition to end the consultation. Mrs. Sangare is prescribed an anti-depressant and an anti-anxiety medication to help her sleep at night.

Both the social worker and Mrs. Sangare exit the room to go to the general office and schedule Mrs. Sangare’s next appointment. It appears that Dr.X, who only practices at the center once a week, doesn’t have anything available within two months. Feeling this would be too long for a first follow-up appointment, the social worker decides to schedule something in a time slot usually blocked for non-clinical activities. Mrs. Sangare still has to wait a month for her next appointment. After accompanying Mrs. Sangare to the exit, the social worker and I walk back to Dr. X’s consultation room to debrief. There, Dr.X concludes that Mrs. Sangare’s depression results from her deep sense of abandonment, which seems to repeat itself at different stages: she doesn’t know her mother, her father doesn’t take care of her or harasses her, her paternal aunt cannot help her and makes things complicated for her, no one came to take her back when she fled one day while she was in Mali, no one comes to save her from the hostel where she has now sought refuge...I ask Dr.X whether he doesn’t think that one month is still not too long for Mrs. Sangare to have her next appointment. He agrees that it’s not ideal, especially with respect to the medication regimen. Whenever he can, he adds, he calls patients to check on them, but it is not ideal either.

In a sense, it is challenging to identify the clinical medical anthropology framework in terms of specific clinical processes. The framework offers a general approach rather than a defined methodology with identified clinical tools. The onus is on the disposition of the therapist, and his/her ability to be cognizant of differing explanatory models in the therapeutic context. There has to be a negotiation between the patient’s cultural representations (*illness*) and the therapist’s (*disease*). In this vignette, Dr. X takes into account Mrs. Sangare’s cultural representations when she shares her sense of her life being threatened by witchcraft, as well as sense of shame to her family as the abandoned

child. When Dr. X questions Mrs. Sangare on these issues, it is not to impose an alternative reading to her interpretation of such misfortune, but rather to validate her explanatory model and elicit more information from it. For example, Dr. X's remarks on the different wording for witchcraft (*sorcellerie* vs. *maraboutage*) readily indicates to the patient that the cultural elements in her story are relevant to the therapist, and are therefore taken into account in therapy. In turn, this improves the therapeutic alliance.

One may also suggest that, being referred to a psychiatrist from sub-Saharan Africa, the patient readily feels comfortable sharing such details of her story. In reverse, the therapist himself may be more finely attuned to the nuances in his patient's narrative—such as the discussion on witchcraft in this case—and which may have their importance in the unraveling of therapy and its outcome. Ultimately the psychiatrist's diagnosis relies on psychopathology theory, and a psychoactive drug treatment is prescribed.

- **The ethnoclinical model and “bridging intentionalities”**

Like Minkowska, the Gepela center (Study Center for Research and Teaching on African Languages and Civilizations) is an association. However, it is unique in comparison to the previously described institutions, as it does not directly qualify as a mental healthcare structure. It is a university-based research, training, and consulting structure which regularly organizes mediation sessions with local school officials and immigrant families as problems referred by participating school psychologists arise.

The Gepela's goals are: 1) to research immigrant families' cultures and 2) to inform and train professionals working with immigrants families (specifically psychologists,

psychiatrists, doctors, social workers, and students) (Gepela brochure, n.d.). Although the center mainly intervenes in schools, it also caters to social services, as well as to judicial and health institutions. Once a month, it organizes a seminar open to all professionals encountering difficulties with immigrant families. The goal of those seminars is to analyze the cases presented and elicit the various possible causes of institutional disfunctioning. The center also sponsors “speech groups” (*groupes de parole*) for immigrant parents, in order to tackle difficult situations linked to such issues as migration trauma, the encounter with the host country’s culture, and parenting. Alternatively, or as a sequence, the center sets up ethnoclinical/intercultural mediations, so that comprehension is shared by both immigrant families and institutional actors. The Gepela thus mediates between immigrant families and institutional actors. Finally, it organizes training sessions surrounding the themes of the encounter between cultures, and the management of conflicts in intercultural situations.

The center is directed by Pf. Maiga, an ethnolinguist. Pf. Maiga, who is originally from Mali, was recruited by Tobie Nathan at the George Devereux center as a mediator. Pf. Maiga’s ethnoclinical model is inspired by this notion of mediation. He contends that the Gepela center’s “intentionality” is not to provide mental healthcare per se, but rather to analyze discourse itself. The objective is not to assess the veracity of such discourse, but rather to define its frame of reference. In other words, the purpose is to analyze how meaning is produced. Consequently, the mediator has no “intentionality” either: he is “between” discourses. “He confronts the information he receives to the world it belongs to. He builds bridges between the world of professionals (social workers or psychologists) and the world of patients. The ethnoclinic thus creates a space for

listening, without the purpose of intervening, unlike ethnopsychiatry” (Pf. Maiga, Research Seminar, 3/21/07). The use of the group in mediation sessions, as in ethnopsychiatry, acts as a safeguard: it prevents at once one from imposing a frame of reference, and helps in eliciting different etiologies for a given problem.

Ethnoclinical mediation thus distinguishes between worlds, and one’s presence is as productive as one’s discourse. Towards the end of the mediation, the leading mediator selects one etiology. He then elaborates on the situation at stake using syllogisms (if...and...then...), in order to underline the fact that he does not articulate a truth/solution, but an “intentionality” (Pf. Maiga, Research Seminar, 3/21/07). The latter is then tested with the family in a separate mediation (process of auto-identification). The purpose is to free the family from the school structure and from the actions/discourses of various school actors. It is also to offer alternative references to school actors facing a complicated situation. While there is not a direct medical component to the Gepela framework, the use of the *ethnoclinique* label raises the issue of scientific authority it confers to the group.

Clinical vignette: Performing the ethnoclinique

Sandra, one of Gepela’s affiliated school psychologists, asked me to meet her directly at the school in Cergy. Pf. Maiga and two other school psychologists (one retired) from the Gepela are already waiting for us in the classroom with the school director, the school’s educator, Brandon and his mother. Two psychology students interning at Gepela are also present. Just as during consultations at the Gepela, we all sit in a circle, Pf. Maiga sitting directly next to Brandon. Following the ethnoclinical tradition, he starts by introducing everyone present in the room to Brandon and his mother, except for the school director, the educator, and Sandra, whom they already know. Brandon’s teacher is not present as she has to teach class. Following this quick presentation, Sandra, the school director and the educator take turns describing what has been problematic in Brandon’s behavior. Sandra starts by explaining to us that Brandon is generally “inattentive” and that his mind often seems to be “somewhere else.”

Sandra (S): “Brandon’s school teacher told me that she found his behavior ‘arrogant’ and ‘distrustful.’

School Director (SD): - It seems like Brandon is living in his own world. He feels entitled to do whatever he wishes, which causes conflicts and disrupts the classroom.

School Educator (SE): - Brandon is a very intelligent child. He simply needs to learn how to behave appropriately. He is a child who seeks acknowledgement from others, and who has a hard time being looked at as being just one of the other kids in class.

SD: - His problem is that he does not participate in class. He simply refuses to. Other than that, there is no negative discourse from his teacher concerning his abilities.

SE to Brandon (B): - Your teacher gives rules that apply to everyone in class, and she does not understand why you won’t follow them.”

Pf. Maiga summarizes what has been enunciated concerning Brandon’s behavior. He then tries to initiate contact with Kevin. He teases him about how important he must feel with all the attention turned to him today, how he probably wonders what we all want from him...Brandon remains quiet, imperturbable. He looks around him. His stare does not appear either defiant or unmoved to me, but rather questioning.

Pf. Maiga (M) to Brandon’s mother (BM): “How is he at home?

BM: Pretty much the same. I don’t think he does it on purpose. He’s very forgetful. He’ll do one thing and then forget it right away, as if his mind was ‘taken’ all the time. You have to repeat everything to him, and congratulate him for each of his actions. Sometimes, I feel like he’s testing me as well. He can be very cheerful, you know. Sometimes just hops around. But he has a hard time growing older. His head is taken by many things which I cannot understand.

M to B: What do you think about when your mind wanders?

B: ...

M: For example, now, what are you thinking about?

B: ...

S: That’s exactly what happens in class.

M: And that’s what the teacher interprets as insubordination.

BM: Yes, but he doesn’t do it on purpose. It’s like he freezes. He interprets it as an attack against him.

SE: It’s funny, I haven’t seen this side of Brandon in my interactions with him.

M to Rachelle (another school psychologist): What do you think Kevin thinks?

R: I think we don’t ask the right questions.

M: Why doesn’t he understand that he needs to give us clues so that we can ask the right questions.

S: Perhaps he wonders why we even ask ourselves all these questions.
BM: Ever since he was a little boy, I've been convoked by the school all the time.
R: That's a sign that the school is interested in him and wants to help him.
BM: Yes, that's how I interpret it.
M: Where I live, there is a saying concerning people who don't feel the need to explain things.
Laetitia (the third attending school psychologist): Where I'm from it's 'just do things well and let the others complain'
M: Yes, except you may end up losing your own faculty to speak.
L: I think it is because it is too complicated to explain, so he gives up.
M: So there IS something wrong going on, but what is it?
Intern 1: Perhaps there is something lacking.
M: There are many things we would like to have but we don't have. When I go to bed at night, I think of my children. What about you Brandon?
B: (...)
M: He won't answer any personal question. He tells us he doesn't know who he is.
BM: I was a little bit like him when I was young. I did not answer when asked questions. I would think about strange things. I was afraid to be judged by adults. And I was scared to be 'unveiled.'
M: How does he behave with his father?
BM: You have to ask him the question. I rarely see him.
B: (...)

Pf. Maiga now inquires about the mother's past. She explains that her father took her from Congo- Brazzaville to Marseille when she was eight years old. She did not know she was not going to return home.

M to BM: You don't have an accent. Do you speak Lingala?
BM: I speak French, that's enough.
M: What's your ethnic group?
BM: My father is Congolese. I don't know anything about ethnic groups. Culture, you know, that doesn't speak to me much any more... Anyways, please let's not talk about me, it makes me cry.
M: Well, we have to speak a little about you, so that we can help him (turning his eyes to Brandon). He needs words to express himself. Everything he lives revolves around you. We need to enter your story for his sake.
M to B: Have you often seen you mother crying?
B: (slight nod)
M: Do you understand why?
B: (softly shakes his head)
M: Did you know that your mom came here when she was only eight years old?
B: ...

M: That she came from Congo?

B: ...

M to BM: Where is his father from?

BM: From the Ivory Coast. But his last name is Johnson.

M: There has been a lot of Afro-Caribbean intermixing. Where does his name come from?

BM: (shrugs). You know, even before Brandon was born, a friend of mine told me that he would resemble me in character, even though he would physically look like his father, which he does.

M: When we bring our children to France, we tell them lots of stories. Departures often seem extraordinary, but arrivals are a bit difficult. I wanted to turn around and go back home, but I was afraid to be considered a coward.

BM: For me, things were not so bad, because I thought I would go back.

M: The deal was not respected. (To the rest of us) Madame was betrayed.

BM: (she cries)

M: When we fill our children's suitcases to come here, we don't fill them with clothes for them. We fill them with things to bring people over there.

BM: When we arrived I started realizing my father had married a French woman.

M: Silence was built around the problem: 'I no longer have resources.' The tie was broken. Brandon's mom was uprooted from her tie with her biological mother. She was raised as if she had no one in the world.

BM: My father never took care of me. He would always tell me that the only thing that matters is that I am there with him.

M: Why? What was his representation of you as a child? You know, where I'm from, people say things about this. Were you told things?

BM: I was never told anything. I learned things little by little. I was told I had a lucky star, which is paradoxical considering what I went through.

M: Well, the story may have been modified, either out of spite, in which case it's sorcery, or because the truth was stolen from you. Some fathers say they need their child's good nature. Where I'm from, to have a 'lucky star,' is to have an exceptionally good nature. If the story was stolen, one could think that on the one hand it would serve the child right, or that, because of some constraints, there was no other alternative.

BM: I want to cut ties. I don't want to be 'inside' all of this.

M: Brandon is caught in the same silence his mother is. He's someone who's alone, who builds himself by himself, but under constraints.

Brandon comes from a story in which there is an object being used.

(Looking at the Gepela psychologists) How could we explain this to *Madame*? How could I translate this into your language? I would say

(turning to BM) that you are like a sponge. Brandon comes from the sponge, so he has a lot to build. Madame, your story does not belong to you. Brandon finds himself in a situation in which he is alone. Solitude has made him strong, to the point that he no longer feels the need to answer questions. (Turning to the rest of us) It really is too bad that the

teacher is not here to listen and to realize how lonely Brandon often feels, and that he doesn't want to bother anyone. (Turning to the SD) Do you understand Mr. Director?

SD: (nods)

M: Brandon does not feel alone in dual relations. But once he's surrounded by others, everything becomes dangerous to him.

The mediation ends, and Brandon and this mother exit the room. Pf. Maiga readily suggests to his colleagues that a meeting should be organized at the Gepela center with Brandon's mother. He cautions the school director that the school may require too much of her attention and time. He asks him to work with them in alleviating school demands on her part for a while.

After the school director and educator leave the room, he addresses the school psychologists, asking them to work on helping the mother elaborating a coherent discourse. "It must be a group elaboration, so she no longer feels alone. We can't let her fall back into 'anomie.' And yet, it's just the classical schema in which immigrants fall. When that happens, the most unlikely scenarios are thinkable. Anything can be accepted and interpreted as a danger. Brandon is like the grip of a knife for a grinding stone: he himself becomes an instrument in the story."

Through this vignette, one can observe the ethnoclinical process of identifying "intentionalities," first, the school's, then the family's. The school's "intentionality" relates to Brandon's inattentive behavior, and it being disruptive of class activities. Outside of the school educator, who seems to have been able to build a privileged, one-on-one relationship with Brandon, no one else is able to have access to the child's impressions. In that way, both Brandon and his mother are able to listen to the school's interpretation, without any sanctions or conflicts being raised.

Then, both Brandon's and his mother's "intentionalities" are elicited. Facing the child's silence, Ismael Maiga resorts to a technique of eliciting various etiologies of the situation, in a manner which is reminiscent of the role of co-therapists in the transcultural psychiatry setting. That is, propositions are put forth as to what explains Brandon's behavior (Pf. Maiga: "Where I live, there is a saying concerning people who don't feel

the need to explain things,” followed by Laetitia: “Where I’m from it’s just ‘do things well and let the others complain’”), without firmly determining it. A proposition is nonetheless elaborated by Ismael when he says that “He won’t answer any personal question. He tells us he doesn’t know who he is.”

The focus then shifts to Brandon’s mother, whose family story and immigration experience seem to inform the team about a problematic process of identification between the mother and her child. The elicitation of the mother’s story brings an understanding that her “intentionality” is to protect her child from seeing her pain by hiding her life story to him. As a result, Brandon is unable to build his own story, and becomes introverted, which may partly explain his behavior in class.

Pf. Maiga thus successfully elicited each party’s “intentionality.” The school director is cognizant of the pain Brandon’s mother experiences, and how it affects her child. The mother may also understand how her behavior impacts her son’s behavior at school, and in general. Brandon has had access to his mother’s story. Ismael’s diagnostic conclusion is that Brandon’s mother needs support first to be able to help her son. Culture is only referred to when the technique of etiology elicitation is resorted to. However, it is not used to essentialize the situation as a product of cultural misadaptation or identity conflict.

- **Synthesizing the three new approaches**

I argue that the three “specialized” mental healthcare centers have successfully established a new genre in articulating definitions of “specialized” mental healthcare provision that simultaneously reiterates the relevance of immigrants’ cultural

representations in the clinical encounter, without characterizing it as all-encompassing—as Nathan did. The concept of cultural affiliation is somewhat “neutralized.” Instead, one speaks of “hybridity,” “explanatory model,” and “intentionality.” Such choice of a lexicon leaves place for a language of symmetry and of exchange (the trans- of transcultural, the bridging of intentionalities and “between-ness of the ethnoclinician, the alchemy between the “disease” explanatory model of the biomedical practitioner and the “illness” representation of the patient).

Bourdieu argued that the counter-effects of authoritative and legitimate language were censorship and euphemism:

The specialized languages that schools of specialists produce and reproduce through the systematic alteration of the common language are, as will all discourses, the product of a *compromise* between an *expressive interest* and a *censorship* constituted by the very structure of the field in which the discourse is produced and circulates. This ‘compromise formation,’ in the Freudian sense, is more or less ‘successful’ depending on the *specific competence* of the producer, and is the product of strategies of *euphemization* that consist in imposing forms as well as observing formalities. (1991:137, emphasis in text).

In the discursive transformations of “specialized” mental healthcare centers, one witnesses such self-regulation in action. But, perhaps more importantly, as Bourdieu also pointed out, these forms of euphemization carry an effect of concealment through which a form might be changed, but not its substance (1991:142). In other words, it may be argued here—as was most notably transparent in Moro’s comment that she preferred the transcultural psychiatry label over ethnopsychiatry because it discursively dissociated her from Nathan and because it was internationally marketable—the clinical practice of the “specialized” mental healthcare centers did not necessarily change *in substance* following Nathan’s demise. Based on the clinical illustrations of each clinical orientation, however,

I argue to the contrary. Indeed, if, as I have shown, specialized institutions' choice of novel discursive forms responded to the political pressure that resulted from the debate around ethnopsychiatry, as well as from the necessity for each one of them to respectively secure a monopoly of knowledge within their field of expertise, these newly created theoretical framework actually found their articulation in clinical practice.

III. Networking Expertise

The shape and very existence of a domain of expertise, such as the one of “specialized” mental healthcare, results from the “assemblage” (Latour 2005) of persons, texts, buildings and technologies which make up for a seemingly coherent homogenous social product. In this last section, I attempt to disassemble this whole, so as to trace the associations (“connecting sites,” Latour 2005:119) of these heterogenous elements which together perform “specialized” mental healthcare expertise. I argue that doing so is important in order to understand what is at stake, beyond improving the quality of clinical care to immigrants: namely, the acquisition of institutional capital and the consolidation of scientific legitimacy.

University diplomas and on-site/off-site professional training

Beyond being sites for consultation, the three specialized mental healthcare institutions I describe have extended and formalized their expertise in university programs, as well as by providing professional training not only to medical/psychiatry or psychology students, but also to a wide array of other institutional actors interested in/confronted to cultural difference in the context of their professional activities. Being at

once sites for therapy, research, and teaching provides these specialized mental healthcare institutions with institutional weight, by also enabling them to control the entire web of communicative circuits as it pertains and links up to the public health realm.

Designing university curricula both serves as scientifically legitimizing the centers' practices, as well as it opens up networking opportunities through institutional actors attending classes. University-based programs are the following:

- University Certificate in Transcultural Psychiatry (Université Paris 13, Hôpital Avicenne : Pf. Marie-Rose Moro) – since October 1998.
- University Certificate, “Health, Illness, Healthcare and Cultures” (Faculté de médecine Paris Descartes & Hôpital européen Georges Pompidou - Service de psychologie clinique et psychiatrie de liaison: Pf. Silla Consoli, Dr. Rachid Bennegadi).
- Master in Psychology. Internship in Ethnoclinical Care (Université Paris 8 – Centre Gepela: Pf. Ismael Maiga).

The university certificate in Transcultural Psychiatry has a heavy institutional weight, as its scientific community cross-cuts university affiliations and non-academic health-related organizations. The members of this Transcultural Psychiatry scientific community respectively represent Doctors without Borders, the universities of Paris 13 (where the diploma is actually offered), Paris 5 (pluridisciplinary but famous for its school of medicine), Paris 7 (pluridisciplinary), EHESS (School for Advanced Studies in the Social Sciences), and the International Association of Ethnopschoanalysis. It presents itself as “analyzing the links between psychopathology, cultures and migrations with the help of

anthropologists, linguists, clinicians, public health practitioners, specialists in education sciences, philosophers, and researchers in psychiatry and the social sciences.”⁴⁷ It offers clinical practice through a short-term, supervised internship at various affiliated transcultural psychiatry clinics working with migrant families and their children. It also introduces transcultural clinical work in alternative contexts such as trauma, disaster, and war situations where humanitarian workers and emergency healthcare practitioners intervene.

The graduate diploma in “Health, Illness, Healthcare and Cultures” links the Minkowska Center –a public health structure, with the George Pompidou European Hospital (Department of Clinical Psychology and Liaison Psychiatry), and the School of Medicine at the university of Paris 5. It lists as its objectives “the analysis of cultural representations of health and disease on health behaviors, patients’ demands and patients’ compliance. It uses a clinical medical anthropology perspective to provide strategies for intervention in public health. With the help of anthropologists, sociologists, public health practitioners, psychoanalysts, social workers, specialists in educational sciences and philosophers, it contributes to improving healthcare offer, support and delivery to refugees in France and Europe.”⁴⁸

Finally, the Gepela Center participates in the Master in Psychology of University Paris 8 as a location for internship in ethnoclinical care. Although it functions separately as an association, its director teaches at Paris 8. The University of Paris 8 also offers a University Diploma entitled “Clinical Practices with Migrant Families: Prevention and Intervention.” The latter is offered to all Master level professionals and “delivers higher-

⁴⁷ Source : http://www-smbh.univ-paris13.fr/smbh/enseig/enseig_diu_du/dupsytranscult_html

⁴⁸ Source : <http://www.univ-paris5.fr/spip.php?article1670>

level knowledge in psychology, psychopathology, anthropology, linguistics, pedagogy—all necessary tools for clinical work with migrant families.”⁴⁹ As a diploma in ethnopsychiatry, it does not link up with Gepela.⁵⁰

Outside of the university setting, specialized mental healthcare institutions extend training offers to individual institutional structures. In the course of my fieldwork, I have found the Minkowska Center to be most aggressive at this type of activity, with the publication of an extensive “training catalog” organized around four thematic sections: physical health, mental health, social health, and ethical issues. It advertises itself as an enterprise in “transferring competences, (...) also part of our institutional project on building coherence and articulating with clinical activities and research, as well as communicating with professionals seeking our assistance.”⁵¹ The catalog underlines the 45 year-long clinical experience accumulated at the Center, the ultimate interactive pedagogy skills of the Center’s training team, and the convivial atmosphere of training internship. While I spent time at the Center, I often found the training coordinator negotiating training partnership with major hospitals in Bordeaux and Toulouse. She would take trips to meet medical teams on site and advertise Minkowska’s training programs. She would often frame this aspect of her job as participating in Minkowska’s growing national influence in terms of imposing its theoretical approach to healthcare. Several times, she mentioned competing with Avicenne on the ground, transcultural psychiatry having a larger international resonance, and therefore broader marketing

⁴⁹ Source: <http://www.ethnopsychiatrie.net/activit/desu2004.html>

⁵⁰ In my dissertation, I plan on analyzing the curricula’s contents in detail, especially with respect to their use of and references to anthropological material

⁵¹ Centre Française Minkowska. Formations 2008 et 2009. Santé, Maladie, Soins, Cultures.

appeal, than the clinical medical anthropology approach, still in the early stage of its development.⁵²

Competing in a field: scientific texts, multimedia, and international networks

In his definition of the expert, Cicourel notes that “Expertise can be described by reference to the differential way sources of potential information are perceived and understood by novices and experts, particularly in the way they use language to authenticate their status vis-à-vis one another.” Language, therefore, is central to assessing the authority of the expert. Of course, “attributing (...) expertise to someone [also] assumes training and experience associated with a title and a prior credentialing process (...) [along with] Identifying symbols or outward appearances [that] can allow or restrict access to particular spaces and equipment or artifacts” (2000:72).

One of Minkowska’s competing strategies is to invent expertise and training tools. The Center is most proud of its interactive multimedia training tool, named “Ameclin.”⁵³ I was present the day the direction team met to discuss the naming of the “interface.” The name had to sound catchy to be sold and eventually patented. The use of Ameclin is taught to the training staff at the center, and used in any introductory training session, or at any event where Minkowska is introduced as an institution. It introduces, using basic terminology, the clinical medical anthropology approach as facilitating the clinical encounter and, more specifically, the exchange of “explanatory models” between biomedical clinical practitioner and patient. Recently, the Center put together a

⁵² I will also analyze the content of training materials/catalogs in detail.

⁵³ I have an electronic copy of this interactive tool, which I was given permission to use in my dissertation work.

pluridisciplinary mediation structure with culture brokers, named “Mediacor” (February 2009), designed to assess healthcare access and treatment outcomes for immigrant patients.⁵⁴ Minkowska has also become part of McGill University’s International Consortium for Cultural Consultation, a network of centers engaged in research on cultural consultation and the cultural formulation in psychiatry and mental health care. The network is organized through the Cultural Consultation Service of the McGill Division of Social and Transcultural Psychiatry.

In many ways, in the clinical context notably, frontiers between the centers, especially between Minkowska and Avicenne, are very porous. For example, the head of JB Carpeaux’ consultation offers consultations one day per week at Minkowska, one day a week at Avicenne, and offers one lecture in the Transcultural Psychiatry university program. Scholars and practitioners participating in the certification program with Minkowska also contribute to Avicenne’s. References to transcultural psychiatry and ethopsychiatry are used alternatively at Avicenne, while training sessions in transcultural mediations are offered at Minkowska. Therefore, the need to distinguish one from one another results from a battle in institutional magnitude, which obviously goes along with accreditation and increased funding, not to mention professional legitimacy and respect for professional working at these various institutions.⁵⁵

Like Minkowska, Avicenne provides professional training to various institutions through its affiliated International Ethnopschoanalysis Association, not through the hospital directly. Additionally, it offers to train “cultural mediators” and “specialized

⁵⁴ Source: http://www.minkowska.com/article.php3?id_article=2541&var_recherche=mediacor

⁵⁵ I found the same alternative use of the labels in the clinical context, notably in patients’ files, which I had access to at Minkowska.

interpreters” who will be able to work in outside health structures and apply transcultural psychiatry skills. Finally, they offer their “expertise” for institutions needing the help of “transcultural specialists” (namely “Hospitals, especially from the Public Assistance System, Justice, National Education, etc.”).

In 2000, Avicenne launched a scientific journal named *L’Autre: Cliniques, Cultures, Sociétés* (The Other: Clinics, Cultures, and Societies). While I was conducting fieldwork, Minkowska was actively working at launching its own scientific journal, and had just received funding for a pilot issue. The first issue of this journal, named *Transfaires et Cultures* (a pun on the word Transfer—but here in the sense of transmission of knowledge—and Cultures) was published in December 2009.

All lead therapists are very active on an international scale. Pf. Maiga has served as a consultant to the United Nations. He has established scientific research collaboration with the University of Bologna, in Italy, on ethnoclinical mediation. He has also carried out teaching initiatives in Mali, at the University of Arts, Languages, and Social Sciences (FLASH) and at the New Conservatory of Arts and Multimedia in Bamako. Marie Rose Moro has presented her work around the world as the President and Founder of the Association for Etnopsyoanalysis (AIEP). Moreover, she regularly participates in humanitarian missions with Doctors Without Borders. Finally, Dr. Bennegadi was recently appointed secretary general to the Transcultural Psychiatry section of the World Psychiatry Association, as well as head of scientific research of the newly formed EuroMed’s research committee, in which Marie Rose Moro also participates, and which was created in Lyon in March 2007, with the goal of constituting a network of experts

from Europe and the Mediterranean region (hence its name) on migration and mental health.⁵⁶

My goal in enumerating these various professional titles and activities is to give a measure of what is at stake in the field of specialized mental healthcare. I argue that the reason why there does not exist a single paradigm for culturally-sensitive mental healthcare in France partly stems from the competitive nature of the field, and the related dynamics of acquiring scientific capital, as I have illustrated in this chapter.

Conclusion

Reading this chapter may give one the impression that specialized mental healthcare institutions in France actively participate in the political ideology in place, which misrecognizes the many social, economic, and cultural dilemmas facing immigrants in France today. Yet this dissertation research contradicts such conclusion. Although, as I hope to have shown here, specialized mental healthcare institutions have indeed discursively sanctioned France's political ideology by re-entextualizing their respective clinical frameworks within the boundaries of the communication sphere which this very ideology imposes, in practice, they genuinely strive to improve immigrants' not only health, but social conditions.

In some respects, as I will show in detail later, the clinic actually offers a space for contestation of French immigration politics, both on the part of specialized mental healthcare practitioners, but also for some immigrants who have learned to maneuver French institutions and their discourse. Nonetheless, contestations are often limited by the

⁵⁶ The first meeting, which I attended, took place on November 17, 2007. The group's first newsletter summarizing the event is available online at: <http://mighealth.net/eu/images/f/f1/News.pdf>

very limits of the structures they take place in, and I have often witnessed practitioners' frustrations with their own inability to effectively bring about change. In a sense, specialized mental healthcare institutions are caught in a paradox, wherein their possibility for their very existence and institutional weight, bound by "the regulative use of the republican idea" as Taguieff (2001) calls it, simultaneously constricts their practical margins of maneuver in supporting immigrants.

Synopsis of Chapter 4

This chapter analyses the elaboration of a field of “specialized” mental healthcare addressing immigrants in contemporary France, from psychologist Tobie Nathan’s first ethnopsychiatry consultation, to the three “specialized” mental healthcare approaches I selected as representing contemporary alternative paradigms. I drew from Bourdieu’s definition of the “scientific field,” that is, a competitive social space, determined by specific historical and social conditions that also shape its claims to legitimacy (Bourdieu, 1991).

First, I reiterated the specific sociopolitical conditions that together created a “universe of possibilities” (Bourdieu, 1991) for ethnopsychiatry to emerge in the early 1980s, namely: the increase of family immigration, the popularization of cultural mediation, and a political climate favoring “the right to difference.” In such context, Nathan’s theory of culture as a closed system, while controversial, sanctioned the political ideology in place at the time. I then showed how in 1993, when Nathan created the Devereux Center of ethnopsychiatry, the political climate was drastically less pro-immigrant: rather, ethnic difference was denigrated and criminalized (headscarf affair, excision trials, anti-polygamy laws). Shortly, Nathan found himself publicly delegitimized: on the one hand, the scientific critique bore on his extreme culturally-relativistic stance and on his rejection of psychoanalysis’s theory of psychic universality, while on the other, the media made moral judgments on his persona as neo-racist and anti-republican. I concluded that Nathan’s initiative failed because its discourse

trespassed authorized and legitimate representations of culture and its relevance in the French republican context.

In the second section of this chapter, I analyzed how, in the aftermath of Nathan's public debunking, "specialized" mental healthcare survived and continued to develop as an autonomous field. By introducing and identifying the three main paradigms which characterize the field today—namely, transcultural psychiatry, clinical medical anthropology, and ethnoclinical care—I described how institutional legitimacy was reclaimed through the creative appropriation of politically and scientifically "authorized" discourses and clinical labels. Through clinical vignettes, I illustrate these new approaches respectively. Also, while I contended that their respective institutional discourses necessarily euphemized references to culture as a counter-effect of institutional legitimacy in the ideological republican context, they simultaneously consolidated dynamic, complex understandings of the concept of culture and of its relation to psychopathology, which they successfully articulated in the clinical context.

Finally, I addressed the mechanisms by which these new "specialized" mental healthcare institutions competed and asserted their respective forms of expertise. I detailed the following components that altogether "assembled" and put in "network" with one another (Latour), determine the strength of scientific expertise: the creation of academic graduate programs, the institutions of on-site and off-site professional training, the marketing of scientific "tools," the publication of scientific journals, and the affiliation to international organizations working on the relation between culture and mental health.

I concluded by arguing that, in order to maintain institutional legitimacy in the republican context, specialized mental healthcare discursively sanctioned a system in which cultural stigmatization is misrecognized. By doing so, it may be argued at this point that specialized mental healthcare institutions limit their margin of margin of maneuver in contesting the depoliticization of “immigrant suffering.”

CHAPTER 5: Performing Expertise – A Reflexive Field

In this chapter, my goal is to introduce the internal complexities that characterize “specialized” mental health institutions. After establishing the structural features of the field they inscribe themselves into (the macro-context of my institutional analysis)—namely the close interaction between political conjunctures (immigration policies and racial discourses in particular) and the evolution of mental healthcare provision to foreign populations—I want to introduce the individual figures who “perform the field.” By doing so, I hope to provide “thickness” to the macro-analysis I just provided and describe how the constraints structural forces impose on social agents in an everyday setting are alternatively negotiated, contested, or sanctioned by the latter in complex, multi-layered ways. This leads me to introduce a broader reflection on the relationship between individuals and the system (Ortner, 1984).

If, as I have shown, the production of knowledge on specialized mental health is shaped by local political ideologies and evolves along changes in political conjunctures, it is also interdependent on the creative and multiple ways mental health experts—as well as their trainees or affiliated colleagues—practice (or appropriate) that knowledge (Giddens, 1984). In her analysis of practice in public psychiatry, Lorna Rhodes (1993), comparing the clinic to a pentimento—“a term used to describe those old paintings in which one image has been painted over another, but the overlying image is so thin that the one under still shows through” (1993:131)—illustrated how, on the one hand, a structural analysis shows the continuities and reproduction of a certain social order, while on the other, the analysis of practice reveals *both* continuities *and* disjunctions.

Here, before turning to the analysis of clinical interactions in the following chapters, I want to talk about the individuals who are deeply committed to both clinically improve the mental health outcomes of immigrant populations, and to challenge the reproduction of a stigmatizing social order. This commitment stems both from professional ethics, as well as from deep, personal convictions. Now, it may be naïve or superfluous to assert that specialized mental health experts' and trainees' personal life trajectories are intertwined with their professional identities. To some extent, this intersection applies to all of us. However, through informal conversations, the elicitation of life histories, and structured interviews, I found both specialized mental health experts and trainees to be readily self-reflective on their positioning within the field.

As far as experts are concerned, I argue that as immigrants, specialized mental healthcare practice holds a mirror function. This function is further accentuated by their trained understanding of the concepts of countertransference⁵⁷ (Freud, 1989[1940]) and decentering (Devereux, 1967) which they apply beyond the therapeutic context. I also found this reflexive dimension articulated in the contents of the transcultural psychiatry training program in which I was enrolled for a year. In this program, reflexivity was not only introduced as a method in approaching transcultural interactions, but it critically exposed the institutional positioning of specialized mental healthcare practice, specifically its “mediating” function between immigrant families and state institutions. Throughout, this chapter simultaneously provides an understanding of how the relevance

⁵⁷ Countertransference was first coined by Freud to refer to the patient's influence on the therapist's unconscious feelings. Devereux used it in relation to the anxiety produced by the observation context in behavioral sciences. This results in analytical distortions on the part of the observer, which may be corrected if anxiety is considered as an intrinsic characteristic of data collection and analysis in behavioral science, and incorporated into methodology.

of the concept of “culture” in care is articulated and problematized, both by experts and by trainees.

I. Becoming an expert: internal deliberations on “specialized” mental healthcare

I borrow British sociologist Margaret Archer’s definition of reflexivity as the “regular exercise of the mental ability, shared by all normal people, to consider themselves in relation to their (social) contexts and vice versa” (2007:4). Reflexivity forms the basis upon which social agents determine the course of their actions—depending on their individual constraints—and as such the concept sheds light on what motivates social agents’ actions and on how they adapt to their social contexts. Incorporating reflexivity in social analysis thus unveils the interplay between structures and subjects. It provides an alternative to the classic “two-stage model” (Archer, 2007:14) in social theory which fails to capture the richness, variability, and contradictions of human actions and motivations—and which account for the double-binds I introduce in the later section of this discussion. Instead, Archer proposes a “three-stage model” which incorporates reflexivity as an independent social process, and adds that, beyond the direct dynamic between structural contexts and subjective dispositions, “courses of action are produced through reflexive deliberations of subjects who subjectively determine their practical projects in relation to their objective circumstances” (Archer, 2007:17). This process was actually presented in Garfinkel’s ethnomethodology, which emphasized that even routine interactions involve constant “reflexive accounting” (Garfinkel, 1967).

Recently, sociologists have paid greater attention to reflexivity as a characteristic of modern social life, leading to a theory of “reflexive modernization” (Beck, 1992; Giddens, 1991; Beck et al., 1994). This body of literature points to how “late” modernity fosters increased reflexivity at the social level, a result of the disintegration of entrenched structures and a dissolution of life worlds—a “liquid modernity” as Polish sociologist Zygmunt Bauman metaphorically characterized it (Bauman, 2000). Archer contends that the problem with this theory is its central conflation of structure and agency, and its failure at elucidating the subject-object relationship as a process (2007:34). I dispute Archer’s critique with respect to Giddens’s work in particular (Giddens, 1991), which I believe does problematize modern reflexivity as a subjective, deliberative process, notably through his deconstruction of the modern self. In this part of my dissertation, I contend that immigration (in the case of experts) and the frequency of direct encounters with culturally diverse populations (in the case of most trainees), have self-disembedding⁵⁸ qualities which raise existential questions and foster self-reflexivity, particularly in relation to the relevance of “culture” in professional interactions and beyond.

The experts: Immigration, reflexivity, and the professional project

The analysis of institutional discourse and its authority necessitates a focus on the voices behind expert discourse, which lend visibility and thickness to the authority of the knowledge they embody. In France, the leaders of the various forms of institutional expertise on “specialized” mental healthcare for immigrants themselves are immigrants.

⁵⁸ In Giddens’s work, the concept of “disembedding” refers to “the lifting out of relationships from local contexts and their recombination across indefinite time/space distances” (1991:242).

They can be said to embody the cultural expert as such, as do many of their colleagues and apprentices that work and train with them. It is not a personal judgment, then, to say that these leaders have invested strong personal convictions in their professional endeavor. Beyond language, who they are and their life trajectories lends authority to them being able to understand the particularities of “immigrant suffering.” In terms of absolute knowledge this may sound like a relativist assertion. In terms of expertise, and in this case in particular—*cultural* expertise, the expert being himself/herself a migrant is a powerful credential in terms of symbolic institutional representation, and it is something that “specialized” mental healthcare institutions actively use.

In the transcultural psychiatry group consultation setting, the therapist’s cultural difference is purposefully highlighted in therapy: co-therapists are intentionally providing diversity to the therapeutic setting, and they are invited to articulate their cultural difference as a therapeutic tool. In the clinical medical anthropology setting, the understanding of the confrontation of explanatory models in therapy entails experts’ distanciation from their own cultural medical interpretations. Similarly, ethnoclinical practice encourages experts to establish discursive equivalences between different cultural frames. Self-reflexivity, in those clinical contexts, is a characteristic of the profession. In all cases, the embodiment of experts’ cultural difference is not understood as a “natural,” and therefore legitimate, source of expertise. Rather, it is perceived as arousing a sense of comfort on behalf of the patient, which in turn creates a hospitable, “free-speech” environment.

Regardless, it is relevant to note that the proximity with the patient as linked to one’s scientific expertise is peculiar to that field of cultural expertise, be it in the medical

realm or elsewhere. A book, co-written by Prof. Marie-Rose Moro and her collaborators at Avicenne, attests to that. The book comprises a collection of essays on each therapist's life trajectory, revealing at once one's cultural origins and detailing the decisive moments and encounters that made one choose to become trained in transcultural psychiatry. In her preface to the book, Moro argues that research should be more closely linked to life, so that the first is able to manage the complexity of the second. She uses an analogy to cooking: "cooking first involves mastery over complex techniques, so that it become natural, and so that one is then able to experiment with products and become creative that way" (2004:40).

All leading specialized mental health experts share the experience of immigration. Prof. Maiga, leader of the ethnoclinique, emigrated from Mali as an adolescent, and went to France to complete his high school degree. He then integrated a Parisian university where he successfully completed a PhD in sociolinguistics. Marie-Rose Moro, head of the transcultural clinic at Avicenne, migrated from Spain with her parents as a young child, and received her entire education in France. She completed her residency in psychiatry in Paris, at the Avicenne hospital. Her colleague at the Jean-Baptiste Carpeaux clinic, Kouakou Kouassi, left the Ivory Coast to complete his medical studies in Paris. He trained as a psychotherapist after an encounter with Tobie Nathan at a community mental health center in Paris, before Nathan opened his ethnopsychiatry clinic at Avicenne. Dr. Bennegadi, who introduced the clinical medical anthropology approach at Minkowska, migrated from Algeria to complete his residency in cardiology in Paris. In part because of an issue of degree equivalence between Algeria and France (after independence, medical school in Algeria was longer recognized a French educational institution), Dr. Bennegadi

switched to psychiatry and, while completing his residency, obtained a graduate degree in Anthropology.

Colonization, immigration, and cultural identity

For most experts, this experience of immigration readily triggered self-reflexivity—albeit in different ways. For Moro, drawing from her own autobiographical account (Moro, 2004:95-106), this experience cemented her trajectory as a therapist. She recalled the story she created as a child, about her family’s train journey to France, and in which she had imagined her father had met a woman who had told her father about the Ardennes, a northeastern region of France bordering Belgium. Instead of heading to Paris then, where his brother-in-law had settled, Moro’s father had decided to continue the family’s journey further east, until he reached Charleville-Mezières, a town close to the border with Belgium. Moro knows this is the official migration story, “a family novel” as she puts it. But “this encounter, an interest in the Other, a test about the courage of the Other and of changing one’s destiny, a beautiful child utopia which I still carry with me and which, I believe, makes for my being a therapist” (2004:98). She also recalled the legacy her grandmother in Spain, who cultivated a passion for cinema:

Cinema was her passion. She was fascinated by the dreams, that other reality she saw on the screen, that form of creation. She needed that illusion, that transgression to survive as well. She was criticized for her bad behavior (...). Yet she followed her idea, her own theory on life, these theories I relentlessly look for in my patients (...). I am passionate about these theories on life which each of us strives to give shape to and which is the center of our subjectivity and of our creativity (2004:99-100).

In Moro’s case then, the existential relevance of dreams in her family history, and the importance of the related mind’s creative potential which the experience of migrating

only exalted, are obvious underlying elements shaping her professional project as a psychiatrist, and her interest in psychoanalysis in particular.

For Dr. Bennegadi, childhood experience in colonized Algeria, prior to moving to France after Algeria's independence, instilled an identity dilemma as he perceived himself as being both Arab Algerian and French. In the life history he wrote for me, he recalled:

It was not clear to me, especially as a child, that I had to absorb at a young age the paradox of being a French citizen, as explained by my French teachers, and simultaneously having to understand the terrible repression against people of my Arab ethnic group who were carrying on the fight against French colonialism in Algeria, Morocco and Tunisia during my youth.

(...) My father would try to help my siblings and I comprehend this apparent paradox of allegiances by explaining that we Algerians had nothing against French civilization, but we would never accept it under pressure and intimidation.

It took me years of both humiliation and gratification to resolve this dilemma of identifications. Eventually, I was able to defend both the poetry of Victor Hugo and the extraordinary stories of the golden age of Islam; both transmitted by my father, who I came to realize had decided to leave to me and to each of my siblings, the opportunity to evolve our own self-image as being both Arab Algerians and French.

My first real cultural shock was when I discovered in 1962, when Algeria became an independent country, separate from France, that all my college friends were gone; forced by the intense turmoil of those years leading to independence, to identify themselves definitively as French citizens and return to mainland France, 'the metropole', despite their families having lived for several generations as French Algerians. That is when I suddenly realized that I too would one day have to make a similar choice of having to identify myself as either Algerian or French; and could no longer be viewed by others, or view myself as what would now be called a 'bi-cultural' person.

