Mediators, peers, and interpreters: Coming to the care sector's rescue

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

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

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

From a multitude of individuals to the need for mediation

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

For example, the last ten years has seen a continual rise in the number of new migrants arriving in France. Migrants have many care needs, which are largely dealt with by the *permanences d'accès aux soins de santé* (PASS) (health care access services) and by *équipes mobiles psychiatrie précarité* (EMPP) (mobile mental health outreach teams for vulnerable individuals). Controversy has arisen among care providers over the specific needs of migrants and the question of whether certain tailored measures need to be put in place, such as ethnopsychiatry in mental health care. The late twentieth century saw considerable tension between the various different theoretical schools (corresponding to a similar number of types of care facility). Nowadays they tend to dissipate in the face of expectations for effective health care and an increasing number of initiatives for providing bespoke care services for migrants, particularly involving mediators and/or interpreters. Public authorities are now in agreement that migrants are not a specific group of service users as such; rather, they are a group with specific needs. This use of third-party mediators appears as an opportunity to offer adapted and personalized care services without having to set up specialist care services that correspond to service users' particular administrative or ethnic categories. What is more, the authorities are now promoting the use of interpreters and mediators[2] in care teams, and are encouraging those who provide these services to professionalize and specialize.

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

The effectiveness of peers

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

Different peer figures can come together or coexist within the various programs, and they question the

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

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

relationship with knowledge or experience depending on the practical challenges that arise. For instance, individuals need to be understood and possibly translated, and it may be useful for individuals to meet up with others who have similar problems. Although the efforts of peer mediators are promoted in social work, their participation in care programs for migrants gives rise to other problems, especially in relation to their recognition (or not) of being part of the community in which they are working. What skills were used as the basis for selecting them? How are they involved in relationships? In what way are they peers? Is the knowledge that is built up in this context transferable or objectifiable? These questions bring us to the debate around the formalization and training of mediators, peers, and interpreters, which will be dealt with thematically in the articles that follow.

Mediators, peers, and interpreters

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

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

Peer support and recovery

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

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

about their practice.

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

Status tensions

In her article, Laëtitia Schweitzer sounds a dissonant, or at least highly reflexive, note. She highlights "the importance of not simply accepting a positivist vision of peer work, a view that may itself produce some effect, in an absolute context devoid of all contingency or any situational features." The development of peer work belongs to a context of increasingly precarious work in the fields of social work and health care. Schweitzer goes on to note that there is "confusion between peer work and the participation of individuals who are receiving support. Peer workers are, by implication, the representatives of these individuals and, on the grounds of parity, they give them a voice before the bodies that coordinate their medical and social support." The articles on peer mediators generally focus on questions linked to their status, rather than on matters of practice.

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

The neutral and transparent interpreter

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

The same issue of neutrality (here, we may talk about the transparency of the interpreter's intervention) is discussed in the article by Vanessa Piccoli and Véronique Traverso. The idea behind their contribution is that, beyond the specificities and individual cases, recurring discursive practices in consultations with interpreters can be identified, the detailed description of which can facilitate training and discussions of good practice and standards. Their article describes a procedure observed in psychological consultations with migrants, whereby interpreters, in translating a description that a patient gives of his or her emotional state (whether past or present), will comment on the patient's lexical choices and on any non-equivalence between the languages concerned. In doing this, interpreters depart from their classic neutrality and erase any illusion that language is transparent.

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

The interpreter as a full-fledged participant

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

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

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

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

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

care professionals coming in above the experiential and cultural knowledge expressed in local languages. There are parallels between this investigation and the issues of colonial heritage, and the authors refer to "scarring ambivalences" when it comes to the recognition of the socio-professional status of the Mahoran hospital staff who provide translation services.

Ada Luz Duque's article, which is based on her experience as a professional interpreter, begins with the premise that the use of an interpreter's services generally addresses a need for linguistic understanding, rather than any real willingness to engage multidisciplinary support. From this starting point, Duque examines the position of the interpreter in the patient–caregiver–interpreter triangle, stressing the point that the interpreter—perhaps inevitably—brings his or her own interpretation, who brings—perhaps inevitably—his or her own interpretation and affects to the situation. Duque also demonstrates how the changing and necessarily improvised nature of the interpreter's work means that it can always be adapted depending on what transpires, despite sometimes being analyzed in "too fixed a manner." She laments how rarely consideration is given to opportunities to work together in developing practices and approaches to care in a non-standardized way.

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

Experience and concern

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

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

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

address issues around the role of the facilitator in such groups. They argue that "peer meetings help people to feel less isolated, to reclaim their own story, and to search for meaning in their experiences."

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

Reference list

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