Culture Brokers, Clinically Applied Ethnography, and Cultural Mediation

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Cultural consultation frequently requires the use of resource people who can help interpret the cultural meaning of illness and healing. This task goes beyond linguistic interpreting and may be essential even when patient and clinician share a language. This chapter explores the multiple roles of culture brokers or mediators in health settings. In some settings, the task of cultural mediation is viewed as part of the cultural competence of health professionals, while in others, it is assigned to medical interpreters (who function as community interpreters) or involves a new type of practitioner. The professionalization of culture brokers (implying a definition of duties and conduct) has occurred in several national health care systems, with variations in status, roles, and practices.

A growing literature on this subject shows the timeliness of efforts to combine interpreting skills with an anthropological approach to mediation. However, the literature is very scattered and comes largely from Europe where several models of cultural mediation have been developed. To date, there has been no systemic literature review of evaluation and implementation studies of culture brokers, including issues pertaining to policies, laws and regulations, formal and informal role definitions, recruitment and training methods for culture brokers, training for health professionals on how to work with brokers, quality assurance standards and mechanisms, and evaluations of process and outcome.

This chapter will look at the practice of cultural mediation and the role of culture broker in medical settings with a focus on the Cultural Consultation Service (CCS) of the Jewish General Hospital and ethnopsychiatric consultation in other settings. First, we examine the concept of culture broker in anthropology and its introduction in medical settings with underserved communities, especially Aboriginal communities and immigrants. Second, we discuss cultural mediation models that have emerged in the last 15 years in Europe, by providing a few examples of implementation and policies, mainly drawing on the models of cultural mediation used by ethnopsychiatric consultation clinics in France and Italy. Finally, we describe the cultural mediation practice of the CCS, providing vignettes that illustrate the roles of culture brokers, ethical issues relating to their participation in clinical settings, and the ways they contribute to cultural formulation and intervention.

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L.J. Kirmayer et al. (eds.), *Cultural Consultation: Encountering the Other in Mental Health Care*, International and Cultural Psychology, DOI 10.1007/978-1-4614-7615-3_6,

Current Anthropological Views of Culture

In recent years, multicultural governances in many parts of the world have increasingly recognized the fact that their diverse populations require specific services that are responsive to their "culture" (Gershon, 2006). The use of culture as a category to conceptualize citizenship rights and services carries both possibilities for recognition of diversity and improved social integration as well as the risk of creating essential identities and "othering" or institutionalized racism.

Since its inception as a discipline, anthropology has focused on culture as a key framework for analysis. Debates in anthropology over the past 25 years regarding the political and epistemological implications of the concept of culture have emphasized the fluidity of cultural entities and have encouraged an interest in hybridity, creolization, and métissage (Abu-Lughod, 1991; Appadurai, 1996; Bibeau, 1997; Clifford & Marcus, 1986; Hannerz, 1992; Marcus, 1992). These debates along with the forces of globalization have led to changes in the notion of culture with increased recognition of people who are situated "in-between" different cultural worldviews and who, therefore, function as cultural mediators or brokers. While earlier studies of culture brokers focused mainly on the analysis of the personal stresses experienced by people required to play the role of mediators, recent studies of tourism and mobile populations have highlighted the impact of culture brokers on cultural formations (Adams, 1997; Amit, 2007; Chambers, 2000).

While collaborations between clinical practitioners and medical anthropologists have increased in recent decades, the interactions between these two domains of knowledge are not without tension (Kleinman, 1987). When anthropological concepts of culture are deployed in clinical settings, they are often reformulated in the language of "cultural expertise," translated in easy-to-use "explanatory models," and hints on how to ensure compliance of specific ethnocultural groups (e.g., "the Sudanese," "the Sri Lankan") as if these were well-defined and homogeneous categories (Kaufert, 1990; Kleinman & Benson, 2006; Taylor, 2003b).