Bennegadi's case is particularly fascinating as it portrays the intricacy of the issue of cultural allegiance under colonial time. The dual sense of cultural belonging, which was easily negotiated by Bennegadi as a child—mainly because it was accommodated by his family environment—was later denied to him upon his choice to immigrate. The

necessity to move beyond cultural identifications, as mandated by the clinical medical anthropology model introduced by Bennegadi at Minkowska, may in that sense be the fruit of a personal existential struggle, which found its productive outlet in Bennegadi's professional project.

In one of the many personal conversations I had with Pf. Maiga, during which he would spontaneously discuss his personal and professional trajectory in France, Pf. Maiga expressed his frustration with the generalizations people made about "African cultures," including in academia. Pf. Maiga told me that in the course of his doctoral training, he took classes in anthropology at the Ecole des Hautes Etudes. This is where he became aware of the generalizations French anthropologists made about African cultures. He sometimes felt uncomfortable at the lack of respect these generalizations translated for him. To this day, he is critical of anthropologists for lumping populations into cultural wholes that create "neat" scientific categories, but which have no relation to reality whatsoever. The son of a noble Songhai family, he takes pride in the history and prestige of his ethnic group in Mali, which he is fond of sharing with his friends and colleagues. In that respect, I would argue that Pf. Maiga's ethnoclinical model, and its insistence of eliciting patients' nuanced cultural narratives without attempting at intervening on their meaning, outside of simply understanding their particular "intentionality," may reflect Pf. Maiga's experience of cultural reductionism through that of immigration.

The universal and the particular

Pf. Maiga's frustration with the categorizing tendencies of academia informs his professional trajectory as an ethnoclinician, and the initial appeal of Nathan's

ethnopsychiatry approach. Indeed, Nathan's insistence on the culturally particular, and his critique of ethnoanalysis as a culturally-abrasive approach that imposed a western model of care, found resonance with Pf. Maiga's experience in French academia. Upon being hired at a Parisian University specializing in African, Asian, East European, and Ocean languages and civilizations, he was approached by Tobie Nathan, to participate in the ethnopsychiatry training program ("Clinical Practices with Immigrant Families") with Centre George Devereux at University of Paris 8. This is where he became trained as an ethnoclinician. Although he is often reluctant to comment on his relation with Nathan, he clearly detaches himself from the approach of his mentor, mainly on the grounds that Nathan sought to heal, while Pf. Maiga's ethnoclinical approach is strictly discursive. In fact, as Pf. Maiga's ethnoclinical model may bear the same resistance to the superiority of western scientific models as Nathan's, his ethnoclinical practice—as will be evidenced in the next chapters' clinical vignettes—places most emphasis on the particulars of cultures.

In his biographical account (2004:116-123), which he published in Marie Rose Moro's collective book, Kouakou Kouassi attributes his interest in the relevance of the culturally particular in universalizing medicine to an encounter, as a medical resident, with a Malian patient who had lived in the Ivory Coast, and who had been hospitalized for malaria treatment. During his hospitalization, the patient developed an abscess as a result of a parasite infection. As Kouassi recalls, the infectious disease specialist called to treat the abscess

was embarrassed to articulate a diagnosis and propose a treatment. The doctor in charge thus asked me whether I would take care of the patient, since I was also African. I then suggested the application of a traditional treatment often used in Baoule villages to extract the parasite. After this

successful therapeutic outcome, my desire to articulate Western medical knowledge with that of traditional African medicine grew stronger (2004:117).

From that experience, Kouassi thus drew an exalted sense of professional purpose, in which his cultural origins could serve as improving healthcare outcomes for “African” patients.

For Marie Rose Moro, it is her immigration background, her desire to become “a French doctor” as her father had hoped she would, and her passion “to engage with multiple worlds” (2004:101) which led her to pursue graduate studies not only in medicine, but also in philosophy. In her auto-biography, she states how the philosophy of French Enlightenment period fascinated her, and helped her think about universal values:

Imagine how the daughter of immigrants like me could be fascinated by this search for the universal. That training taught me a lot, particularly to build ideas, defend my positions, and it took care of my complex vis-à-vis the universal. *The universal can only be reached from the particular* (Moro, 2004:102, emphasis in text).

Moro chose her specialty in psychiatry to reconcile her love of both medicine and philosophy. During her residency, she rapidly became appalled at how medical professionals represented immigrants and their children. She started thinking of a clinic that could provide better care to these patients, and was told about Pf. Lebovici’s consultation at Avicenne where a psychologist, named Tobie Nathan, had developed a technique he called ethnopsyoanalysis. Feeling determined to improve healthcare provision to immigrant patients and their children, she switched her residency to Pf. Lebovici’s consultation at Avicenne, where she met Nathan. The latter readily took her under his protection. She then met Lebovici and told him she wanted to prepare her graduate research on “immigrant children’s vulnerability.” Lebovici agreed to mentor her

work. After learning from Nathan by practicing with him in his consultation, she took his position as he left to create the George Devereux Center: “I made the system more flexible, diverse, and complex. But above all, I adapted it to the second generation of migrants, to babies, to children, to adolescents and their families. Nothing gets lost...” (2004:106).

For Dr. Bennegadi, the confrontation between the particular and the universal occurred as, after completing his medical degree in Oran, he was called to start military service in the Algerian Sahara, and work with the Bedouin population of that region. During two years, he thus ran a local hospital, and operated in extremely difficult sociopolitical conditions. In his life history, he writes:

I soon discovered that I had to take on responsibilities and make decisions I had not been prepared for, and I also had to cope with different conceptions of health and illness among people in the same country I grew up in and who presumably shared the same cultural background and values I grew up with. I realized every day how large the conceptual gap between me and my Bedouin patients was, when I had to explain to them the causes of infectious diseases, as well as psychiatric problems. In order to try to convince them to accept modern medicine’s treatment methods, I had to learn how to negotiate an acceptable treatment plan; integrating my scientific knowledge and skills with traditional beliefs in illness causation and treatment regimens. I learned how to integrate the biomedical value system I learned in medical school with traditional Bedouin magical beliefs, without losing my mind, or my status as a doctor trying to do my best for the sake of my patients’ well-being.

This experience led Dr. Bennegadi to seek a degree in anthropology while completing his residency in psychiatry in Paris. In that context, he received a grant from the Fulbright Foundation to study “culture and personality” at the Institute of Personality Assessment and Research (IPAR) at UC Berkeley, where he became familiar with the clinical medical anthropology framework, which would later influence the creation of his approach at Minkowska:

That was a major learning and growth experience for me. Once again I had to cope with a very different educational system and different values than I had grown up with in French Algeria and in France. That experience, and my need to cope with the conceptual changes inherent in adapting to living and studying in California, changed my way of thinking, just as anthropology had opened my mind and my sphere of interest to ethics, philosophy and cybernetics.

Back in France after four months in California, I took an active part in introducing clinical medical anthropology in French cultural studies, which seemed to me at that time, to be very ethnocentrically biased. I don't know just which aspects of my life experience up to that time gave me this feeling, but I did understand that changing culturally engendered thought patterns would require a sustained effort over many years, and I decided to commit myself to that endeavor.

Again, these self-reflexive narratives seem to reveal a direct correlation between experts' life trajectories and their understanding of the relevance of both the universal and the particular in the therapeutic context, and sometimes beyond it. Interestingly, Moro and Bennegadi, who have developed the more clearly universalistic clinical frames (transcultural psychiatry and clinical medical anthropology, respectively), both had personal and academic experiences which directly placed the universal and the particular in tension, and which resulted in their emphasizing the universal imperative in cultural competence.

The trainees: “self-disembedding” mechanisms and “adapted” responses to cultural difference

In the context of my enrollment in the graduate program in transcultural psychiatry, I became interested in the reasons that motivated individuals to seek such training. Students were extremely heterogeneous. They came from a wide range of institutions. The goal of the program consisting in training participants to the application of the transcultural clinic in social, educational, school, and judiciary services, students were selected partly on the basis that they represented such services. Candidates were

only admitted on the basis that they held a graduate diploma.⁵⁹ In order to validate training and earn a graduate diploma in transcultural psychiatry, students had the choice of writing a thesis – under the supervision of one of the program’s instructors, writing an article, or writing a notebook (an alternative for those who did not want to write something as constraining and elaborate as the thesis). Students were given the possibility to complete their training in two years. The majority of students attending the program had full-time jobs, and they were actually funded by their employers to be trained in transcultural psychiatry. For them, the two-year option gave the opportunity to manage an otherwise heavy workload.

Given my broader dissertation research interests, I decided, for my training validation, to write a thesis on the program participants themselves, as a way to elicit their motivations for enrolling in the program, as well as their problematization of the relevance of culture in mental healthcare with immigrants. I announced my project at the end of class one day, and asked for interview volunteers. While many students had been curious to talk to me about my project and about my anthropology background more generally, they were initially hesitant to volunteer. Then, as weeks went by, and, I imagine, as some realized there was nothing compromising about the interview, a few more came to me to volunteer. I thus conducted interviews⁶⁰ with a heterogeneous sample of twelve students (out of the forty enrolled), three men and nine women. The overwhelming majority of students attending the training were women. The professional

⁵⁹ The transcultural psychiatry website of Avicenne specifies the following required university training: PhD in medicine, medical residents, certified health professionals (nurses, midwives...) or “medico-social” professionals (educators, social workers), graduate students in psychology, anthropology, or law. It also mentions that professional experience working with migrants, or in a transcultural setting, is desirable, but not mandatory. Applications from candidates in other professions or from abroad are examined.

⁶⁰ The interviews were digitally recorded.

diversity of the sample I interviewed reflects the institutional reach and ramifications training programs in cultural competence have, and how successful specialized mental healthcare centers' networking efforts have been.

An interesting finding in the analysis of these interviews is that most students have a very generic idea of how to label such program, almost always making references to ethnopsychiatry, even when referring to the knowledge they acquired through the transcultural psychiatry training program. I suggest that this speaks to the enduring legacy Nathan has left on the French institutional landscape, its greatest strength being its ramifications throughout the institutional system, which leads people today to inevitably associate specialized mental health training—whichever approach it is—to ethnopsychiatry. Although the definition of specialized mental healthcare centers' distinctive theoretical orientations was not something I had specifically addressed in my interview questions, it nonetheless came up in students' narratives. Three students in fact told me they had considered the George Devereux Center for their training, before they learned about the transcultural psychiatry program. One of them considered that his training in transcultural psychiatry fulfilled his curiosity on ethnopsychiatry:

S4: It was in the context of my BA thesis, which I entitled ethnopsychiatry and migration, so it was theoretical work. At the moment, I don't practice. I'm in Paris to train as an educator with gypsy populations (*les roms*). (...) Well I discovered ethnopsychiatry through this theoretical work. What fascinated me about ethnopsychiatry was that it destabilized the laws and the precepts of occidental psychology we are taught at school. It truly broadened my vision of psychology. I realize that all we are taught is aimed at a specific population, the occidental world, and we are not the center of the world. The majority of this earth lives a different lifestyle. So we can't use the same method to treat an African, an Asian. (...) I know one of the founding fathers was Devereux. This was a colonizing country. So colonized populations also came to France to seek wealth. They had to put up with the power of the French. It only seems fair that we should welcome them. I think my training with Marie Rose Moro could help later

in terms of getting a job. I have my BA in psychology. I had never done any specialization. I was interested in ethnopsychiatry. I saw this opportunity, I took it.

Most interestingly, students' narratives revealed internal deliberations on “trigger events” or encounters that led them to seek training in transcultural psychiatry. In my analysis, I once again borrow Giddens's concept of “disembedding mechanisms,” which I apply to the individual level of reflexivity⁶¹, and which I understand as the mechanisms which lift the self out of conventional social interactions, thereby threatening its “ontological security” (Giddens, 1991:36)—that is the sense of continuity and order in events and social relations—and leading to existential questions and narratives of the self.⁶² In the following paragraphs, I identify those mechanisms as articulated by students.

Encounters with difference: Discrimination and trauma narratives

Many of the professionals enrolled in the program provided services to immigrants, or cared for them as patients. It is in the context of such encounters that they may have felt at a loss as to how to properly handle interactions in which they felt they lacked a sense of shared reality, or felt powerless as witnesses to discriminatory forms of treatment. As the following student explained:

S8: First there was the encounter with several persons who had already done the training, including a nurse who works at the same hospital I work, and who had already completed the training and it made me...it started when I studied. The last internship you do as a nurse, we must take...well we're always supposed to care for patients during the internship, but this last one, I invested myself more with the patients I cared for, because the internship lasts longer, because there's an examination at the end. And for my examination, I had cared for migrant

⁶¹ In contrast to Giddens, who uses this concept at the societal level.

⁶² Giddens defines “narrative of the self” as “the story or stories by means of which self-identity is reflexively understood, both by the individual concerned and by others” (1991:243).

patients, so I had gone to see her [the nurse who completed the TP Program], so she explained several little things to me which led me to a reflection...and I told myself that the reflection was indeed different from what I may hear...I mean, she didn't really talk psychiatric pathology...she explained things differently, which surprised me a bit. And then I met a psychologist who also did the training here, thanks to that nurse...they're both part of that association, so I go to the association, and then that's it...and then maybe there were colleagues, their way of seeing things, which sometimes bothered me, which made me think, well that's strange this perspective they have on...on difference actually... (...) it was through patients too, but more through my colleagues. *This notion of difference, all the time, which was...I don't know, I felt like they took less care of patients of foreign origin, that there was a lot of distance taken vis-à-vis those patients to not care for them, because there was a lack of understanding...* (emphasis mine)

This student's comment does not emphasize cultural competence, but rather a sense of discomfort in the face of the unequal treatment foreign patients experienced at her institution. She did not enroll in the program to receive cultural knowledge, but to learn how to handle situations of cultural discrimination.

Other students were confronted, also in the context of their work, with the trauma narratives of refugees. These narratives provoked feelings of helplessness. I do not imply that students were unaware of such narratives, but having to deal with them in face-to-face interactions produced anxieties, and feelings of incompetence in responding to the situation properly:

S1: *Then there were two or three determining events for me. The first one was...well, our service is very well know by public institutions, but people who come see us have heard about our services by word of mouth. That's how a group of individuals from the Ivory Coast came to see me. They came individually with a very specific demand, which was to obtain a transcribed recording of their history. For the first time, I was confronted with people's story in the most raw and flat representation. So that was really a shock for me because then I could really put a face on the stories. People told me things, confided not only about events, but about the emotions they felt, the questioning they had when they came here. That's when I found myself helpless. I felt overwhelmed by all of this, because it's*

difficult to listen to. It's difficult to receive. These are such painful stories. So that's when I started to actively look for training programs which could help me with the listening part of my job, although for this part I felt more or less equipped. But I became aware that there were elements of these narratives with those people which were tied to the fact that we didn't live in the same universe, even though in daily life we walk next to each other. *I had the feeling I missed important things which might be said,* in little sentences or attitudes, but which would not make sense to me. Also, I had the possibility to receive such training where I worked. So that was the first decisive stage. Then I had this second encounter with another man from the Ivory Coast. I'm gonna call him by his first name, that'll make it easier. This one was called Ahmed. He had come accompanied by a fellow countryman who told me: "He's really not doing well. We must do something. So I received him. He had this fixed expression, with wide-open eyes, a highly marked face. His speech was very chopped. He would also be shaking at times. He tells me he has problems with his wife, that she only comes at night with their children, and that they all leave before the day starts. My first reaction was that this was not something for me. This gentleman is really not doing well. So I made an appointment with a psychiatrist. I accompanied him there to the first appointment. The psychiatrist told him: "you don't really know what day it is, ok, and you hear voices, uh? Well just take this [medication], and come back in three months." This was a first contact with psychiatry which left me a bit perplexed, in terms of the efficacy of the method. So I talked to Ahmed, asked him how he felt about him. And he told me he wanted to find something else. So I looked up places in Belgium, close by the district where he lived, and I found a service called [association name, catering to immigrants and asylum seekers] constituted of a small team of psychotherapists who work individually. This when Ahmed told me: "I want you to be present when I speak." So this raised questions for me. I wondered what my position was. *Who am I in my work? I thought well I'm like a blank page upon which they come to inscribe whatever they want about their history. I felt a bit overwhelmed about it.* So the therapy started, and I started to understand the situation, including what he meant when he said "my wife comes to see me at night." Evidently, it was not the physical presence of his wife and children he was telling me about. I think this is probably the most horrible story I was told, and I hope it won't happen again too often, even though I know it might happen again. But it's so awful, I'd rather be naïve and believe that this doesn't happen as often as that. (emphases mine)

This student emphasized not only the difficult position of professionally handling the response to trauma, but the anxiety caused by the mere act of listening, of becoming the indirect recipient to trauma. Again, the issue of cultural competence was not her first

concern in seeking training in transcultural therapy, but rather a concern with both learning to personally distance herself from trauma narratives, as well as to properly orient and soothe the narrators.

For some, trauma narratives elicited strong feelings of empathy, which in turn led them to develop strong personal ties with the narrators. Nonetheless these narratives left students with the same questioning in terms of “adapted” understanding:

S2: For the past five and a half years I worked at this association [association for young adults, partly funded by the Social Fund for Youth], from what we offer, in fact, 2/3 of them come from the migration—that I can’t really explain to myself yet, most of them from Africa...(…) It varied from the past five years. A lot came from Mali and Senegal, but especially Mali. There were also British-specking African countries, Cameroon, and a lot from RDC. We have a girl from Nigeria, one from Angola. They learn French more or less quickly. Most of them arrive not speaking French. Others learn so quickly... [This one girl] had a father from Sierra Leone, and a mother from Siberia. The father was an air pilot, did an internship in what was the USSR then, and met his wife there, in Siberia. They had children, went to live in Sierra Leone. Then there was a revolution, the father was assassinated. The mother was in Moscow with the children. She went back there to get some belongings back, and that’s when she was raped and assassinated. And it’s her daughter whom I’ve met. She’s the first one I met at the center, and she really left a strong impression on me. She herself was raped and declared dead. By fainting to be dead, she managed to escape. Some people came to her help, and finally the Red Cross. She was directed to a camp in South Africa, then was sent to London, and eventually landed in Paris. She went to middle school here, enrolled in a program training social and healthcare assistants. She now works for the city of Paris in nurseries. She plans on being certified as a nursery/pediatrics auxiliary. She has a lot of energy and vitality. She’s very intelligent. So I’m sure she’ll succeed. I no longer see her, but I felt a very strong tie to her.

I also developed strong ties with this other young girl from Central Africa, another very dramatic story. Parents both living in Bangui. Both students in law, working for administrative services. During the last coup, the father was asked to side with the rebel, he refused and was shot. The mother organized the exodus for the whole family. Middle-aged children, including that girl, were taken to the border – some border, I can’t remember which one, where the mountains are – and the small ones stayed with their mom. And this young girl and her brothers deliberately

separated, to cross the border more easily, and then she never heard back from anyone, neither from the brothers or from her mom. So she's very, very hurt. Psychological support was very complicated...she always resisted strongly. She had absences... so took on that path...well, not as successful as the girl from Sierra Leone, with exams and all, but she has a strong will. She was very depressed for a year and a half, and then things shifted. She met a psychiatrist who put her under medication...that helped her. She quit her meds a year ago. She's much better. She often has, like many of these kids – not just from Africa, or immigrant kids, but kids in general – they have a lot of health issues. They somatize a lot...like headaches.

Sometimes I'm left questioning things. When they talk to me about events they experienced in Africa, about things they live there...the question of time for example. Speech. Exchange through speech. There's that one girl in particular, who actually gave me the idea for this research project, who recently told me that...she's from Congo RDC, from Kinshasa... she talks a lot...well, talking about herself is difficult. I don't approach things saying "please, talk about yourself...these things take a little time. The exchange needs to be natural. Recently, in the bus, we were coming back from her high school in the end of Essonne. And she told me: "you know, I feel like two persons, you know, that sign with two faces of two persons"...so I was like "you mean like yin and yang?" and she was "yeah, that's it, that's how I feel" So that questioned me a lot... *but I don't know what to do with it. And I told the psychologists about it, but they don't know what to do with it either. None of them, and I really appreciate them, none of them does transcultural work.(...) I think that often we miss an understanding, or we lack a way of being that is more adapted.* (emphases mine)

For this student, the search for "adapted understanding" and his drawing a relation with "transcultural work" hint that "adapted" listening calls for a culturally-appropriate response. While he never makes a reference to the concept of culture per se, his vivid recollections of culturally singular scenes, as well as his puzzlement at the last girl's comment on feeling "like two persons" lead me to suggest that, contrary to what previous comments suggested, he may be expecting more from the training than simply a technique of listening.

Narratives of such encounters also brought up cultural repertoires of difference, such as the following discussion of “the veiled woman” as “the subjected woman, or the woman who does not want to integrate:”

S7: I resisted a lot to women wearing the veil, for me these were interviews that did not necessarily go well, because *I had a representation of the veiled woman, the subjected woman, or the woman who does not want to integrate...* for me it hid many things, the veiled woman...so for me, it was the subjected woman, I...well that’s related to my own lived experience that I saw it as problematic...this I laid on the couch during psychoanalysis, and the transcultural training opened me up to that...*for me, the veiled woman is not only a subjected woman. It can also be an independent woman, but who also wants to protect her culture also.* So I carried several interviews later, which went very well, because for example I could not address the woman’s condition with a veiled woman, I couldn’t bring myself to talk about her child rearing methods. I was closed up. Because, I thought, “she’s going to find this intrusive, so I don’t ask the question.” So there’s nothing that came back in return, because the woman in front of me must have found me rigid, whereas now, because I am no longer afraid of this veiled woman and of what she represents, I’m not going to ask her, I’m not intrusive, I’m not going to ask her the question, but we address the issue nonetheless. It comes up at one point or another. So it’s not necessarily...it’s the knowledge from the training that helps me, but at the same time, it’s...it pushed me...it opened the psychic space – as they say – for me. I can tell now that, everything the other brings me, *I’m no longer afraid of it. It diminished...well the sense of strangeness (l’étrangeté)...* (emphases mine)

This last comment is reflective of a tension so common in the discourse of social agents who work with immigrant populations: on the one hand, it clearly articulates a conscious and benevolent effort at moving beyond the notion of cultural belonging—and the stereotypes attached to it (“the veiled woman”)—while on the other, it rationalizes this effort by resorting to other essentializing cultural categories (“It can also be an independent woman, but who wants to protect her culture also”).

“Practiced” narratives of the self: Psychoanalysis and reflexivity

For some students, there were interesting intersections between their interest for the training and personal identity issues. Some linked their interest to “situations of encounter” to their own experience with psychoanalysis:

S1: Well, about ten years ago, I started undergoing psychoanalysis, which after all this time makes me interpret situations – whatever they are – in a particular way, with a focus on the individual. Little by little, this influenced my way of working. It influenced me to see people in a different light. I no longer reduced them. I saw them *in their social dimension*.

S7: Already I had started psychoanalysis, so I’m on the couch twice a week, and I think that’s necessary to really *be open to others without having all the parasites of our own existence and of our own lived experience*. (...) Analysis enabled me to know myself very well, in order to know my reaction with respect to the other, my resistances...

Psychoanalysis is thus perceived as operating a form of self-transformation providing one with ontological security in the face of potentially destabilizing encounters with the Other. Knowing the self—rather than the Other’s culture—is therefore paramount to producing conditions in which the Other is perceived as another self (“in their social dimension”), an individual equal.

In one interesting case, resistance to psychoanalysis originated from the individual’s own cultural ambivalence and belonging:

S6: I was certified at 23...ok, psychologist at 23...that posed me some problems, including with respect to my positioning as a clinician, because precisely I had not acquired knowledge of myself just yet. And despite a two-year analytical work, which helped me a lot, but with which I had some resistance...it helped me at the personal level, but with respect to professional positioning, it didn’t really help me to have a true identity as a clinical psychologist, a professional identity. That’s also how I want to frame what led me to take this DU in transcultural psychiatry. I had this instability professionally speaking, at the level of this identity. For me this actually played out about two years ago, as I tried to develop my knowledge of my religion – I am Muslim. So I started to read the Koran, and to be interested in what Muslim religion represented, outside of the transmission which my family and my peers gave me...I really wanted to

access this knowledge but on my own, through my own readings, which is something I had never done before.

For this young Muslim psychologist, it was the encounter with the self/the same which interfered with her professional obligation to maintain neutrality. For her, the question was not an issue of not understanding the cultural context of her patient, but of identifying with that patient and being biased to her religious affiliation, which in turn affected her neutral position in the context of therapy. Two encounters, in particular, forced her to question her clinical neutrality:

S6: I could think of others, but these are the two which really left an impression on me. One is about this woman from North Africa, a little older than me, who came to talk to me about bewitchment, difficulties linked to a problematic of bewitchment, and with respect to her husband who had converted – who was converted by Jehovah’s witnesses. And so I felt completely fascinated by what she was telling me. But fascinated in the sense that, since I believed in it, it prevented – I think, retrospectively – it prevented this woman from projecting herself in a healthcare approach. That is, my role is obviously to listen and to hear the person’s suffering, but it’s also, in cases like this one – and here one is confronted to a problematic of chronic depression for this woman, but there also, it prevented me to reach that diagnostic because *I based my opinion upon a cultural etiology*. So this woman did not have the possibility to appropriate a healthcare approach for herself. That is, at that time, I had suggested to refer her to the Minkowska Center, with a psychiatrist, but *she could not appropriate that healthcare approach for herself, because, I think, I did not allow for...uh...a space, which I would call transitional, where she could at once hear that I was taking into account what she brought to me, as an understanding of her illness, but that I also positioned myself as a clinician and that I allowed her to have a different interpretation (lecture) of her ill (mal)*. But what happened there is that she brought an interpretation to me, which I completely appropriated, and consequently, when in turn I wanted to work a referral so that she could have access to care with a medication treatment through the help of a psychiatrist, the therapeutic alliance did not occur. I think that’s what happened. It prevented the therapeutic alliance from occurring, and so there was no follow-up. And I didn’t hear from that woman.

(...) And then another situation, about a year after, or maybe a little more than a year after, a Malian woman of Muslim religion, aged about 40, who found herself in a major conflict with her father, who was afflicted with

several cancers, and his terminal phase, and whom she knew was going to die. He had actually come to France, not to die, but to try and get healthcare here, but in France he was told he was going to die. And so, a very important conflict because her father married this woman who was 13 years old, it went really bad for her, and so all that this can imply in terms of filiation and transmission, of reject with respect to this filiation, and so she didn't want to go back to her country for her father's funeral, and by refusing to do so she brought herself in a precarious relation with her family, who said "it is your duty to come back home and spend 40 days here" because that is the custom "40 days here, regardless of what happened with this father, it's your duty"... and my to tell her – I can't remember exactly how I put it, but I remember more or less that I told her "you know, in Islam, filiation is something very important, and you must not break the ties which unite us with our parents. And so I was siding with her family. That's how, on the spot, I felt like expressing this to her. But then *I asked myself questions in terms of the legitimacy I had, and above all the question of neutrality, my neutrality.* As it happens, she appropriated that, but she might just as well not have. And even in the instance that it was functional for her, to this day I ask myself about the legitimate grounding of my position, because I did take a position, clearly. One knows today how the patient can identify himself/herself with the word of – not the psychoanalyst in this case – but of the psychologist, precisely in relation to her transference. And in this case, transference was positive in relation to me, and counter-transference was positive in relation to her. So that's the influence I had on her. (emphases mine)

Lessons learned: Beyond "culture," beyond immigrants, beyond specialized care

In a sense, for some of the students I interviewed, the training in transcultural psychiatry triggered its own set of existential questioning. In fact, as the following student expressed, the training experience left her with more uncertainties that she had before entering the program:

S3: For me now this training creates a lot of uncertainties. I know I will go beyond that. But for now, when I see a mother and her child, not necessarily migrants, (...) I wonder "what right do I have to give them such or such advice". So I'm gonna have to think of another way to provide a substitute cultural frame of reference (*contenant*)⁶³ to these

⁶³ I have found no formal translation for the concept of *contenant*, which I chose to translate as "substitute cultural frame of reference" here. The student here draws from Nathan's theory of the relation between *contenant* (literally, "the container") and *contenu* (literally, the contained). Nathan perceived culture as something enveloping the individual (hence the idea of the "container" or *contenant*), and as something vital for his psychological well-being. Each individual possesses an internal cultural frame, which functions

families who are in the expectation, who designated me to bring it to them. But that's the question I am asking myself now: "what am I gonna have to do to rebuild this *contenant*?" Obviously I'm going to reconstruct it with the family, and this will vary from one family to another. I think there will be more or less flexibility and variability according to whom I will talk to. I think the main tool is one related to one's own personal transformation. (laugh) But I think the main tool is the modification of one's position vis-à-vis the family, and accepting to have to build something, because I'm not going to linger in the emptiness...everything that is deconstructed by this training, everything that is questioned rather, of course I will not stop there, but for now I'm in the midst of uncertainty.

Appropriating the theoretical frame of ethnopsychiatry ("to provide a substitute cultural frame of reference"), the student thus emphasizes *the technical aspect* of competence in the interaction with migrants, rather than its *cultural substance*. In fact, she underlines that the technique equally applies to the self ("one's own personal transformation"). More importantly, perhaps, she points out that what she learned does not apply solely to migrants. She reiterated this assertion later during the interview:

S3: We can destroy some of these dogmas which put obstacles in the encounter with the Other. Because in fact, we realize there are a lot more acquired things than there are innate things, including with babies! So perhaps it helps one become more careful in the way to support the other, and diminish (...) at a small scale the part of suffering that the other, *not necessarily migrant, but also migrant*, brings to us during consultation. I think it gives one greater benevolence, and also confidence that we are not out of the subject. That is, *we are engaged ourselves, without disturbing the clinical scene too much with our own defenses, but bring a greater part of our cultural self, without being ashamed of doing so, but as a way of inviting the other to do the same. Acknowledge more what comes from our own culture.* (...) As far as the tools, I cannot foresee what they will be. It's probably about acquiring more benevolence, flexibility, and authenticity vis-à-vis the patient, whether he comes from...because to me, being French is a very theoretical notion... I can't really see what it is to be French. Yes, to have the right to vote in France, perhaps. But we're already hybrid. I completely feel the heiress of this hybridity. For me, the best way to communicate that to people is to be benevolent with them,

in perfect symbiosis with the external cultural frame, the fist feeding off the second. In this perspective, immigration potentially triggers trauma situations, since it disrupts the symbiosis, thereby weakening the individual's internal psychological frame.

whoever they are. Not more with migrants than others, but no less either. Certainly not. It's in that sense perhaps that one can say to be taking a universal position, that means not to make any differences. (emphases mine)

While she insists on the hybrid nature of French identity, she also displays her ability to “decenter” by acknowledging the influence of her own cultural principles, and how they may distort her perception in a transcultural situation. She speaks of a learned sense of flexibility, which I found reiterated in other students' comments:

S5: As an occupational therapist more specifically, these persons, when there's a language problem, I just launch a simple activity where we can share things, answer one another. [reference to Winnicott and the concept of “free associations”]. And at that point I was confronted with things I was not accustomed to. I had patients who used the drawings to tell me communicate things about their country (...) these were not drawings in the sense that they simply like to draw, they were like traces...sometimes it made me think of “well if I move out, I take my pictures along with me.” Of my family, of where I lived, these things that trace out past, that make up our story. In their case they don't have any. So it's like they have to represent their past that way. (...) They tell me who they are. Then what do I do with that? I don't necessarily have the tool to think about it and do something with it. So I tried things. I had an experimental period. And it was interesting, because patients really engaged with it. I don't know whether it was about a possibility to give something to the other from one's past...and it was often like that, but not always. And it's normal, as we discussed in the program: it's not necessarily because we work with migrants that the issue of the transcultural comes up. And that really resonated with me. I have indeed had patients who migrated recently, but for whom this is less of an issue. There are quite a few things like that, that I here in the graduate program, and that make me think “OK, here I was indeed dealing with something cultural, but there I wasn't.”

The new sense of flexibility equates with finding creative ways—outside of culturally-adapted ones—of transgressing what seems to make therapeutic care provision because of unusual or unknown clinical circumstances. This flexibility, which again is not defined in terms of cultural competency, seems key to measure the necessity of referrals to “specialized” mental health institutions:

S5: I work in a public hospital. One must be open to any psychiatric consultation. It can be anyone. With respect to specialized centers, we may play the role of a relay, or of referral. We may think: well here is a case where migration is very important, and I need a relay, so I'm going to ask for an ethnopsychiatry consultation. I think it's very important that there exist specialized services that are not sectorized, which we may call or rely on, be it for the issue of migration, or for social issues. Sectors may develop specialization, as long as it does not impede what is not relevant to it, just because it is linked to it...that would be the risk. We may specialize in healthcare provision to migrants, but where I work we don't exclusively cater to migrants. We may want to be available for them, but not exclusively, so we don't think that each time it's a problem...so *the specialization, I think it's like a kernel in a whole, you must not forget about the whole, other wise the risk is to think that the specialization is what is general, and then there's a problem. One tries to be closest to the person as possible, but this may end up leading to the contrary.* So I think it is nice to have these specializations outside of the sector. To distance oneself from the patient, whether it's about migration or not, that's what the counter-transference analysis is about. I don't distance myself with migrant patients only. That's just something that's part of my work practice. (emphasis mine)

It seems fair to conclude from students' general comments on the relevance of culture in mental healthcare provision to immigrants that understandings of that relevance as disseminated by experts in "specialized" mental healthcare institutions is non-essentializing, but rather insistent on problematizing culture from the standpoint of one's own representation biases. While this problematization of culture produces more uncertainties for some, it also leads trainees to critically reflect on the potential, unintended essentializing consequences of cultural expertise, and to carefully weigh the necessity its application in transcultural situations.

II. Graduate Training in Transcultural Psychiatry: Institutional Reflexivity

In this second part, I approach reflexivity from a different perspective, one which is less concerned with the kind of ontological questioning described in the first part.

Instead, I turn to reflexivity as it relates to epistemological concerns and institutional positionality. Participant observation in the Transcultural Psychiatry program unveiled a problematizing of knowledge in the field of specialized mental health in two different ways: 1) subjective interpretation and the relative impact of cultural difference in the therapeutic interaction and beyond; and 2) institutional intervention and the positionality of specialized mental healthcare in “mediating” between state institutions and immigrant families. Based on my class notes as well as on recorded lectures, I analyze the content of the program. My goal is not to provide a descriptive account of the classes that were taught. Rather, I want to emphasize the aspects of the training that speak to the institutional positioning of transcultural psychiatry as specialized mental healthcare. I call attention to lecturers’ critical position,⁶⁴ vis-à-vis both the system and themselves, with respect to the problematization of culture through clinical referrals.

The curriculum was organized around a general course on the one hand, and a specialty option on the other. The general course developed four main thematic units: 1) introduction to anthropology; 2) introduction to the transcultural consultation; 3) focus on transcultural consultation with children; 4) focus on linguistics and translation in the clinical context. Students were also required to enroll in one of the four specialty options offered in the program: 1) humanitarian psychiatry; 2) mediation practices in a transcultural context; 3) individual, family and society in Asia; 4) trauma consultation with asylum seekers and refugees. I selected the second option, focusing on mediation practices in a transcultural context, as it addressed the articulation between specialized mental healthcare expertise and referring institutions.

⁶⁴ This critical standpoint is particularly relevant in light of the double-bind dynamics I analyze in the last part of this dissertation.

**“Decentering” and “counter-transference:”
The relevance of culture in clinical care and beyond**

Entering this program, I was anxious to observe how anthropology was introduced to an audience of non-specialists, and especially how it was apprehended in terms of its relevance to clinical care. Of course, I had learned superficially about each three main specialized mental healthcare centers’ theoretical approaches, and their respective take on the role of culture in representations of mental suffering and its taking into account in healthcare delivery, but taking the training program enabled me to analyze this articulation in depth.

Our introduction to anthropology class was delivered by Pf. Moro herself. Anthropology was not so much presented as a discipline allowing one to decode cultural systems, but rather as a methodological approach enabling one to “decenter,” and avoid projecting one’s own cultural logics onto another. Reading anthropological accounts was not encouraged as a way to build a catalogue-like knowledge of cultures around the world, but rather as a way to become sensitive to cultural diversity, and to indirectly distance oneself from one’s own cultural beliefs and convictions. Being an anthropologist, the presented approach sounded to me like a self-evident truth. It was informative, however, to observe how unsettling this could be to many students in the program, as some of the trainees’ comments illustrated earlier in the chapter.

Decentering, it was argued, could be learned by training – that is by cognitively being exposed to anthropological readings on various cultures; it could be acquired by working collectively with individuals from different cultural backgrounds – that is by affectively learning to confront unfamiliar representations of reality; and finally, the previous two steps would lead to the most unsettling and difficult part of the learning –

that is by gradually becoming conscious of one's own cultural attachments (an example was given of the difficulties encountered by female therapists in working with North African male patients). A great part of the first class was devoted to explaining the choice of the transcultural approach in that respect, as opposed to intercultural or intracultural approaches in therapy. The "trans-" prefix alluded to the fact that the approach did not strive towards an all encompassing knowledge on all cultures, but rather towards the acknowledgement of the cultural mechanisms that shape individuals' cognition, and the necessity of integrating this acknowledgment to one's own understanding of reality in interacting with others.

Moro thus clearly departs from Nathan's culturally relativistic stance and his perspective on cultures as closed systems, all-encompassing in the definition of individuals' cognition. To Moro, cultures can be about hybridity – *métissage*, as she calls it. She refers to rituals which were no longer carried out in sending societies, but which are re-enacted in the migrating context, as a means to resist exclusion and reassert cultural belonging. Moro reminded us that the anthropological method of decentering was useful in drawing links between the universal and the particular, aiming at reaching the first through the second. As a psychiatrist, she believes in the fact that the human psyche functions the same way, across cultures. Anthropological knowledge thus can teach us about the particular representations the psyche projects in each culture, so the clinician can then assess how it relates to the universal mechanisms of the human psyche.

Another important concept in transcultural psychiatry is the notion of counter-transference, referring here to the clinician's own response to cultural difference in therapy. Counter-transference relates to the affective dimension of the therapeutic

relation between patient and practitioner. As far as the therapist is concerned, its cultural dimension, Moro explains, can range from fascination to rejection and racism. This cultural dimension is linked both to the therapist's professional identity – being a biomedically trained clinician, and his/her cultural identity – being born and raised in France for example. Moro gives us the example of one patient who perceived her as a representative of the French State – a standing symbol of the colonial period he lived through. This patient was delirious, but resisted taking all forms of neuroleptics, and was completely closed off to therapy for that reason. According to Moro, this patient tested her capacity to take his discourse seriously, for what it was. This proved that the obstacle to establishing a therapeutic relationship can come from the representation of the therapist himself/herself, and not the patient. And above all, Moro concluded, one must avoid reaching general conclusions such as “the Soninke believe that...” The goal is to let oneself be transformed.

The following day, we were actually offered a three-hour long class, taught by an anthropology-trained psychologist, on the evolution of the concept of culture within anthropology. We started with early physical anthropology's racially imbued discussions of the concept, to contemporary anthropologist Amselle's groundbreaking theory on hybridity (*Logiques métisses*, 1990). Emphases were laid on the work of Boas and his contributions to counter racist ideology at his time; on Malinowski and his interest in testing Freud's theories, notably the concept of the Oedipal complex; on Benedict, Mead, and others belonging to the School on Culture and Personality; Levi-Strauss and his structuralist approach to cultural variations on universal symbolic structures; and finally Devereux's approach to alternating the use of anthropology and psychoanalysis in

working with culturally different patients, the relevance of counter-transference in the relation between patient and therapist.

The psychologist, who is in charge of a mediation group at a major psychiatric hospital in Paris, ended his lecture with two cases, which according to him illustrate the paramount importance of kinship systems in situating patients' problem. The first case concerned a family from Cameroun, in which the maternal grandmother claimed guardianship over her grandson, because her daughter was now single, and traditionally her children should be sent to her parents. The situation alerted the school director, whom upon hearing that the grandmother had slapped her grandson several times, had called the police, which then had led to the grandmother's arrest for child abuse. The mistake of referring institutional actors in this case, the psychologist underlined, was that they made a cultural assumption that a child should necessarily be with his mother – and that therefore staying with his grandmother could be readily interpreted as abuse. Moreover, the fact that the family spoke French led them to conclude that there was no need for an interpreter, when in fact the use of the latter could have prevented a major cultural misinterpretation in the first place. The second case presented concerned a child hospitalized in a psychiatric hospital for violent behavior. His father had shared his guilt about not paying the dowry in full, which, he thought, had triggered his son to become sick. This case thus dealt with the issue of cultural variations on the representation of children that are “different,” as is often relevant in the case of autistic children.

Finally, a third case was brought up, about a young female refugee from Angola, staying at an emergency shelter in Paris. She came from a family of diamond dealers. Her brutal transition from living a luxurious life to now be without any means and housed in a

low-income suburb, triggered a psychological trauma. At which point, the psychologist commented: “So the issue in therapy is, how to situate her?” One student interjected: “Well, how relevant is the transcultural approach here?” The psychologist agreed that indeed, a common-sense sociological approach to this young woman’s brutal life transition sufficed on the surface. Yet, he agreed that cultural elements became relevant as this woman insisted on leaving the room she occupied, because her window looked onto a cemetery where the previous owner of the house – a noble at the time, was buried. Another student interjected: “Come on! It’s got to be more complex than that! She’s in Paris, she also has a community here...it’s much, much more complex!” The psychologist, visibly unsettled by the comments, responded that, “in any event, when you’re there to apply a transcultural approach to a problem, you’re never on the front line. Our work is not to substitute the work of institutional actors in the field. We only offer an intermediate space.”

Moro’s class underlines that training in transcultural psychiatry is not based on a cultural cookbook. Anthropology as a discipline offers the clinician—or any other professional attending the training—a technique of “decentering,” an exercise at becoming self-reflexive. Obviously, interest in different cultural forms of social organization and representations of mental disorders are relevant to the exercise—as long as they remain technical and avoid the pitfall of fascination or of arbitrary projections. The students’ reaction to the second part of the class is interesting in that respect, in that it caught such arbitrary projection being imposed by the lecturer himself. Whether one may interpret such “side-slipping” as a form of professional deformation, I will show in the last part on clinical ethnography that such tendencies to push the cultural expertise on

the part of specialized mental health experts sometimes create the stigmatizing situations it precisely seek to avoid. Cultural expertise comes as a double-edged sword. I argue that, what is relevant here, is that the conscious goal of specialized mental health expert is, in principle, to present cultural expertise as a technique—a sensibility even, not a pre-determined analysis.

Institutional positionality: Mediating between immigrants and institutions

Instructors in the program were often critical of how institutions framed patients' needs and/or suffering. This dimension of training has to be emphasized in light of the double-bind situations that arise in the clinical context, and which are often linked to the ambivalent nature of referral for immigrant patients or their children. The issue of the patient's need was actually the theme of one of the classes that were taught. The class was team-taught by a psychologist who specializes in linguistics, and by another psychologist who received training in anthropology. The class was particularly interesting in that it emphasized the dual facet of "specialized" mental healthcare in general, one emphasizing its expertise on the relevance of culture in the expression of mental suffering or mental disorders, and the other one reflecting on its limits and on the institutional misuses of this expertise. In that respect, it seems important to note that the concept of "mediation" is often substituted for that of the consultation or of psychotherapy, in that, while therapy is obviously primordial for the transcultural team of clinicians, there is an acknowledgement that, because of the nature of referrals, the team's role primarily resides in mediating between immigrants and institutions. The case presented in class by the psychologist-anthropologist illustrates this point.

Problematizing the patient's "need" (*la demande*)

The psychologist-linguist first started lecturing on the concept of "the need." This need, he explains, is initiated by a desire to be helped. This desire may be characterized as stemming from the individual, or from the family more broadly. Family framing, the psychologist explained, is characteristic of immigrants, for whom it is often difficult to separate the individual from the family, the lineage, the clan. Also, he added, the narrative is not always explicit, especially in relation to the dynamics of transference and counter-transference in therapy. He then prompted the class to provide him with translations of the concepts of need/desire/request in other languages. The exercise was a pretext to illustrate how the concept of "need" may be translated in several different ways within one language, each translation coming with singular meanings and representations. These pointed to "movements of thought" as the psychologist called them, indicating that one concept may be translated differently according to the context individuals find themselves in, and the appropriate linguistic register that comes along with the realization of that particular context (i.e. daily life register vs. healthcare register).

The psychologist continued to explain that often, clinicians tend to equate the need of the patient with the kind of care they offer. In other words, before taking time to elicit the nature of the patient's need in his/her own terms, the clinician has already formulated an interpretation which, in turn, will shape nature of the therapeutic relationship. A student interrupted him: "Well, at Avicenne, it is professionals who interpret the need anyways, not the patients. They can't express their need directly." The psychologist responded that "the one who is suffering does not necessarily have the means to express a need for support. He or she shows signs of that need. The function of

the consultation is precisely to have the need emerge as it should, directly from the patient.” The same student retorted: “Perhaps, but the need has already been interpreted regardless, through the referral to the consultation.” At which point, the psychologist-anthropologist intervened: “I think this may simply be reflective of the particular relationship between clients and institutions here in France, which amounts to the relationship between the one who knows, and the one who doesn’t.”

The psychologist-linguist concluded his intervention by arguing that what is important in analyzing the patient’s need, is that it is not strictly related to the individuals. The transcultural consultation considers the patient’s need to be tainted by his/her relationship with his/her physician, or even by the relationship between his/her family and the referring institution. Transcultural therapy works at extracting the patient from that context which influences the need. Again, the psychologist’s comment appears relevant as it highlights the technical, self-reflexive aspect of transcultural psychiatry for both clinicians and non-clinicians, rather than a primarily culturally-interpretive frame of analysis.

A reflexive case-study

As the psychologist-anthropologist took over, she addressed the institutional dynamics that shape the way patients are referred to the consultation. She readily used the concept of mediation as a substitute to that of the consultation, which acknowledges transcultural clinicians’ position as intermediaries between immigrants and institutions. She narrated the case of a school physician who referred a young Malian boy, enrolled in second year of kindergarten, and who apparently refused to talk at school. All facts

surrounding the little boy, Amadou, were reported to the transcultural clinician by the school. It is readily indicated that Amadou's mother only speaks Bambara. The school thus made the decision to convoke Amadou's father, who immediately felt insulted by the school's attitude, and threatened to remove his child from school, claiming that if the school did not want his child, he would take care of him himself, and Amadou would speak Bambara at home. At that point, the school reacted, seeing Amadou's education threatened by his own family, and made a referral to the transcultural consultation. The school's physician voiced the possibility of a problem with Amadou's cognitive development. Suspicions of family conflicts were articulated. Ultimately, the school expressed its concerns with the necessity to re-establish a dialogue with Amadou's family.

The day of the first consultation, the group received the school physician, the mother, and an interpreter. The doctor explained that Amadou was aggressive at school, and that he did not partake in activities. He added that Amadou's father only spoke to him in Bambara, that himself had not been to school, and that ultimately, Amadou would become *like him*. Amadou's mother responded that there was no problem at home. If Amadou felt provoked at school, then he defended himself. Ultimately, he would be taken care of at home. The psychologist interrupted her narrative to point that the violence of the situation was instigated by the school, as the request for help did not come from the mother herself. In the clinical context, this obviously posed a problem of therapeutic alliance. The goal of the consultation was to try and reverse the actors' perspectives on situations – which would be an unusual thing to do in other healthcare contexts. She went on to explain how the family migration history was elicited from

Amadou's mother. The clinicians were informed that the mother joined her husband later on in France, and that Amadou was their first child to be born in France. The mother thus informed clinicians that Amadou occupied a special place in the family, but also that she arrived in France extremely depressed after leaving her other child behind in Mali. Slowly, she became accustomed to the group and let her sadness come out. The psychologist insisted that she also seemed to feel comforted by the presence and words of another African clinician. The mother revealed how much the presence of Amadou comforted her when she arrived in France. They had a very strong bond now.

Feeling more at ease, the mother changed her discourse. She no longer felt in conflict with her interlocutor. She was, however, in conflict with her husband, something the school had completely missed. She wanted to establish a contact with the school, but the school contacted the husband. The issue of the language spoken at home was also perceived differently by the mother and the father. The psychologist thus underlined how the lack of dialogue between the parents and the school resulted from a stereotyped perspective on the Other's need. As far as the school physician was concerned, by locating the problem in the child and drawing conclusions about cognitive deficiencies, he deepened the gap between both parties.

"Cognitive deficiencies were definitely not the place to start with," the psychologist explained. "Not to mention that it is common among families from sub-Saharan Africa to think that the age of knowledge starts at seven years-old. Before that, mothers take care of children. The whole thing was ill-interpreted by the school." At the second consultation, the father's presence was requested. The latter came with his son, but not his wife. The husband claimed he only came because his wife worried. He stated

that in France he is obliged to send his child to school much too early. The school physician commented that Amadou's behavior has improved slightly, that he was less agitated. The father explained that the education team at school has forbidden him to speak French at home, when he felt it was important to speak to his son in Bambara. In fact, the school had only advised him to do so, but the father's reaction spoke to the rigidity of the relation between the parents and the school. This triggered the parents to act defensively vis-à-vis the school, and the father to feel threatened by a rupture of knowledge transmission with his son.

“These,” the psychologist explained, “are clues that we pick up on instantly as transcultural clinicians. We tried to have the father speak to us about his own fears, but he wouldn't. In any case, that's not what he had come for. Now he felt in a position to give his children the possibility of speaking French at home. He had retained his authority and renewed the dialogue with the school. Meanwhile, we clinicians felt like we had failed. Of course, I personally know we had not failed. It all depends on what we interpret it is that we wanted. It depends on what we understand the need to be. What is important is the change in the relation between the child, his family, and the school.”

Again, it is important here to underline that the intended action of the healthcare center goes well-beyond the limits of clinical care. The project is a wider one that intends at modifying social agents' defensive position in the intercultural encounter. This is equally relevant to the specialized mental healthcare training programs, especially as they address a general audience of non-clinical specialists.

Conclusion

In their assessment of the dialogue on cultural competence in American public health, Carpenter-Song et al. lament that “Many cultural competence efforts construe culture as

something to know rather than something to be ready for” (2007:1365). My observations of 1) experts’ and trainees’ self-reflexive stance on the relevance of culture in healthcare provision and its limits, and 2) the “specialized” mental healthcare institution’s own critical self- positioning in responding to culturally stigmatizing referrals of the other, show that, on the contrary, current efforts in specialized mental healthcare provision in France emphasize culture as “something to be ready for.” This positioning, however, cannot avoid the culturally stigmatizing nature of some referrals that are made towards “specialized” mental healthcare institutions. Hence the frustrations which so often occur in preclinical and clinical contexts, and the “mediating” rather than “curative” or therapeutic role that experts are bound to take on, negotiating between referring institutions and immigrant individuals.

Synopsis of chapter 5

In this chapter, I moved beyond the macro-analysis of institutions, and the study of the interaction between political conjunctures and specialized mental healthcare provision, to focus on the relation between individuals and the system. Focusing on the individuals who “perform the field,” namely, experts and trainees, I argued that specialized mental health expertise was a singularly reflexive field. I showed how such reflexivity focused on the definition and relevance of the concept of culture, both at the level of individual encounters and at the level of specialized mental health as an institution.

In the first part, using the concept of “self-disembedding mechanisms” (Giddens, 1991), I showed how experts’ shared experiences of immigration enforced a professional project in specialized mental healthcare, albeit in different ways. Based on their individual narratives, I analyzed how they problematized the relation between the universal and the particular, in life in general, and in mental healthcare in particular. Overall their narratives emphasized cultural competency as a way of thinking one’s relation to the other and to oneself, rather than as a technical skill. I then teased out the “self-disembedding mechanisms” that motivated students to seek training in the transcultural psychiatry program. I identified 1) feelings of helplessness in the face of discriminatory situations and in listening to trauma narratives, and 2) a self-reflection on one’s response to cultural difference through psychoanalysis. I observed that trainees did not necessarily expect encyclopedic cultural knowledge from their enrollment in the program, but rather appropriated knowledge on transcultural encounters as two-way learning encounters.

In the second part, based on participant observation in the transcultural psychiatry program, I described the institution's critical concern with 1) the relative impact of cultural difference in the therapeutic interaction and beyond, and 2) the role of "mediation" between state institutions and immigrant families. Using class lectures as illustrations, I showed how transcultural psychiatry's approach to the relevance of culture drew from contemporary anthropological definitions of the concept, and how it emphasized the importance of self-reflexivity in the transcultural encounter through the concepts of "decentering" and "countertransference," rather than the cumulative knowledge of world's cultures. In addition, I analyzed the institution's self-critical stance in relation to its "mediation" role in culturally stigmatizing referrals. Lecturers thus problematized how referring institutions interpreted immigrant patients' "need," forcing "specialized" mental healthcare institutions beyond the limits of clinical care.

I concluded that, while current efforts in specialized mental healthcare provision in France emphasize culture as "something to be ready for" rather than as "something to know," this positioning nonetheless confronts the culturally stigmatizing nature of some referrals. Hence the frustrations which so often occur in preclinical and clinical contexts, and the "mediating" rather than "curative" role that experts are bound to take on, between referring institutions and immigrant individuals.

CHAPTER 6: Referring and Naming

I am sitting in Jeanne's⁶⁵ office, at the Minkowska Center, informally discussing her stress and workload. That day, she talks to me about one of her greatest burdens, which is to manage the "old" secretarial team, referring to three secretaries, two of whom have been working at the Center for over twenty years. The adjective "old" is used not only in reference to the secretaries' lengthy service at Minkowska, but also to indirectly underline the fact that the organization, institutional standing, and clinical framework of the Center have shifted significantly during these past two decades. Accordingly, the Center has gone through several changes, filing and referral practices figuring among the most significant ones. Conflicts occurring at the Center among the staff are often related to internal resistance or lack of adaptation to such changes.

As we carry on our conversation, Jeanne suddenly interrupts her sentence, paying attention to the voice of one of the "old-team" secretaries answering a phone call in the office next door. I start listening as well, trying to understand what suddenly caught Jeanne's attention, and why. The secretary, Andrée, asks her phone interlocutor: "Camara...Camara...is that Soninke? Where is the patient from? [Pause] And what language does he speak? [Pause] I'm going to try and see if I have any available appointment with Dr. S. then..." Jeanne makes eye contact with me again. She rolls her eyes and says: "See what I have to deal with, everyday? Imagine if the public health evaluation team heard that one day! This could cost us our public health accreditation! I keep telling them not to do this anymore, openly asking details about patient's ethnic

⁶⁵ With the exception of the lead therapists in each specialized mental health institution, whom I have already identified under their real name, I use pseudonyms for all other informants in the ethnography.

background over the phone. This is not how we do things anymore! I'm telling you, I can't wait until they all retire and I no longer have to deal with this!"

I. **Referring and Naming**

Studies have pointed to forms of creating or reproducing population hierarchies along racial or ethnic lines, notably through bureaucratic practices, and in particular through communicative practices that help justify a social separation between legitimate citizens and others, be they classified as immigrants, refugees, second-generation immigrants, foreigners, etc (Codó 2008, Urciuoli 1996). The denunciation of polygamy—a widespread practice among West African immigrant households—as being the root cause of the 2005 suburban riots in Paris, provides a perfect example of such discriminatory communicative strategies. Yet again, the analysis of institutional actors' language through referring practices highlights that resorting to common evaluation repertoires that stigmatize immigrant populations simultaneously seeks to solve the practical obstacles such populations face.

In my chapter on institutional expertise, I have already established how and why discursive coding (in a politically legitimate and authorized language) is resorted to in the various specialized mental healthcare centers' institutional framework. After re-situating Nathan's discourse on ethnopsychiatry, I analyzed the extent to which recent mental health care institutions for migrants continue to essentialize and normalize cultural difference among immigrant populations. I argued that, while they acknowledge the critique of Nathan, they continue to reproduce exclusionary forms of care, by merely "softening" their discourse along politically appropriate lines in order to survive

institutionally. Meanwhile, they hardly challenge the sociopolitical conditions that made the first ethnopsychiatry initiative possible, and through which this relation to otherness remains essentialized, and sometimes the very basis for referrals to their centers.

Accordingly, I concluded, specialized mental healthcare centers find themselves caught in a paradox, in which they struggle against the very system they help perpetuate. At the same time, I would argue that these centers' enduring presence on the French public health landscape speaks to increasingly frequent debates about the need to positively recognize cultural differences in the public sphere, mainly for pragmatic reasons such as language obstacles or institutional discrimination in general.⁶⁶ While this form of acknowledgement may appear patronizing, it nonetheless highlights the complex realities institutional actors confront on their job daily. And one of the ways they make sense of these complexities is precisely to call for a public recognition of cultural differences.

In this chapter (and in the third part of this dissertation more broadly, from Chapters 6 through 8), I thus move beyond institutional discourse, and analyze referring social agents' communicative practices in framing "immigrant suffering." I start with filing and referring practices (the management of patients prior to consultation). I assess the extent to which referring institutional actors promote discriminatory practices by categorizing immigrants as radically other and by arbitrarily sending them to "specialized" institutions where their otherness can be dealt with, and as a result, become institutionally manageable. What are the rationales for referrals? What representations of immigrants circulate in institutional reports/meetings? How is the relationship between cultural difference and mental health disorder articulated? I simultaneously examine

⁶⁶ Again, see the debate on ethnic statistics. The recognition of cultural differences is often referred to as *diversité* (diversity), as illustrated in the recent March 2010 governmental report (Lozes and Wiewiorka, 2010) dedicated to "The fight against racism and communautarism."

specialized mental healthcare centers' response to referral categorizations of immigrant patients. Do clinical practices related to the categorization of patients, such as filing and diagnostic practices, comfort a line of differentiation between French "nationals" and immigrants? Is it the case that, by abiding by a political rhetoric which forces these centers to reiterate this line of differentiation, the latter indirectly participate in the reproduction of differentiating practices? How do we qualify differentiation in that context? Can we speak of "positive" differentiation?

In the opening to this chapter, I highlight Minkowska's organizational transition to being accredited by state health authorities (*accréditation de la Haute Autorité de Santé*), as it significantly altered naming practices and filing methods. This example, I argue, sheds light on the interaction between political ideology⁶⁷ and filing practices in particular, and contributes more broadly to the literature on how political ideology shapes communicative practices (Bourdieu 1991, Hanks 1996). More specifically, it addresses France's long-standing anxieties with naming identifiable immigrant groups, at the same time as it struggles with the necessity to structurally acknowledge them.⁶⁸

This unwillingness to *officially* acknowledge cultural differences, outside of the generic label "immigrants," under the pretense that it would affect their *intégration* into mainstream French society—or alternatively, as it would prove discriminatory to do so—has led social agents to resort to alternative naming strategies that draw on common cultural representations of immigrant others. For example, in her analysis of the rhetoric of racism and anti-racism in France among French and North African male blue-collar/manual workers, Lamont showed how racial boundaries are euphemized by

⁶⁷ Here I refer to France's republican model of integration based on the logic of universal rights that denies the relevance of ethnic differences.

⁶⁸ This tension, I believe, is perfectly epitomized in the recent debate on ethnic statistics.

references to moral evaluation criteria that frame difference in universalistic terms (2000:57), such as solidarity and civility. My analysis of West African patients' files instead delineates a code of social differentiation, including references to immigrants or their descendants' sensitive residential environment for example (read: immigrant suburb), children's educational difficulties (read: poor parental educational support), communicating abilities (read: foreign accent), family structure (read: polygamous unions, or single-headed households), etc. Such codes were not articulated, I believe, in "simple cause and effect sequences" (Urciuoli, 1996:41). Rather, they result from a long-term accumulation of representations related to the treatment of cultural difference in France. These representations, circulated over time by politicians, scientists, and the media, thus take their contemporary shapes in the public imaginary, to become "common sense". This is not to say that representations thus come to be internalized by individuals and unproblematically projected onto daily practices—following Bourdieu's model of habitus—without being contested. In fact, the reality of the clinic, as well as the complexities of the interactions between referring institutional actors and "immigrant" populations, show that the impact of such representations in daily practice is much more nuanced.

1. Instruments: Filing without differentiating? (internal representations)

In this first part, I address the interaction between political ideology and filing practices by analyzing internal representations of immigrant populations in these three centers. By "internal representations" I refer to the ways specialized mental healthcare centers' staff frame their management of culturally diverse patients. I discuss filing

methods in particular, as a bureaucratic instrument for categorizing individuals, and therefore as a lens through which to analyze the classification of immigrant patients.

As in any other medical institution, the first appointment at a specialized mental healthcare center leads to the opening of a patient file. This file has a standard format across medical institutions. Some institutions use blue and pink files to color-code patients' gender, while others do not. The file is an approximately twenty-page long blank notebook, which, after each appointment, is supposed to be filled by the therapist/social worker with summaries of the consultations, the dates at which they took place, and a mention of who was present during the consultation. The front of the file bears the patient's assigned therapist's name, as well as the patient's number. On the inside of the file cover, other indications include the patient's name, family status, social security status, legal status, place of birth (often accompanied with a mention of the patient's ethnic group and spoken dialect), the date of arrival in France when it applies, the name of the referring institution/institutional actor, and a sentence summarizing the reason for the referral.

Minkowska: Adapting to French public healthcare guidelines

At Minkowska, a separate sheet of paper is inserted in the file containing the same information aforementioned, but with supplementary details to be provided concerning the patient's living situation (i.e. at one's parents, in couple, at a shelter, alone with one's children, etc.), the existence of a legal protection when it applies (i.e. under legal surveillance, under hospital supervision, under tutor supervision, etc.), type of social assistance (i.e. disability/unemployment/social security stipends), place of external

referral when it applies (when the patient is sent to another structure than Minkowska's), school status, and professional status.

Initially, this sheet contained a space to indicate the nature of the consultation with respect to the patient's geographic area of origin. There were seven groups of choices: 1) Africa / Indian Ocean / Caribbean, 2) Spain and Spanish-speaking countries, 3) Portugal and Portuguese-speaking countries, 4) Central and Eastern Europe, 5) Turkey, 6) Asia, and 7) North Africa. Following this indication, secretaries had the choice of assigning patients to therapists specializing in each of these areas. Files were logically organized accordingly. Patients were thus cast into categories that related cultural belonging to very broad cultural/linguistic areas. One has to bear in mind here that this categorization followed the rationale of Minkowska's founders, who wished to improve mental healthcare provision to second-world war refugees by providing them with therapy in their language of origin. The languages offered at that time were German, Russian, and Polish. It is following the diversification of immigration that the Center developed the seven "geocultural" areas mentioned above, with the same linguistic concern for therapy facilitation.

This model of organizing the clinic, however, became increasingly problematic as the Center made efforts to dissociate itself from Nathan's culturally-specific model of culturally-competent care – even though their cultural categorization schemes were different. As I explained in the chapter on institutional discourse, mental healthcare provision could continue to label itself as culturally competent and to address the needs of "immigrant" populations in the name of healthcare access for all, but it could no longer allow itself to refer to specific ethnic groups or officially triage patients according to their

place of origin, as was the case at Minkowska in its early years. The visible needed to be made invisible.

It was only recently, then, that the geographic area indication was removed from the patient's information sheet. This change came in the context of Minkowska's being audited by the National Department of Social Affairs⁶⁹ in order to verify whether the Center complied with the 2006 legal amendment concerning services provided to patients in the hospital system.⁷⁰ In March 2007, Minkowska was officially certified as fulfilling the quality of services required from public health institutions in France. Following her comments on the "old" secretarial team ways noted above, Jeanne explained to me how Minkowska's director, its head psychiatrist and herself painstakingly prepared the staff for the audits.

We had to have the secretaries practice, so that they would change the way they answer the phone. They could no longer just triage patients by asking questions about their ethnic group or their place of origin. There is no obligation to refer a patient of African origin to Dr. Y. [one of the two clinicians of sub-Saharan African origin working at the Center], simply on the basis that he or she is from Africa. We don't want to be perceived that way. Really, their only potential concern should be about patients' spoken language. It's hard for the secretaries to understand though, and honestly, they just don't put much effort into it. They're close to retiring and they won't change their ways. I keep explaining to them the AMC (Clinical Medical Anthropology) framework, the importance of finding a middle-ground between culture as all-encompassing in healthcare delivery, which ultimately leads to patients' stigmatization, and culture-blind care, which leads to ethnocentrism, but... it's hard to change old habits..."

⁶⁹ Inspection générale des affaires sociales (IGAS) is a state organism in charge of "controlling institutions (...) which provide social services (employment, career training, social security, public health, healthcare delivery, family services, child services, *intégration*, local policies)." <http://www.travail-solidarite.gouv.fr/web/inspection-contrôle-evaluation-igas/presentation-igas/qu-est-ce-que-inspection-generale-affaires-sociales.html>

⁷⁰ Charte des patients hospitalisés. English version available at: <http://www.sante-sports.gouv.fr/IMG/pdf/anglais.pdf>

We can see in Jeanne's comments the direct negative organizational impact that resulted from a seemingly minor policy change in the filing of patients, and the tension it incurred among the staff.

On the one hand, the changes Jeanne refers to do inscribe themselves logically within the Center's AMC framework, and within the French public healthcare framework of healthcare access for all, regardless of national origin or legal status. On the other hand, in practical terms, patients at Minkowska continue to be dispatched to clinicians on the basis that their culture of origin, and possibly their spoken languages, matches. In fact, with the development of translation services, language has become less of a concern on the clinician's part. This tension between institutional discourse and clinical practice unsurprisingly triggers internal misunderstandings and conflict situations, especially among the "old" staff, which understandably negotiates this paradox less easily. Shortly after Jeanne complained to me about the "old" team's behavior in her office, I took the opportunity of doing research in patients' files, located in the secretaries' office, to approach the same issue with Andrée. "So I just learned about the auditing process for the accreditation," I started, "and about the small changes that came along with that in the referring system...that must have been stressful for you all." "This is just ridiculous," Andrée replied in a low tone of voice, presumably not to be caught commenting by the senior staff. "Jeanne keeps being on our case about not asking details on the patients' origins over the phone, but how else would we go about and organize referrals here? I've been the appointed secretary for Dr. Y. and Dr. Z. for years now (she points to their respective appointment books, piled on her desk). It has always made sense so far that we refer patients of African origin to them. After all, they do understand the culture and they

do speak the same language as the patient's sometimes. That's why people presumably call us for. To find someone to talk to who will understand."

I nod at Andrée's comments, reminding myself that, after I was given permission to go through patients' file for my research, I was indeed sent to Andrée, as the secretary "in charge of African patients." She had pointed me to the filing cabinet behind her, where all the files of "African patients" were grouped. And, in fact, this was exactly how each filing cabinet was organized: according to patients' geographic area of origin.⁷¹ Of course, only the staff would know that, as there are no visible geographic-coding signs on the filing cabinets. Moreover, in terms of clinical organization, Andrée is right, and this differentiation system has been in place since the creation of Minkowska. Again, the Center was, after all, a locale meant to provide post-war refugees with the possibility of expressing trauma in their native language, so as to logically facilitate mental health therapy.

It may be that the Nathan stage in specialized mental healthcare provision created this fear of establishing a system in which an ethnic Bozo can only be treated by another Bozo, and ultimately remain a Bozo for his mental well-being's sake. As I showed in the chapter on the making of expertise, this analytical aberrance did create a gap between the danger of extreme relativism in healthcare provision to immigrants on the one hand, and the universalistic principles of the republican state on the other. It is no surprise that the centers' expert discourses always struggle to find a middle ground between the two, particularly Minkowska's AMC framework. The French republican rhetoric, with its implicit anxieties about immigrants' integration, provides the very basis for such

⁷¹ The Center underwent significant building renovations this summer, which led to the reorganizing of the filing system by the secretaries themselves. I left after this was completed, and I am not sure whether patients' files are still organized the same way.

Manichean perspective on references to cultural differences in the public sphere: it either negatively discriminates by acknowledging them or positively integrates by ignoring them. And yet, in daily practice, the dichotomy does not seem to make much pragmatic sense, as apparent in Minkowska's filing example and through Andrée's reaction.

Services specialized in mediating cultural differences, and catering to a wide array of institutions, continue to thrive for a reason. Institutional actors need the support of interlocutors in their encounters with cultural differences. One may analyze this search for support as the vehicle of State paternalism and as driving the management of immigrant families so they fit the French mold, but I believe that such analysis limits our understanding of the complex interactions between immigrants and their families, institutional actors, and those who mediate between the two. Rather, they follow differentiation pragmatics, according to which it still makes sense at Minkowska to make an appointment for a West African patient with one of the two clinicians who themselves come from West Africa, not solely on the grounds that they are familiar with illness representations in that "cultural area," but because they may speak the language of their patient, which may indeed improve the therapeutic interaction. Depriving immigrants of that possibility would result in clinically managing generically "other" bodies and in practical terms, diminish the possibility of a therapeutic interaction if the patient's language skills are insufficient for communication. The issue, however, may not so much lie in the cultural rationale for mental healthcare therapy itself, but rather for the cultural rationale behind the *referral* itself, regardless of mental health concerns, as I will analyze later in the chapter.

Jean-Baptiste Carpeaux and Avicenne: One filing for all?

At the Jean-Baptiste Carpeaux center, just as at Avicenne's transcultural consultation with which it is affiliated, the ethnopsychiatry consultation is part of a larger medical structure, except JB Carpeaux only serves the local district. Appointments are made through a central medical office, where the patient's file is first opened. Information on the patient's culture of origin may be provided by the referring institutional actor. The issue of classifying patients according to their culture of origin is irrelevant insofar as there is only one therapeutic team: the ethnopsychiatry group. The rationale for referrals, as mentioned in my previous accounts of the clinic, rests on the principle that the patient in question is "culturally different" and that his/her differences hinder the work of referring institutions/institutional actors. Regardless of the immigration generation they belong to, or where they come from, patients at the ethnopsychiatry consultation (and at Avicenne's transcultural consultation alike) are institutionally labeled as culturally "other."⁷² Before the first appointment, arrangements may be made for an interpreter to be present at the consultation, if a language barrier is indicated at the time of referral. The clinical team itself, following Nathan's idea of the consultation group, is intended to be culturally diverse.

Naming and referring practices thus follow the public health code by not having to target specific immigrants groups. Moreover, the ethnopsychiatry consultation at JB Carpeaux and the transcultural psychiatry consultation at Avicenne each constitute one service within a "mainstream" public healthcare institution. Therefore, catering to immigrants does not define the institution as it does at Minkowska. For referring institutional actors, however, the "ethno" of ethnopsychiatry, or the "transcultural" of

⁷² This speaks to the problematic use of the "immigré" or "migrant" categories in France, which do not distinguish between individual's legal status, country of origin, generation, etc. This is discussed in Part I, Chapter III of this dissertation.

transcultural psychiatry, both speak for themselves and make it clear that all immigrant “others” are welcome. Accordingly, patient files are standardized. They are numbered as soon as they are opened. But unlike at Minkowska, patients’ files at JB Carpeaux and Avicenne are classified strictly following their numerical order, not the patient’s cultural area of origin. The file may be accompanied by a letter of referral, although I have rarely seen correspondence in the files. Secretaries sometimes summarize the rationale of the referral themselves on the patient file. This summary then serves as an element of contextualization for the team of therapists and psychology interns attending the consultation. When the referring actor is present during the first consultation, other elements of contextualization are provided, as described elsewhere in my clinical accounts at the centers, and written down as part of the consultation narrative.

As public health structures, JB Carpeaux and Avicenne are subject to auditing by the National Department of Social Affairs (NDSA) as well. But as providing a “public service” in general, their activities may be monitored by yet another State-mandated organization: the *Haut Conseil à L’intégration* (HCI—Governmental Expert Commission on Integration). This organization’s mission is “to give its opinion and make any useful proposition ...on issues related to the integration of foreign residents or residents of foreign origin.”⁷³ Pf. Moro, head of the transcultural clinic at Avicenne, recounted her experience of being audited by the HCI during a symposium which closed the year of academic training for students of the transcultural psychiatry program. That year’s student cohort, which I was part of, had decided to organize the morning session around the theme of ethnic statistics. At the end of the session, as the audience was discussing the paradoxes of being trained to work with culturally diverse populations in a context

⁷³ Website presentation at: http://www.hci.gouv.fr/rubrique.php3?id_rubrique=8 , accessed on 3/10/10.

where institutionally acknowledging those differences was the source of a heated political debate, Pf. Moro offered to illustrate the point. In the context of a report on *laïcité* (secularism) in public services (HCI, 2007), an HCI committee had interviewed her, and she was asked to justify a mental health consultation targeting immigrant groups specifically. Among other things, she was asked for epidemiological data sustaining the relevance of cultural representations in the treatment of mental health disorders among immigrants. At one point, she answered to one of her interlocutors that she could only draw from the general clinical and medical anthropology literature, as well as from some epidemiological studies carried out abroad, as a “scientific measure” of the interaction between culture and mental health. She added that clinical reports from her specific transcultural consultation at Avicenne would further attest to the importance and benefits of providing a culturally competent clinical team, while adhering to the public health model of healthcare access for all. Moro reported she felt great animosity from committee members, as someone promoting discriminatory treatment in her own establishment. Ironically, one member asked her: “Well, how could you claim to be culturally competent yourself, considering you’re not an immigrant and you’re French.” Her interlocutor’s assumption was that she was *française de souche* (ethnically French), presumably because neither her phenotype nor her last name would reveal clues about her “foreign ties” (although, as she commented herself, Moro is spelled with an ‘-o’ at the end, instead of say, ‘-eau(x)’ or ‘-ot’, which would appear more “traditionally” French spellings). What was particularly interesting was how the committee members drew the connection between being “culturally competent” and necessarily being an immigrant – however they define the term. In this particular instance, “cultural expertise/competence” is

indirectly put in relation to racial belonging. Moro kept it to herself that she was born in Spain and had immigrated to France with her parents until the end of the interview.⁷⁴

Echoing Minkowska's response to the NDSA audits, Moro's experience highlights the inherent contradiction of a system in which, for fear of accusations of discriminatory practice, public service professionals carefully refrain from making references to cultural differences in institutional discourse, while at the same time catering to these very differences and referencing them in daily practice and interactions. The HCI hearing illustrates how State discourse also enters in contradiction with itself as, on the one hand, committee members critically argued with Moro on the discriminatory potential of offering a separate, culturally competent consultation, in direct opposition to the system's universal values; while on the other hand, they evaluated the scientific validity of the cultural consultation on the basis of racial indicators, and even put forth an understanding of cultural competence based on the same principle of ethnic belonging Nathan had defined for "ethnoclinicians"!

The difference at Avicenne and JB Carpeaux, however, is that there is actually no triage of patients according to their culture of origin. The group consultation is unique in the respective institutional structures, and therefore patients of all origins consult with the same group of clinicians. The latter intentionally representing various cultural origins – following Moro's concept of *métissage* (hybridity)⁷⁵, there is actually often a chance for one of them to come from the same "cultural area" as the patient, or to understand the

⁷⁴ The relationship between specialized mental healthcare practitioners cultural competence and their personal life trajectories is problematized in Part II, Chapter II of the dissertation on "Practicing Expertise"

⁷⁵ The concept is introduced in Chapter IV on "The making of expertise," 2. "Competing for a new paradigm"

patient's language. However, patients cannot be pragmatically "matched" to a particular clinician, as they would be at Minkowska.

Gepela Center: Mediating for "Africans"

Because Gepela does not qualify as a public health institution per se, there is no required medical filing of patients per se. Mediations need to be accounted for in the association's activity report, but medical filing itself is carried out prior to ethnoclinical mediation by the center's team of school psychologists on their respective work sites. Because the Center's expertise is on African "Languages and Civilizations," the assumption is that referred students and their families necessarily "originate" from the African continent, although changes in immigration demographics have led to mediation cases about patients from Southeast Asia for example, but only rarely. Families are thus selectively identified by the Gepela school psychologists, on the basis that they come from Africa. Other institutional actors who are familiar with the Center's activities may make referrals on the same basis.

There exists a reversed contradiction with Gepela, in the sense that it institutionally qualifies as an association (law of 1901), whose goal is "to inform and teach about knowledge in Africa," and therefore positions itself as an expert on African "languages and civilizations." And yet, with respect to its activities as an ethnoclinical center, Pf. Maiga, Gepela's director, often insists that it is not the place to categorize patients into cultural groups – which he often blames anthropologists for doing. Rather, ethnoclinical mediation focuses on "intentionality" or discourse production – regardless

of the culture.⁷⁶ The ethnoclinician is situated “in between” in the mediation encounter, and therefore does not need to be culturally affiliated with the patient. Nonetheless, as is the case with ethnopsychiatry, the “ethno-” of “ethnoclinical mediation speaks for itself: all non-French nationals are welcome. In Gepela’s case, however, this categorization is intriguing considering mediation mainly targets French born and raised second- or third-generation children of immigrants, primarily of African ancestry. Granted, mediation with these children also involves parents or other family members.⁷⁷

Gepela, unlike Minkowska and Avicenne or JB Carpeaux, is not bound by institutional audits. As an association, it does have to account for its activities in other ways,⁷⁸ but being first and foremost presented as a research and training center, its focus on Africa is not deemed discriminatory. The center does not directly “act” as a public service, it “listens” as Pf. Maiga often underlines. The limits of “listening” can be debated in light of the direct link between ethnoclinical mediations and the action taken by its affiliated school psychologists, or with respect to the Center’s “interventions” at school sites. Regardless, the students and families with whom Gepela works are almost exclusively from Africa, or of African descent. There is an underlying understanding between Gepela’s director and its psychologists that they provide expertise on Africa (they actually do take trips to Mali on a regular basis as part of their broader training and participation in Malian university programs).

⁷⁶ Ethnoclinical mediation is detailed in Chapter IV on “The making of expertise,” 2. “Competing for a new paradigm”

⁷⁷ I remind the reader here that, through the intervention of its member school psychologists, Gepela mediates between school officials (administrators or teachers) and children’s families.

⁷⁸ *Rapport moral* or *Rapport d’activité* (Report of activities)

Internal contradictions

Although the three specialized mental healthcare centers—Minkowska, Avicenne/JB Carpeaux, and Gepela—offer variations on the impact of French republican ideology and its appending politics of representation, they all underline the same contradiction between a *bureaucratic language*, phrased along republican lines of non-differentiation, and *clinical practice*, pragmatically organized on the basis of cultural differentiation. This does not appear problematic for the organization of the clinics themselves, which, outside of occasional staff frictions and misunderstandings, this contradiction does not seem impact too greatly. I would argue, however, that this form of institutional regulation limits specialized mental healthcare centers in challenging the management of immigrant populations within the system more broadly, in that it creates what I refer to as a “double-bind” – the oscillation between contesting a regulative system in which cultural difference is often pathologized and accessorially used to disguise discrimination, and indirectly legitimizing in terms of professional expertise. This “double-bind” will appear more clearly by the end of this chapter, after the discussion of referrals, and it will be discussed directly in the next chapter entitled “Circulating and Contesting.”

2. Referring: repertoires of representations and structural obstacles

(external references)

In this second part of the chapter, I continue to look at the interaction between political ideology and referring practices, this time by analyzing external representations of immigrant populations. By “external representations” I refer to the ways referring

institutional actors – situated outside of specialized mental healthcare centers – frame their rationale for considering specialized mental healthcare centers as appropriately addressing the needs of their immigrant clients. I base this analysis on the study of files of West African patients I had access to at Minkowska. I delineate a typology of representation repertoires. I also analyze pre-consultation meetings I was able to attend with referring actors. I particularly examine how the latter frame the basis of the patient’s mental health issue, and how the mental healthcare center staff responds to them.

At times, the patient’s file is supplemented by letters of referral from various institutional actors. At Minkowska, out of the 30 patient files I had access to for 2007 (I specifically selected immigrant patients from West Africa, or of West African descent), 10 contained such supplemental information. Referral documents are extremely heterogeneous in form and origin, from hand-written individual requests for consultation to letter-headed court orders for therapy. This heterogeneity illustrates the depth and breadth of state population management processes in the reconfigured field of mental health. In this sample, two referrals came from the National Education System (one from a school psychologist and the other from a school teacher), three came from medical workers (two clinical psychologists and a pediatrician), one from social services, three from legal services (one court order, one association applying educational support on a court order, and one from child protection services): virtually all state institutions are thus represented in this sample. Accordingly, documentation supplementing the referral varies, from inspired narratives on the patient’s social history, to a school student competence and knowledge evaluation, or a “social report” displaying the patient’s family administrative status and budget details in tables.

Interestingly, I found that expressed motivations for a referral are often laid in ambiguous terms. With the exception of the referral from a pediatrician, which specifies medical disorders suffered by his patient (“relationship disorder,” and “invasive development disorder”), or of a clinical psychologist’s direct reference to “depression, weight loss, and cannabis consumption,” other referrals recurrently point to “difficulties,” “suffering,” or “fragility.” To underline that descriptions of patients’ mental health status prior to consultation are ill-defined may seem derisory in the sense that referrals may seek specialized mental healthcare centers specifically to clarify a diagnosis for them. It becomes informative, however, to investigate the extent to which the relationship between patients’ social history and cultural background is much less ambiguously drawn by referring institutional actors. These relations appear to also inform rationales for mental healthcare referrals. The wording of such relations varied from one referral to another, and in some files, the relation is only made implicitly. Following are the common representation schemes I was able to identify. I choose to pay particular attention to the choice and combination of elements which are used to create patients’ social history and which presumably draw upon a common cultural (French) frame of reference, one which is intended to elicit signals to the reader, and lead the latter to a form of conclusive judgment on what is understood as standing outside of “normal” – sometimes described as mentally healthy—boundaries.

Communicating cultural differences, locating pathology

Throughout referral documents, I found references to patients’ social history to be framed either in terms of social precarity, or “unusual” family arrangements (or both).

Some referral letters include class-based forms of judgments pathologizing *banlieue* (suburb) lifestyles. For example, an implicit relation is drawn by a middle school teacher who, in her written request for a specialized mental healthcare consultation, reports to have “noticed a singular form of suffering” in one of her students. The social history she provides for her student – specifying his residence in a “sensitive neighborhood and a *communautaire* (read: ethnic-conflict prone) environment,” as well as his mother’s trips to Mali, during one of which he was sent to a social shelter by child protection services – hints that this “singular form of suffering” may be related to the student’s cultural origin and her precarious social milieu. Life in the *banlieue*, as often portrayed in the media, readily projects images of social precarity and delinquent youth, but also images of dysfunctional households.⁷⁹ Those three elements are combined in the letter of a social worker discussing the case of a “juvenile delinquent.” The letter narrates the youth’s social history, which includes his delinquent acts (mainly theft), his problems at school, and “his fragility in the relationships he has and the choices he makes. ... He has trouble saying ‘no’ to his entourage and asserting himself.” Rapidly, the young man’s acting out and his apparent difficulties in communicating with his mother—a reference to him belonging to a female-headed household is skillfully inserted here—are all assumed to be linked to his “communication difficulties” in general.

Although one would expect referral letters to specialized mental healthcare centers to emphasize mental suffering at some point—be it reported in obscure terms or/and implicitly linked to ethno-cultural difference— I found several instances that instead seemed to focus on cultural difference in patients’ behavior and practices, coded

⁷⁹ An analysis of such representations will be found in Part I, Chapter III of this dissertation. I’ll add references here later.

in terms of unusual family arrangements. Thus a letter from a social worker refers a separated Malian mother of four, who seems to have difficulties establishing a relationship with her fourth child— whom, the letter specifically indicates, was born out-of-wedlock. The social worker hints at her misunderstanding of the patient’s culturally-distinct behavior (“she could not divorce because of family pressures,” “she rarely looks at her child and calls her ‘it’. She plans on entrusting her with her sister who lives in Mali and who does not have any children”⁸⁰). Only then, the social worker emphasizes the patient’s mental and physical distress (“if I keep thinking too much my head will break,” or “my head spun and spun, and then it fell”).

Another referral, after strongly emphasizing the social precarity of the patient, appears to identify his mixed cultural background as the root of his mental suffering. In this referral, a clinical psychologist, working for a district’s “Department for Social Insertion, Fight Against Exclusion and For Employment,” writes of a young unemployed man he refers to the center as being “in a state of deep suffering. Born in France, he lives between two cultures, which prevents him from establishing real markers (*repères*).” This is an interesting comment, reflective of France’s uneasiness with the concept of hybridity: in the Manichean opposition between the “immigré” and French categories, there seems to be no room for that concept (Taguieff, 2001:213).⁸¹ Specialized mental healthcare professionals often comment on how France forces a cleavage of identities on immigrants’ descendants, resulting in mental suffering. In parentheses, the psychologist juxtaposes to this diagnosis that the young man’s father has two wives and that he was

⁸⁰ The practice of entrusting children for various reasons is well-documented in sub-Saharan Africa. Therefore, it does “make sense” in local understandings of family ties.

⁸¹ Although during his presidential candidacy speech, Nicolas Sarkozy referred to himself as French of mixed-blood (*un petit français de sang mêlé*) (see Le Monde, 2007).

raised by the second one, presumably presenting this non-normative and culturally-specific family arrangement as pathological, or at least, worthy of attention. At the end of his letter, the psychologist seals his diagnosis of the patient (depression, weight loss, cannabis consumption), which again he juxtaposes with the patient's own interpretation of his suffering: "he believes to have been cursed (*marabouté*)".

Again, I would argue that such vague and interspersed references stand as coded signs that are locally intelligible. For example, after briefly making reference to the patient's country of origin, the letter of a clinical psychologist—who cares for the patient's four-year old son's speech disabilities—establishes the "*difficulties* experienced by Mrs. D. to *situate herself in her own history*. We thus thought of your consultation as *appropriate to her problematic*, and we thought it would allow her to have support *from where she is situated*" (emphases mine). This last example not only perfectly illustrates the art of coding cultural difference without naming it, but by referring the patient's relative herself to the specialized mental healthcare center, it highlights the relationship being implicitly drawn between the patient's already established disorder (speech disability) and the parent's cultural difference (and related suffering). One may very well consider that a young child may be affected by his/her parents' mental suffering, whether this suffering stems from the experience of migrating or not. But then again, why would such a connection not be articulated, in an otherwise very detailed referral correspondence? What does the unspoken speak to?

Managing immigrant families

An alternative question to be asked may be the following: what motivates referring actors to establish a relationship between cultural difference and mental suffering? As I have asserted before, such relations are related to common cultural representations of immigrants that stigmatize them in reference to their social milieu and their lifestyle, and which referring actors indirectly help reproduce and disseminate. However, I would also argue that the assumptions drawn about the risks immigrant patients incur from their social milieu and from their own social practices seem to hint at the principle that relieving a patient's "suffering" entails broader action by his/her entourage. A pediatrician, director of a "Center for Early Medical and Social Action" outside of the Paris region, referred the mother of his four-year old patient to the center "so that [she] can, in her language of origin, provide explanations on her son's *difficulties* (emphasis mine)." The child himself, the pediatrician indicates, suffers from "a relationship disorder" doubled with "an invasive developmental disorder." Interestingly, the doctor's report is accompanied by a letter hand-written by the child's father himself, who wonders whether his son is "autistic," in his own terms, and whether the doctor can provide medication to help the latter sleep. He specifies that his son's condition seems to have been triggered by an episode of high fever when he was still an infant. This letter leaves the reader to presume that the child's parents put forth a biomedical diagnosis that very much coincides with the pediatrician's. This alternatively leaves one to ponder on what basis the mother would be referred to the specialized mental healthcare center. What other diagnosis might the mother offer, that would facilitate this pediatricians' treatment of his patient?

Similarly, a Parisian court, ruling on two “juvenile delinquents” to be placed under an “educational assistance measure,” orders for the delinquents’ parents to be sent to a specialized mental healthcare center. In the judgment letter signed by the judge himself, it is indicated that “a consultation measure is entrusted to an ethnopsychiatry center (no specific institution is targeted) to allow Mr. and Mrs. D. to speak to therapists of their language and culture.” The judgment letter is accompanied in the patients’ file with a copy of the ruling, which adds that “It is expected that light will be shed so that we can apprehend the situation with respect to the cultural representations of persons concerned. [This is] why we call for *an ethnoclinical intervention* of several consultations (four maximum) (emphasis mine).” The letter specifies that a report is expected from the ethnopsychiatrist/ethnoclinician, and that consultation fees will be paid for by the Public Treasury.

In the aforementioned cases, the relationship between cultural difference and mental health suffering seems far-stretched. However, one could also see it as offering support services to populations that would otherwise be criminalized. In both cases, the centers’ “cultural expertise,” however it is perceived, not only reaches beyond mental health issues per se, but comes to serve as a tool to manage institutional dead-ends, as the following pre-consultation meeting at Minkowska illustrates:

Jeanne, one of Minkowska’s social workers, receives a psychologist working at a municipal career and support center for youth in a northwestern suburb of Paris. The latter had contacted Jeanne over the phone, and had expressed her desire to meet with her so as to discuss the case of a 22 year-old man she hoped to refer to the center.

Jeanne invites me to attend the consultation. As the psychologist walks in, I am being introduced by Jeanne as an anthropologist and affiliated researcher with the center. After the three of us take a seat, Jeanne invites the psychologist, Mrs. P., to tell us about this young man, named Idriss, whom she has assisted at the career center. She starts by specifying that

Idriss is French-born, but that she is unsure as to whether he is of Malian or Senegalese origin. From what Idriss had told her, when he was five, he was taken “home” (*au pays*) by his father, and had come back to France when he was already 19 years-old. His mother had passed, but Mrs. P. didn’t know when. Idriss has a stutter. He has never gone to school, neither “at home,” nor in France, because his maternal grandfather did not want him to. “What about the Coranic school?” Jeanne interjected. Mrs.P. thought he had not gone to Coranic school either, but she was not sure about it. She was informed, however, that he was the only one among his siblings not to have been sent to school. Yet again, when Jeanne asked her what Idriss’s position among his siblings was, Mrs. P. was unable to answer.

Mrs. P goes on to inform us that when Idriss came back to France, his father stayed “home.” Idriss thus came to stay with “a lady” he calls his aunt, who in fact *appears to be* his father’s second wife, and with whom he does not get along at all. “I suspect she beats him. I don’t have proof of that, but I do know for sure that she rejects him, and that they have an extremely difficult relationship.” Idriss’s main problem, she continues to explain, is that he can neither read nor write. His stutter only adds to these handicaps, and makes it difficult for him to find a job. He’s been hired by a state-sponsored association assisting unqualified youth to find a job. Thanks to this program, he has been working on a construction site where he is being trained as a heavy machinery operator. He has already failed the qualifying test once, but his employers are still “very satisfied” with his work. They find him to be “responsible, reliable, and amiable.” They work hard to find him a real job before his contract with the association ends. “But there’s another problem,” Mrs. P. adds, “which is about his supplemental health coverage (*mutuelle*). He pays for it, but his father manages it ‘from home’. So when Idriss gets reimbursed from his healthcare expenses, his dad is the one collecting the money.” She explains that Idriss needs to obtain a CMC (a separate bank account). He has been assisted by the career and support centers’ social workers to take the measures which will help him obtain the CMC. However, the latter have encountered several obstacles already. Initially, Idriss’s aunt had refused to provide them with a housing certificate. Mrs. P. recounts that this prompted her to call the aunt herself, and with the help of a French-speaking family member (for “the aunt expresses herself very badly,” as she put it), she managed to obtain the certificate. Unfortunately, one piece of documentation is still missing, which is the copy of the aunt’s residency permit.

Mrs. P. comes back to Idriss’s stuttering problem. She explains that he has been going to a speech therapist for about three months, which enabled him to progress rapidly. But because of the reimbursement issue, he has been unable to pursue therapy. “Paradoxically”, Mrs.P. adds, “the progress he has made expressing himself better has enabled him to socialize with people more easily, which led him to hang out with the youth in his

neighborhood. Not a good thing, these boys. They are all involved in small delinquency and theft. I'm concerned Idriss goes down the same path." She goes on to complain about how people who are supposed to assist Idriss at the youth center have a bad attitude. "Especially the district's social worker who keeps repeating there is nothing she can do for Idriss, even though she has always been unwilling to even call his aunt." She proceeds to talk about herself, how she feels overwhelmed at work, feeling helpless in her attempt to have work colleagues collaborate with one another and, in this case, with Idriss's family. She is the only one to have gone through the trouble of contacting the family, whom she finds "very nice and available." She herself is very limited by precarious work conditions at the youth center, her contract being renewed every three months, and working only four hours a week. "I'll tell you, this doesn't make one feel like investing oneself in the job. We can't possibly do everything. We're not gods!"

Finally, she asks Jeanne how Minkowska can help her. "What cultural aspects would help me better understand Idriss's situation?" She suddenly turns to me: "What if he were a child-sorcerer, what would that mean? How would things go?" Seizing my puzzlement at both the bluntness of the question and the awkwardness of its content, Jeanne jumps in to suggest various scenarios following which Idriss's specific position among his siblings and the conditions of his childhood would impact his relationship with his family, more specifically with his father. "But all of these are hypotheses, considering I don't have enough information to guide me here." Nonetheless Mrs. P. insists and goes back to those scenarios, only to ask again how such cultural clues would help clarify the Idriss's situation.

"Well, at this point, I'm afraid I don't have much to offer in terms of explanation. I could offer to contact and meet with the aunt. I could also contact the sector's social worker. (Mrs. P. rolls her eyes) Once contact has been made with the family, a mediation could take place."

Mrs. P. responds that the priority now is to help Idriss become independent, in terms of healthcare coverage, but also as far as housing is concerned. Jeanne, however, cautions her not to destabilize family relations. She offers Mrs. P. to be available by phone if she needs further assistance. She then launches into her presentation of the Clinical Medical Anthropology Framework. I ask Mrs. P. where she heard about Minkowska. She answers that she indirectly heard of the center when she was taking psychology classes at the university, and she was taught about ethnopsychiatry.

Idriss's psychologist comments on obstacles which are less psychological than structural in nature. Idriss's family history has indirectly produced a complicated administrative

situation, which the psychologist has trouble solving, partly because of language obstacles (references to Idriss's aunt speaking abilities). Idriss's absence of schooling further complicates his already precarious situation, seriously limiting his possibilities for financial independence and social autonomy more broadly. In fact, the stigmatizing assumptions in the psychologist's narrative, which may be linked to cultural representations of immigrants in France (for example, the point she makes about Idriss's family structure as deviant: "a lady" he calls his aunt), overall emphasize class-related issues over culture (for example, reference to a violent suburban environment: "I suspect she beats him," "the youth in his neighborhood ... they are all involved in small delinquency and theft").

This ambivalence, between acknowledging concrete structural inequalities and making sense of them as being ineluctably linked to representations of what immigrant life/lifestyle is like, often transpires from pre-consultation meetings with institutional actors. Frequently accompanying those narratives are expressions of professional burn-out, and feelings of discouragement in having to face such complicated situation. Immigrants and their descendants are thus often portrayed as being "difficult" to deal with, sometimes leading institutional actors to dead-ends. How then, does a referral to a specialized mental healthcare center inscribe itself in such a context? The psychologist's request is for Jeanne to elucidate a structural conundrum, not a mental health issue. Why, then, refer her patient to Minkowska? Her insistent demands on a cultural deciphering of the situation hints to the fact that it is the "specialized" aspect of Minkowska she seeks, not its mental healthcare services.

Republican ideology and its politics of representation are not as clearly articulated in institutional actors' rationales for referrals, as they are in specialized mental healthcare centers' rhetoric, where they trigger clear contradictions between discourse and practice. On the one hand, one may argue that they imbue referring institutional actors' essentializing representations of immigrants' lifestyles and environment as pathological – thus directly echoing the political rhetoric on how immigrants “un-integrated ways” (read: culturally different ways) breed social problems, and in turn mental suffering.⁸² On the other hand, referral narratives display a paradoxical acknowledgement of immigrants' vulnerability to social inequalities. Institutional actors' referring immigrants to specialized mental healthcare centers regardless of suspected mental health disorders does not necessarily imply that they directly pathologize cultural difference. They may simply find immigrants “difficult” to deal with, because those difficulties immigrants face are not acknowledged by the system as such, and instead are blamed on cultural difference. Rationales may stem from genuine concerns for helping immigrants via institutional routes, the most “hospitable” and “practical” of which are specialized mental healthcare centers.⁸³

Conclusion

I argue that the aforementioned contradictions echo France's long-standing anxieties with naming identifiable immigrant groups, at the same time as it is struggling

⁸² Again, see example of the 2007 suburban riots during which political commentators referred to polygamy as breeding delinquent youth and leading to social unrest.

⁸³ In the next chapter, I discuss this idea of specialized mental healthcare centers as “sites of hospitality,” where patients may express themselves and be heard in their human/social dimension, beyond the cultural lines which formed the basis for their referral.

with the necessity to structurally acknowledge them. This results in discursive ambivalences, between acknowledging concrete structural inequalities on the one hand – which are irrelevant to cultural interpretations, and making sense of those as being inextricably linked to immigrants’ “different” lifestyles – which calls for “specialized treatment” on the other. Immigrant families are thus readily portrayed by referring institutional actors as “difficult” to deal with, and specialized mental healthcare centers constitute the only “qualified” institutional way out of these “difficulties,” whether these are relevant to mental health issues or not. As a consequence, cultural expertise comes to matter more than health issues per se. Therefore, the medical rationale for referrals is often unclear, and the common stigmatizing treatment of immigrants remains unchallenged.

Synopsis of Chapter 6

In this chapter, I investigated the interaction between French political ideology – specifically, its model of integration which denies the relevance of cultural differences – and the representations of immigrants disseminated in specialized mental healthcare centers. I looked at how this interaction affected the centers’ internal organization, through naming and filing practices. I then analyzed how it shaped the centers’ external representations, through referral documents and pre-consultation encounters.

I showed that, for two of the three specialized mental healthcare studied, the positioning in the public health landscape necessitated an official coding of cultural differences, seemingly supporting the republican ideological status quo. However, this does not impact the actual organization of those centers, which continue to triage patients following their cultural differences. This obviously triggers tensions for health practitioners and staff in daily practice and interactions.

I described how referring institutional actors resorted to a common repertoire of representations in coding patients’ cultural differences, sometimes in stigmatizing ways – namely through references to immigrants’ social milieu and family structures – that also seemingly support the ideological pathologization of culture. However, the representations they circulate simultaneously call for a pragmatic acknowledgement of the structural inequalities many immigrant families face, and the expression of the mental suffering such inequalities produce, even though problematically, mental suffering as such may not constitute the basis for their referral.

I argued that these paradoxes echoed France's long-standing anxieties with naming identifiable immigrant groups, at the same time as it struggles with the necessity to structurally acknowledge them. This results in discursive ambivalences, between acknowledging concrete structural inequalities on the one hand (which are irrelevant to cultural interpretations), and making sense of those as being ineluctably linked to immigrants' "different" lifestyles (which calls for "specialized treatment") on the other. Immigrant families are thus readily portrayed by referring institutional actors as "difficult" to deal with, and specialized mental healthcare centers constitute the only "qualified" institutional way out of these "difficulties," whether these are relevant to mental health issues or not. As a consequence, cultural expertise comes to matter more than health issues per se. Therefore, the medical rationale for referrals becomes unclear, and the stigmatizing treatment of immigrants remains unchallenged.

Through the analysis of referrals, it becomes apparent how specialized mental healthcare centers are sometimes pushed at the margins of the institutional system in France, a position which sometimes leads them to accept cases that seek to manage cultural difference beyond the confines of mental healthcare. As I have shown, the health rationale for immigrants to circulate from one "mainstream," state-mandated institution to a specialized mental health center is sometimes unclear, outside of its relation to the "patient's" cultural difference. However, the framing of that difference clearly emphasizes social issues—such as poverty, poor housing conditions, broken families, or delinquency—which are not intrinsic to immigration or cultural belonging.

CHAPTER 7: Circulating and Contesting

In my previous chapter on “Referring and Naming,” I investigated the interaction between French political ideology and the representations of immigrants disseminated through referral documents and pre-consultation encounters in specialized mental healthcare centers. In particular, I identified the use of a common, culturally-appropriate repertoire of representations to refer to West African immigrant families—focusing on immigrants’ social milieu and family structures. Such repertoire reproduces widespread stereotypes, and that seemingly supports the republican ideological status quo. However, the use of such discriminatory representations simultaneously seems to call for a pragmatic acknowledgement of cultural differences and an affirmation of their relevance both in their relation to the structural inequalities many immigrant families face, and to the expression of the mental suffering such inequalities produce. I argued that the aforementioned paradoxes echoed France’s long-standing anxieties with naming identifiable immigrant groups, at the same time as its struggling with the necessity to structurally acknowledge them. This tension, in turn, produces discursive ambivalences. More problematically, it makes the medical rationale for referrals unclear, and leaves the common stigmatizing treatment of immigrants unchallenged.

In this chapter, my goal is to show that the clinical reality of these centers indicates the need for a more nuanced conclusion, which limits both specialized mental healthcare practitioners’ agency in the institutional landscape, and immigrants’ ability to appropriate or contest their institutional circulation. Theoretically speaking, this draws attention to the necessity of analyzing state-related dynamics, namely institutional

regulation, through daily practices and individual interactions (Codo, 2008; Terrio, 2009; Urciuoli, 1996). Again, this unveils tensions and contradictions, and the strategies individuals employ to manage them or cope with them. Thus I divide this chapter in two parts: the first one focuses on how specialized mental healthcare practitioners manage the contradictions of their own institutional position, and alternatively find avenues to contest it; the second part focuses on patients, the ways they put the regulative system to the test by directly contesting it, or by becoming socialized in it and finding ways to mobilize it to their own advantage. This division is arbitrarily made for analytical purposes, as the two parts often overlap and echo one another. Ultimately, this chapter seeks to evaluate the extent to which specialized mental healthcare centers participate in the regulation of immigration.

I. Specialized Mental Healthcare Practitioners: Between Legitimizing and Contesting

1. The double-bind

In my previous chapter on referring practices, I analyzed two referrals requesting consultation sessions for clients' family members at Minkowska. One was issued by a pediatrician, the second by a Parisian court. The first one requested support for the mother of the pediatrician's autistic patient, so that she could, "in her language of origin, provide explanations on her son's difficulties." The second one ordered, from a ruling on two "juvenile delinquents," that the parents to be sent to a specialized mental healthcare center, "to speak to therapists of their language and culture," so that the Court could

better “apprehend the situation with respect to the cultural representations of the persons concerned.” Interestingly, in his correspondence with referring institutional actors, the same specialized mental healthcare psychiatrist (whom I will call Dr. Kamil) contested both referrals’ outwardly culturalist rationale.

In his first report, which he qualifies as “a transcultural psychiatry report” (in the clinical medical anthropology center), Dr. Kamil responds to the referring pediatrician: “Even though the parents, following their culture of origin, evoke the possibility of the intervention of mystical forces – ‘djinn’s’—they do not exclude the high fever episode as a cause of possible autism.” The letter concludes that mainstream pedo-psychiatric care should be sought for the child. Surprisingly, he ends by mentioning that Minkowska is “available for *an intervention* regarding the parents” (emphasis mine). Therefore, although the psychiatrist clearly establishes that there he believes there is no etiological conflict at stake that would justify a referral to a specialized mental healthcare center, he nonetheless offers his services, ambiguously termed “an intervention.”

In the court case, which specifies that a report is expected from the ethnopsychiatrist / ethnoclinician, the same psychiatrist (this time, borrowing the judge’s reference to the “ethnoclinique” as the judge did) remarks that “Mrs. D., who came to the consultation without her husband, did not understand the motive of this consultation.” He continues by explaining that his patient acknowledged the *difficulties* the couple went through and the stress they endured from living in socially precarious conditions. He adds, “the interview did not unveil any psychological pathologies, but suffering caused by social precarity *and some difficulties due to cultural integration*” (emphasis mine). He

continues “the center is available to respond to the demands of the persons concerned *themselves*.”

These two cases very well illustrate the double-bind which many specialized mental healthcare therapists face, between disputing the culturally stigmatizing basis upon which some of the referrals are made on the one hand, and preserving their professional positioning (and indirectly that of the center they work at) by catering to the demand for cultural expertise on the other. Accordingly, their position oscillates between contesting a regulative system in which cultural difference is pathologized – and accessorially used to disguise discriminatory practices—and indirectly legitimizing it in terms of professional expertise.

2. The double-bind in its clinical context

Returning to Paris in the summer of 2009, I was given the opportunity to attend an off-site consultation with the Minkowska Center. This was a new experience for me, as this consultation was part of a new work initiative at the Center, called MEDIACOR.⁸⁴ This newly-created, interdisciplinary work-group was set up as a result of the Center experiencing excessive patient referrals—many of them seemingly unjustified or misdirected, and of being unable to meet the demand. The goal of MEDIACOR, therefore, is to analyze incoming referrals—in a way the secretarial desk, which takes appointments, would not have the time, or the qualifications to do. Its task is to contact referring institutions when referrals are deemed problematic; that is, when the role of Minkowska as a specialized mental healthcare institution is unclear in accommodating

⁸⁴ MEDIACOR is an acronym that stands for *Cellulle de MEDIAtion, d’ACcueil, et d’ORientation* (“Mediation, Counsel, and Orientation Group”).

the referred individual. When referrals are clearly misdirected, the group is in charge of finding an alternative, a more appropriate, “mainstream” structure that will take charge of the individual. Ultimately, the group’s goal is to compile and analyze data on both problematic and successful referrals, so that guidelines and new policy may be implemented to improve the referral process, and ultimately improve patient care.

Whether MEDIACOR constitutes first and foremost a triage tool, rather than an acknowledgement that many referrals have been misdirected or arbitrary over the years (which would carry with it an underlying critique of the referral system and of the management of immigrants in general), may be too early to assess. Nonetheless, this effort at re-assessing the rationale for referrals seems to confirm that specialized mental healthcare centers can act as sites of contestation for the institutional stigmatization of and discrimination against immigrant individuals. More importantly, it brings to bear the articulations – through the referral process—between shared cultural representations of immigrant individuals and their lifestyles, which are often intangible, and their materialization/circulation through institutional reports and the different steps that are part of “the making-of” of the referral per se, until its evaluation and negotiation into specialized mental healthcare centers.

I drove to the psychiatric hospital, located in a close southeast suburb of Paris, with Jeanne and a Wolof-Soninke-Bambara interpreter, Salimata. Mr. Kouyate, a middle-aged, first generation immigrant from Mali, had come to Minkowska a few weeks earlier, accompanied by a family elder, to discuss his wife’s case with one of the center’s psychiatrists, whom I call Dr. Duriez. At that point, Mrs. Kouyate, who had been a patient at Minkowska back in 2004, had been hospitalized under constraint and diagnosed

as psychotic. Her three children had been placed in foster care by social services. The hospital's psychiatrist had also contacted Dr. Bennegadi at Minkowska because she fell at a loss with the patient and was looking for a "more appropriate" structure that would share the responsibility for therapy, somewhere where her patient's culture would be "understood." The family mediator had informed Dr. Duriez that Mr. Kouyate was planning on taking his wife back to Mali for her to be cured. According to him, she refused to go, for fear of never being able to come back to France and of seeing her husband bring a new, younger wife instead.

After going through a series of locked doors, Jeanne, Salimata, and I finally accessed the psychiatry ward. The atmosphere was tense, as we came across delirious patients, some physically debilitated as well. This was a public structure, devoid of any aesthetic warmth. The walls were either bare concrete or white. We were directed upstairs, where we met Mr. and Mrs. Kouyate, who were waiting for us. At that point, Jeanne realized that the patient spoke Khasonke, not Soninke, as she had first understood. Salimata did not speak that language. This was a huge disappointment for Mr. Kouyate – who had been waiting for this meeting to happen for weeks now, as well as for us. Mrs. Kouyate, on the other hand, appeared expressionless. Salimata said she could contact a friend by phone who would help, but one of the instrumental bases for this visit—that is, helping Mrs. Kouyate interact properly with her psychiatrist and unlock the patient-doctor relationship, had disappeared. I paused and wondered how Mrs. Kouyate might feel, isolated in this place for almost two months now, away from her children, and with nobody to talk to. The situation in itself might drive one into a state of madness...

The psychiatrist arrived considerably late to our scheduled appointment. She greeted us together with Mrs. Kouyate and her husband. She seemed in a rush and acted hyperactively. Jeanne introduced me as a visiting anthropologist doing research at their Center. The psychiatrist firmly shook my hand and asked me: "Great! You speak African?" Disconcerted by the question and the psychiatrist's abruptness, I did not have time to answer before she immediately turned to Salimata and asked the very same question. At that point, Jeanne announced to her that she had mistaken the patient's language, and that for today's meeting, they would have to resort to a translator by phone. "It's not possible, it's not possible," the psychiatrist kept repeating. "This is a disaster. What are we going to do? I sure don't know what to do anymore! Do you realize how important this was going to be? How long I've been waiting for your *intervention*?" Exasperated, she rushed us all into the consultation room. A nurse and a psychology intern were also present, which made eight of us in a very small room, devoid of any object but a desk with only a telephone on it, and chairs for us to sit on.

The psychiatrist first asked Mr. Kouyate's permission for having the Minkowska team attend and intervene in the consultation, then instantly asked him how his spouse was doing. Mr. Kouyate replied that ever since she was hospitalized things were much better. Now she actually answered when he greeted her. The psychiatrist turned to Mrs. Kouyate and asked her whether she agreed. She answered that she was not sick. Very aggressively, the psychiatrist explained to her patient that the French Republic had laws, and that if she refused treatment, her children would remain in foster care. [the husband proceeded to translate the psychiatrist's comments to his wife in khasonke]

Mrs. Kouyate indicated that she simply hurt “there” (she pointed to her back) now and then. The psychiatrist turned to us, looking exasperated:

See, what difficulties I have to face...I am practicing veterinary medicine. I do admit that Mrs. K looks more relaxed, but she is delirious, and I cannot access her delirium. The major worry now is to have her understand this law issue, and the legal implications of her forced hospitalization. Someone must explain to her that I will not let her out unless she accepts to regularly go to a place where someone speaks African.” [Mr. K. translates at the same time to his wife]

The psychiatrist addressed Jeanne and asked her whether the Center was able to provide drug injections. Mr. Kouyate interrupted them to tell them that his wife asked why the State had taken her children. The psychiatrist did not answer. She turned back to Jeanne and pursued the subject of treatment: “she must have one shot per month”. Jeanne replied that this could not be done at Minkowska. Meanwhile, informed of what was being said by her husband, Mrs. Kouyate shook her head in sign of refusal. Noticing this, the psychiatrist, increasingly exasperated, replied: “But you MUST!” Jeanne suggests at this point that it would be better to resort to a Khasonke interpreter from ISM (Inter-Migrant Services).⁸⁵ Mr. Kouyate interjected that even if we called for an interpreter, his wife would not change her mind and would not listen to us. “She simply does not understand why the State has taken her children,” he repeated. [Again, he translated to his wife about the necessity for her to accept the slow-release injection treatment if she wanted to be released from the hospital and take her children back. Meanwhile, I asked the psychiatrist whether she had heard about ISM services before. She answered that she did, but that it would not be enough to have called them, that she needed help from

⁸⁵ Inter-Migrant Services is an association which was created in 1970. It provides translation services, on the phone or on site, in 85 languages and dialects. They are the main referral for translating needs in French institutions.

professionals familiar with “African customs,” or from “an African psychiatrist who can deal with Africans”].

The psychiatrist repeated to the patient that she would also have to go to consultations at the Minkowska Center, where there would be a translator. Jeanne asked her what the patient told her about when she didn't feel well. “Does she talk about *djinn*s, about *maraboutage*, about *seitan*...?” she asked. The psychiatrist turned to Mr. Kouyate: “You said that, before, you would bring rice bags to Mrs. Kouyate, and she thought they were poisoned.” Before waiting for an answer, the psychiatrist picked up her phone and called ISM, which connected her with a Khasonke translator. Then she addressed Mr. Kouyate again: “Mr. Kouyate, explain to the interpreter what the problem is: that she refused to feed her children, and that she didn't want to put food in the fridge...” [She passed the phone to Mr. Kouyate. Followed a phone exchange between them]. The psychiatrist, extremely restless, abruptly took the phone away from Mr. Kouyate's hands. The translator, now on speakerphone, explained to us that, according to Mr. Kouyate, his wife wouldn't agree to go to the external consultations. At home, according to him, she refused to cook, to feed her children, she insulted him all night long (he specified that she had not insulted his mother or father yet, but she did call him “all kinds of birds' names”). Even the children were afraid to approach her. He felt angry at her because she always took the children away when he held them in his arms.

While Mrs. Kouyate responded to the interpreter, the psychiatrist quickly commented: “see, evidently there is also a conjugal problem which I cannot have access to either.” The interpreter translated Mrs. Kouyate's response:

Mrs. K explains that her last child was born prematurely, and that she was placed in an infant foster care home shortly after she left the maternity

clinic. According to her, the problem was that Mr. K refused to take care of the child. As far as she's concerned, she never caused him financial problems. During her pregnancy, her husband asked her how she had gotten pregnant [something the psychiatrist was hearing of for the first time]. She told him she had never been with anyone else. Still, Mr. K refused to take care of the child. Moreover, as their marriage was arranged, between families, he went and told everyone she was crazy. She explains that she belongs to the *griot* caste, and therefore she sometimes sings the songs of her country. Because of that, Mr. K claims that she is crazy, when in fact, singing simply makes her feel happy.

The psychiatrist then informed us that Mrs. K firmly contends that her one but last child is not a girl, but a boy. The child is named Sadio. [The interpreter proceeds to translate this information to Mr. and Mrs. K]. The psychiatrist continued:

Psychiatrist (P): "See, she has to be dealt with by Africans!"

Interpreter (I): Mrs. K never said that Sadio was not a girl. She lost twins before Sadio was born.

Mr. Kouyate (Mr.K): There have never been any twins. I'm her husband. I know.

P: But Mr. K said that...

Salimata (S): Precisely, when there is a problem, people only listen to Mr. Kouyate, and it distorts everything.

P: I do know that. That's why I need someone to help me here.

I: Mr. Kouyate says that he hasn't had any sexual relationships with his wife. That's why he had questions about her pregnancy. He had doubts. Then, when the child was born, he made calculations again, and he concluded that the child was conceived when they still had intercourse.

P: Please ask more details concerning the gender of the child.

S: Both spouses are from the *griot* caste, so this is normal. After the death of twins, it is customary to name the following child Sadio, which is a gender-neutral name.

P: See, I don't know these things. I'm swimming. How can I practice psychoanalysis under these conditions? [turning to Jeanne] Do you have psychiatrists who speak African ?

I: Mrs. Kouyate doesn't want to respond to that. She says that her husband rejected her and her children. He even sent the police to come and take her away. She was unable to go to her post-delivery ob-gyn appointment.

P: Please ask Mrs. Kouyate why she won't use the food her husband brings to her.

Mr. K.: She pretends it is because of the diseases in the subway.

I: Mrs. Kouyate says she does not refuse to give the food to her children. It's only that sometimes, the children themselves do not like what Mr. Kouyate brings home. For example, she says that her daughter Fatoumata, who loves yogurts, pointed to her once that the yogurts her father had brought were past consumption date.

P: Well, when did the problems start then?

I: Mrs. Kouyate repeats that the last time she had intercourse with her husband was the time she fell pregnant with Sadio. She reiterates her accusations. She says that once, she and her husband had such a violent fight that the firemen had to intervene. She had to hide.

J (to I): Do you find Mrs. Kouyate to speak coherently?

I: I would not reply to this question on the basis of a single phone interview.

P: I prefer that. Please ask the same to Mr. Kouyate. [To Jeanne] Is there a possibility for a psychiatrist at Minkowska to care for Mrs. Kouyate with a translator, and then we could have a discussion from psychiatrist to psychiatrist?

Mr. K: It's in 2002, after Fatoumata's birth (the second child), that the illness started. At that point, we had no problems. She's the one who is sick. Just take a look at the file written up by the judge for children. As far as I'm concerned, I have nothing to blame myself for.

P: There are two things that are important at the moment, Mr. Kouyate. The first one is for me to be able to send your wife to a psychiatrist at Minkowska. The second is that this woman, whether she is sick or not, is in a context which I yet have to understand. But to put it bluntly, I'm fed up with this. I really need to obtain this permission to send her to Minkowska.

Mr. K.: Everybody already knows the file. Everybody knows the cause of the illness. I have explained it many times myself.

Mrs. Kouyate shakes her head in apparent disapproval.

I: Mrs. Kouyate asserts that she has no illness problem. The cause of this is her husband's doubt. That's what triggered it all, when he said she was crazy and he was going to divorce her. At that time, she had told him she would agree to divorce, but that she would not move from here, that she would stay in France where she was brought to in the first place.

P: Mrs. Kouyate, I am placing conditions on your hospital discharge. In a way, I am not leaving you any choices. As long as you refuse to go to that meeting [at Minkowska's], you will not get out of here.

J: Then she should come accompanied by a nurse.

Repeatedly, Mrs. Kouyate mutters in French: "I am not sick, I am not sick."

P (to J): Let me tell you about my job. Here I'm working on a psychoses case, but I'm trying to understand the context. For example, I learned that Mrs. Kouyate could not have children when she was in Africa. But I need to know more...

Mr. K: My wife is being a pain with this ob-gyn appointment she was unable to go to. I want to explain to her that it's not urgent, but she won't listen to me. And she already knows the psychiatrist from Minkowska.⁸⁶ I can already tell you, she won't accept to go.

P: Really, we're in African times... We are attending a three-way deaf conversation.

Jeanne then carefully tried to present Minkowska's AMC (clinical medical anthropology) framework to the psychiatrist. The latter, exasperated, barely seemed to listen. She responded that she could no longer put up with such work conditions. She said she finds no gratification in her work (she spoke of "professional narcissism"), that she can't do her job properly, that she is overwhelmed ("I'm swimming"). Jeanne subtly attempted to explain to the psychiatrist that being an expert on "African culture" is not the key to unlocking this situation. She quickly explained the concept of "explanatory models" and the "disease, illness and sickness" triad, and tells the psychiatrist that rather, the key is for the mental health practitioner to accept his/her patient's illness representation, so that in turn, the patient himself/herself may receive the practitioner's advice on treatment. Leaning over her desk, with her arm holding her head, the psychiatrist looked in a state of utter professional burn-out. With a deep sigh, she reiterated her indecent working conditions, thereby dismissing Jeanne's comments. We

⁸⁶ Dr. Sarr is a Senegalese psychiatrist who receives patients mostly from sub-Saharan Africa (even though it is inappropriate to present him as such under the Center's new organization rules, which prevent the distribution of patients according to their national/ethnic background)

left with Jeanne committing to working out an appointment at Minkowska with Dr. Kamil, together with a Khasonke interpreter, on the condition that, at that point, Mrs. Kouyate would have agreed to the extended-release drug regimen and to meeting with the Minkowska's team.

On our way back to Minkowska, Jeanne and Salimata had a heated conversation about the psychiatrist's attitude. They found her to infantilize the K. couple and to address them in a way she would probably never address French, white patients. They were shocked at her use of the expression "veterinary medicine." "She may suffer from professional burn-out," Jeanne commented, "but that is no excuse to treat her patient the way she does." They lamented Mrs. Kouyate's fate, and the necessity to find a way to have her be seen on her own, so that she might feel less on the defensive with her husband. Jeanne also commented that the danger with MEDIACOR is for its mediating assistance offer to be seized by referring institutional actors as an exit door and an easy answer to their unwillingness or resistance to treat some patients.

At the hospital, an appointment was scheduled with Mr. Kouyate at Minkowska, on the basis that his wife would eventually accept the psychiatrist's treatment and be allowed out of the hospital. The day of the appointment, Mr. and Mrs Kouyate both came. Mrs. Kouyate had apparently agreed to the drug regimen. Her children, however, were still placed in foster care. Unfortunately, ISM failed to acknowledge Minkowska's request for a Khasonke translator, and Dr. Kamil was forced to send the couple back home, after re-scheduling an appointment both with them and with ISM. On the second appointment, Dr. Kamil gathered Mr. and Mrs. Kouyate, the Khasonke translator, Jeanne, a secretary and myself in the mediation room. The goal of that preliminary meeting, Dr.

Kamil later explained to me, was to reassure Mrs. Kouyate that Minkowska was in a different position than the hospital's psychiatrist, thereby making her feel less defiant and open to therapy. Dr. Kamil also intended to bring up the possibility for one-on-one therapy sessions to Mrs. Kouyate's husband, so as to show respect to his position as the family decision-maker.

I left France before therapy started with Mrs. Kouyate, but Jeanne informed me that Mrs. Kouyate has maintained her drug regimen, and is now receiving therapy at her district's medico-psychological center with a "regular" psychiatrist. The MEDIACOR intervention can thus be said to have been successful in many ways. Most importantly, it extricated Mrs. Kouyate from an environment which could have further damaged her mental health, and in which she was being mistreated by her own appointed mental health practitioner.

Nevertheless, the context of therapy which I witnessed was utterly dehumanizing. In that respect, the hospital psychiatrist's references to practicing what she called "veterinary medicine," as well as the infantilizing and brutalizing way she addressed the Kouyate couple, relate to my impression. The psychiatrist's way of addressing her patients' cultural difference relayed a mixture of astonishing ignorance (her belief that there exists such a thing as an African language) and a dose of stigmatizing comments on a generic African Other ("she has to be dealt with by Africans" or "we're in African times!"). While her attitude should certainly not be generalized to represent how all referring institutional actors handle their immigrant clients, the overall attitude of feeling unable *from the onset* to address immigrant clients/patients' needs *because* of their cultural difference is a recognizable pattern, echoed in my chapter on referrals, and

acknowledged by specialized mental healthcare centers themselves. The very existence of MEDIACOR attests to that.

Accordingly, what can be said of specialized mental healthcare centers' responses to the issue? Jeanne's attempt at mitigating the hospital psychiatrist's comments on her inability to treat Mrs. Kouyate, as well as at sensitizing her to an alternative perspective on the doctor-patient relationship in therapy (i.e. the clinical medical anthropology framework) failed. In some instances, Jeanne did appear constrained to legitimate the psychiatrist's culturalist interpretation of Mrs. Kouyate's case by justifying her presence and positioning herself as a cultural expert ("Does she talk about *djinns*, about *maraboutage*, about *seitan*...?"). Ultimately, one may argue that by accepting to receive Mrs. Kouyate at the Center, and thus to be perceived as a place where African doctors can deal with African people, Minkowska indirectly legitimates a regulative system at the margins of which it operates as an institutional dead-end. Again, this illustrates the double-bind specialized mental healthcare centers often find themselves in, contesting the stigmatization of their immigrant patients, while simultaneously legitimizing it merely by positioning themselves as cultural experts. However, Mrs. Kouyate's "reintegration" into a mainstream public health structure shows that, by mobilizing its resources outside of its own institutional walls, Minkowska successfully challenged and addressed the stigmatizing basis of a referral.

3. Activist roles

The extent of specialized mental healthcare centers' legitimization of a system in which immigrants circulate from one institution to the next on the basis of their cultural

difference may also be nuanced in light of the activist role specialized mental healthcare practitioners may play in protecting patients against deportation, or advocating for them in complicated legal situations, such as related to their illegal immigration status. In France, there is the possibility for immigrants to be granted temporary legal status on the basis that the type of medical care they require is unavailable in their home country, and without which their life would be put at risk. The legitimacy of the medical claim is ultimately assessed by an appointed physician at the local Prefecture (*Médecin Inspecteur de la Santé Publique*), but the latter may base his/her decision upon external medical expertise, outside of the “non-descriptive” medical certificate systematically required in such procedure.⁸⁷ The mental healthcare specialist’s expertise –provided he/she is certified as a mental health expert—thus may be taken into account and support the patient’s case.⁸⁸ Minkowska’s psychiatrists are certified to establish expert certificates, but I have only encountered one such document for the year of 2007. The latter established that a female patient had engaged in therapy for five months, that

she suffers from an anxiety and depression syndrome, accompanied by cephalalgia, insomnia, and memory loss, induced by maltreatment and threats endured in Mauritania, where she was forced to leave her daughter in the same slave conditions she herself suffered. Her health condition

⁸⁷ In this certificate, the Doctor strictly needs to state that the patient suffers from a diagnosed pathology which requires full medical attention and treatment, the lack of which could result in severe consequences for the patient, and that the patient would be unable to receive such treatment in his country of origin (following the 1998 amendment to the 1945 law related to the conditions of admission and residence of foreigners – see: <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=LEGITEXT000006069184&dateTexte=20090923>) The “non-descriptive” certificate is used to register the request at the local Prefecture, and is meant to ensure the patient’s medical confidentiality (although breaches of confidentiality by Prefecture clerks have been reported).

⁸⁸ I should specify here that the final decision is taken by the Prefet, who is not constrained to take the medical opinion into account when deciding to grant legal status. Applications for legal status under medical reasons increasingly encounter obstacles, having been publicly denounced –under increasingly restrictive immigration laws – as providing a strategy for dishonest individuals to gain legal status by “faking” their illness (<http://www.odse.eu.org/Les-dix-ans-de-la-regularisation>).

necessitates long-term medical treatment, the lack of which could trigger exceptionally severe consequences for her.

The certificate fails to mention that the patient could not receive such treatment in her country of origin. In principle, the appointed Doctor to the Prefecture already has access to an extremely controversial list of serious pathologies classified by countries in terms of availability and access to treatment, which contains very limited and inaccurate information.⁸⁹ It would be difficult to assess the extent to which the specialized mental health expert's narrative weighs in the decision to grant or not legal status to their immigrant patients. It has been argued that the official list of pathologies was, after all, a bureaucratic tool designed to help limit the admission of immigrants on the basis of their health, and that it was less the individual's state of health that mattered in the end than the theoretical possibility for access to treatment in countries of origin.⁹⁰ Ultimately, the final decision is made by the Préfet on a case-by-case basis.

In other instances, specialized mental healthcare practitioners' activist roles may have a stronger impact. At Minkowska, Jeanne brought to my attention the case of two female twins from Cameroon, born in Douala in 1986, and who came to France in 2001 for their studies. Linda and Vanessa were first referred to the Center in 2003 by the education team of Child Protective Services (ASE) and by a psychologist working in foster care services, concerning "a severe family conflict" and involving the twins' father

⁸⁹ The list is only internally accessible to Public Health officials. In April 2007, a petition was drafted by the Observatory of Foreigners' Health (ODSE) to contest the list, accompanied by a counter-expertise from Doctors without Borders, establishing the inaccuracies of the data. For example, the list indicates that Niger offers sufficient mental healthcare, despite the fact that Niamey, the country's capital, only counts three psychiatrists for a total population of 700,000 (<http://www.cettefrancela.net/volume-1/descriptions/article/la-cooperation-des-services-1#nh2>).

⁹⁰ ODSE, 2008. La régularisation pour raison médicale en France: un bilan de santé alarmant. Report available at: http://www.odse.eu.org/IMG/pdf/ODSE-rapport2008_.pdf

in Cameroon. The girls were seventeen years old then. The educators' report specifies that one of them, Linda, presented "preoccupying mood swings." In France, they were housed at their maternal aunt's, who was married to a French citizen, who apparently requested for the girls to study and stay with her in France, which the father readily accepted. A few months after their arrival in France, the girls started complaining about abuse, and accused their aunt of prostituting herself. A complaint was filed with the juvenile justice, and the girls were each placed in foster care, each with a different family. As the judge considered for the girls to promptly return to their father in Cameroon, the father rejected the idea on the ground that his daughters had dishonored his family. The latter sent a letter to the girls' appointed educator, which is included in their patient file. In the letter, the girls' father asks the educator to deliver the following message to his daughters:

From now on, we no longer consider you as our children, so you must forget about us. There are five of you, not mentioning the extended family, and I am only a farmer. I don't have the means to take care of you. When your aunt decided to take care of you in France, it was a great relief for your mother and me, especially with regards to those illnesses you were victims of, stemming from those witchcraft practices you exposed yourselves to. But unfortunately, she turned you both into housemaids. [Follows a lengthy paragraph on the debts the girls left behind, and all the expenses which the family can barely meet]. You must forget us. I repudiate both of you from now on. ... It you had stayed calm at your cousin's, there would be no talk of deporting you from France. So this is your problem. I cannot afford to take you back. ... if you insist on coming back, I will take you to the sorcerers myself!

The girls came for a meeting at Minkowska, a few days before their scheduled audience in Court, worried at the thought that they could be sent back home against their own father's will. The educators, in their report to the judge, argued that the ruling should be deferred for at least six months, so that a proper therapy program could be engaged at

Minkowska. Clearly, therapy and cultural mediation provided the reasons upon which a case justifying the girls' residence in France could be made.

Unfortunately, the judge only granted the girls three months to prepare their defense. At the time of the hearing, the judge agreed to hear the case, on the condition that education services submitted the Court with a convincing educational project for the girls, and that the girls' parents accepted to sign a delegation of parental authority (both of them were still minors). The delegation of authority was easily obtained from the father, but the guardianship judge still had to legally authorize it. Educators remained pessimistic regarding the chances for the girls to be granted legal status in this situation. Coincidentally, shortly before the Court hearing, the father sent another letter, reinstating his repudiating both his daughters:

Rituals were carried out in the family to free ourselves from you, and to cut the cord that tied you to this family and to our ancestors, who protect us. So at the customary level, you no longer have any protection, and you are abandoned to your own fate as well as you become an easy prey for witchcraft. If you want to stay alive, avoid all contact with me or with anybody else in the family. [Follows another lengthy paragraph on the family's meager budget and inability to care for two more persons anymore]. (...) This is my last letter. I don't want our ancestors' wrath to strike me as it will strike you if you insist on keeping in touch with us.

With these letters, along with educators' report of the girls' good conduct, satisfactory school reports, and Minkowska therapeutic testimony, the judge eventually granted Linda and Vanessa a one-year, renewable residency permit. Both signed a "Young Adult Contract" to continue receiving State financial, educational and psychological support.⁹¹ One of them, Linda, moved out of her foster family's home into a studio apartment, while

⁹¹ This *Contrat Jeune Majeur* is offered by Child Protective Services (ASE) in support of young adults who are less than 21 year-old, and who are placed in foster care, or receive no parental support.

Vanessa chose to stay with her foster family. They are now enrolled in a study program which alternates classes and professional training (*Scolarité en alternance*).

However, they never resumed therapy at Minkowska. Therapeutic conclusions sent to the judge stated that both girls suffered, albeit in different ways, from disrupted adolescent development, the latter taking place in “the peculiar context of cultural relocation, further aggravated by this rather tragic situation of the father’s rejection,” in Jeanne’s terms. The letter also stated that it was only on the basis that the girls would be granted legal status that a true therapeutic work could start. This work included an attempt at renewing ties with Linda and Vanessa’s father, through mediation in Douala with a local psychiatrist, contacted by Minkowska and specializing in family therapy.

Minkowska’s role was instrumental in building a strong defense case for these two girls, even though I would argue that the center’s role as a cultural expert in this case was also instrumentalized by the other parties at two levels. First, the girls’ engagement in therapy for the strict duration of the trial suggests they had limited interest in seeking psychological relief, and were rather strategizing to strengthen their case for obtaining legal status. Second, the timing and framing of the father’s letters in Cameroon raised my suspicion with regards to their authenticity. Indeed, both letters seemed to frame the unraveling of the legal case almost too perfectly. Also, in my opinion, the father’s recurrent references to witchcraft threats as well as to the financial situation of the family did not seem genuine. I did not raise this issue with Jeanne, as I understood from her presentation of the case and reaction to the father’s letters that she did not share my suspicions. She seemed proud of Minkowska’s role in the legal outcome, and I did not want to offend her with my instrumentalization theory. Ultimately, while Minkowska’s

success does speak to its ability to directly challenge a system that seeks to regulate immigrant populations, it also underlines the potential for serving alternative external agendas—the patients’ themselves.

II. Immigrant “patients”: Between Contesting Institutional Circulation and Mobilizing Specialized Mental Healthcare Centers as a Resource

I argued earlier that specialized mental healthcare centers’ position at the margins of the institutional system entails that they indirectly participate in the regulation of a population deemed “different” and consequently too difficult to deal with. Sometimes in a dehumanizing fashion, as was the case with Mrs. Kouyate in the MEDIACOR case, immigrants are sent to a specialized mental healthcare center, as a place where cultural experts will know how to deal with whatever is impeding the work of the referring institutional actor. The following case provides yet another illustration of such a dynamic, albeit one in which the patient and his family themselves contest their circulation along with the cultural stigmatization it implies.

1. Contesting at the margins

The first appointment with Madan took place at Jean-Baptiste Carpeaux in November 2007. At the time, Madan was 19 years-old, and the oldest son of his family. He and his family are from Sri Lanka. He has been referred to the ethnopsychiatry consultation by his psychiatrist at Lariboisiere, whom I call Dr. Robert. According to the leading psychologist at the Carpeaux Center, Kouakou Kouassi, Dr. Robert frequently sends patients to the consultation when immigrant patients or their children are diagnosed

with somatization and the psychiatrist finds himself in a therapeutic dead-end. Madan came accompanied by his mother, father, maternal uncle, and one of his cousins. There was no interpreter, which posed a problem considering the family did not speak French very well, except for Madan who had been schooled in France. The maternal uncle, who had been in France the longest, took charge of translating for the family. At times during the consultation I was asked by the leading psychologist to intervene in English with the mother when necessary, as she understood it.

For three weeks prior to the appointment, Madan had been suffering from mysterious, recurring “fits”, which commonly started with painful headaches. As the pain became unbearable, Madan usually collapsed and lost consciousness for two to three minutes, during which his whole body stiffened and he urinated on himself. The family was heavily frustrated by the situation in which they found themselves with Madan. They reported that Madan had been suffering from these kinds of episodes for two years now, and that they had been more frequent recently. They had been sent from one doctor to another—“all kinds of specialists”— to try and find a solution to Madan’s problem. At Lariboisière, Dr. Robert prescribed several neurological tests, including a MRI, all of which were inconclusive. The epilepsy hypothesis was thus ruled out. That same afternoon, Madan was scheduled to meet with another neurologist.

During that consultation, the family voiced its frustration with doctors’ inability to diagnose Madan’s problem. They took turn at exchanging comments on the subject with the team, until suddenly the mother interrupted them and directly questioned Dr. Kouassi: “So we want to know, what can you *actually* do for us? We have seen so many doctors until now, can YOU help my son?” Taken aback, Dr. Kouassi responded that he would

call Dr. Robert that very day to consult him on Madan's medical history to try to understand Madan's needs better. Apparently destabilized by the mother's blunt interjection, he quickly moved on to explain that in the meantime, the consultation could be used as a way to supplement doctors' work by making sense of Madan's recurrent epileptic-like episodes in the broader context of the family's history. "Perhaps," Dr. Kouassi said, "there are things about the family which Madan is strongly concerned about or anxious about, but which he cannot express." Following the family's lack of response, he went on to ask them: "What would one do in Sri Lanka when faced with a similar problem? Are there illnesses in Sri Lanka which resemble Madan's fits? And if there are, what kind of medicines would one prescribe?" Madan responded that yes, there could be "cultural interpretations" to his problem at home (*au pays*). But he did not elaborate and no one in the family seemed keen on doing so either. Instead, everyone sat silently. They all looked withdrawn, and one could sense the despair and frustration that all of them experienced. Until the maternal uncle broke the silence this time, claiming that "what preoccupies us, is what doctors HERE think!"

After the family left the room, Dr. Kouassi observed that there was no point in trying to elaborate with the family on a cultural interpretation of Madan's problem, if the family itself did not readily make such interpretation. Even the maternal uncle had reported that his 92-year old mother in Sri Lanka had never heard of such a thing. The co-therapist, whom I call Mrs. Marielle, suggested that next time there should imperatively be a Tamil interpreter present during the consultation. She added that it would be useful for Dr. Robert to be present, so that the family could directly confront the "medical

world” in a friendly environment, and so that he could reassert the legitimacy of his own diagnostic.

A month and a half later, in December 2007, Madan and his family came back to the consultation. This time, a Tamil interpreter was present. Again, Madan was accompanied by his maternal uncle and his parents. His cousin did not come. Thanks to the interpreter, and to the relief of the consultation team, Madan’s father was able to speak for himself that day. Prior to the family entering the room, there were indeed concerns about the maternal uncle’s problematic presence as overshadowing Madan’s parents’ comments, and as short-circuiting Madan’s father’s authority in therapy. This, Dr. Kouassi thought, could actually constitute an insight into problematic family dynamics which potentially directly affected Madan. Because of Madan’s parents’ financially precarious status, and the lack of space in their apartment, Madan had been sent to live with his uncle. He constantly fought with his parents over school: “School does not interest me,” he said. “I just want to work and help the family.”

During consultation that day, Madan’s father commented on his son’s reticence to finish school. A few days before, as he was driving his son to school, a fight erupted between them over this school issue. Suddenly, Madan was struck with convulsions. His father commented on how helpless he felt that day. Hearing the despair in her husband’s voice, Madan’s mother lowered her head and started to sob. Then she raised her head again, and commented on how her son often scared her. “We often have violent arguments. He’ll get upset, and then he grabs his head, makes strange sounds, and collapses on the floor. Then he urinates everywhere. I just don’t know what to do.” Then she took her head in her hands and resumed crying silently. Looking frustrated, his eyes

filled with tears, Madan's father suddenly removed a stack of X-rays and medical prescription from the satchel he carried with him into the consultation room. Looking straight in Dr. Kouassi's eyes, he raised the papers in the air and shook them energetically: "Will you finally tell us what those mean? Will you give us an answer? Who will explain things to us?" Then, turning to the Center's general physician who attended the consultation that day, he asked: "You, you're a doctor. Can you tell me what those results mean? What do they say my son's problem is?" Visibly discomforted, the physician took the lab results handed to him and turned to Dr. Kouassi, who returned him the same hesitant look. He then turned back to Madan's father: "I am not a psychiatrist...I really should not step in." Then he took a look at the results for a few minutes, and added: "To the best of my knowledge, the results look normal, but you should really ask Dr.Robert" Dr. Kouassi then disclosed that he has called Dr.Robert, the referring psychiatrist at Lariboisière, but that the latter would not agree to come to the consultation. Over the phone, Dr. Kouassi continued, Dr.Robert had explained to him that he deemed he did not have to justify his treatment and diagnosis to Madan's family. His only concern was with Madan as his patient, and that he could deal with him strictly during individual therapy. This was actually a major issue of contention with Madan's parents who had recurrently asked the psychiatrist to let them in during the consultation, and allow them to participate in therapy. But Dr.Robert had always refused. It sounded as if the psychiatrist had reached a point of annoyance with Madan's family, to the extent that he was barely willing to communicate with them, even outside therapy. "What we want to know," Madan's father asked, "is why Dr. Robert will not hospitalize our son. Doctors don't believe us. They haven't seen Madan when he has a fit. If they would be

willing to keep him in for two or three days, then they would see for themselves, and maybe then they would be able to understand what's wrong with him. Why won't they just do that? Can you convince them to do that? They won't listen to us.”

The family's narrative seemed to indicate that family therapy might be a relevant therapeutic option to help solve Madan's mysterious fits. Indeed, Madan unknowingly finding himself at the center of shifting family dynamics within the context of a complicated immigration experience could provide an explanation for the kind of somatization he experienced (and which Dr. Robert had determined). However, this was obviously not something that was discussed with the family by the referring physician from Lariboisière. To complicate the situation further, the ethnopsychiatry group, in an attempt to show itself useful and accommodating to the family, perhaps recast the situation too rapidly in cultural terms, which failed immediately. In this situation, Madan and his family clearly put the rationale for their referral to a specialized mental healthcare center to the test, confronting cultural and medical experts with medical data and requesting interpretation. Meanwhile, the specialized mental healthcare center shifted from being a site where cultural difference is deciphered, to being a site of hospitality, where patients may express themselves and be heard in their human dimension, beyond the cultural lines which formed the basis for their referral and presumably hindered Madan's recovery. Rejected by their son's physician, the ethnopsychiatry consultation was the only place Madan's family could go back to and be heard without judgment. It is in that non-discriminatory capacity, rather than for its cultural expertise, that the center helped Madan. This led to interesting discussions on broader issues tied to the immigration experience, and the production of suffering it entailed.

Another month and a half later, in February 2008, Madan and his father returned to the consultation. This time, neither Madan's mother nor his maternal uncle were present. To the team's surprise, Madan appeared radically different. He came into the room with a beaming smile. His father's facial expression, on the other hand, was completely sunk in, and he appeared very depressed. The Tamil interpreter was present. Madan gladly announced that he no longer suffered from his fits. As Dr. Kouassi questioned him about when the fits disappeared, Madan answered: "I don't know. They just stopped, like that. I don't know how, but everything is better now." A few minutes later, he informed us that he had quit school, and that he had found a job, which allowed him to help the family now.

Concerned with Madan's father, Dr. Kouassi asked the latter whether he was dissatisfied with his son's choice. He answered that he wished things were different for him, but that he respected his son's decision and that, above all, he was relieved that he no longer suffered from these scary fits. "I want my father to be proud of me," Madan interjected, "just as I am proud of him and who he is. Now I want to help him provide." At these words, Madan's father suddenly broke into a sob. Not disconcerted for a moment, Madan laid his hand on his father's back, giving him a compassionate yet assertive look. Then he turned to us: "You know, this is tough for my father. He used to have a good position in Sri Lanka, working at a bank. Now he can't even provide for a roof for his own son." He proceeded to tell us more about the problematic relationship between his father and his maternal uncle. The latter had helped the family come to France in the first place, and obtain legal status. He also housed them for a while, and helped them financially. This had given him an authoritative position in the family, which

Madan's father found hard to deal with. "But now things are going to change," Madan asserted. Dr. Kouassi asked both of them whether they still expected something from their doctors at Lariboisière. They answered that they didn't. However, gaining his composure again, Madan's father asked Dr. Kouassi whether the consultation could help him and his family with obtaining better housing. The request made Dr. Kouassi laugh uncomfortably. The truth is, patients often make such requests during consultations. Dr. Kouassi responded to Madan's father that he could put him in touch with the Center's social worker, but that he could not personally be of much help to him in that regard. Madan and his father agreed to come back for a final check-up consultation.

A month later, in the middle of March 2008, Madan's mother showed up alone at the consultation. She was accompanied by the usual Tamil interpreter. She explained that she should be at work, but that she had asked her boss to come a little later to be able to come to the Center. She would only need a written official medical justification on her way out. She added that Madan and his father were unable to come that morning because they both worked. Her facial expression looked peaceful, and she smiled a lot. She confirmed that her son's medical problems seemed to have been resolved. There were no more fits. Madan had decided to quit his psychotropic treatment. He still lived at his uncle's, and actually worked for him now. He was feeling much better now. Since he had quit school, he no longer thought about his problems (Madan's mother noted that Madan had spent the past three years stuck in the same grade). "Working will change his mind," she said. "He has grown up. He's twenty now. He said he wanted to be responsible, and return to his normal self." She told us that, on his own initiative, Madan had always saved money for his parents. He had always had that sense of responsibility. Despite expressing

her relief that her son's fits had disappeared, Madan's mother was also regretful that he had not been able to pursue his education. "I thought he would have that chance in France. But the most important is that he feels better. He will be able to get some internship later." Some of the interns present at the consultation commented that it would be good for Madan to come back to the consultation himself at least once, and "bring closure to the therapy." But neither Madan, nor his family, ever came back. After Madan's mother exited the room, Dr. Kouassi concluded: "Well, it looks like order has been re-established in the family. Migration sometimes disrupts the order of things. The difficulty is to reestablish this order. The persisting problem with this family, in the end, is that the uncle has definitely taken on the role of the oldest son in the family, of the family head."

The psychological repercussions of such "disruption in the order of things," as Dr. Kouassi put it, indeed are common to the individual experiences of immigrants. Individuals of all origins ascribe varying meanings to this destabilizing experience,⁹² and when they cannot express it verbally – their bodies may somatize the suffering it entails in various ways. By agreeing to listen to Madan's family, Dr. Robert at Lariboisière may have brought relief to Madan's suffering more rapidly. Cultural expertise was not of the essence, as therapy at JB Carpeaux illustrates. In fact, the consultation's attempt at eliciting cultural interpretations of Madan's fits were quickly contested by the family. Rather, the flexibility of the group consultation in accommodating family needs and allowing time for the family narrative to surface, both provided the elements to Madan's recovery. The help of the translator would have been readily available to Dr. Robert, just as it would have been to the hospital psychiatrist in charge of Mrs. Kouyate in the

⁹² This is what Pf. Moro refers to as the "loss of homeostasis" in transcultural psychiatry.

MEDIACOR case. Eventually, after contesting Dr. Robert's referral to JB Carpeaux, Madan and his family were able to adopt the ethnopsychiatry consultation as a resource of their own.

Alternatively, family members may resist seeing their history discussed in a group, and choose to alleviate suffering in their own way. Such resistance was encountered by the transcultural psychiatry group at Avicenne during therapy with a Moroccan family. The consultation was intended for the family's seven year-old son, who came accompanied by his father, a first-generation immigrant from Morocco. The mother was unable to leave her work. Apparently, she had never come to the consultation with her husband and, according to Dr. Moro, always had an excuse as to why she could not participate. The child had been referred to Avicenne for "not paying attention in class" (*problème d'inattention*). His teacher was "under the impression that he is always absent, as if constantly dreaming." His appointed psychologist at Avicenne, who summarized the boy's case to the groups, added that the situation seemed to have evolved since last year, when the teacher's complaint was about "behavioral problems" (*problème de comportement*). The therapists in the group agreed that something had happened that the child witnessed, but which they had not been able to identify. It was all the more difficult since the mother would not participate in family therapy. The father, on the other hand, was reportedly more and more open to therapy. During that consultation, he revealed that his wife was very upset by her father's death, which had occurred a month earlier. Since then, she had spent her time crying on the phone, talking to her family in Morocco. The father also disclosed that underneath the child's bed, his wife had placed a small Koran and an amulet. He insisted that he hadn't touched it, and that he hadn't even

broached the topic with his wife. He said he didn't believe in those things, but that all these "herb doctors" had all sorts of remedies for all sorts of ills.

The therapists discussed how the parents had different strategies about their son. As they commented, "they [the parents] haven't met yet" (meaning that they were very detached). Moreover, the father works during the night, and his wife works during the day. It was concluded that the mother was still trying to "figure out who she is in the migration process" (she was born in Algeria, but grew up in Morocco, then fled during the war), while the father did not have such issues. Meanwhile, the boy sat at the table, doing many drawings, most of them Japanese Manga characters, such as Sangomo and his son, who are both very powerful. "He has a great imagination," Moro commented. "He's evidently very intelligent. He's listening to his father speaking, and he replies to the messages through his drawings, like this one showing Manga characters, which speaks to father-son relations and the transmission of knowledge/power." Another interesting point, according to Moro, was that the boy dreamt about sorcerers who attack people, and that he would wake up crying. The father said he was not aware his son had nightmares. He never expressed anything to his parents. One of the co-therapists interjected: "It makes me think of the story of this river people cross where I'm from. They use a wooden plank. The child waits to see if his parents can find their balance on the plank, and that the latter doesn't sink under the father's weight, before he tries it himself. I think it's the same with this little boy: he tries to understand the relation between his parents and the path. He interrogates that relationship..." After other co-therapists took turn at articulating similar metaphors, Moro abruptly concluded: "The interesting part of this situation is the failure of our clinical structure. All clinical options

have been exhausted. Only the group consultation seems to work, but how to go further if the mother won't participate. Sometimes we must accept that families develop their own strategies. We can help them only so far as we can, but we cannot impose anything on them.”

This last case illustrates the limits of specialized mental healthcare centers' interventions with immigrant families and the management of their “difficulties.” It also underlines that placing an analytical emphasis on the regulating feature of the specialized clinics obliterates immigrant patients' negotiation (as in Madan's case) or resistance (in the case of the mother of this Moroccan family) to the referring system.

2. Institutional Circulation as a Resource

Earlier, I discussed the activist roles specialized mental healthcare centers can play in diverting their cultural expertise in public health to alternative ends, such as in legal cases. The following cases, however, demonstrate how, from the perspective of the “patient” who has learned “the ropes of the system,” this activist role equally becomes appropriated as a strategy to obtain various institutional advantages. Referring institutional actors participate in this diversion of the specialized mental healthcare center's role, as the following cases illustrate.

Jeanne recounted a problem she had concerning a patient referred to her by a social worker in Orléans. The latter had heard about Minkowska via the Internet. The patient had come to obtain a psychiatry certificate for his asylum application. Apparently, he was being seen by a psychiatrist in Orléans, but the latter refused to write such certificate on the basis that it would negatively interfere with the therapeutic relation.

This is why the social worker took an appointment for him with Dr. S. at Minkowska, but the patient was mistaken on the scheduling of the appointment (or, Jeanne said, it might have been a mistake on the part of the secretaries) and showed up on a day when Dr. S. did not offer consultations. Jeanne received him in her office nonetheless, considering he had just spent three hours in the train to come to his appointment in Paris. Jeanne recalled she had tried to explain to him, “as diplomatically as possible,” that Minkowska was not an institution that simply produced certificates, and that its purpose was to offer therapeutic support primarily, or to accompany other health institutions in that respect. Interestingly, she attributed this institutional diversion of Minkowska’s cultural expertise in healthcare towards alternative ends to the legacy of early ethnopsychiatry initiatives in France:

These referrals happen less and less often. These damages caused by the culturalist era are getting fixed. Nathan spoke about everything and anything, and created many stereotypes. The responsibility of holding some knowledge on a culture can be great, and sometimes it’s anxiety-ridden. It’s better to be humble about one’s own cultural knowledge, rather than assert things about culture that will quickly be appropriated towards negative ends by referring professionals. Sometimes, I feel like that’s all people expect from me: to assert things on patients’ culture, as if that’s where the answer to all ills was located... (Personal communication, 12/03/08).

She followed her comment by a discussion on the need for a referral processing platform (MEDIACOR at this point had not been created), which would help avoid cases like this one. I believe that for Jeanne, as a social worker, the line between mental healthcare support and the social or legal advantages it may offer for some is particularly thin. Straddling both fields, she may be the person most aware of the “double-bind” the Center often finds itself in.

Such instrumentalization tactics on the part of referring institutional actors or “patients” themselves thus bring specialized mental healthcare professionals to question their role and purpose within the system. At JB Carpeaux, I attended a consultation with a Congolese woman, Mrs. Nkandu, who had been referred by a social worker at Lariboisière. The team’s co-therapist, Mrs Marielle, commented again on the increasing number of referrals that the Center receives from the hospital. Dr. Kouassi, the Center’s head therapist, responded that “they found a way out for those instances when they can offer no solution to somatization problems.”

Mrs. Nkandu came looking completely depressed. Her husband, she explained, was verbally violent with her and her two daughters, aged nineteen and fourteen. She drank at night in order to be able to fall asleep. She expressed her wish to leave her husband and reported to have made an appointment with the local social worker regarding an alternative housing solution. Unfortunately, her daughters were older, a factor which played against her in her position on the list of housing demands. She says she didn’t want her husband to come to the consultation. After talking to Dr. Kouassi about her daily life distress, she eventually disclosed that she was advised by the social worker to come to the consultation, that perhaps medically proving how seriously mentally affected she was, her chance at obtaining social housing along with a stipend would increase and would happen more rapidly, solidifying her demand to housing authorities. Dr. Kouassi answered with a laugh, launching: “Now, that’s interesting to know.”

As soon as Mrs. Nkandu left the room, Dr. Kouassi entered said vehemently:

So now I seriously doubt the sincerity of this woman. She imposes a very Manichean vision on the situation she’s in. I think she simply takes

comfort from her position as a victim, and that in reality, things are much more complex with her husband. So my hypothesis here is that she simply tries to instrumentalize her position as a victim, not just from us, but from social workers and others attending to her case. You know, this really makes me think of many other Malian families I've encountered at Avicenne. I especially remember this case, in which a woman had led the therapists and her social worker to believe, for a whole year and a half, that her husband would not give her any money from family stipends (*allocations familiales*), and that she could never keep enough food in the fridge to feed her family. It's the social worker who eventually discovered this woman had been lying to them, when she met with another Malian client who is friend with that woman, and who indirectly disclosed one of her friends emptied out the fridge each time social services came to visit her house. The social worker made the connection at that point.

Mrs Marielle commented that the popularization of what she called “the victim position” is partly a co-production of the multiplication of social services and the benefits they offer, that it would be preferable to impose limits on that. “Family stipends, the creation of the ‘isolated parent’ status, all these things have triggered a mess among immigrant families, both in France AND in Africa, where folks wait for the money of these benefits to come in...”

It is necessary here to place Mrs Marielle's comment into context, in order to understand how specialized mental healthcare services may be perceived as an important resource to be mobilized by immigrants in pooling resources from the welfare system. The “Isolated Parent Stipend” (*Allocation Parent Isolé*) was popularized in the aftermath of the 1993 Pasqua Laws, which prohibited polygamy as grounds for family reunification. Only “first wives” were granted legal status in France, which left many women undocumented, yet unwilling to return to their country of origin. Under a state effort to regulate, and ultimately eradicate, the practice of polygamy in France, social workers encouraged immigrant women to divorce their husband as a way to retain legal

status and benefit from the Isolated Parent Stipend (Sargent and Cordell, 2002). Although the popularization of this stipend appears to have had limited effect on the practice of polygamy, it has been the topic of much discussion among institutional actors as emblematic of how regulation-intended institutional tools can be re-appropriated by immigrants to their own benefit. It is in such context that West African women were thus suspected to “play the victim” of polygamous arrangements, only to benefit from social stipends.⁹³ Such discourse has fueled conservative positions in public discourse, including extreme right-wing claims that immigrants are only in France to rip the benefits of a generous welfare system, away from the *français de souche* (“indigenous” French) who are legitimately entitled to claim those.

No such discriminatory or moralizing statements were made in the context of the clinic. While specialized mental health care practitioners may feel frustrated at the instrumentalization of their services within the larger system, it is the system itself that they question, not their immigrant patients. Also, when one of the student interns at JB Carpeaux asked Dr. Kouassi why he had not insisted on having Mrs. Nkandu’s husband come to the consultation, he responded that

In the clinical context, one must be careful and take it slowly. You can’t simply ask this woman whatever we want. For now, it’s essential that we comfort her, so that slowly she is willing to make some concessions. It’s like with those therapeutic injunctions. The judge is the one who makes the decision, and he’s also the only one who can dismiss the case. The therapist can do whatever he wants with the patient...as long as the patient is not ready to start therapy, it won’t work. He only comes to get his therapist’s signature, and that’s it. As far as therapy, he simply plays the game...one must admit that French administration is heavy, and complex...and especially fragmented! What causes problems in the case of therapeutic injunctions, but also for measures taken by social services

⁹³ The situation is reminiscent of the “welfare queens” debate in the US, and the moral judgments that came along with it.

with migrants like with that Malian woman, there's no fluidity, or coordination whatsoever between services.

Again I was struck, perhaps naively, that Dr. Kouassi comments on such scenarios – which would understandably be unnerving to any therapist bore no moralizing comments on the patient. I believe this underlines the argument I made earlier, in reference to Madan's case, about specialized mental healthcare centers not merely being sites where cultural difference is deciphered, but also sites of hospitality or institutional flexibility, where patients may express themselves and be heard in their human dimension, where broader issues – tied to the immigration experience and to the production of suffering it entails – may be addressed. Specialized mental healthcare practitioners' comments on their patients' instrumentalizing positions in fact seem to question state-mandated institutions' problematic management of immigrant populations, which itself produces such diversion strategies. Where immigrants' legitimacy as a social group is questioned outside of the clinic, it becomes reasserted by specialized mental healthcare practitioners as they allow themselves to step out of their cultural expert role, and instead bring their understanding of the institutional vulnerability of immigrants to the fore.

Conclusion

In conclusion, this chapter again challenges the argument following which specialized mental healthcare centers merely contribute to the broader institutional stigmatization of immigrants in France. As I have shown here, such an argument limits the proactive –even if restricted—posture of many specialized mental healthcare specialists in the clinic, just as it ignores the potential of immigrant “patients” to resist the institutional manipulation of their social vulnerability in various ways.

Specialized mental healthcare centers' acknowledgement of their problematic position at the margins is relatively recent, and the result of a now decade-long reorganization of specialized mental healthcare in the aftermath of the Tobie Nathan experiment. While it is unclear how the double-bind these centers face can be addressed, it seems to me legitimate to affirm that such initiatives as MEDIACOR at Minkowska point in the direction of a timid, yet important acknowledgment of the structural obstacles and stigmatizing practices to which immigrants are particularly vulnerable.

Synopsis of Chapter 7

In this chapter, I described the various ways in which both specialized mental healthcare professionals and their immigrant “patients” contest the rationale of a referral, test the limits of cultural expertise, or instrumentalize that expertise to solve legal or social issues.

In the first part, I focused on specialized mental health practitioners. I framed the double-bind situation the latter often find themselves facing—between disputing the stigmatizing basis of some referrals on the one hand, and preserving their institutional positioning by catering to the demand for cultural expertise on the other. I illustrated this double-bind through a clinical vignette, unraveling the various stages of an arbitrary referral successfully contested by a specialized mental healthcare team and resulting in the patient’s “reintegration” into mainstream psychiatric care. Using other clinical vignettes, I also illustrated practitioners’ activist roles in assisting some patients with legal issues, such as obtaining a visa for medical reasons, or strengthening a legal case for a visa renewal.

In the second part, I turned to “patients” and the ways they put specialized mental healthcare institutions to the test. First, using two clinical vignettes, I showed that patients sometimes directly contested the basis of their own referral in the context of therapy. For both cases, I observed that this brought another facet of cultural expertise, one in which specialized mental healthcare institutions no longer acted as sites where cultural difference was taken into account, but rather as sites of hospitality or institutional flexibility, where immigrant patients’ suffering may be heard without being stigmatized.

Secondly, based on additional clinical scenes, I described ways in which patients instrumentalized specialized mental healthcare therapy to serve alternate purposes, such as to process legal paperwork for asylum, to obtain low-income housing or stipends.

I concluded that this chapter revealed another dimension of specialized mental healthcare, namely the use of cultural expertise as opening the path to mainstream care or/and to being able to see the suffering patient beyond the suffering immigrant, as well as a tool to contest the regulative system when immigrants may not have the legitimacy to do so.

CHAPTER 8: School Referrals

In this chapter, I would like to capture the tensions detailed in the previous two chapters of this third part, around naming and referring practices as regulative strategies in the management of immigrant families on the one hand, and their contestation in specialized mental healthcare clinics on the other. Using school referrals as a lens through which to capture these tensions seemed relevant to me, not only because I have encountered many such cases in my field observations, but also because French institutional discourse on children potentially unveils regulative, or normative, definitions of what a “standard” socialization model and “normal” behavior are.

Examining how such definitions are articulated through school referrals thus contributes to my analysis of specialized mental healthcare centers as sites where social and political representations of immigrant identity are projected, and where the border between caring and regulating sometimes becomes blurry. Children of immigrants are particularly vulnerable to regulative discourse, and are the object of scrutiny through institutions’ efforts to manage immigrant families.⁹⁴ French schools play a particularly important role as an institution of integration and as a “public socializing agent” (Bowen, 2007:12), training children to become ideal French citizens. Education, in the broad sense of the term, tends to reproduce unequal social relations and cultural representations that symbolically reinforce such inequalities (Bourdieu and Passeron, 1977). Thus, I would argue that modes of representations of immigrant children by French institutional actors act as the “mirror function” (Sayad, 1999) of revealing how France approaches the “integration” of its immigrant populations.

⁹⁴ See Susan Terrio’s analysis in *Judging Mohammed*

The identification of immigrant children's behavioral problems or learning disabilities – and these two often problematically overlap – is frequently accompanied by discussions on immigrant families' socialization model (in reference to French standards) and on what constitutes abnormal behavior/disability. Moreover, it sheds light on the very categorization of these children as “children of immigrants,” or as “immigrant youth,” as politically meaningful. Noiriél pointed that the children of Italian, Polish or Armenian immigrants in France were never categorized in that way (2001:224). According the French historian, we must question that category as stigmatizing in itself, and as participating to a form of racial uniformisation of “visible” Others (namely, “blacks” and “Arabs”). Noiriél hypothesizes that the category is in fact the product of the popularization of state “social support” policies (*l'aide sociale*), as a way to at once define, diagnose and solve social ills. This may explain why it is rarely acknowledged in its racial dimension, especially in schools (Van Zanten, 2009), where mechanisms of discrimination have received limited sociological attention (notable exceptions include: Dubet and Martucelli, 1996; Felouzis, Favre-Perroton and Liot, 2005; Payet, 1995; Van Zanten, 2001). Encounters around school referrals in specialized mental healthcare centers, I argue, bring these issues to the fore, as the latter act as experts in mediating between immigrant families and cultural representations of French norms.

First, it is important to underline how schools have become the sites, in recent years, for the policing of urban violence – too often associated with “children of immigrants.” The “*Base-Elève*” project (Student Basic Information Project) for example, established in 2007, required that information on all children enrolled in kindergarten and primary schools be recorded in a central filing system, accessible only to heads of schools

and city mayors. Its official intention was to facilitate the general management of schools. The project was highly contested for several reasons, the first being that it initially requested detailed information on children's family members, such as nationality, year of arrival in France, native language and culture of origin. In the summer of 2008, Xavier Darcos, then Minister of Education, was pressured to remove such data. Today, the files contain limited contact information, such as a family reference for emergency cases, and a phone number. The project was also designed in the aftermath of the urban riots of 2005 and 2007, which had triggered a national discussion, not so much on the socioeconomic inequalities that were the root cause of such violence, but focusing on the management of early delinquency patterns among urban youth.

The discussion about delinquency, in fact, had been initiated well before the riots, and had most likely fueled discontent among disadvantaged suburban youth. It had been spurred by the Ministry of Interior, then led by Nicolas Sarkozy, and had resulted in the adoption of a law in 2003 on "interior security."⁹⁵ In that context, the government had created a parliamentary study group, called the "prevention commission on interior security." The group was headed by moderate right politician Jacques-Alain Bénisti, and was highly criticized by French intellectuals and school representatives, as it established a clear parallel between bilingualism among children of immigrants, and the risk for delinquency.⁹⁶ This claim was corrected in 2005, as the group released another version of their report, and stated that bilingualism was in fact a great opportunity for children.

⁹⁵ Law of March 18, 2003 on national security (*LSI* or *Loi Sarkozy II*) : <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=LEGITEXT000005634107&dateTexte=vig>

⁹⁶ Assemblée Nationale, XIIe Législature. 2004. Rapport préliminaire de la commission prévention du groupe d'études parlementaire sur la sécurité intérieure. http://www.afrik.com/IMG/pdf/rapport_BENISTI_prevention.pdf

A few years later, in 2007, the adoption of a law related to delinquency⁹⁷ made schools privileged partners in the institutional detection and prevention of delinquency. On the basis of equations between education and police surveillance, some school directors chose to oppose their school's participation in the *Base-Elève* project. Other "privileged partners" in the *detection* and *prevention* of delinquency were mental health professionals, especially psychiatrists. In the Bénisti report, a section was devoted to psychiatrists' collaboration with schools:

At the level of kindergarten, it would be useful to design a culture of dialogue with pediatric psychiatrists and teachers, so as to detect very early on any behavior or attitude which could develop into violent behavior, or lead the child to fail at school.

Pediatric psychiatrists must be sensitized to the school environment and, alternatively, kindergarten assistants must be sensitized to pediatric psychiatry, so that together they may detect and diagnose children's troubles (*maux*), before making a referral and establishing a broader plan of action (*dispositif*) for prevention around the child. The network of inter-district psychiatry functions well, and could be centralized at the departmental level, with the establishing of a coordinator.

Children with *difficulties* deserve more attention than others, as early as kindergarten. Therefore it is important to facilitate pediatric psychiatrists' access to schools, so that they can carry out proximity work (*faire un travail de proximité*).

The family physician must also play an important role in the group of referral actors intervening around the child, because he/she is knowledgeable about the family, and has their trust (my translation, 2004:16).

This had inspired Sarkozy to include a mental health component to his law on delinquency, but under the pressure of the psychiatry community, he was forced to remove it.

⁹⁷ Loi du 5 mars 2005 relative à la prévention de la délinquance: http://www.interieur.gouv.fr/sections/a_la_une/toute_1_actualite/archives-actualites/archives-securite/loi-delinquance-5-mars-2007/downloadFile/attachedFile/mise_en_page_5_web.pdf?nocache=1178545944.26

This political and legal background underlines how, in the detection of behavioral disorders or disability among children of immigrants, one must be aware of the interaction between political ideology and the policing of individual behavior through health and educational policies in particular. It is this problematic interaction which the shifting line between caring and regulating in specialized mental healthcare school referrals emphasizes. In this chapter, I devote a first section of my analysis to school dynamics in the detection of behavioral disorders or disability among children of immigrants. I pay particular attention to ways the recently updated law on disability – theoretically intended to improve care and school environment for disabled children – triggers conflictual situations with immigrant parents. In a second section, I turn to how specialized mental healthcare centers manage school referrals on the basis of behavioral disorder or disability. Just as I have proceeded in the previous two chapters, I examine how these centers are caught in a double-bind where their institutional positioning and the very nature of their expertise places them in a position to both amend and contest the dynamics of referrals.

I. Starting at School: Locating “Difficulties,” Naming Disorders and

Disabilities

“Difficulty,” as a term of reference in the language of the French education system, is fraught with ambivalence. To start with, the term is very vague and could theoretically encompass references to problems in various domains. Generally, school actors use “difficulty” to refer to the fact that a given child is failing at school (*en échec scolaire*). In fact the term of “student in difficulty” deliberately replaced the term of “student failing”

in the 1980s, in the National Education system's effort to counteract previous segregating practices leading to early and arbitrary orientations to special aid schools (Monfroy, 2002:33-34). Yet again, "difficulty" remains ambiguous, as it can potentially refer to several different gradients of severity in the definition of failure. Consequently, "difficulty" is used as a generic term, as concerns are initially raised with regards to a given child's problematic school progress, before specific causes are identified, through psychological and medical assessments for example. It remains undefined, both in National Education official texts and in the professional literature, which makes naming and identifying a social process (Monfroy, 2002:34).

In chapter 6, discussing naming and referring practices, I mentioned how "difficulty" as a concept was also often resorted to as a euphemizing and culturally meaningful term that conflated stigmatizing representations of immigrants' cultural differences with an acknowledgement of the structural inequalities to which they are particularly vulnerable and which may inform their suffering. Incidentally, this chapter on school referrals reveals a parallel use of the concept in reference to "children of immigrants" in schools, as being both "difficult" in the context of the classroom (read: either disruptive or absent-minded), and as presenting a higher incidence of learning "difficulties" (for which various diagnoses are later provided). Indeed, as noted in the previous two chapters, discussions on the identification of the nature of such "difficulties" often convey stigmatizing representations of immigrants' unusual family structures, lifestyles, and childrearing practices more specifically. More often than not, these are perceived as negatively impacting children's learning abilities, as well as "proper" behavior – however schools define it. Therefore, the connotations of the use of

the word in reference to immigrants and their children, as well as the racial prejudices and moral comments it circulates, require careful attention in the making and naming of school diagnoses, namely learning disabilities and behavioral disorders.

Immigrant descent as the basis of “difficulties”?

In a referral letter to Minkowska, drafted by a school psychologist of a special-aid high school, exhaustive technical evaluations are provided in separate reports on the “patient” student by every school instructors. Although these evaluations clearly establish the various learning disabilities that the student presents, the psychologist asks: “we wish to understand this student’s *difficulties* so we can help her as well as we can” (emphasis mine). In the attached letter of the school director to the district’s superintendent (formally asking for the student’s referral to a special-aid high school), however, those *difficulties* are clearly summarized. Indeed, it is specified that after two years spent in middle school, she could still not read nor write, and “evidently, could not learn her lessons.” Consequently, the student had been oriented to a professional school where she was taught the manufacturing of leather goods. Again, there, she was unable to complete the program, for, “in addition to the problems already mentioned, she [the student] has *difficulties* with drawing and understanding. She has trouble following guidelines, if she follows them at all. She also displays light *difficulties* in the manual domain.” One might ponder what kind of supplemental information the school might expect from a specialized mental healthcare center, when the student’s learning and motor skills disabilities have been so clearly established, and when the orientation to a special-aid school has already

been decided (the district superintendent letter of notification for the orientation decision being itself included in the patient file).

What alternative *difficulties* does the school psychologist's referral letter allude to, that presumably necessitate cultural expertise of some kind? Nowhere do references to the student's cultural background appear in the patient's file. It is indicated that she was born in France. The only clue to the student's "cultural difference" being her last name, which suggests that her family is from West Africa, most likely from Ivory Coast or Guinea.⁹⁸ What kind of reasoning motivated the school psychologist to link this student's learning disability with her cultural background? Hypothetically, one might imagine that the psychologist equated the student's parents' cultural difference with limited educational support to offer to their daughter, and related difficulties navigating the French educational system and follow-up on their daughter's progress. But then, why would this not be clearly articulated by the psychologist? One would think that so many efforts placed into providing a detailed account of the school situation would be accompanied by an equally detailed rationale on the cultural expertise request. Is this what the choice of the word "difficulties" encapsulate? Does the use of such an ambiguous term signal self-censorship in naming the student's cultural difference, or is the relationship between cultural difference and the learning disability presumed as being common sense, so it does not even have to be articulated? Is the word "difficulty," so often mentioned in school referral narratives, a proxy that implies a relation between school problems and cultural difference?

⁹⁸ Reports have been published in France on employment discrimination based on candidates' last names (Meurs, Pailhé, and Simon, 2006).

In his discursive analysis of the construction of an learning disable student, Mehan focuses on “the competition over the meaning of ambiguous events” as a variety of social actors gather in schools and “try to decide whether a child is ‘normal’ or ‘deviant,’ belong in a ‘regular educational program’ or in a ‘special education program’” (1996: 254). In France, the classification of disabilities have become increasingly formalized through state legislation⁹⁹ and related institutional re-organization.¹⁰⁰ The goal has been to give the family more agency over the future of their child and over school decision-making, at the same time as allowing disabled youth to remain in the least restrictive school environment as possible. However, the administrative management of disabilities at school, from diagnosis to placement, has become increasingly complex and burdensome – despite its intention to improve attendance of disabled children and increase check-ups in the diagnostic process. The language of this new system, with its plethora of acronyms (for which the French seem to have a peculiar inclination), is also difficult to process. School actors, whom I encountered during pre-clinical consultations or whom I interviewed, themselves complained that they had trouble keeping up, especially considering the system’s rules evolved constantly.

Seeing one’s child diagnosed with a learning disability is a stressful experience for any parent. But with the new legislation, parents’ responsibility in taking charge of managing the disability report has burdened them further. Primarily because of the language barrier, and because of existing tensions with the school as a State institution, immigrant parents may find themselves in extremely anxiety-ridden situations, during which they understand the future of their child may be at stake, but based on a rationale

⁹⁹ See my case studies for references to the 2005 Law on handicap in France

¹⁰⁰ Elaboration of “Personalized School Projects,” see organigramme (Appendix E).

they may not understand or which they may disagree with. Conflicts between immigrant parents and school officials thus recurrently occur around the disability diagnosis and the special-aid school orientation. Such conflicts –rather than the diagnosis per se – form the basis of school referrals to specialized mental healthcare centers. But before I turn to the analysis of how specialized mental healthcare centers manage such conflicts, I first examine how the disability diagnosis and referral system is organized in schools.

Disability Representations: The Conflicts between Schools and Immigrant Families

During my training in the Transcultural Psychiatry program, I had the opportunity of meeting Murielle, a school psychologist working at a primary school in an eastern suburb of Paris. This suburb hosts a large Malian community, and it had been the site of violent riots in both 2005 and 2007. Recently, it has received a lot of attention in the context of new politics of urban planning to improve life in the suburbs. Degrading high-rise buildings are being torn down, and slowly replaced by low-rise apartment complexes. As we drove to her school, Murielle commented that having nicer buildings would most likely not solve the social issues facing a majority of families in her district.

The suburb is also categorized by the national education system as a Priority Education Zone (*Zone d'Education Prioritaire*, commonly know as *ZEP*), which means that it receives greater funding and autonomy in order to face socially-related school problems.¹⁰¹ Since 2007, ZEPs are part of the Ambition and Success Network (*Réseau*

¹⁰¹ ZEPs were created in 1981, as part of the Mitterand government's social policies, as an effort to address academic failure rates in lower socio-economic residential areas. In 2006, they were redefined as the Ambition and Success Network, and more recently, in 2008, they were incorporated in the government's Urban Policy Program (*Politique de la ville*), which educational agenda focuses on "bringing hope back in

Ambition Réussite), whose goal is to ensure “equal access to school success” (*égalité des chances*), and to develop partnership between the school, families and other related institutions (Dubet, 2004). Murielle describes for me what her role as school psychologist is, in the context of the RASED – the Special Aid Network for Students with Difficulties.¹⁰² RASED *interventions*¹⁰³ must take place during school time, and must be planned in collaboration with school teachers during regular school staff meetings. Parents must be informed of such interventions when their child is concerned, and they must provide their agreement for the intervention of a school therapist or psychologist. The RASED may feel not competent enough in addressing the child’s difficulties, in which case, external consultations can take place (this is how, with children of immigrants for example, the RASED can be short-circuited, and children sent to “specialized” health/mediation structures) (see organigramme- Appendix E).

RASEDs address problems from kindergarten to elementary schools exclusively. Each RASED is typically in charge of all schools in one geographically-defined school district. A RASED team is constituted of a special-aid teacher in charge of learning disabilities (“Maître E”), a special-aid teacher in charge “socialization/relational” disabilities (“Maître G”), and a school psychologist.¹⁰⁴ This wide range of specialized

the suburbs” (*Espoir Banlieues*). In his inauguration of the Program, President Sarkozy pointed out that the “malaise” characterizing French suburbs was not simply related to structural decay, but threatened “the very idea of the nation (...) [as] being also related to identity, culture, morality, in short, it is human and not simply material” (Elyséethèque, Speech of February 8, 2008).

¹⁰² RASEDs were created in 1990 by the National Education Ministry as a “resource network” contributing to newly defined politics of school “adaptation and integration.”

¹⁰³ The word is the same in France. Here I want to draw attention to this interventionist language in schools.

¹⁰⁴ “Maître E” and “Maître G” receive their training from IUFM (National Training Institute for School Teachers). They must already be certified as school teachers, and must have at least one year experience in a regular classroom.

support, from pedagogical to psychological, is also perceived as preventive in nature. As one school psychologist explained to me:

as soon as children – and potentially their families – are identified as having difficulties with school – whether it is *a problem of cultural adaptation*, of understanding what the institution expects from them, or simply of wanting to learn – we can coordinate *an intervention* to prevent problems from worsening. The goal is also to encourage sharing perspectives and partnership between the various professional actors in the school system. Ultimately, this should lead to the best adapted response to any kind of problem (emphases mine).

Once a disability has been diagnosed, the school psychologist must meet with the child's family in order to file for disability and decide on an orientation to a special aid school institution. CLIS classes, for example, are “school integration classes” (*classes d'intégration scolaire*), located within primary schools, and enrolling a small group of children (twelve children maximum) presenting some kind of disability. Some CLIS are structured to respond to a specific handicap – mental (CLIS 1), auditory (CLIS 2), visual (CLIS 3), or motor (CLIS 4). CLIS classes thus assist children who are considered unable to integrate an ordinary class on their own. They provide these children with individualized teaching, while allowing them to also partake in the school's collective pedagogical projects with the rest of the pupils. Depending on the level of his/her disability, a child can spend some time in “regular” classes, where he/she can follow the general curriculum at his/her own pace.

Until the adoption of a new law on the rights of disabled persons in February 2005,¹⁰⁵ referrals to CLIS classes were decided by a special education commission

¹⁰⁵ LOI N° 2005-102 DU 11 FEVRIER 2005 POUR L'EGALITE DES DROITS ET DES CHANCES, LA PARTICIPATION ET LA CITOYENNETE DES PERSONNES HANDICAPEES, see <http://www.education.gouv.fr/cid207/la-scolarisation-des-eleves-handicapes.html>

(CCPE – District Commission for Pre-Elementary and Elementary Education),¹⁰⁶ and with the agreement of the family. Out of concerns with the social isolation and social reintegration of “disabled” pupils, new conditions were added to the actualization of such referrals, which gave greater involvement to health structures attending to the child’s disability, and to the child’s family. Since the beginning of the 2006 school year, families must constitute the file for referral to disability structures on their own.

MDPH structures (Departmental Houses for Disabled Persons) were created to discuss the referral propositions and grant, or deny, approval. Upon this first approval, a second round of approvals must be granted by a “commission on the rights and autonomy of disabled persons”¹⁰⁷ on the one hand, and by the healthcare structure monitoring the child for his/her disability on the other. An individualized “project” (“Personalized School Project” or *PPS*)¹⁰⁸ is then proposed to the family, who has to grant final approval for the referral. Depending on enrollment availabilities in the child’s school district, the School Superintendent assigns a class to the family.¹⁰⁹

Teachers in charge of CLIS classes have received specialized training, and they work in close collaboration with the school’s “pedagogical team,”¹¹⁰ as well as, ideally,

¹⁰⁶ For information of the constitution of such commissions, see <http://pedagogie.ia84.ac-aix-marseille.fr/isle/Fiches/fiche03.htm>

¹⁰⁷ Commission des droits et de l’autonomie des personnes handicapées (CDAPH) : http://www.travail-solidarite.gouv.fr/spip.php?page=article&id_article=3347

¹⁰⁸ The PPS “defines schooling options as well as pedagogical, psychological, educational, social, medical and paramedical interventions responding to the particular needs of students with a handicap” (12/30/2005 Decree). It is put together by a multidisciplinary team appointed by the MDPH (Home of Disabled Persons).

¹⁰⁹ For a table on the evolution of referrals before and after the February 2005 law, see http://www.ien-st-jacques.ac-rennes.fr/ais_orientation_clis.pdf

¹¹⁰ In primary schools, the “pedagogical team” consists of the school director, tenured teachers, replacement teachers, and special aid teachers.

with healthcare structures assisting their pupils. Alternatively, at the secondary level, there are UPI (Integration Pedagogical Unit) or a SEGPA (Adapted Section for General and Professional Teaching).¹¹¹ Both are equivalents to CLIS classes at the secondary school level, UPIs pursuing an alternative education between small-scale, specialized units and regular classrooms, and SEGPA being located outside of regular secondary schools and emphasizing on the individualized professional training of disabled children.

Murielle describes her role as a school psychologist in this complex referral system:

My mission right now, in work in a ZEP, which is a population of 90% migrants, and the largest population I have are Malians. I'm in the Maitre G network. (...) I'm also in charge of constituting files for the MDPH now, since 2 years ago there was the creation of the MDPH, so for all children integrated at school, we must open a file. And before it was not like this. Before the psychologist tracked children facing deficiencies, carried out his/her assessment and we had commissions within the National Education system, so we verbally presented our case, and we defended it, and children were oriented. Now it is up to parents to contact the MDPH, that is...well, what constituted a problem for me was with respect to the foreign families who do not master the French language, I am explaining to them that their child is encountering deficiencies, well I don't tell them, I tell them he/she is experiencing great difficulties, and that it requires an orientation, so I feel like I completely cheat them, because they don't understand. Once I use simple words, what I tell them no longer means anything, and I must lead them...well, before my position was to explain to them the state of their child to that the orientation took place, and I had the institution behind me, pressing me, who was in the urgency. (...) Now, I just let the parents lead their own path, and let's say that I accompany them. This doesn't necessarily satisfy the institution, but this, I take full responsibility for. It's kind of a passive resistance. Let's say that I leave time to time.

Murielle thus readily states the dilemma of this new disability policy that puts families in charge of the disability filing process. Although the policy is intended to foster families'

¹¹¹ See <http://education.gouv.fr/cid207/la-scolarisation-des-eleves-handicapes.html>

decision autonomy, it becomes apparent, through Murielle's experience, that often a decision has already been made by the school, and that families receive heavy pressure to both accept the disability diagnosis and process the disability file with the MDPH. "It requires a lot of patience and tenacity," she says. "The most difficult thing is to constantly have to mediate between the child's parents and the administration. Often, it is the administration that pushes for a mental health referral, so they can get rid of a complicated situation." Seizing my interest in her comments and work experience, she invited me to attend an appointment with the Malian father of an eight-year-old child, still enrolled in kindergarten, and diagnosed with autism.

Before Mr. Diarra arrives, Murielle detailed the situation for me. Salif, Mr. Diarra's son, was diagnosed with autism four years ago, at the end of his first year in kindergarten. Of course, autism is a tricky diagnosis, considering there exist no medical tests for it. A diagnosis must be based on observation of the individual's communication, behavior and developmental levels. To complicate things further, many of the behaviors associated with autism are shared by other disorders, such as developmental delays, behavioral disorder, or hearing disability. Therefore, detecting autism can take time. As far as Salif was concerned, Murielle explained to me, he would rarely make eye contact with people, had an extremely limited vocabulary and mostly articulated sounds, and would isolate himself, as if drawn in his own world. At the end of Salif's first year in kindergarten, the Diarra family was called to school by the Director, so as to discuss an alternative school project for Salif. The school incorporated a part-time class for children with disabilities (CLIS), which Salif was eligible to attend. Following the law of February 2005, the conditions of schooling for disabled children must be adapted in order

to see educational and therapeutic needs complemented. The organization of schooling is presumably done within the framework of a partnership between the family, the school, and the service of care; a personalized project of schooling is then defined on the basis of a precise evaluation of the needs for the child. The project is then regularly readjusted. Generally, the child is accommodated with part-time school, alternating with specialized care.

Unfortunately, at the time Salif's case was discussed, the class had reached its maximum of pupils enrolled. The school's director was therefore approaching the Diarras with the possibility of their son being sent to a medical structure outside of school (IME¹¹²). Salif's father was opposed to the idea. His son was "special," he told the school Director, but certainly not disabled. He was cast a spell upon (*marabouté*) the day he was born. His mind was governed by a *jinn*, who would not let go of him. Salif's father was of the opinion that, one day, his son would come back to his own self, being freed from the spirit in his head, and that things would resume to being normal. In fact, Murielle explained to me, the parents had consulted with a multitude of diviners (*marabouts*) in Paris, with the hope of finding the right "cure" for their son.

Almost four years had elapsed between the first meeting between the Diarras and the school Director, without the two parties being able to reach an agreement on Salif's schooling orientation. During that time, Murielle had acted as a mediator between the school administration and the parents. At several instances, the school Director had threatened the Diarras with a lawsuit for child maltreatment. Murielle had successfully bought more time from her at each threat, convincing her that the Diarras needed more time and space to come to terms with the situation, and that it was in Salif's best interest

¹¹² *Institut Médico-Educatif* or Medical and Educational Institute

to lead his parents be part of the decision-making. Outside of meetings with Mr. Diarra to deal with the administrative conundrum Salif's case had become, Murielle would also see Mrs. Diarra on a regular basis. She suspected the latter suffered from a severe post-partum depression following Salif's birth. She had shared with Murielle's difficulties relating to her son, and confessed she often simply left him sitting in front of the TV, where he would be so absorbed by images that she would not have to deal with him.

A few months before my visit at Murielle's school, the situation had shifted. That morning, Murielle was receiving Mr. Diarra to discuss the family transformations, along with Salif's progress, and the father's decision to finally sign on to the Personalized School Project adopted by the MDPH for Salif. The appointment had been difficult to schedule, Mr. Diarra working long, ever-changing shifts as a janitor at Charles de Gaulle airport, also a long transportation trip away from his residence. When Mr. Diarra arrived, Murielle asked him permission for me to attend their meeting, to which he agreed. He was eager to tell Murielle about the trip his whole family had undertaken to Mali, with Salif and their other newborn child. It was his and his wife first time back home since they had come to France. The trip was transformative for the family at many levels, one of which was Salif's behavior. Mr. Diarra had taken Salif to "the bush" (*la brousse*) where they visited a renowned ritual specialist. The latter had prescribed the family a variety of different herbal remedies, some to be mixed with food and liquids, others to be mixed with Salif's bath water. Every night, Salif was administered a ritual bath, and within a week, Salif seemed to display significant behavioral changes, making efforts at uttering complete sentences, and making eye contact more regularly. Mr. Diarra commented:

I think the *jinn* has left, finally. You know, when I think about all the money I invested in those *marabouts* (ritual specialists) here in France... I know people say they're all charlatans, but when you're in our situation, you try everything. (Turning to me) You know, if it was not for Murielle, I don't know what would have happened with Salif. I know people at school mean well for him, but as his parents, don't we know best? People have been so mean to us at times. Only Murielle took the time to listen to us, me and my wife also. She understands. [Turning back to Murielle] Thank you, really.

After Mr. Diarra leaves, Murielle takes advantage of recess to take me to the Kindergarten section of school and meet Salif. When I see him, he is playing ball with one of the school assistants. Although he seems to lack in agility and coordination, he appears very engaged in the game itself (they simply throw the ball at each other, although Salif does not always seem to intend to throw the ball back at the assistant). Murielle interrupts them to take Salif to a reading room, where she observes him play with a variety of plastic objects. She then has him sit between the two of us, and we flip the pages of a children's book, paying attention to how he engages with the contents. At one point, he stops and points at the drawing of a mountain and, aloud, articulates "*Montagne!*" (Mountain!). Murielle turns to me with a look of amazement. "See, he never ceases to amaze me. He appears to have such a limited vocabulary, and yet he regularly comes with these words out of nowhere..."

Disability diagnoses may sometimes be very difficult to establish. It may be related to the very nature of the disability, as with autism in Salif's case. In schools, it is not the existence of the disability that is so much problematic – be it related to mental, auditory, visual, or motor skills. Rather, it is the severity of the disability and how to deal with it that becomes more complicated. As Salif's case illustrates, the difficulty also resides in communicating the disability to immigrant parents, and negotiating the

potentially divergent explanations the latter may have on the disability and its origins. Schools may not always be willing to take time and accept such negotiations. Were it not for Murielle's personal engagement with the Diarras and her sensibility to their conflict with the school, Salif's parents would have been brought to a justice court, and Salif most likely placed in foster care by child services. A referral to a specialized mental healthcare center would have certainly taken place.

What Salif's case highlights is the rigidity that institutional actors often readily display with immigrants and/or their children, which ineluctably creates conflicting situations, where there should not be any – or at least where they could easily be avoided. The Diarra family was fortunate to find someone like Murielle to mediate for them. Her willingness to listen and to show the family hospitality were essential in unlocking this situation, and avoiding a referral to a specialized mental healthcare center, where the same dispositions – listening, tolerance, and hospitality – would have been offered (see Madan's case in chapter 8). Communicating acted as a substitute for referring (and potentially suing).

Behavioral Disorders: The Conflicts between Teachers and “Children of Immigrants”

I have just described the intricacies of negotiating the representations of a child's diagnosed disability between school officials and immigrant families. I showed how the new law on disability, by placing families in charge of the disability file, has heightened the tension in this negotiation between the two parties. A second challenge related to the detection of “difficulties” among children of immigrants in schools is linked to the

impact of broader racial and ethnic prejudices on children/teachers interactions. In that respect, one category, which seems to plague children of immigrants, appears particularly problematic: the behavioral disorder category.

When I asked Murielle to tell me which obstacles children of immigrants commonly face at school, and which may lead them to be referred to a special-aid school, she replied:

First of all, we work a lot with the small one in kindergarten on language. There's no mastering of the language, and teachers don't understand that the native language is very important, to be able to access the French language. So the representations they always have...and may tell them...it's always...they're going to tell the family, "you absolutely have to speak French at home," when the mothers don't speak French, or speak it badly (*elles le baragouinent*), so it's useless to tell them that. So the first objective of networks, that's what it is, the French language. And there, what's most blatant, is with the older ones, it's behavioral disorders, children who react very strongly to teachers' reactions, who reject the frame (*le cadre*), who don't understand rules...

To Murielle, it is those labeled "behavioral disorders" which are most problematic with respect to children of immigrants. She addressed how such diagnoses may be culturally biased and discriminatory, imposing an etiology of pathology that is imbued by racial and ethnic prejudices on generic African lifestyles and family arrangements:

if you will, behavioral disorders, teachers interpret it that way: "it's normal, it's a migrant's child, from a polygamous family, the mother doesn't master the French language." So it's all the clichés they put into it...when it's simply, of all evidence, effectively, the child who must live at home following an African style (*vivre à l'africaine*), and at 8:30 in the morning, he must change hats, and directly live as a French child, with a French history, a French family...and teachers think there's no problem, to come at 8:30 in...whereas...it's a problem for the child...so indeed, we say, well they adapt, they adapt, but at what cost also? So there are children who do not adapt, and on the other hand, I have very rigid teachers...so as long as this rigidity doesn't...but because they are afraid

of it, because they don't know, and there's no training for teachers in psychology, there is no psychology training at any point in the teacher's training curriculum, and on migrants, there's nothing. All the more since we are in a ZEP, which is aberrant...uh...[the teachers] are interested (*ils sont demandeurs*).

... the child I was talking about earlier and who had reacted very violently, who wanted to jump over the fence because he was wearing his hat and he refused to take it off...he was simply like all the children...all the children had had their heads shaved...so he didn't take his hat off...that was nothing...it could have been defused in ten seconds by the teacher, and in fact, it was a detail for her which took huge proportions...because it was...for her it was the lack of respect for the teacher, when it was not that at all. It was an 11 year-old child who didn't want to show his shaved head...so the proportions it took is that the teacher would not accept him in the classroom, the child was not allowed to cross the entrance door, so he fled to the playground, he jumped over the fence...he didn't understand either...and so I talked with him for 30 minutes, and I when took him back to the classroom, the teacher said "I don't want him anymore." So it's violent. I received it very violently. And I thought to myself, "how does *he* interpret that?"

When I ask Murielle why, in her opinion, teachers respond differently to children of immigrants in the classroom, she does mentioned cultural discrepancies between children and teachers, but she also underlines the negative impact of teachers' representations of these children as being threatening, suburban thugs:

I have education teams...the three I saw last Monday were related to behavioral disorders, because there's a misunderstanding between the child and the teacher. The child isn't able to digest all the information he's given. He doesn't have the vocabulary. He has a very simple vocabulary. So the teacher can tell him anything. He has behaviors the teacher will not understand, like, "he doesn't look me in the eye, but if he looks me in the eye, he's not allowed to look me in the eye"... so, details... I think that the migrant child scares teachers, so automatically they show greater resistance, whereas a child...a French child...there's not this feeling of discrepancy. The teacher feels more at ease. The teacher is scared I think. Especially in the CM2¹¹³ with the older ones. The teacher is afraid, and so automatically he is more rigid. Whereas I saw an eleven year-old child who cried, who didn't want to take off his hat, and who, once he took his hat off, started sucking his thumb. So as far as I'm concerned, I readily see

¹¹³ Fifth grade.

the child. I don't see the *potentially dangerous*... that is, the teacher has a lot of *fantasies*. So the teacher told me, "this child will be dangerous." So I told him "so right way, we're going to refer him now because, potentially, in two years, he will be *difficult*. See, it's ridiculous. Many things are being projected...and...when in fact this child, I saw social services for him, and so social services told me "we're going to uphold the measure, because this child, well, he's adorable"...you know, in another context, but social services receive transcultural training...much more than teachers...well, some of them, in my district at least, we're lucky for that (emphases mine).

Stigmatizing projections thus heavily shape teachers' categorization of children of immigrants as "difficult" children, bound to become "children in difficulty."

Although it did not focus on cultural/racial stigmatization in relation to children of immigrants at school, Monfroy's study on the definition of students in difficulty in ZEPs found that "students from lower social classes are frequently perceived [by their teachers] through very generic representations, massively resorting to images of deprivation and social misery, as well as to explanations framed in terms of 'sociocultural disability'" (2002:35). Teachers' representations thus focus on students' behavior and attitude – rather than academic performance strictly, with a strong propensity to psychologize problems (Monfroy, 2002:35). These attributions, which are external to the school context, lead teachers to commonly categorize students in difficulty in two broad categories: withdrawal (*figure "du retrait"*) or resistance (*figure "de la résistance"*) (Monfroy, 2002:36). Parallel qualifications are used with children of immigrants, as case studies in this chapter recurrently demonstrate. Monfroy also shows how such external attributions lead teachers to "consider children's difficulties as being unrelated to pedagogy and/or school, but rather from a lack of will, of interest, or of motivation, sometimes a pathological problem (paralysis – "*un blocage*"), on which they cannot act

because they would be related to these students' personal characteristics and/or their families" (Monfroy, 2002:37). Again, one may easily understand how, in addition, stigmatizing stereotypes about immigrants' unusual family structures and lifestyles – and the dangerous youth they breed, would make children of immigrants particularly vulnerable to such categorizations.

Interestingly, Murielle commented that there are contradictions between teachers' negative responses to children of immigrants, and the fact that they choose to work in a ZEP district, in which they will most likely have to deal with such demographics in the classroom:

what is astonishing is that in general, they stay, they stay there very long. So there, the motivations... it would be interesting to work on the motivations of teachers in ZEP. And who stays, at the same time as they have trouble doing their work. Because I think that the behavior...because I think that it kind of reminds one about colonialism...uh, that is, in the end we stand above. We still feel like we stand above (*on se sent au-dessus*). And would those same teachers go to a school in a bourgeois neighborhood, they wouldn't have the same reactions. Because the kinds of reactions they have in a ZEP, parents wouldn't accept that. I...motivations – it would be interesting to see... Why are they there? Because the youngest who come go away very quickly. At the end of a year, they understood, they leave the ZEP. I'm telling you about teachers who have been there for over 10 years. Who feel bad, who are depressed on top of that. So the child faces depressed persons who react violently at some times, but who stay nonetheless in the ZEP. Whereas we....well I chose. I chose the ZEP. And I have other colleagues for whom it's not working. Well, they leave, they go to small towns. They're vaccinated, they go back. But among psychologists, we listen a lot to families and to children. And so what is not easy is to be available to listen to families, to children, to teachers, it's difficult to split oneself.

In her study on the definition of students in difficulty in ZEPs, Monfroy concludes that teachers' suffering and professional burn-out weigh significantly in the subjective assessment of such students, and the consequences that derive from such assessment (responsibility withdrawal, referral to RASED, special aid orientation request, etc.)

(2002:39). All of these reasons make referrals for children of immigrants particularly problematic.

Murielle came back to the ambivalence of making families responsible for managing the referral themselves in such contexts:

Well, what's complicated for me, perhaps that's why I did the training, is precisely the referrals. Parents are asked to be responsible, it's very good, to make them responsible (*on les responsabilise*), but they...*even a French family*, it's very, very hard, see, to refer a child, to elaborate a super complicated case. Me, they come to work on the file with me, I don't understand anything. Frankly, the formulas, the boxes to check... And on top of that, there are their representations. For them, their child is not sick, he's not deficient. It's something else. For example, I have a case study for my thesis...it's a "unique" child (*un enfant singulier*), but in the end, I have to help this father make his way to make a decision, you see. So, that's why I did this training, you see. Because there, I feel like there is something that's going wrong at the level of the institution, at the level of the administration, and Malian families are being asked a lot. It's nice to give them responsibilities, but they need to be accompanied, and I'm afraid to get involved in...to betray...to betray.

Because the goal I have is to accompany children, but they don't understand. They're not in that system at all. And so, well what's characteristic is those children of migrants who are referred...uh...I mean you go to a CLIS, if you will, in my district, out of 12 children, you have 10 blacks (*tu as dix "blacks"*). And our tests, uh, well, even though it's the WISC-IV¹¹⁴, I find it to be more and more cognitive. I find it to evaluate children poorly. So evidently, we have children who are labeled as deficient, and that, that hurts me too. ... Things have changed in the last three years, since I've come to work in the district, we work a lot on...we think a lot about referrals. So now, I have nearly two referrals a year [instead of the 12 referrals per year that her predecessor averaged, as Murielle specified earlier in the interview].

...it is said in the texts that when you have a doubt, *a doubt*, you can make a referral (emphasis hers). Uh...I think a doubt is not sufficient because it can cause a lot of damage. So I wouldn't say I expect facts either, because sometimes, uh...but it has to be prepared, and it's prepared with the family. ... If you will, now all the education teams come to see

¹¹⁴ The Wechsler Intelligence Scale for Children (WISC), developed by David Wechsler, is an intelligence test for children between the ages of 6 and 16 inclusive that can be completed without reading or writing. The WISC generates an IQ score. The current version, the WISC-IV, was produced in 2003. Each successive version has been reformatted to compensate for the Flynn effect, refined questions to make them less biased against minorities and females. See: http://en.wikipedia.org/wiki/Wechsler_Intelligence_Scale_for_Children

me, and we discuss the referral again, what's positive, what's negative, what it can entail, and then I inform the parents. Always, always. And sometimes, when it's sexual abuse, it's direct. You call social services, you contact the attorney, and you don't return the child to the family. But with respect to Mal...with respect to foreign families, there was the story of this drawing... I told you about that... the child is being told "draw your fears." And the child drew his fears, and his brother with a big knife, and there was a big commotion, referral, child removed from the family, and there was a mom who was sinking, and she had her children taken away, and her head was pushed under water...in brief...but she got them back, and it took a long time for her to get them back...that was my objective, that was my big work three years ago, and now, with social services, I have positive feedback. They tell me "ah, it's nice because now, referrals, there are less of them, it's carefully examined," so for them it's easier after that to work with the family.

Again, what stands out in Murielle's comments is her personal commitment as well as the rigidity of the school with children of immigrants and their families. This rigidity is mostly informed, as she herself points out, by fantasies, not only about how culturally different immigrant family lifestyles and socializing manners are, but also about how such lifestyles and manners in turn breed violent, delinquent youth, threatening them in the classroom. Some teachers are afraid, Murielle also underlines. While cultural difference and the preconceived ideas related to that difference may cause such reactions from teachers especially, the political discourse that encourages relations between security, delinquency, schools and immigrant youth to be drawn most likely contributes to exacerbating these fear sentiments.

Listening and Communicating: The Missing Link

Murielle's professional testimony highlights the importance of establishing a respectful dialogue between school actors and immigrant families as a way to avoid arbitrary referrals as well as biased diagnoses which may negatively and unfairly impact the future school trajectories for children of immigrants. This is especially true of

behavioral disorder diagnoses, for which the assessment is relatively more subjective. Murielle dedicates much of her time and energy to acting as a safeguard in the establishment of such assessments. Disability diagnoses, on the other hand, being subject to a series of broader institutional assessments—both medical and educational—are less likely to form the basis of an arbitrary referral (even though some disabilities are more difficult to measure objectively than others). For those cases, it seems to be the negotiation of the diagnosis itself with the family that is more problematic, and which may hinder an appropriate therapeutic response. Immigrant parents may indeed provide culturally different explanations for their child’s disability, as Salif’s case illustrates.

II. From Schools to Specialized Mental Healthcare Centers: Circulating and Contesting

In this second part, I examine how specialized mental healthcare centers become involved in the negotiation of disorder/disability diagnoses for children of immigrants. On what basis is their professional expertise involved? What is their position vis-à-vis schools’ decisions? How do they apprehend the relation between cultural difference and the presence/development of a disorder/disability among children of immigrants?

Pre-Consultation Meeting with Gepela: Communicating vs. Referring

Sandra, one of the school psychologists affiliated with the Gepela, is the referring psychologist for several schools in a Northeastern suburb of Paris. This means that “problematic cases” are signaled to her by school teachers or administrators and that upon assessment of the situation she decides whether to orientate the child and his family to the Gepela for consultation or not. The referral is organized in several stages. With

respect to the “child in difficulty,” Sandra first evaluates the situation at work by meeting with the child and his family. It sometimes happens (as I witnessed once following her to another school site) that she responds to her colleagues’ referrals, who also have her meet with the child and family, to assess a given situation. She thus has built a network of professional relations who may rely on her as a “special expert” or consultant for cases related to children of immigrants.

I accompanied Sandra to an “education team” meeting in a school in one commune in a northeastern suburb of Paris. Such meetings occur when a pupil is identified as being “in difficulty.” The team’s goal is to discuss the nature of the difficulty, and assess whether it stems from a disorder or a disability, in which case the school is obligated to inform the child’s family and organize, in coordination with the MDPH, a “Personalized School Project” for the newly-labeled “disabled” child. Sandra is not affiliated with this school in particular, but she participates in the RASED (Special Aid Network for Students with Difficulties). It is important to note here that Sandra was invited to attend this meeting – concerning the child of Malian immigrants – because the school psychologist knew of her work with the GEPELA, and called her as an expert in the possibility that cultural elements arise in this family’s case.

As we walked to the room where the meeting would take place, Sandra explained to me that the “education team” had not formally identified any disability with Moussa yet. Moussa was the son of a Malian single-mother, who also had a daughter in kindergarten. Sandra informed me that there had already been a meeting during which Moussa and his mother were present. The meeting had lasted three hours, and Moussa had appeared extremely calm to Sandra. He displayed constructive and controlled

drawing skills which, to Sandra, seemed to contradict the school teacher's report, according to which Moussa had problems with motor skills. Sandra warned me that the RASED team had suspicions concerning the teacher's report, that they were questioning whether the latter lacked a positive perspective on Moussa, and whether the problem at stake was a reactionary problem on behalf of the teacher, rather than some type of disability with the child. Sandra added that were some kind of "disability" identified by the team and reported to the school administration, Moussa's mother would have four months to fill out the disability declaration paperwork and submit it to the district's MDPH. Should she fail to do so, the school could threaten her with a lawsuit.¹¹⁵

As we entered the room, we were met by the school's psychologist, the "Maître E" (in charge of learning disabilities), the "Maître G" (in charge of relational disabilities), and Moussa's school teacher. Moussa's mother had been informed of the meeting and was expected by the team, but she ended up not coming.

The meeting started with a discussion of last month's meeting with Moussa's mother. The school teacher struck me as looking extremely uncomfortable during the discussion, especially as Sandra reiterated her observations that Moussa had not appeared to have any of the motor skills deficiencies he had been reported to have. Before Sandra had finished speaking, the school teacher stood up and nervously went through a folder filled with children drawings. She was shaking. The team members exchanged looks of concern, until the school psychologist, in a reassuring voice, invited the teacher to join the circle again and sit down:

School Psychologist (SP): We are not saying that your observations are wrong. We are simply trying to assess the situation at this point, and

¹¹⁵ As it happened with Salif's case, described in the previous section of this chapter.

determine how serious those motor skills problems you mentioned are. If Moussa appears normally stimulated outside of the classroom, we may wonder what constraints he feels when he is in the classroom. Perhaps his behavior is reactionary to something yet to be determined.

Sandra: Hasn't there been a medical diagnostic yet? I thought Moussa was to be tested for a potential neurological disorder.

Maître E: There hasn't been a diagnostic yet.

Teacher: Well, I'm worried about Moussa. Do we HAVE TO wait for a diagnosis? [Looking overwhelmed and teary-eyed] My problem is that Moussa won't stay still on his chair, and he keeps disturbing his school mates. He's always provocative with them. I can't always punish him! Honestly, I'm tired. It's difficult enough to manage a classroom. I can't just focus all my attention on him constantly.

Maître E: He has incorporated all the learning skills he should have acquired by now though. He just doesn't show them in the classroom. Perhaps we can obtain permission from the school superintendent to have him repeat his CE2 (third grade), even though he's already repeated a grade before...

Teacher: The problem is that Moussa does not benefit from a listening structure at home. Let's not fool ourselves here. *It's not a disease or a disability issue.*(emphasis mine)

Sandra: She's right. The school has only helped Moussa's existing problem emerge. The trouble is, Moussa's family won't understand his behavior the same way we do. Although they did agree to have the medical tests carried out. But I have to tell you, there will necessarily be a confrontation issue between our perspective on Moussa's disability –if disability there is, and the family's cultural understanding of the situation. Not mentioning that this situation is very confusing and scary for Moussa.

A discussion followed concerning the family's living conditions and the mother's situation. After she left her husband (no mention of the reasons why she did so), she and her children sought shelter at what is commonly named "the 115," a program for homeless people, established by the City of Paris, and coordinated by the Social Service branch of SAMU (Emergency Medical Assistance Service).¹¹⁶ For weeks, the family traveled from

¹¹⁶ This program was initially established in 1993. This organization assists homeless people to find a bed in an emergency shelter, mainly through a toll-free telephone number (115). These shelters are usually run by

one shelter to another, until they found housing in a structure welcoming single mothers and their children.¹¹⁷ The school psychologist explained that Moussa's mother had been feeling depressed and vulnerable. She often expressed fears of her children being in danger, especially since she had found a job and had to leave her children on their own more often than she liked. The situation worsened when her daughter, accompanied by Moussa on her way to kindergarten, was hit by a car near school. Fortunately, she suffered no injuries. Shortly thereafter, the mother's "companion" left her without notice. This triggered a long discussion on the sincerity of the companion's feelings for Moussa's mother, considering he was an illegal immigrant, and was most likely interested in a romance that would lead him to obtain legal paperwork:

Sandra: I wonder how she interprets all of this. The fact that she didn't show up this morning may mean that she's not doing well, that she's isolating herself.

Teacher: - You know, I must say that when I pay attention to him specifically, Moussa behaves really well. Everything is fine. I think he's looking for a privileged relationship.

Sandra: - And he surely can't find that at home either. His mother raises them like in Africa, with everybody else...

At that point, a bell rang, indicating it was time for recess, and everyone had to resume their regular activities. A meeting was scheduled again for the following month.

This case started with an ambiguous situation. First, the teacher's report on Moussa's motor skills disability appeared to be contradicted outside of the classroom

independent private charitable organizations having an agreement with the SAMU social. The SAMU social also has minibuses collecting homeless from the street to bring them to these shelters. Homeless people needing medical care are referred by the SAMU to public hospital or day care centers. In emergency shelters, homeless peoples are offered a bed, dinner and breakfast for 3 consecutive days.

¹¹⁷ These shelter structures vary according to the location, and some target specific populations, such as women victims of conjugal violence.

context, as verified by Sandra during the first Pedagogical Team meeting, and by “Maître E,” who presumably met with Moussa outside of class to assess his learning abilities in general. Quickly after hearing those expert counter-assessments, the teacher suggested that Moussa might merely be seeking attention, and that “he’s looking for a privileged relationship.” Her willingness to try and situate Moussa’s contradictory behavior was facilitated by Sandra’s intervention. This is where, I believe, Sandra’s expertise came in as relevant. As she herself put it in her description of Gepela’s “intervention,” her role is more that of a conflict mediator between immigrant families and school institutions, rather than of a “specialized” psychologist (very much echoing Murielle’s description). She attempted to show where and why different interpretations of Moussa’s behavior may emerge. By allowing the possibility for Moussa’s mother to be interpreting the situation differently than the school (“Moussa’s family won’t understand his behavior the same way we do” or “I wonder how she will interpret all of this”), as well as initiating a discussion on Moussa’s family environment (unstable living conditions and their impact on child care), Sandra successfully led the teacher to feel less defensive about her response to Moussa’s behavior, and be more receptive about apprehending him differently in the classroom. The communication Sandra’s presence encouraged ultimately prevented Moussa’s case from being referred outside of the school, to a specialized mental healthcare center like Gepela.

One may nonetheless find Sandra’s approach problematic through the stigmatizing representations of immigrant families it indirectly reinforces. Indeed, themes discussed – notably comments on unusual family structures, childrearing practices, and precarious social environments – do disseminate moral judgments (especially in the

discussion of Moussa's mother's relationship) and indirectly comment on how immigrants deviate from "standard" socialization model and "normal" behavior. Surely, Sandra's approach is not intended to reinforce such commonplace stereotypical judgments on immigrants' lifestyles and their suspected impact on their children's problematic behavior. However, this is the risk her "specialized" mental healthcare expertise itself produces. Moussa's teacher may be willing to concede that there is no actual disability at stake here, but she may very well conclude from the discussion on generic ways of raising children in Africa that it is Moussa's culturally different background that make him behave abnormally in the classroom. Sandra's closing comments ("His mother raises them like in Africa, with everybody else...") seemingly validate this conclusion. In other words, Sandra's intervention may have unlocked the conflict between Moussa and his teacher (and potentially with the family), but it simultaneously may have encouraged the discussion of problematic behavior in culturally stigmatizing terms, using the same line of argumentation that so often makes the behavioral disorder diagnosis particularly problematic for children of immigrants.

Later that day, it was precisely the use of this culturally stigmatizing rhetoric that Sandra and I witnessed during a departmental MDPH meeting, where Sandra was replacing her sick colleague.¹¹⁸ The meeting gathered specialized teachers, social workers, the MDPH doctor, an academic/pedagogical advisor, the department's school superintendent, and Sandra as the referring school psychologist. The cases presented that afternoon all concerned children who had already been transferred from regular schools to ITEPs (Therapeutic, Educational, and Pedagogical Institutes). Their eligibility for

¹¹⁸ Each school district appoints a school psychologist to represent his/her colleagues' work at MDPH meetings.

another transfer to SEGPA (Adapted Professional Education Sections) was discussed. Each child's learning difficulties were assessed from both educational and psychological perspectives.

I was struck (and so was Sandra, as she later told me) by the discussion of one case concerning Bacari, the twelve year old son of a polygamous family from West Africa. The father had two wives, living in two separate apartments, but on the same floor of a building, and fifteen children. The social worker appointed to the case had reported that the all children in the family displayed educational deficiencies. A legal "educational measure" had in fact been implemented by the youth justice services on the family.¹¹⁹ Bacari's school psychologist recommended for Bacari to be sent to a SEGPA boarding school, but the school was far from the family's apartment, and therefore raised transportation issues. At this point Sandra interjected:

Sandra: What exactly does Bacari's family understand of this Personalized School Project?

School Psychologist: Not much. What they don't understand is how disturbing for the child it is to go from his father's apartment to his mother's.

Sandra: Well, there are a lot of fragmented families in which children don't have any adaptation issues.

SP: It's not the family structure per se that we question. It is simply the psychological state of the child we are concerned about.

MDPH Doctor: We have great difficulties communicating with the father, but the family is very cooperative in general.

Sandra: In the written report, in the educational deficiencies box, there are references to Bacari's "improper clothing" and "bodily hygiene issues." How relevant are those?

SP: Uh...not sure. This was written by the school teacher.

¹¹⁹ Educational measures are implemented by the judicial system. They make take several forms, depending on the nature of the family's problem (socioeconomic precarity, child abuse, conjugal violence, child delinquency, etc), ranging from part-time surveillance and assistance at home, to foster care placements. <http://www.justice.gouv.fr/index.php?rubrique=10042&ssrubrique=10270&article=11984>

[Each written report consists of a double-sided sheet of paper, with relatively succinct comments on it. It usually is filled out by the child's teacher.]

Superintendent: I suggest we hold making a decision for now. It's not clear yet whether there will be a spot available in a SEGPA class, and the transportation issue needs to be dealt with.

Very quickly, the team switched to another case. Aside, Sandra showed me another note on Bacari's report, stating the following: "susceptible to delinquent tendencies."

Although it would be improper to bear judgment here on the accuracy of the diagnosis for Bacari, given the limited information revealed about the context in which a diagnosis was made, it is interesting to note how, once again, discussions of Baraci's deficiency relate to his family's unusual living arrangement. In fact, no one raises questions concerning the evaluation establishing Bacari's deficiency itself. An underlying moral discourse on the practice of polygamy, and its indirect relationship to delinquent "tendencies," are seemingly meant to reinforce the MDPH's expertise (Smardon, 2008). One may very well imagine, however, that the issue of a potentially unstable family structure and visible signs of a lack of hygiene in a child may raise red-flags in the psychological evaluation of any child, whether of immigrant parents or not. Interestingly, it is Sandra here who objects to a potentially culturally stigmatizing reading of the polygamous family structure as psychologically damaging to children, by establishing a parallel to other forms of "fragmented families" (single-headed households, blended families, etc.) in the "general" population, and by simultaneously contesting the arbitrary relationship between family structure and child pathological behavior.

The overlap between differentiating representations of children of immigrants and judgments on their mental well-being (and by extension, their families') thus appears to

be quite complex, as it is often difficult to clearly identify the share of stigmatizing cultural representations that may inform school referrals from benevolent concerns with problematic family environments. I suggest that in fact, it is this complex overlap that informs ambiguous referrals, especially those calling for behavioral disorders, as they depend more on subjective assessments than disabilities do.

More problematically, it seems like the conflation of cultural stigma and concerns with pathology-producing structural factors is encouraged by the intervention of specialized mental health experts themselves. As apparent in Sandra's position on Moussa's case, specialized mental healthcare professionals often become caught in a double-bind between disputing the stigmatizing basis upon which some of the referrals are made on the one hand, and preserving their professional positioning (and indirectly that of the center they work at) by catering to the demand for cultural expertise on the other.

Therefore, where their intervention may simply be perceived as one among other institutional resources in helping with seemingly unsolvable situations, specialized mental healthcare experts may be the ones feeling the need to justify their intervention and institutional use by eliciting a cultural interpretation of the situations at stake. This is the problematic "double-bind" which I have identified through school referrals, and which I will now illustrate with clinical scenes in each of the three specialized mental healthcare centers.

School Referrals and the "Double-Bind:" Clinical Scenes

As I have shown in chapter seven on circulating and contesting, specialized mental healthcare center's discursive ambivalences – as they are produced by an institutional discourse framed around republican political ideology – limit their margin of maneuver in contesting the tension between caring and regulating as articulated above. The double-bind I refer to, then, also relates to specialized mental healthcare centers' contesting referrals based on perceptions of essential cultural differences, while simultaneously finding themselves in a position to legitimize those by performing their role as cultural experts. The following school referrals highlight this ambivalent position.

Case 1: Individual School Actor Referral

Jeanne called me to attend a pre-consultation meeting with a school assistant.¹²⁰ The latter called Minkowska about the possibility of referring a child from one of the district's schools she worked at. When the school assistant entered the room, Jeanne introduced me as an anthropologist and as a research associate. When Jeanne asked the school assistant how she had heard about the Center, she responded that she had done her own research and had found Minkowska online. The Center's description had led her to think that it would respond appropriately to the needs of a pupil her school has been concerned about. Therefore, she had taken it on her own to call the center and set an appointment.

¹²⁰ School assistants, as I have mentioned before, have an unclear status in schools. Their position was created by the government as part of a broader plan to create jobs for the unemployed. They are usually precarious (short-term), low-paid jobs. In the context of schools, their authority is ill-defined. They are meant to assist teachers with their students and with class activities, however that is defined by the teacher himself/herself, or the school director. For example, they may watch over children during recess, organize school supplies, etc.

The school assistant first asked Jeanne to introduce the Center once again and detail their activities. Jeanne launched into a lengthy presentation, starting with the history of the Center, from its creation in the 1950s to respond to the health needs of post-war asylum-seekers, to its evolution into a clinical medical anthropology structure. “This orientation,” she explained, “takes into account culture in therapy, without falling to the extreme of defining all pathologies as culturally determined. It also seeks to avoid denying the influence of culture altogether, which eventually leads to racism and ethnocentrism. What the Center does is that it takes into account the cultural nature of the clinical encounter between two explanatory models – that of the patient, and that of the clinician.” She made references, in English, to the concepts of “disease,” “illness,” and “sickness” as used by the Center in its institutional presentation. “This perspective on mental health allows clinicians to maintain their own theoretical orientation, whether Freudian, Lacanian, constructivist, etc.”

Subsequently to Jeanne’s presentation, the school assistant proceeded to present the case of a third-grade pupil, Anais, the daughter of Mauritian immigrants. She explained that she had recently attended a school staff meeting with the school psychologist, Anais’s teacher, and “the rest of the staff in charge of pupils in difficulty at school.”¹²¹ She had heard the teacher report that Anais had trouble keeping up in class, that it was difficult for her to understand assignments, and even stories. Her grades were failing, and her vocabulary was very limited. She was very shy in the classroom, but sometimes she behaved violently with her schoolmates during recess. The school assistant said she observed that pupils often made fun of her. “She’s really stupid” one of

¹²¹ Here she probably refers to the education/pedagogical team, whose function I described it in earlier cases, constituted by the school psychologist, the “Maître E” and “Maître G,” and the school teacher.

them said in front of the teacher during recess. Anais already had “problems” in kindergarten: the school had her repeat her third and last grade (*grande section*).¹²² “When she went to primary school, no one followed her evolution, and now, no one wants her to repeat a class again,” the school assistant added. After the staff meeting, she went to talk to Anais’s teacher, and told her that perhaps she could pay more attention to the little girl, and try to make her look good in front of the other pupils. She informed us that Anais was often absent from school. During the first school trimester only, she had been absent nineteen times, her mother alternatively reporting Anais’s stomach pains, headaches, or fever. “To me,” she said, “all of those are psychosomatic symptoms, you know.”

The school assistant had then decided to schedule a meeting with Anais’s mother directly. No one else at school had bothered to do so, she pointed out. She had heard Anais’s teacher mention that perhaps Anais’s mother was an alcoholic (even though, according to the school assistant, the teacher had never met the mother). “As far as I’m concerned,” she continued, “I suspect there might be conjugal violence behind all of this,” a comment to which Jeanne responded with a nod. The school assistant went on to explain that Anais’s mother was a stay-at-home mom, who had arrived in France in 1991. Anais’s father was a painter, but she had never met him. They also had a son, born in 2001, who was failing at school as well, “which strengthens my suspicion that there may be a problem at home. The day I visited her mother at their home,” she continued, “Anais seemed very happy that someone had come out of concern about her. But the mother

¹²² Kindergarten takes three years in France, typically from age 3 to 6. The grades are successively called: “*petite section*” (first year), “*moyenne section*” (second year), and “*grande section*” (third year).

appeared very reticent when I spoke to her about psychotherapy for Anais. You're gonna have to take it slow with them!," she warned Jeanne.

This meeting took place early in April. When Jeanne called the Center's secretary to schedule an appointment, there was nothing available before the end of the month. The school assistant seemed very disappointed hearing that. However, Jeanne readily reassured her, telling her that she had made a good decision referring Anais to the Center, and that they would use this first appointment to make a first assessment of the situation. "I agree," Jeanne said, "that Mauritian families often display very rigid family structures, accompanied with conjugal violence. Perhaps we can investigate this option as a key to explain this child's school problems. Also, in these families, people often try and make sense of their children's school failure. They look for outside explanations – sorcery for example – which could influence the child's behavior and therefore explain problems at school." Jeanne then asked the school assistant whether she would be willing, as the referring person, to accompany Anais and her mother at the Center on the day of the appointment. "Well...I don't have much time off...I already took it on my free time to come here and try to help this family. I have a family of my own, you know," the assistant replied, looking at her agenda. "No, I don't think I'll be able to make it for that appointment."

After the appointment was scheduled and the school assistant left the room, I stayed with Jeanne to assess her impressions on the meeting. I asked her about the weight of the school's cultural representation of Anais's parents on the child's academic difficulties. She quickly responded that there indeed might be a true learning disability at stake here, without there being any issue with the family. But what she seemed most

concerned about was the school assistant's behavior and her unwillingness to go out of her way to accompany Anais and her family at the Center. "She bothers reporting the situation to us, and then she won't come here to help solve it!" she said, irritated. "It's the same problem with social workers. We apply rules under the pretense of exploring situations with people and help them solve their problems. For example, a lot of social workers confronted with quarrels among polygamous families refer women to shelters, without even bothering to speak to their husband first. I mean, everyone knows the husband is a central figure in the African family! Then they act surprised when women come back to their husbands after a week, without the root problem being solved! This is why so many migrants hate social workers!"

Two weeks later (the appointment was rescheduled earlier than planned thanks to a cancellation), Anais came to the Center with her mother and younger brother. Jeanne invited me to attend the consultation. Before we entered the room, she told me that the school assistant had called her to let her know that the situation seemed to have greatly improved at school after the teacher had decided to focus her attention on Anais. With the help of the school psychologist, the teacher had made efforts to boost Anais's self-confidence, both in private meetings and in the classroom. Since then, everything seemed to have gotten "back into order." And indeed, the consultation with the family was very short. Anais's mother said that she had no problem to report concerning school. Anais concurred, smiling and responding briefly, when asked by Jeanne, that she liked school and her teacher. Jeanne tried at various instances to elicit information concerning Anais's mother's immigration story, her husband's work, and her life at home. The mother gave her straightforward, factual answers, giving me the impression that, while appreciating

Jeanne's concern, she was unsure as to how these questions related to her little girl. Meanwhile, her six-year old son jumped up and down restlessly, constantly pulling his mother's hand to stroke his face. After the family left and we exited the room, Jeanne turned to me and declared: "Surely there was no need for a psychological follow-up here... The little boy, on the other hand... I wonder if he could use some therapy!"

This case is particularly interesting, as the referral results from the individual initiative of the school assistant, who took it on her own to help Anais and her family. It is unclear whether her individual referral effort resulted from the cultural reading she had made of the situation, or whether she seriously suspected violence at home and framed her referral vaguely in cultural terms so as to access an additional outside intervention. A lack of institutional resources may have motivated the school assistant, more so than cultural bias. In fact, what this case more clearly shows is Jeanne's responsibility for imposing a cultural interpretation of the situation, when she suggested that "Mauritian families often display very rigid family structures, accompanied by conjugal violence." Jeanne instead contested the school assistant's intervention on the basis that she had decided to manage a "problem" without personally engaging with it. Jeanne's parallel to social workers' detrimental interventions among African families translates her critique of institutional actors' intrusive and inappropriate behavior, lacking sensitivity to what she thinks are well-known cultural rules. As the cultural expert, it seems that Jeanne did not want to reject the possibility of a clinical consultation for Anais, and therefore herself assumed the existence of relevant cultural dynamics underlying Anais's potential learning disability. She placed herself in a double-bind situation where, despite the lack of

relevant cultural factors in Anais's case, her institutional expertise placed her in a position to pursue the case with a clinical intervention.

Case 2: Personalized School Project Referral

At Jean-Baptiste Carpeaux Center, I was informed about a Mauritanian family who had come to the center twice over the past year. The family had been referred to the center by the director of a primary school, who had relayed the concerns of CLIS teacher, a special-aid class in which ten year-old Mamadou was enrolled.

That day, the director of the school, located in the JB Carpeaux Center district (following "sectorization" rules¹²³), attended the consultation along with Mamadou and his parents, Mr. and Mrs. Sylla. A Soninke translator was also present. After the lead psychologist, Dr. Kouassi introduced everyone in the room to the family, as he routinely did, he asked the school director to speak first and summarize Mamadou's progress since the last consultation at the center. Before she started speaking, she waited for Mr. K's attention, which was then directed at Mr. Sylla, who appeared restless and who was muttering to himself. "What's going on, Mr. Sylla? Do you have something to say?," Dr. Kouassi declared. Mr. Sylla, seemingly embarrassed, quietly responded that he did not have much time, because he had to work after the consultation. "Well, Madame la directrice, go ahead, explain the situation to us," Dr. Kouassi said, now turning to her, right after glancing angrily at Mr. Sylla. "Well, I'll start with the bad news. Mamadou has started acting defiant with adults again. It seems like he feels persecuted by others looking at him. The teacher reported he has sudden fits. He usually starts clenching his

¹²³ See Barral, Catherine. 2007. Disabled Persons Associations in France. *Scandinavian Journal of Disability Research*, 9(3&4): 214 – 236.
<http://www.informaworld.com/smpp/content~content=a787305419~db=all>

fists, and then he bursts out in anger. His teacher doesn't know how to handle the fits. The good news is that he has started reading. He still has trouble with writing: he has difficulties situating himself in space. He even has difficulties reproducing models." Last time the consultation took place with the Sylla family, the group had recommended a medical assessment to be carried out at the hospital on Mamadou's motor and mental skills. That day, the translator informed us that the family had opposed such assessment because they were scared it would involve physiological tests as well, such as taking a blood sample, etc. At least, that is what they said their oldest son, who is enrolled at the same school, told them he heard from the school doctor.¹²⁴

In French, Mr Sylla explained to us that the reason why his son acted violently could be linked to the fact that he was not used being in a group. "If he went to school more often, he would get used to it, and maybe things would get better," Mr. Sylla said. We learned that Mamadou only attended school part-time for now, all day on Mondays and Fridays, and on Tuesday and Wednesday mornings. The translator reported to us that Mamadou's parents wished he would go to school everyday, all day, like the other kids. Mr. Sylla became animated, and switched to Soninke. He complained that Mamadou did not have homework at night. So he taught him Arabic – which by the way, he insisted, Mamadou understood very well, and which also proved that his son's intelligence could not therefore be an issue. The underlying comment here was that, according to Mr. Sylla, the school was the issue, not his son. He continued by explaining that Mamadou's older brother could even help him if he had homework, but since he did not, all he did was play. "But it's normal, Mr. Sylla," Mr. K. said, apparently trying to act reassuring this

¹²⁴ One issue to be developed here are problems subsequent to immigrant parents relying on their children as translating institutional actors' discourse for them.

time. “Mamadou must rest at night. Perhaps you could check on his reading progress.”
“Well,” Mr. Sylla responded, “The school hasn’t even sent me Mamadou’s school report!
I don’t know anything!”

During this whole exchange, Mamadou sat quietly. He seemed very calm. At the far end of the couch, distant from where her husband was sitting, Mrs. Sylla was nursing her last child. She also appeared very serene, smiling at times, as if amused by the interactions and perhaps withholding information from us. At the very end of the consultation, she briefly commented on Mamadou’s behavior at home, slightly contradicting her husband’s observations by saying that her son was “very slow” at home too. As Mr. Sylla had to leave for work, the session ended quickly. The school director, however, was invited to stay for debriefing.

Two main topics were discussed by the group after the family left: 1) Mr. Sylla’s behavior and the Sylla couple as reflecting gender relations among immigrants and their impact on relations with society at large; and 2) Mamadou’s school orientation. Dr. Kouassi started by analyzing Mr. Sylla’s anxieties with respect to properly assuming his fatherly role at school.

African men have power outside home, women have power inside. Men are naturally competitive, but in France, they feel incompetent in front of institutions. They feel castrated in their role. I mean, why would Mr. Sylla be frustrated with the school rather than with his son’s problems? Not mentioning that this places Mamadou himself in a difficult situation: he’s neither from here, nor from there.

The group’s co-therapist, Mrs. Marielle, voiced her doubts concerning Mamadou’s mother. Apparently, at the family’s last consultation, the latter had come alone with her son. Mr. Sylla had been on vacation in Mauritania for three weeks. During that

consultation, she was said to have a different attitude than her husband concerning Mamadou's behavior. She seemed to go along with the school's diagnosis. "It's less difficult for women, because they're the ones interacting with institutions on a daily basis, the co-therapist."¹²⁵ This actually gets reflected in immigrants' children at school. Girls are more successful than boys are."¹²⁶ Mrs. Marielle added that she suspected Mamadou's mother had intercepted his school transcript when it came home, taking advantage of her husband's absence, and thus managing tensions at home between her husband and her son.

The school director stood up, and as she was about to exit the room, turned around and asked Dr. Kouassi: "By the way, I will need your signature for Mamadou's coming school orientation decision, and to prove that there's been a healthcare follow-up."¹²⁷ Mr. K. stared at her, surprised: "Well, that's the first time I'm being asked something like that. I believe I can't do that, because this is not a child psychology consultation. Who took care of the signature before?" The director explained that Mamadou used to go to another community mental health center (*CMP*) specializing in infant-juvenile care. The center's psychologist had retired, and that's how they were referred to the Carpeaux consultation (it is interesting to me that the origin of the referral only revealed itself after the third consultation with the family!). The news triggered a

¹²⁵ This phenomenon was actually documented in the literature on West African immigrants in France. See: Quiminal, Catherine, Babacar Diouf, Babacar Fall, and Mahamet Timera. 1995. "Mobilisation associative et dynamique d'integration des femmes d'Afrique subsaharienne en France." In *Migrations Etudes*, 61:1-12. Also : Quiminal, Catherine, and Mahamet Timera. 2002. "1974-2002: les mutations de l'immigration ouest-africaine. » In *Hommes et Migrations*, 1239: 19-39.

¹²⁶ This was also well documented. See, for example: Timera, Mahamet. 2002. "Righteous or rebellious? Social trajectory of Sahelian youth in France." In D. Bryceson & U. Vuorela (Eds.), *The Transnational Family: New European Frontiers and Global Networks*, pp. 147-155.

¹²⁷ This signature is part of the new conditions imposed by the February 2005 law on handicap.

discussion concerning the level of disability suffered by Mamadou, as if, suddenly, Mr. K. felt invested with a sense of responsibility with regards to Mamadou's school orientation – which partly seems the case under the new law. “What concerns me, Mr. K. said, is that Mamadou will never be able to reintegrate a normal school.” The director explained that the therapist's comments would weigh on whether Mamadou was sent to a UPI (Integration Pedagogical Unit) or a SEGPA (Adapted Section for General and Professional Teaching).¹²⁸ As I stated earlier in this chapter, both are equivalents to CLIS classes at the secondary school level, UPIs pursuing an alternative education between small-scale, specialized units and regular classrooms, and SEGPA's being located outside of regular secondary schools and emphasizing on the individualized professional training of handicapped children. According to the school director, SEGPA's are more successful at helping children integrate a relatively normal social life.

“When you think that this situation started with the decision of one school doctor in kindergarden, without any second opinion having ever been sought...,” the co-therapist sighed. When I asked her what had happened, she explained to me that Mamadou had been sent to a CLIS classroom when he was four years-old. His parents had let the school make the decision. Mr. K. interjected: “That's immigrant families' misfortune! They don't know any better! No one supported them, and now it's too late to do anything. It's just horrible. Mamadou's fate really could have been different. Now he's condemned.” The co-therapist turned to the school director:

Co-therapist [to the school director]: “You have to take care of Mamadou's file so the signature can be obtained, so at least he's able to go to a SEGPA. It's YOUR role to accompany him.

Mr. K: Yes, but this can create difficulties with teachers.

¹²⁸ See <http://education.gouv.fr/cid207/la-scolarisation-des-eleves-handicapes.html>

School director: No, it's not the case here. I'll take care of it. You know, I'm frustrated myself. Eleven of the twelve kids in this CLIS class are children of immigrants...

Mr. K: (heavy sigh) They're making ticking bombs. If no one mobilizes for the children, arbitrary referrals like this one happen, and parents are helpless."¹²⁹

As with Jeanne's response to Anais's case earlier, it seems that a cultural interpretation of Mamadou's case is elaborated by the specialized mental healthcare team itself, rather than from the narratives of the school director, or of Mamadou's family itself. Mamadou does seem to experience major learning disabilities (at ten years-old, he has trouble writing, situating himself in space, and reproducing models), which would make it relevant for him to be sent to a "special aid" school or classroom. Mamadou's father seems upset at his son's difficulties, and unwilling to accept his son's learning disability, but nothing in his objections indicate a form of resistance resulting from cultural differences. As far as the issue of discrimination in the school referral, it is both the specialized mental healthcare team and the school director that make the claim.

Neither the school director, nor the consultation team, however, readily had access to details concerning Mamadou's first CLIS orientation. For all parties, nonetheless, the possibility that the orientation to a special-aid class may have initially been arbitrary – or that, at least, it was articulated without any third party supervision – appeared very likely considering the fact that Mamadou is the child of immigrants.¹³⁰

Like Murielle, the school psychologist interviewed earlier in this chapter, the school director complained that most children in special-aid classes were children of immigrants.

¹²⁹ The case study of the school psychologist in Meaux will illustrate a case in which parents are opposed to the school decision. Coming soon...

¹³⁰ A direct orientation to a special-aid class could no longer occur in that fashion, following the 2005 Law on Disability.

Dr. Kouassi was concerned about the broader social consequences such referrals may have. Through his indignation on how immigrant parents are treated within the school system, his feeling of powerlessness emerged, as he so often expressed outside of consultations. Unfortunately, like Jeanne, he placed himself in a double-bind situation where, as a “specialized” expert, he concerned himself more with the possibility of stigmatizing treatment than with the expression of Mamadou’s disabilities, or with Mamadou’s father’s denial of the latter.

Case 3: Cultural Variations on the Concept of Disability

We met at Gepela to discuss the referral of a primary school boy, the son of a first-generation Senegalese immigrant, to a special-aid class. The school’s educator was there to introduce the case. She explained that Abdullah’s father wanted to take him home to Senegal. The father was a famous ritual specialist (*marabout*), who lived in the South of France with his second wife, and often traveled to the East Coast of the United States where he catered to the Senegalese community. Abdullah seemed to be extremely intelligent, but spent class time daydreaming. Sarah commented that “school may feel too commonplace and boring, considering the intrigues going on in his life.” His teacher had reported that he kept writing things in Arabic on his hands, and she really disliked that. The situation of Abdullah’s mother was briefly addressed, the fact that she and Abdullah lived in an apartment in a dangerous northern, Parisian suburb. She never came to meetings with the school officials. She said she was too busy earning a living, although it was suspected by the educator that she left Abdullah home alone at night to spend time with her lover. Abdullah’s two significantly older brothers were never around: one was in

jail for drug trafficking, and the other one was suspected of walking in the same footsteps, engaging in gang thefts and small drug trafficking.

The teacher thus had written a report to the school director, so that there could be an intervention on what she classified as Abdullah's "disability." The case was being discussed at Gepela, as Sarah had been asked to act as the referring psychologist for the case, and as both the necessity and possibility of a referral were being assessed. Pf. Maiga commented on this concept of the "disability situation." To him, the category was very much one that was "imposed by those who have the power to decide" and that participated in a new system of victimization. Disability, in this case, points to a "deficiency" which cannot be resolved. Schools do not deliberate on a student's "disability," they can only detect "deficiencies." Pf. Maiga commented on his distinction between the two:

One can envision different forms of disability. Take Mrs. Soumara, this Soninke woman who went to live with a Khasonke man. This is a disabling situation, which triggers much suffering. But to make sense of it, one must search elsewhere. This is a closed question for biomedicine, because it can only accommodate the *disability*. However, to understand the suffering at stake, one must adopt a different paradigm. There's a Bambara expression which says that 'what comes after does not always logically follows what came before' ... Take this woman of unusual beauty from the Ivory Coast, who was taken to France because she was 'special.' Once in France, she had an accident from which she suffered debilitating wounds. She is now a *disabled* person. But for her, it means more than that: she is simply no longer the same person.

Or take that African worker, who slipped on a French frie at work, and injured his back. He too, was categorized as *disabled* by his doctors. But that's certainly not what it meant to him. In his opinion, someone did something to him. His back aches probably indicate that someone does not want him to have children – you know that a back ache in a young adult is always thought to be linked to his sexuality... The concept of being 'sterile' is complicated for him. Those are three situations in which the *disability* is not experienced or identifiable in the same way. None of these persons considered themselves to be *disabled* in the long-term. *Disability* is assigned as a social status. *There is the experience of being disabled,*

and the status of being a disabled person. The last one is about social recognition.

Let's take the example of autism. There are several etiologies for autism. There is 'the abikou child' – or the child that was exchanged before the delivery. Or the child who doesn't bear the right name, and who doesn't answer when he is called. Or a child believed to be non-human, who was carried by something else. Or he can be the tenth child in a Bete family (Ivory Coast), who is thrown away – like sacrificed children in Benin and Togo. All of those children are considered non-viable, and nothing is done for them to be able to survive. In a rich family, having an autistic child can be considered being the price of becoming successful. People do not intervene with those children, which is exactly contradictory to what French schools do. *There is a problem with the words that are chosen* for those children. Those words are also categorizing for parents. It is tricky to grant a status – which opens up rights, without categorizing at the same time. For this beautiful woman from the Ivory Coast, *the disability status* paradoxically facilitated her life, as she came to France undocumented, and as her new status enabled her to obtain a residence permit. Yet, for her, life is over. Being categorized as *disabled* entails that her situation cannot be solved, which throws her into a state of depression. She may be legally disabled, but not socially.

...In Mali, there are albino people. Their disability is perceived as a virtue. Their skin color results from their father-hunter killing a pregnant animal. In such cases, people say that the virtue of the animal is transposed onto the hunter's infant. The question is, whether the *deficiency* is visible or not; with words, how is the school going to integrate children of different backgrounds, manage the consequences, obtain their families' support? The problem is, when institutions want to change things, parents feel endangered. How to elaborate singularity from the perspective of the norm on the basis of traditional etiologies, legal framework, and psychology?

In other words, what Pf. Maiga offers as a response to Abdullah's situation are possible cultural variations on the concept of disability. While his discussion of the illocutionary force of categories—its subjectification properties for parents vs. its legal implications for school administrators—is fascinating and generally informative, it does not, practically speaking, address Abdullah's case directly. The fact that Abdullah writes Arabic on his hands, and that it bothers his teacher, is put forth as a potentially stigmatizing referral explanation. On the other hand, comments on Abdullah's family environment, while

attentive to details of family intimacy, do not address what may seem as potentially psychologically destabilizing factors for any child, such as the parents' separation, their lack of presence around Abdullah, Abdullah's precarious living environment, or his brothers' trafficking activities and judicial trouble. In that respect, it remains unclear how relevant Pf. Maiga's discussion on the cultural variations of the "disorder" concept is to assisting Abdullah's school educator with the referral.

In a subsequent seminar discussion with Gepela members and psychology students, Pf. Maiga further elaborated on how school referrals should be articulated and dealt with in an ethnoclinical perspective:

The first question to be asked is: are there other referents to explain the *disorder*? It's easy to find solutions at the theoretical level, but it's more difficult to do so at the practical level. Remember that school teacher who during one of our mediation sessions completely transformed his perspective on the child? It completely unlocked the situation. The child is not always at the root of the *disorder*. Another problem is also how the child is represented in class. We must wonder: is it sufficient to speak to the child only?

...There subsist the issues of transmission and of identity. There, the intervention of the psychologist can be justified, so as to prevent a cleavage or, alternatively, to prevent confusion. This is where the linkage must be built, not as an initial measure, but as a consequence. The possibility for a linkage is the consequence from having been able to instigate other paradigms and to let them be articulated. The ethnoclinical intervention in the school context must be considered *a complementary intervention*. It must be initiated as a discussion, followed by a meeting with the concerned actors, the investigation of the different emerging discourses, and a resulting complementary support to school efforts. The situation should not be perceived as pathological from the start, and it should not be considered as solved by the school once mediation with our structure starts. Our intervention should be pursued in and with the school institution itself. (emphases mine)

Pf. Maiga's comments are based on the ethnoclinical approach which acknowledges that "children of immigrants" are more susceptible to be "students in difficulty." It does not

contest schools, however, for using that label disproportionately. Rather, it criticizes schools, and “conventionally-trained” school psychologists, for participating with the cleavage between the institution and immigrant families, rigidifying the opposition between two cultures, which itself negatively impacts children of immigrants’ proper academic progress and behavior (Mesmin, 2001). Pf. Maiga contests that, by excluding immigrant families as intrinsically different, and sending them to cultural experts for an intervention, they cannot help children’s situation, but rather contribute to reinforcing their school difficulties. An ethnoclinical intervention, Pf. Maiga contends, is only useful insofar as the school participates with the mediation with families, rather than substituting the ethnoclinical team as responsible for these children and their families.

It is true that, as this chapter illustrated, communication between school officials and immigrant families often is the “missing link” in avoiding conflicts around referrals, or in preventing referrals based on ambiguous diagnoses. In those instances, specialized mental healthcare experts’ roles as mediators do prove to be positively instrumental. Pf. Maiga considers this expert intervention to be only “complementary” to school efforts. In that respect, he readily acknowledges the limits of cultural expertise, and its role as primarily encouraging both parties—institutions and immigrant families—to acknowledge the existence of different cultural paradigms so as to avoid conflict. Yet again, as evident in Abdullah’s case, this perspective may yet again, by its very discussion of cultural paradigms, produce its own cultural—and potentially stigmatizing—reading of a situation.

Conclusion

I argue that the study of school referrals sheds light on the fact that references to essentializing cultural representations are not necessarily discriminatory in nature. In fact, most cases illustrated in this chapter argue to the contrary, revealing that such references are drawn from a cultural repertoire in which interpretations are internalized, and make practices readily definable, and hence manageable (Essed, 1991). Specialized mental health experts, however reflexive they may be about making sure not to reify cultural difference and to counter essentializing interpretations of that difference when they identify it, are not free from relying on the same references. Broader discriminatory representations of “children of immigrants” (and once again, the very existence of this social category speaks for itself) as potentially dangerous delinquents, or stigmatizing discussions of “normal” behavior, do impact how these children may be perceived in schools, as Murielle’s comments illustrated. However, a closer examination of the nature of referrals and of their development, indicate that these do not directly inform the rationales for referrals. Or perhaps, one may speak of positive differentiation, as references to essentializing cultural representations in this chapter’s cases generally aim at solving conflicts or at negotiating between immigrant families and school officials?

To be sure, any conclusion about discriminatory treatment at this stage would only be tentative, as its study would first require a broader sample of children, and second that sample would have to be comparative.

Synopsis of Chapter 8

In this last chapter on school referrals, I summarized the tension, captured in earlier chapters, between caring and regulating. I deconstructed this tension in two stages: 1) the identification of behavioral disorders or learning disabilities among children of immigrants; and 2) specialized mental healthcare's impact on the negotiation of those diagnoses.

In the first part, I analyzed the process by which diagnoses are made in the identification of behavioral disorders and learning disabilities. I described the use of the concept of “difficulty” in that process—a formal concept of reference in the educational system jargon—and argued that it conveyed the same meaning analyzed in earlier chapters, namely a conflation of generic cultural representations and benevolent attitudes towards the acknowledgement of structural issues. I investigated the extent to which immigrant descent constituted a basis for disability or disorder diagnoses. Based on the description of recent legislative changes—that both empower and burden families by increasing their decision-making power in such diagnoses— I argued that it was more the negotiation of the diagnosis that created conflict with immigrant families and informed specialized mental healthcare referrals, rather than the diagnosis itself. I illustrated this argument with the case of the autistic child of Malian parents reported to me by a school psychologist, in which school and parents stayed in conflict for years. Based on an interview with that same psychologist, who works in a ZEP school with a high proportion of children of West African descent, I investigated the impact of racial/ethnic prejudices on children/teachers interactions—especially as related to discussions of problematic

behavior—showing how they come to be children of immigrants come to be characterized as “difficult.” I contended that a mix of preconceived ideas on cultural difference were exacerbated by a political discourse encouraging a direct relation between security, delinquency, and “immigrant youth.”

In the second part of this chapter, I focused on how specialized mental healthcare institutions became involved in the discussion of school referrals and negotiated disorder or disability diagnoses. Based on participant observation at an “education team” meeting at a school in a northeastern suburb of Paris, I followed the intervention of Sandra, a specialized mental health expert, in the negotiation of a suspected disability case. The learning disability was defended by the teacher, but was contested by the education team. I showed that, while Sandra’s expert intervention allowed for the teacher to become open to an alternative explanation for the student’s behavior, and to ultimately revise her initial allegations, Sandra’s arguments paradoxically reinforced essentializing representations of immigrant families. Showing how she later criticized that same essentializing perspective at MDPH meetings, I concluded that Sandra’s contradictory position was symptomatic of the unintended stigmatizing consequences of cultural expertise. This led me to revisit the concept of “double-bind” facing experts, which reiterates the observed ambivalence displayed by experts between contesting essentializing representations of cultural differences on the one hand, while legitimizing them by performing their role as cultural experts on the other. I illustrated this double-bind through clinical vignettes related to school referrals in each of the three centers.

I concluded that references to essentializing cultural representations are not necessarily discriminatory in nature. Rather, such references are drawn from a cultural

repertoire in which such interpretations are internalized by social agents, and make practices readily definable, and hence manageable. In the case of specialized mental healthcare interventions in particular, one may speak of positive differentiation, as references to essentializing cultural representations in this chapter's cases generally aim at solving conflicts or at negotiating between immigrant families and school officials, precisely so as to avoid the stigmatization of children.

CONCLUSION

I have shown that the nature of culturally-sensitive care in French mental health has matured towards non-essentializing, dynamic, and complex uses of the concept of culture in therapy, which also emphasize cultural expertise as a reflexive technique—construing the encounter with culturally-diverse populations as a shared learning experience, rather than as a form of encyclopedic knowledge of world’s cultures. There are, of course, notable distinctions between the institutions I described in terms of the shape of therapeutic care: the transcultural psychiatry model is firmly rooted in the practice of ethnopschoanalysis, clinical medical anthropology puts forth the theory of explanatory models as applicable across clinical forms of mental health delivery, and the ethnoclinical model provides a dialectical framework upon which psychologists—but also other social agents—may elicit culturally diverse etiologies in a non-biomedical, conflict-free environment.

Major obstacles to the functioning of specialized mental healthcare centers in addressing “immigrant suffering” stem from two main issues, which become particularly evident through the analysis of referrals and extra-clinical interactions. The first relates to culturally generic representations that social agents may have about immigrants or their children, and which may misinform their rationale for specialized mental healthcare referrals. Within this configuration, I identified two situations: 1) cases in which cultural difference is perceived as an obstacle to the proper institutional management of the individual from the onset (as in the case of Mrs. Kouyate’s psychiatrist, Dr. Duriez; or the case of Madan’s psychiatrist, Dr. Robert), or as producing pathological behavior that can

only be “deciphered” by a cultural expert, but in both cases, *cultural expertise is reduced to a translation activity*; 2) cases in which cultural difference is perceived in terms of language barrier and of differing social representations, and triggers situations of conflict or misunderstanding, in which case *cultural expertise comes in less as an essentializing knowledge than as an instrument of mediation—and sometimes of contestation*, and as an additional resource when other options have failed (this was evidenced in the school referral cases such as Salif’s, the ten year-old autistic student; as well as in the contestation cases, such as legal case of the Cameroonian sisters, Linda and Vanessa).

In most cases where a referral to a specialized mental healthcare center is not clearly based on cultural motives, this dissertation has shown how referring social agents problematically conflate representations of cultural difference with social issues. I have shown how, in the referral of sub-Saharan African families in particular, representations of immigrants commonly convey judgments on unusual family arrangements, delinquent youth, or “odd” lifestyles. These representations are not necessarily deemed to produce pathological mental health disorders, but rather, as a result of structural inequalities, to engender suffering—itself not clearly identified in terms of mental health pathology. In fact, this is where resorting to specialized mental healthcare goes beyond its role as providing cultural expertise, and when immigrants’ “difficulties” come to the fore of discussions. These “difficulties”—a cultural euphemism relating the notion of cultural difference to issues of social precarity and conflictual relations with institutions—test referring actors’ agency in terms of the limits of their professional intervention. In those situations, the latter resort to specialized mental healthcare not as a discriminatory way to avoid responsibility for their clients by referring them to be dealt with by specialized

mental health experts. Rather, they use specialized mental healthcare as an additional resource, a hospitable environment where the complex, multi-layered facets of their patients' "difficulties" may be alleviated or resolved.

Paradoxically, as some of my ethnographic cases illustrated, experts at times are the ones who unintentionally essentialize their own patients' cultural difference—or the situations presented to them—as a direct result of precisely trying to avoid stigmatization. I analyzed how this “double-bind” results from 1) the framing of institutional discourse following republican ideology— which leads to discursively avoiding references to culture while reifying it in practice, thereby producing clinical incoherence and contradictions; and 2) their very definition of specialized mental health “experts” and their positioning in an autonomous, competitive field – which sometimes places them in situations of wanting to solve difficult situations or perform their role by over-emphasizing the relevance of culture and the salience of their cultural competence framework. In this way, they run the risk of reifying culture along with existing stigmatizing representations.

The literature often notes that such unintended consequences of expertise result from an understanding of cultural competence as encyclopedic knowledge of world's cultures and their particular representations of health and illness, rather than as a reflexive attitude towards transcultural situations as two-way learning encounters (Carpenter-Song et al., 2007; Kleinman and Benson, 2006). I argue that the issue might be more complex. In chapter 5, I showed that both for experts, as well as individuals that sought transcultural psychiatry training, specialized mental health expertise is in fact apprehended reflexively—notably through the technique of “decentering” and the

understanding of countertransference mechanisms within the therapeutic encounter and beyond. Experts thus struggle with their own knowledge and representations of cultural difference, and the way they apply the latter. I believe Sandra's attitude, in Chapter 7, perfectly illustrates this point: within one day, she switched from successfully avoiding the establishing of an arbitrary disability diagnosis for Moussa by resorting to stigmatizing representations of the generic African family, to disputing these very representations at a meeting in the discussion of Bacari's special aid referral.

One solution to reduce biased or ambiguous referrals may be *integrated*, culturally-sensitive care, and a more systematic use of interpretation services. My research has not provided much data on the issue of translation, other than Mrs. Kouyate's case, but existing case studies have shown that actors in public health institutions may still feel, for various reasons, that resorting to translators is an unnecessary waste of time (Sargent, 2005). In mental healthcare therapy, where communication is paramount, this simply amounts to a denial to provide care. Dr. Duriez, Mrs. Kayoute's psychiatrist, knew she could resort to translating services, but decided not to on the basis that such intervention was the role of "cultural experts." In that case, the availability of translating services on-site might not even have made a difference in Dr. Duriez's perspective. However, I would suggest that the availability of cultural brokers *within* the hospital structure she worked at, and who could have assessed the need for translation services, might have accelerated Mrs. Kayoute's discharge and her re-integration into mainstream, psychiatric care, rather than her having to endure weeks of isolation in a hostile environment.

By “integrated care,” I refer to the incorporation of culturally-sensitive services to “mainstream” medical structures. Integrated care would avoid the stigmatizing opposition between mainstream care and “specialized care.” I believe that the main reason for the success of the transcultural consultation at Avicenne is precisely its integration of a “specialized” care unit, as a therapeutic option among others (*une Clinique “à géométrie variable”*). Referrals are internally regulated and assessed. In the case of the Moroccan family whose mother refused to participate in care, the hospital could continue to provide a structure where both father and son could receive therapy in mainstream psychopathology services. For the other institutions, their physical isolation as specialized structures itself makes it potentially stigmatizing, especially in the case of clinically ambiguous referrals, which places the institution in a double-bind when they are obligated to accept them. While other institutions do operate “in network” (in collaboration) with other district or partner institutions, they may also be selected for independent referrals, especially Minkowska, which is non-sectorized and may be solicited as an “expert” structure on a broad geographic scale. This is evidenced in the case of the political asylum seeker who is sent to Minkowska by his psychiatrist in Rouen so as to obtain a medical certificate, without assessment of his patient’s file by a therapist on staff. This unintended marketing of “expert” services is therefore another possible consequence of non-integrated specialized care.

The strengths of the clinical medical anthropology and ethnoclinical care models are their ability to address the issue of the relevance of culture in transcultural situations well beyond the context of care. In that respect, they may be most helpful in training a wide variety of social agents to change their negative representations and apprehensions

of encounters with culturally diverse populations. The challenge of ethnoclinical care is its emphasis on sub-Saharan African cultures, and its nuanced elaboration of local etiologies which, while crucial for research and general clinical understanding, may not readily be relevant to direct, practical application. In fact, as some cases in this dissertation have illustrated, ethnoclinical elaborations may lead referring actors to further confusion.

The clinical medical anthropology model, on the other hand, has the advantage of being both culturally nonspecific, and of addressing the therapeutic relation broadly enough so that it can easily be applicable beyond the clinic. This strength, however, may also be its weakness, as I remain unconvinced of its potential for articulation into actual clinical practice. This may be unproblematic, in the sense that Minkowska specifically does not seek to impose a theoretical frame of therapeutic care on its clinicians. But Minkowska clinicians' own adherence to and understanding of the clinical medical anthropology model is unclear (especially among the "old staff" that practiced at the Center long before it adopted the clinical medical anthropology framework).

I believe, however, that this raises the issue of the difficulties of operationalizing medical anthropology in a clinical context, an issue which is recurrently raised in anthropological debates on the possibility for a "clinically applied anthropology" (Chrisman and Maretzki, 1984; Kleinman, 1985; Phillips, 1985). While I will not discuss the issue in detail here, I believe this debate to also be symptomatic of a split in medical anthropology as a sub-discipline, in which applied anthropology is considered as legitimate but less prestigious than academic anthropology. Based on these grounds, I do not want to critique the work of Minkowska on its use of medical anthropology per se.

On the contrary, I think it forces us, as anthropologists, to think of ways to engage our discipline further with the “real” world, and more importantly, to validate or examine the consequences of our work through its applicability for social change and policy impact.

An important limit to improving not only the provision of culturally-sensitive mental healthcare provision to culturally diverse patients, but also to document the social context of “immigrant suffering,” is peculiar to the French context and its unwillingness to make use of ethnic statistics. Needless to say, this seriously constrains the collection of epidemiological data on the mental health suffering of immigrants, its forms, and the context of its production. Methodologically loose and stigmatizing roundabouts are found to track and document the incidence of “risk” for infectious diseases such as HIV/AIDS, tuberculosis, or hepatitis (see, Gilloire, 2000, for example in chapter 3, on “African AIDS”), but such unsystematic and uneven use of biased data further stigmatizes cultural difference and pathologizes it. The lack of interest from policy makers in integrating information on the relevance of culture in the experience and treatment of acute and chronic diseases or mental health disorders is thus reflective of the politically regulative nature of public health policy rationale.

In the French context, the difficulty with both naming and articulating the relationship between immigration and suffering outside of “expert” structures underlines a resistance to acknowledging the relevance of structural factors, beyond culture, that negatively affect immigrants’ health in particular. The acknowledgement of this relation is at stake in advocating for integrated, culturally-sensitive mental healthcare provision: it does not set culture aside as an isolated entity, but addresses its conflation with other

relevant social inequalities that negatively affect health, as so many referring actors in this dissertation acknowledge.

This leads me to address one of the most salient issues in my argument on the constraints of specialized mental healthcare: the difficulty with naming as effectively constraining the possibilities to positively effect change. I have shown that the constraints which specialized mental healthcare institutions experience are unique to the French context, its republican ideology framework in particular. This context makes it difficult to apprehend cultural difference positively, outside of the universalism vs. particularism dichotomy. This dichotomy argues that acknowledging cultural difference leads to stigmatization, while ignoring the possibility that it leads to positive “integration.” Meanwhile, the discriminatory treatment of immigrant populations, along with the racially essentializing representations of “visible” minorities, North and sub-Saharan Africans in particular, remain unchallenged. How can this dichotomy be challenged? How can stigmatizing representations of cultural difference be addressed?

I have shown how, in France, the hierarchization of populations—and the naturalization of these populations’ representations through the French public health discourse—has evolved from a racist, biologizing discourse to a rhetoric on the irreducible nature of cultural difference. Since the 1960s, the idea of “race” was questioned and progressively deconstructed, to finally be established as a concept, rather than a fact of nature. However, as Colette Guillaumin argues, the mere rejection of the notion of race is insufficient, “because that which is negated has *de facto* existence. (...) No, race does not exist. And yet it does. Not in the way people think; but it remains the most tangible, real and brutal of realities” (1999:361-362). The antiracist discourse of the

early 1980s, invoking “the right to difference,” and promoting the use of ethnic references in everyday discourse (such as in the *Beur* movement) only served to reify racist stereotypes. Instead, as I have attempted to show, one observes what Pierre-André Taguieff has called “the regulative use of the republican idea” (2001:310), in which requirement of universality leads to two forms of racism and their doubles: on the one hand universalist racism calls for particularist antiracism, on the other differentialist racism calls for universalist antiracism (Taguieff, 2001:28). This shows the antinomy of the racisms, constructed as mirror images of one another.

I find Taguieff’s normative approach useful in analyzing the structural inefficacy of antiracist discourses, and consequently, their propensity to maintain the status quo on the stigmatization of immigrant populations, as I have shown in my discussion on the making of expertise. However, I find his approach limiting in apprehending stigmatization in everyday clinical interactions. Here I use “stigmatization” rather than “racism” deliberately, agreeing with Gérard Noiriel (2007) that, since racist and antiracist discourses—produced by a small political and media elite—strategically disseminate most stereotypes on immigration (an “archaic form to conquer power,” 2007:39), the use of “stigmatization” appears less politically-laden and better adapted to sociological analysis. As my broader analysis emphasizes the performative power of naming practices, I find it relevant to assign a more objective term that allows for a more complex reading of social agents’ appropriation or rejection of stigmatizing norms in real-life interactions.

It is not enough to say that immigrants are stigmatized. It is important to identify the criteria for stigmatization, to identify what leads to the act of giving someone

differential treatment (Fassin and Fassin, 2009[2006]; Ndiaye, 2008). This can be captured by the collection of ethnic statistics, and the debate on the issue is ongoing in France. But ethnography also constitutes a powerful methodology to capture the complexity of differentiating on a culturally stigmatizing basis.

My data, for example, reveal that institutional actors do not refer immigrant individuals to specialized mental healthcare centers solely on the basis that they are unable to deal with their “cultural difference,” or that they do not want to deal with “Africans.” Their recognition of immigrants’ “difficulties” acknowledges the many structural inequalities to which this group is particularly vulnerable. In that respect, they may perceive specialized mental healthcare not only as a place to soothe the suffering that results from such conditions—which they also acknowledge—but as an institutional resource in a situation where conditions of structural inequalities—misrecognized as such—are indeed difficult to address. In turn, institutional actors couch their rationale in culturally stigmatizing and generic representations of immigrants and their French-born children, especially sub-Saharan Africans—as deviant, delinquent, or promiscuous—not necessarily because they perceive them as such. I believe the situation may be more complex, and my data lead me to think that they may rely on these representations 1) in order to justify resorting to specialized mental healthcare for alternative motives (i.e. as an additional institutional resource), or 2) because they draw from a cultural repertoire in which such representations are internalized, and make practices readily definable, and hence manageable (Essed, 1991).

Specialized mental healthcare experts, while reflexive about cultural competence as a two-way learning process, also draw from the same cultural repertoires, especially

when caught in double-bind situations, in which unconsciously resorting to stigmatizing representations occurs in two scenarios which I was able to identify: 1) to justify their institutional position as experts, and 2) to counter instances of illegitimate differential treatment against immigrants or their children.

Ultimately, these observations point to the limit of specialized mental healthcare as a non-integrated structure of mental healthcare provision—that is, as an option of care among others within one institution—as its position of cultural expertise leads to neglecting the conflation between cultural difference and structural inequalities. As a result, it raises issues in clinical practice when the institution also has to face a triage between actual referrals for mental health, and referrals that require attention to broader structural issues.

Contributions to anthropology

My research contributes to the recent anthropological endeavors which have sought to unveil the everyday articulations between the local, the state, and the global, between individual “agency” and institutional constraints. It is located precisely at the intersection between these levels of analysis.

I developed a methodology that traces the circulation of institutional discourse both spatially—horizontally (in-between institutions), but also vertically (from state discourse down to everyday interactions)—as well as temporally. I moved beyond a static framework that singles out levels of analysis, and beyond the traditional structure/subject dichotomy. Drawing from works which have attempted to be theoretically “integrative”—notably the practice theories of Bourdieu (1977) and Giddens (1979)—

and which have striven to capture “structure-in-action” (Zimmerman and Boden, 1991; Giddens, 1984), I add the dimensions of negotiation, interpretation, and subjectification, which ethnographic analyses of everyday interactions are best suited to capture.

As a result, my analysis contributes to social theory more broadly by developing an analytical framework which considers institutions as meta-discursive nodes—that is, points of encounter between state, institutional, and individual ideologies. In this dissertation, identifying the mechanisms and rationales of cultural differentiation in contemporary France, I proposed a three-stage model of analysis of *the institution as meta-discursive node*:

1. meanings and repertoires (the frame)
 - a. genealogy (culture in mental health, the relevance of cultural representations in the French republican context and its evolution in relation to immigration)
 - b. institutional discourse (the regulative impact of the Republican ideology on the framing of specialized mental healthcare expertise)
 - c. personal deliberations (reflexivity, instrumentalization)
2. networks of practice (the movement)
 - a. source (origin of the referral)
 - b. trajectory (rationale for referral)
 - c. practice (negotiation of the referral)
3. subjective processes (the impact)
 - a. internalization/reproduction (the use of generic representations of culture)
 - b. contestation (the use of representations against representations)

- c. double-binds (between contesting representations and using representations)

Such framing deconstructs the complexity of reality in such a way that does not oppose macro to micro analyses, or conflate structure and agency, but rather integrates them at each level. As a result, it allows for contradictions as an object of study.

Thematically, my analysis contributes to a burgeoning work in France today on social representations, namely the articulation between “the social issue” and “the racial issue” (Fassin and Fassin, 2009[2006]). In my work, I apprehended “immigrant suffering” as a socially constructed category whose naturalization in institutional discourse is revealing of larger social and political processes and transformations in French society, specifically those related to public issues commonly referred to as the “immigrant issue” (*la question immigrée*) and the “social issue” (*la question sociale*). The analysis of “specialized” mental healthcare initiatives has revealed how the two issues articulate in complex ways, as the recognition of cultural difference is intrinsically – yet not exclusively – linked to the acknowledgment of both the cultural stigmatization and social inequalities many immigrants and their French-born and raised descendants face, which in turn undeniably engenders suffering. Simultaneously, however, this recognition is constrained by the stigma attached to expressions of cultural difference and related discussions on stigmatization in French political discourse, which only recently has allowed for a discussion of racial discrimination, and its relation to social inequalities. Such discrepancy produces systemic contradictions, which place those whose job is to respond to “immigrant suffering” in an ambiguous, at times contradictory, position.

For decades, as I have shown, “visible” immigration from North and sub-Saharan Africa stood as a proxy for race in France. Today, racial references to “Arabs” and “blacks” encompass several generations of French-born children and adults, but also, insofar as “blacks” are concerned, French citizens from the Caribbean. Recently, French sociologist Pap Ndiaye pointed that our analytical focus should in fact shift to a “black minority”—encompassing black individuals from the French Caribbean, but also the African elite (businessmen, politicians, intellectuals) who generally are not included in the “immigrant” category—and who share the social experience of being considered as “black” (Ndiaye, 2008).

Nonetheless, my research has shown that within this broader racial categorization, representations of sub-Saharan African immigrants and their children rest upon equally generic, but culturally specific representations of “Africans” as promiscuous, with abnormally large families, entertaining odd lifestyles, all of which ineluctably produce psychological distress. As I have argued, it is those representations which, in part, have made “Africans”—not “blacks”—the privileged target of both “cultural mediation” and “specialized” mental healthcare for the socio-historical reasons I have delineated in this dissertation. However, it is, just as importantly, the recognition of the structural inequalities to which immigrants are often vulnerable too, and which, together with the distress induced by the experiencing of immigrating itself, engender psychological suffering. As I have shown in this work, if generic cultural representations of immigrants emerge in institutional actors’ discussions of “immigrant suffering,” it is also because these representations make situations readily definable and manageable, as well as conveying a recognition of “the social issue.”

The question to be asked now, is whether the reproduction of such generic cultural representations, in terms of “positive differentiation” or not, ultimately reiterates the equation, strategically elaborated by French political discourse, between immigration and otherness, or rather, the opposition between immigration and “national identity,” and as a result fails to bring the social issue to the fore. Hence my earlier plea for *integrated* “specialized” mental health services, which would symbolically, but powerfully in my sense, work to destigmatize cultural difference and resist this opposition which is, first and foremost, inherently political.

Until now, I have apprehended the issue of representations—and its intrinsic conflation of culture/race and class—primarily from the vantage point of institutional actors. I would like to acknowledge here that, as a result, my analysis only provides a partial account of how French society represents itself today, and of the mechanisms through which certain representations are reproduced. As I mentioned the use of generic cultural representations as a tool for “positive differentiation” in the recognition of social issues, I want to point to the recent emergence of minority politics in France—the movement of “the Indigenous People of the Republic” in 2005, and the creation of the National Association of Blacks in France (CRAN) in 2007—which indicate that representations are also appropriated by the very individuals they categorize, for recognition and redistribution purposes. Although such minority politics address a much larger social group than the immigrants I identified in this research, and rely on racial representations rather than cultural ones, they signal a transition in the French social landscape, in terms of how difference is addressed and construed.

In pursuing research on representations of cultural or racial difference in mental healthcare provision then, it would be relevant not only to focus on the management of that difference in *mainstream* mental healthcare services—in which such representations could be measured against and compared to representations of “white” patients—but also to link the existing *analysis* of representations to that of *experiences*.

As Eric and Didier Fassin (2009[2006]) recently emphasized, it is imperative that empirical investigations of the representation of social production document to what extent, as a construction, such representation exaggerates some aspects of reality while dissimulating others, and why. In that respect, it is paramount for anthropologists to publicly contribute to this representation of society, aside the images disseminated by the media and politics, which altogether elaborate what becomes “commonsense” representations. In that respect, I am hopeful that my research will contribute to a morally engaged anthropology that exposes cultural prejudices against immigrants in particular, and more broadly, that critically addresses the social mechanisms that produce the categorization and hierachisation of marginalized groups.

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APPENDIX A : Specialized Mental Healthcare Institutions

<p>AVICENNE HOSPITAL <i>“Transcultural Clinic”</i> (Bobigny)</p>	<p>Jean Baptiste CARPEAUX COMMUNITY HEALTH CENTER <i>“Ethnopsychiatry Consultation”</i> (18^e arrondissement, M° Guy Moquet)</p>
<ul style="list-style-type: none"> ▪ Ethnopsychiatry group consultation ▪ Individual therapy (psychoanalytic and psychotherapeutic) ▪ Infant & child therapy ▪ Adolescent therapy (CASITA) ▪ Drug abuse therapy <p>+ <i>Medical and social services</i></p>	<p>Ethnopsychiatry group therapy</p> <p>+ <i>Medical and social services</i></p>
<p>Clinical group:</p> <ul style="list-style-type: none"> ▪ Co-therapists (6–varies) ▪ Psychiatry interns ▪ Transcultural psychiatry program students <p><i>(Referring actors)</i> <i>(Interpreter)</i></p>	<p>Clinical group:</p> <ul style="list-style-type: none"> ▪ Leading therapist ▪ Co-therapist (1) ▪ Psychology student interns ▪ Transcultural psychiatry program students <p><i>(Referring actors)</i> <i>(Interpreter)</i></p>
<p>Referring institutions:</p> <p>Justice courts Schools Social services Medical services</p> <p>Servicing Paris & suburbs</p>	<p>Referring institutions:</p> <p>Justice courts Schools Social services Medical services</p> <p>Servicing 18e & 19e Paris districts</p>
<p>University of Paris XIII</p> <p>Transcultural Psychiatry Graduate University Diploma Students: Health professionals (doctors, psychiatrists, psychologists, nurses, midwives), Paris 13 psychiatry interns, social workers, school professionals, social scientists...</p>	

MINKOWSKA
**COMMUNITY MENTAL
HEALTH CENTER**

*“Clinical Medical
Anthropology”*

(18^e arrondissement, M^e La Fourche)

- Individual therapy (psychoanalytic and psychotherapeutic)
- Art therapy
- Family therapy

+ *Social services*

Clinical group:

- Psychiatrists and psychologists
- Social workers (2)
- Psychology students

(Interpreter)

Referring institutions:

Justice courts
Schools
Social services
Medical services

Non-sectorized

University of Paris V

“Health, Disease, Healthcare and
Cultures”
Graduate University Diploma

Students: Health professionals (doctors, psychiatrists, psychologists, nurses, midwives), Paris 13 psychiatry interns, social workers, school professionals, social scientists...

GEPELA
**RESEARCH & TRAINING
CENTER**

“Ethnoclinical Mediation”

(St. Denis)

- Family ethnoclinical consultation (on- and off-site)
- Coordination/consultation with referring institutions
- Case studies & seminars with GEPELA members

Clinical group:

- Mediator (GEPELA Director – ethnolinguist)
- School psychologists
- Psychology students interns

(Referring actors)

(Interpreter)

Referring institutions:

Schools
Social services

Cergy school district (northwestern Paris)

University of Paris VIII

“Clinical Psychology,
Psychopathology and
Psychotherapy”
Professional Master Degree 2

Students: Psychology students holding a Master Degree 1

APPENDIX B

Referral Table for Patients from Sub-Saharan Africa, Minkowska, 2007*

N° Dossier File Number	Motif de signalement / Diagnostic <i>Rational for Referral / Diagnosis</i>	Thérapeute <i>Therapist</i>	Patient <i>(Gender and birth year)</i>
1.	Battue par mère qd enceinte	N/A	F 1983
2.	Dépression PT - Incendie perte mbres famille	N/A	H 1977
3.	Délit vol/racket - 2 libertés surveillées	N/A	H 1992
4.	Voir courrier	N/A	F 1972
5.	Mariage forcé - Dépression - Secret familial	N/A	F 1984
6.	Pb envoûtement - Marabout - Hallucinations	N/A	H 1979
7.	Mariage forcé - Suicidaire	N/A	F 1982
8.	Excision	N/A	F 1975
9.	Pb enfants	N/A	F 1961
10.	Dépression + hallucinations + refus traitement	N/A	H 1971
11.	Divorce + IVG + se sent responsable pbs enfant	N/A	F 1966
12.	Pb fausse-couches mère + comportement école enfant	N/A	H 2000
13.	Difficultés couple (violence + possible divorce) + enfants	N/A	F 1964
14.	A fui mariage forcé - Rejet du père	N/A	H 1989
15.	A fui pr éviter excision de sa fille + Séropositive (fille aussi)	N/A	F 1966
16.	Retard scolaire, inhibition avec adultes	N/A	H 2000
17.	Paranoïa	N/A	H 1948
18.	Stress ensorcellement mari / Anxiété et nostalgie femme	N/A	F 1968
19.	Trouble névrotique	N/A	F 1972
20.	Pb enfant	N/A	F 1960
21.	Episode dépressif	N/A	H 1974
22.	Episode dépressif moyen	N/A	F 1962
23.	Episode dépressif moyen	N/A	F 1970
24.	Grande précarité	N/A	M 1975
25.	Troubles somatoformes liés à un stress important	N/A	F 1986
26.	Angoisse et dépression	N/A	H 1970
27.	Problème scolaire non identifié. Situation familiale difficile.	N/A	F 1992
28.	Procédure de divorce contentieuse en cours	N/A	F 1978

F = Female / H = Male

N/A: Names of therapists were removed to preserve their anonymity

*Permission to access patients' files was granted by the President of the Medical Commission at Minkowska.

Referral Table for Patients from Sub-Saharan Africa, Minkowska, 2007 (2)

	Pays <i>Country of origin</i>	Arrivée France <i>Arrival in France</i>	Statut <i>Legal status</i>	Interprète <i>Interpreter</i>
1	France, origine Mali	May-97		N
2	Mali (Soninké)	Feb-02		
3	France, origine Mali			N
4	Mali (Bambara)	Sep-02	DA	
5	Mali (Bambara)	Dec-03		
6	France (Créteil)			N
7	France (Montreuil), origine Sénégal			N
8	Sénégal	Oct-04		
9	Mali (Soninké)	1983	Carte jusque 2015	O
10	Mali (Soninké)	Dec-99	ST avec PT expiré	O
11	France, origine Sénégal	Feb-96		N
12	Bénin	Nov-00		
13	Mali (Peulh)	Aug-82		
14	Mali (Bambara)	Feb-06	SP / Considère DA Territorial	
15	Mali (Kasonke)	Mar-06	SP	
16	France, origine Mali (Bambara)	Père 1980, Mère 1999		
17	Sénégal (Mandingue)	Jan-78		
18	Sénégal (Mandingue)	Oct-84	Naturalisation en cours	
19	Guinée (Soussou)	Dec-00	SP	
20	France, origine Guinée (Soussou)	Jun-89		
21	Sénégal (Peulh)	Jan-02	SP	O (ami)
22	Mali (Soninké)	Jan-91	Carte de résident	
23	Mauritanie (Bambara)	Jun-05	Déboutée DA	
24	Mali (Soninké)	Dec-04	SP	
25	Guinée (Diakhanke)	Oct-06	DA, rejet OFPRA, en recours	
26	Guinée	Jan-81		
27	Côte d'Ivoire	Déc.-00		
28	Nigéria (née au Bénin)	01/01/02		O (moi)

Status codes: DA = Asylum seeker; SP = Illegal
Interpreter: O = present; N = not necessary

Referral Table for Patients from Sub-Saharan Africa, Minkowska, 2007 (3)

	Référent <i>Origin of referral</i>	Logement <i>Housing</i>
1	AS CMP (Tel) + Pédopsy.	Foyer maternel, 20e (perte logement)
2	Psychiatre H.Pitié-Salpêtrière	Chez père, 18e
3	Educatrice CAE judiciaire	Chez parents, 19e
4	Psychologue Asso Ni Putes Ni Soumises	Hébergement social
5	AS Savigny/Orge - Asso DIAPSY	SC Orsay + Hôtel
6	AS Espace Insertion 18e (Tel)	Hébergé chez frère aîné, 18e
7	Educateur (Tel)	Centre Michelet, Paris 13e
8	Ami médecin généraliste	Hébergée chez dame 87 ans
9	AS Secteur (Tel)	Hôtel Paris 2e (depuis 5 ans)
10	Médecin généraliste, SAU Montreuil	Hébergé par cousin, St Denis
11	Psychologue CAPP	Domicile, 20e
12	Educatrice Asso. "Emergence"	Centre Hébergement et Insertion Sociale
13	AS Secteur (Tel)	St Ouen
14	Educatrice	Hébergement chez amis "qui se lassent"
15	AS de secteur - CASVP	Hôtel 18e payé par SAMU social
16	Psychologue scolaire	Sartrouville (78)
17	Psychologue CMP 11e	Domicile, 11e
18	Psychologue CMP qui suit 1 des enfants	Domicile, 11e
19	AS CMPP C. Bernard	20e
20	Educatrice CAE Houilles (78) (suit fils aîné en liberté surveillée)	St Germain en Laye (78)
21	AS Hôpital St Louis / Prise en charge Asso. Catho. "Marthe Marie Lazare et les Autres" (20e)	Foyer
22	Conseillère ESF du Service Social Départemental Polyvalent de Paris 12e	Domicile, 12e
23	Compatriote suivie au centre	Hébergée à Aubervilliers (93)
24	Bénévole Asso. de quartier "Amis de la Bienvenue" de Paris 13e	Collectivité. Domiciliation secours populaire 18e.
25	Intervenante sociale de CADA	CADA de Savigny sur Orge (91)
26	Psychologue à Direction de l'Insertion, de la Lutte contre les Exclusions et de l'Emploi	Foyer Sonacotra
27	AS Scolaire	Vitry-sur-Seine (94)
28	Avocate	Ville d'Avray (92)

Referral Table for Patients from Sub-Saharan Africa, Minkowska, 2007 (4)

	Profession / Profession	Prestations / Ressources Medical Insurance /Other Resources
1.	Aide à domicile, BEP San. Et Social	SP / SR
2.	SP	SP / SR
3.	Scolarité spéciale	SP / SR
4.	SP	SP / SR
5.	SP	SP / SR
6.	Agent exploitation intérimaire	CMU / RMI
7.	Recherche emploi	SP / SR
8.	Etudiante	Sécu
9.	SP	SP / SR
10.	Ménage McDo (cultivateur au Mali)	CMU
11.	Aide soignante	CMU
12.	Vient de terminer classe CP	CMU
13.	Aide à domicile	SP / SR
14.	Terminale Bamako / CAP vente France	AME
15.	Formation infirmière	SP / SR
16.	Classe CP	Sécu Père
17.	Retraité RATP	Sécu
18.	Au foyer	SP
19.	SP	AME
20.	Aide soignante	Sécu
21.	SP	AME
22.	Agent d'entretien, en congé parental	Sécu
23.	SP	CMU
24.	SP	SP
25.	SP	CMU
26.	RMI	Sécu
27.	Classe de 4e	Sécu mère
28.	SP	Sécu mari

SP / SR: Illegal status, without resources

CMU: Universal Health Coverage

AME: State Medical Help

Sécu: Health Coverage (Other)

RMI: Stipend for the unemployed

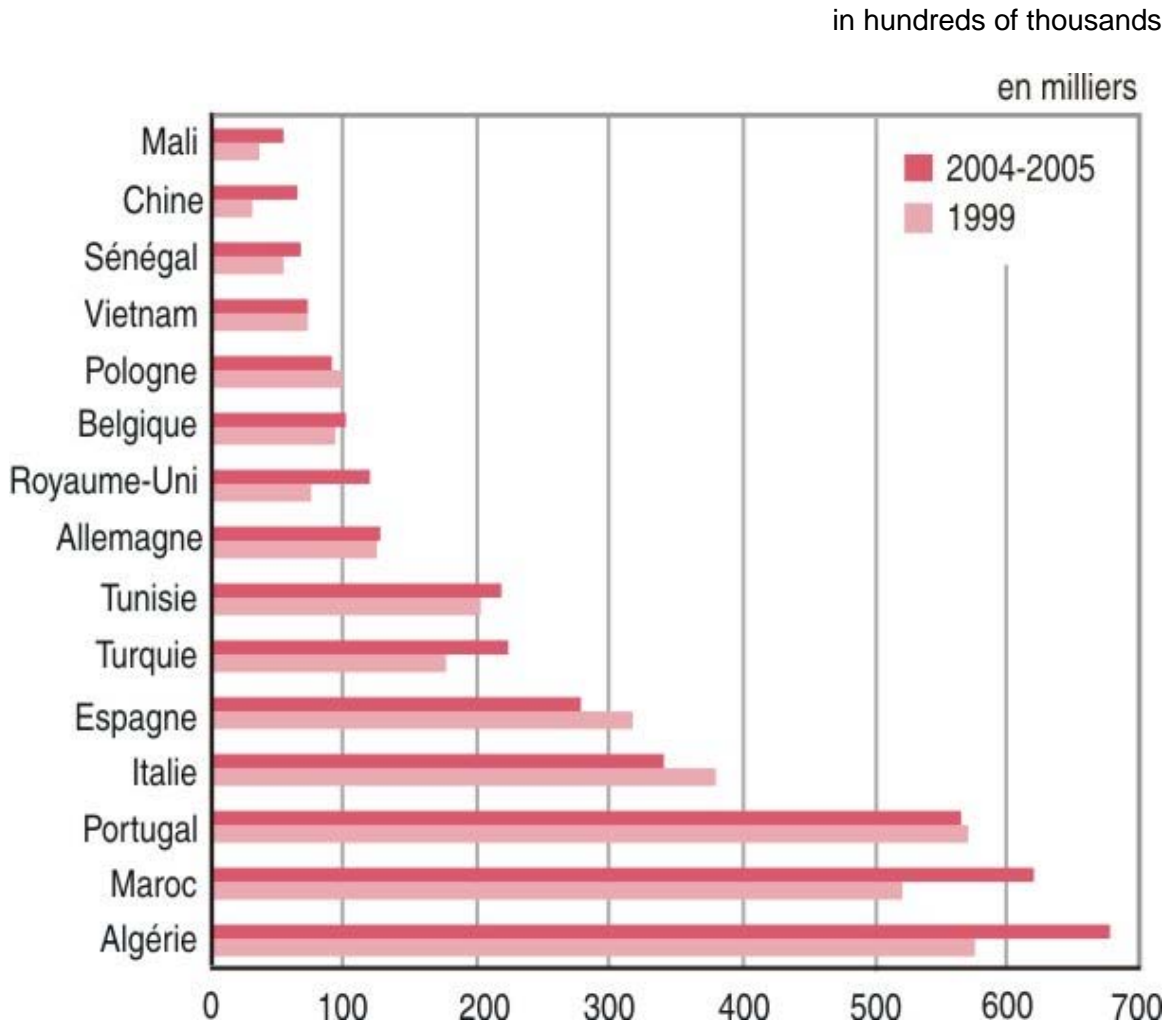
Referral Table for Patients from Sub-Saharan Africa, Minkowska, 2007 (5)

	Commentaires / <i>Comments</i>
1	Lettre pédopsy.
2	"Evènement utilisé pr régularisation" + "pr aspects culturels de la souffrance psychique" (Psy. Réf.)
3	
4	"Demande psychothérapie floue" + Courrier Asso.
5	Voir Association DIAPSY
6	Vu marabout marocain (contact sur internet)
10	A eu traitement à Avicenne en 2003 / refus traitement docteurs (les "médicaments qui font dormir") ou marabout / "ce n'est pas la maladie qui m'empêche de travailler"
11	dame référée par psychologue du fils, qui montre "états d'agitation intrafamiliale et scolaire"
12	"Peurs qu'il avait pu avoir au Bénin se rapportant à la sorcellerie" (Edu. Réf.)
13	aggravé par situation sociale précaire (surrendettement)
16	Pb seulement à l'école. Voir lettre psy.: "a proposé aux parents une rencontre avec votre centre de façon à affiner les causes des difficultés de cet enfant, qui pourraient être d'ordre culturel et:ou liées aux compétences propres à cet enfant"
17	Blocages avec culture, difficulté à renouer liens, impossibilité rentrer malgré retraite
18	Mari a cauchemars qu'il attribue à attaques de sorcellerie / Femme a anxiété et nostalgie - lien avec grande précarité: 2e rdv: "depuis qu'elle a déménagé, elle n'a plus d'angoisses, elle dort tranquille"
19	Elevée par tante, manque affectif de la mère biologique, peur d'échec avec ses propres enfants, dépression perte homme aimé + mariage forcé. 2 rdv: "patiente volubile, construction romanesque de son histoire"
20	Un seul rdv: fils orphelin de père ds délinquance (vol + violence = prison). Fild ds centre éducatif renforcé. Mme a des cauchemars.
21	"Pas de boulot, pas de papiers, y'a rien." Sentiments de frayeur au milieu du sommeil. Anxio-dépressif. Somatisation. 2e rdv "son problème, c'est les papiers."
22	Voir correspondance sociale SSDP. Un seul rdv. 2nd pas venue. Séparée de son mari duquel ne peut divorcer, vit avec autre homme. Souffre double vie. Médiation proposée avec mari.
23	Esclave au pays. Fille désormais dans mains du "maître" là-bas. Pas bcp nouvelles de sa famille. Voir certificat médical de Dorès pr papiers.
24	Un seul rdv. Pas de nveau rdv pris. "Difficultés pour moi: pas de papiers, pas de travail, plus personne au Mali." Dort parfois dans la rue.
25	2 rdv, puis pas venue aux 2 suivants. Veut pas parler maltraitance subie au pays (aurait fait l'objet d'un viol). Vie menacée là-bas.
26	1 rdv, 2 pas venu. A du mal à trouver un travail. Pb de famille avec père. Pense qu'a été marabouté.
27	1 rdv, 2 pas venu. Abandonnée par mère biologique quand avait 8ans. Rapport difficiles avec mère légitime. 2 signalements de l'école. Restée 2 ans en France sans être scolarisée. Dit ne pas aimer les AS en général, car veulent la « placer ».
28	2 rdv, puis pas de suivi. Sentiment comportement de mépris de la part du mari. Coalition contre elle avec belle-mère.

APPENDIX C : Demographic Tables : Immigration Flows to France

Les immigrés selon leur pays de naissance en 1999 et 2004-2005

Immigrants according to country of birth between 1999 and 2004-2005



Champ : France métropolitaine / Field : Continental France

Source : Insee, recensement de 1999, enquêtes annuelles de recensement de 2004 et 2005
/ Source : National Institute of Statistics (INSEE), 1999 census, yearly census studies for 2004 and 2005

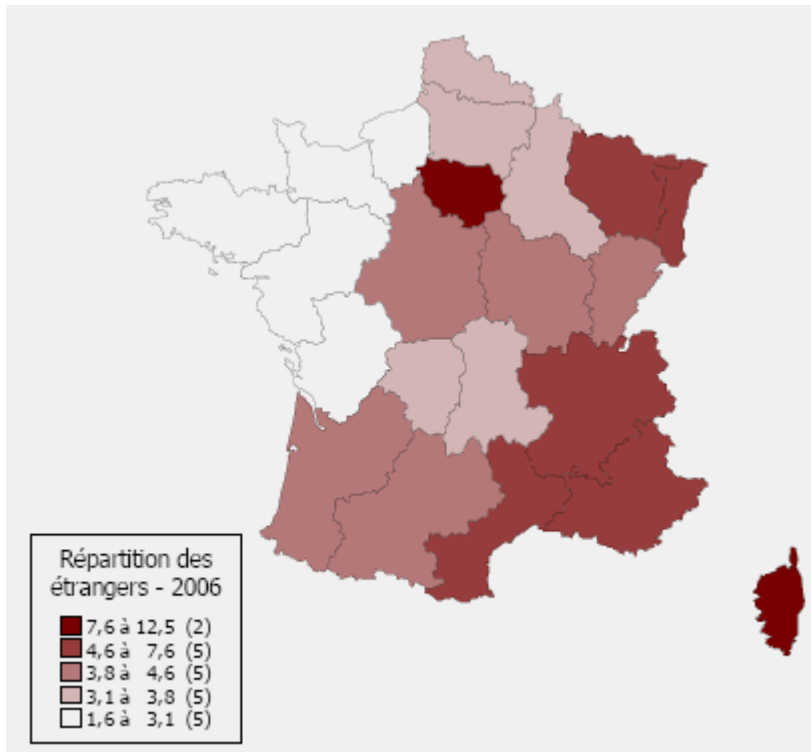
**Evolution de la population étrangère en France entre 1999 et 2006, par nationalité /
Evolution of the Foreign Population in France by Nationality between 1999 and 2006**

	1999 (en milliers)	2006 (en milliers)	Évolution (en %)	Part (en %) dans l'ensemble 2006
Nationalités d'Europe (y.c. la CEI)	1 347	1 428	6,0	40,3
UE à 25	1 219	1 236	1,4	34,9
<i>Espagnols</i>	160	134	-16,3	3,8
<i>Italiens</i>	201	177	-11,9	5,0
<i>Portugais</i>	555	491	-11,5	13,9
<i>Autres nationalités de l'UE à 25</i>	303	434	43,2	12,3
Autres nationalités d'Europe	128	192	50,0	5,4
Nationalités d'Afrique	1 418	1 521	7,3	42,9
Maghreb	1 135	1 087	-4,2	30,7
<i>Algériens</i>	475	481	1,3	13,6
<i>Marocains</i>	506	460	-9,1	13,0
<i>Tunisiens</i>	154	146	-5,2	4,1
Afrique subsaharienne	211	331	56,9	9,3
Autres nationalités d'Afrique	72	103	43,1	2,9
Nationalités d'Asie	411	472	14,8	13,3
Turcs	206	224	8,7	6,3
Sud-Est asiatique	63	44	-30,2	1,2
Autres nationalités d'Asie	142	205	44,4	5,8
Natio. d'Amérique et d'Océanie	84	120	42,9	3,4
Ensemble des étrangers	3 260	3 542	8,7	100,0

Sources : INSEE, recensements de la population 1999 et 2006.

Distribution de la population étrangère en France en 2006, par région

Distribution of the Foreign Population in France by Region in 2006

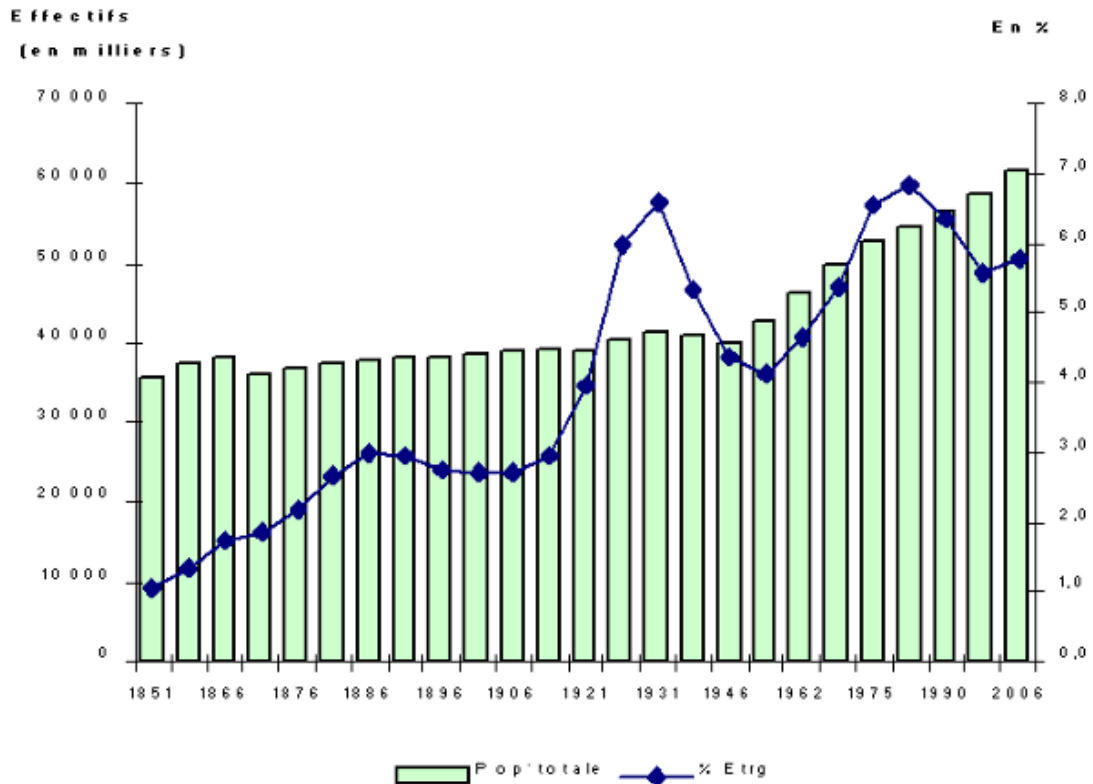


Carte 1 : Part (en %) des étrangers en 2006 par région - France métropolitaine.

Sources : INSEE, recensement de la population 2006.

Part (en pourcentage) des étrangers dans la population totale aux différents recensements de la population depuis 1851 - France métropolitaine.

Evolution of the Foreign Population in France from 1851 to 2006



Source : INSEE.

Notes : 1. De 1851 à 1876, il s'agit de la population résidant en France au moment du recensement. 2. De 1881 à 1936, il s'agit de la population présente en France au moment du recensement. 3. Depuis, population résidant habituellement en France.

Flux d'immigration permanente par motif
Immigration flows according to immigration motives

2003

Nationalité	Travailleurs permanents	Regroupement familial	Familles de Français*	Vie privée et familiale	Réfugiés	Visiteurs	Autres* *	Total
Europe (hors EEE) et ex-URSS	1,144	1,032	624	4,499	3,097	906	485	11,787
Afrique	2,097	19,014	13,122	43,938	4,314	3,259	4,318	90,062
Algérie	397	5,367	4,105	15,884	226	1,441	1,134	28,554
Maroc	707	7,775	2,366	10,789	0	448	254	22,339
Tunisie	194	3,068	3,610	2,265	16	163	109	9,425
Afrique hors Maghreb	799	2,804	3,041	15,000	4,072	1,207	2,507	26,923
Asie	2,013	4,772	1,517	8,779	1,960	1,949	1,202	22,192
Turquie	339	2,768	372	3,882	857	112	283	8,613
Vietnam	84	58	80	582	16	46	43	909
Chine	222	339	149	1,132	39	381	149	2,411
Japon	386	450	81	192	0	250	46	1,405
Liban	364	157	64	246	5	156	12	1,004
Amérique, Océanie	1,244	1,948	961	4,927	366	1,496	316	11,258
Autres (divers, apatrides)	2	2	4	28	53	6	1	96
Ensemble	6,500	26,768	16,228	62,171	9,790	7,616	6,322	135,395
Rappel 2002	7,469	27,267	21,020	43,681	8,495	9,985	5,560	123,477
Rappel 2001	8,811	23,081	18,765	34,682	7,323	8,968	5,026	106,656
Rappel 2000	5,990	21,404	15,992	31,140	5,185	8,424	3,596	97,083

* Conjoints, enfants et ascendants de Français, parents d'enfants français.

** Titulaires d'une rente accident du travail, bénéficiaires de l'asile territorial, étrangers malades, actifs non salariés, familles de Réfugiés et apatrides.

Champ : hors entrants de l'Espace économique européen (EEE).

Sources : OMI, OFPRA, Ministère de l'Intérieur.

Evolution des flux migratoires par région d'origine, de 1982 à 2005
Evolution of immigration flows to France per region of origin, from 1982 to 2005



Source : Insee.

APPENDIX D: Vignettes and Interviews – Dates and Methods Used

** I used pseudonyms for all informants, with the exception of lead therapists in each specialized mental healthcare institution **

Chapter 4 :

Transcultural Psychiatry Vignette (23/01/08) : Extensive field notes, post-consultation
Clinical Medical Anthropology Vignette (12/03/08) : Extensive field notes, post-consultation
Ethnoclinical Mediation Vignette (14/03/08) : Consultation field notes

Chapter 5 :

Transcultural Psychiatry Students: Recorded interviews

S4 (26/01/08)

S8 (16/02/08)

S1 (11/01/08)

S2 (11/01/08)

S7 (15/03/08)

S6 (19/03/08)

S3 (12/01/08)

S5 (10/01/08)

Transcultural Psychiatry Lectures

“Anthropologie et Clinique” (12/10/07) : Class notes

“La demande?” (29/03/08) : Recorded lecture

Chapter 6:

Vignettes Minkowska (5/12/07): Field notes

Vignette Avicenne (7/06/08) : Field notes

Vignette Minkowska on Idriss’s story : Field notes

Chapter 7:

Vignette Minkowska MEDIACOR & Mrs. Kayoute’s case: Consultation extensive field notes

Minkowska Legal case of Cameroonesse sisters

Vignette Carpeaux on Madan’s story: Post-consultation extensive field notes

Vignette Avicenne Moroccan father and son (23/01/08): Post-consultation extensive field notes

Vignette Carpeaux on Mrs. Nkandu’s story (27/11/07): Post-consultation extensive field notes

Chapter 8:

Vignette Murielle, school psychologist (15/03/08): Recorded interview

Vignette Salif's case (3/04/08): Field notes

Vignette Murielle, school psychologist (15/03/08): Recorded interview

Vignette Sandra on Moussa's case at education team meeting (10/04/08): Field notes

Vignette Sandra on Bacari's case at MDPH meeting (10/04/08): Field notes

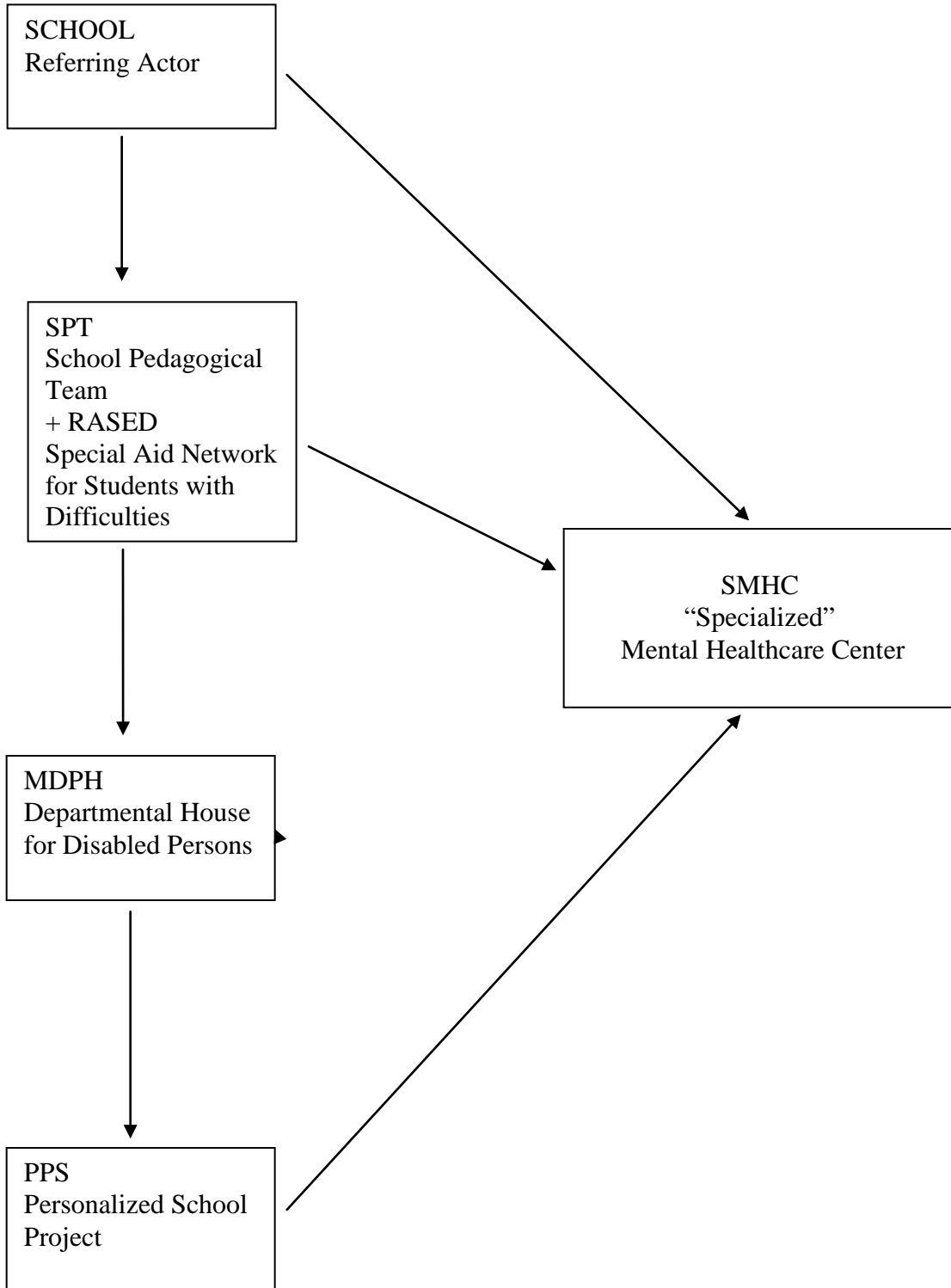
Vignette school referral Minkowska about Anais (18/04/08): Post-consultation field notes

Vignette school referral Carpeaux about Mamadou (15/01/08): Post-consultation field notes

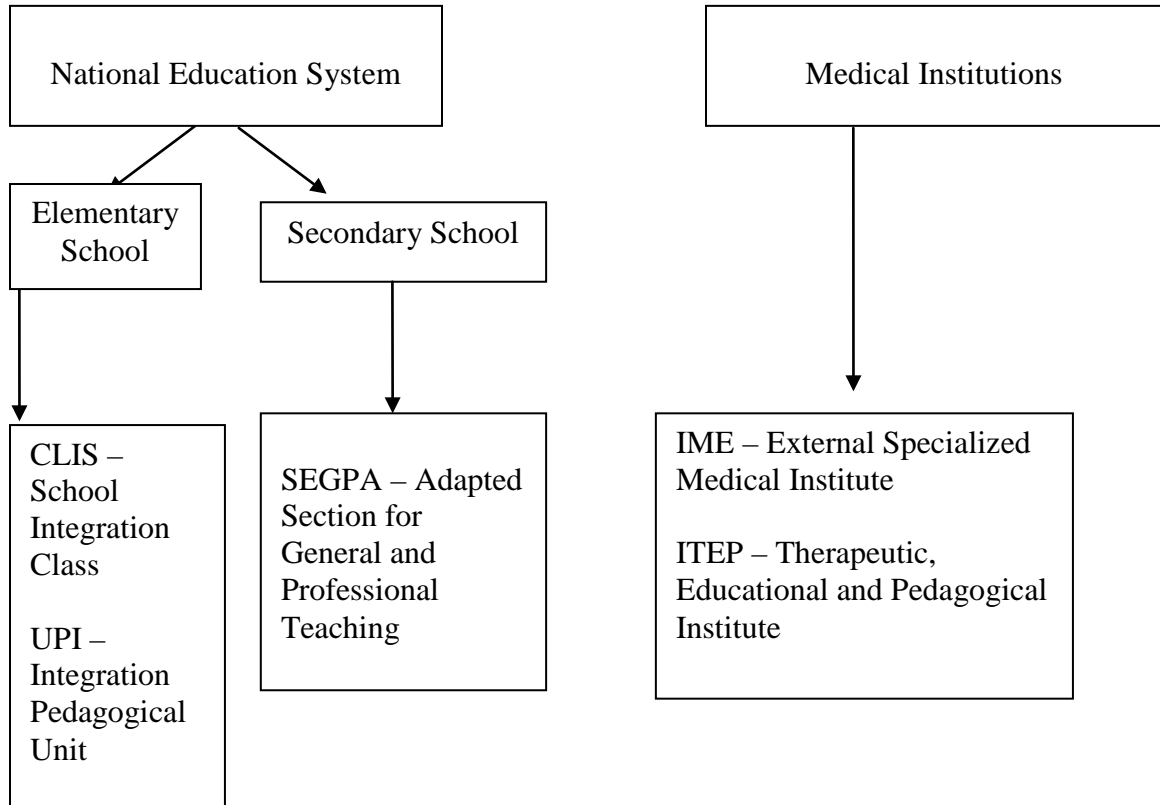
Vignette school referral Gepela about Abdullah (13/12/07): Seminar notes

APPENDIX E: School Referrals Tables

School Referral Process



Special Aid Schools



Within Schools:

Student Facing Significant School Difficulties / With Disability

(Chart translated from existing National Education hand-out to school staff)