In health care settings, "culture" may be treated as a fixed and unchangeable set of categories to be duly noted in the charts of patients from specific ethnic groups. This use of culture involves three basic assumptions that go against the thrust of current anthropological literature. The first assumption is that only immigrant patients are seen as culture bearers whose actions are ascribed to cultural beliefs that need to be "decoded," while health care providers are system bearers (Gershon, 2006), whose actions are rational, acultural, and based exclusively on medical evidence (Taylor, 2003a). The second assumption is that culture can be treated as a fixed characteristic or "factor" that can be applied in the same way to all people who belong to the same ethnic group (Taylor, 2003a, 2003b). Used in this way, culture becomes essentialized and medicalized (Santiago-Irizarry, 2001). The third assumption is that the word "culture" is useful as a less threatening term to stand in for the real problems of poverty, marginalization, and racism, which are more fundamental social causes of health disparities (Fernando, 2003; Gregg & Saha, 2006). The work of the CCS clearly shows the limitations of these three assumptions: medicine and health care practitioners are also shaped by their own personal and professional cultures; culture is not fixed but fluid and negotiable; and, in addition to justifying social regimes of marginalization and exclusion, culture can constitute important clinical problems in its own right. However, anthropological deconstruction of clinical realities, although providing much needed contextualization and critique, can provoke paralysis in clinicians because of their acute awareness of their biases and limitations, unless it also strives to provide a framework to guide necessary action under conditions of limited resources and continuity uncertainty.

Culture Brokers: Definitions in the Anthropological Literature

While the role of the culture broker has been discussed in health, education, business, museums, tourism, and justice, the concept became

widespread in anthropology in the mid-1950s to describe processes of cultural contact in various contexts of domination, including trade, colonialism, nation-state building, and modernization. Eric Wolf (1956) pioneered the use of the notion of culture broker using the term to elucidate the beginning of the conflictual relationship between Spanish colonial rule and local peasant communities in Mexico. Culture brokers, in this context, are "nation-oriented individuals from the local communities" who "stand guard over the crucial junctures or synapses of relationships which connect the local system to the larger whole" (Wolf, 1956, p. 1075). Soon after, Clifford Geertz identified the Javanese *kijajis*, local Moslem teachers of Java, as the "most important cultural brokers" of post-revolutionary Indonesia (Geertz, 1960, p. 233).

In anthropology, culture brokers were initially defined as go-betweens who mediate and translate two culturally distinct realities or groups for the purpose of reducing conflict or producing a change in the quality of the relationship between them (Geertz, 1960; Jezewski, 1990; Paine, 1971; Press, 1969; Szasz, 1994; Wolf, 1956). Whether in negotiation between tradition and modernity (Geertz, 1960; Wolf, 1956), trade (Paine, 1971) or as a part of social networks in contexts of patronage (Barnes, 1954; Boissevain, 1974; Bott, 1957), the culture broker was depicted both as a mediator and an agent of change (Press, 1969). This initial conception of culture brokers shifted in the 1980s to take into account other categories of individuals or social roles that are "in-between" different social worlds and that are situated or position themselves as mediators and innovators, including tourist guides (Brown, 1992), children of migrants (Abu-Lughod, 1991), and native anthropologists (Narayan, 1993).

To be effective, Eric Wolf suggests that culture brokers must operate like Janus, facing both directions and able to cope with the tensions raised by the conflict of interests (Wolf, 1956). The ability to navigate between different cultural worldviews and social environments provides the culture broker with the possibility to acknowledge different perspectives and to adopt diverging, at times contradictory, behaviors, allowing for the creation of spaces for negotiation between them. Innovations come about through the culture broker's attempts to bridge perspectives by circumventing sociocultural expectations and creating new possible ways of doing things.

In the field of ethnohistory, culture brokers appear mainly as individuals who mediated contacts between indigenous peoples and colonial administrations (Szasz, 1994). Culture brokers were those men and women, native and nonnative, missionaries, teachers, and so forth, who had good knowledge of both languages and who were usually related by birth or marriage to both indigenous and colonizing populations. The list of marginal individuals in more recent contexts includes migrant workers, foreigners, second-generation immigrants, persons of mixed ethnic origin, *parvenus* (upwardly mobile marginals), the *déclassés* (downwardly mobile marginals), migrants from country to city, and women in "nontraditional" roles (Turner, 1974). Of course, marginality alone does not equip an individual to be a culture broker. Culture brokers, as mediators and innovators, "must have their behavior sanctioned in some way by the host community and must maintain some sort of acceptable identity with the community of origin" (Brown, 1992, p. 369).

From Anthropological Concept to Actors in Health Care Settings

Across national settings, practices of culture brokering in health care differ greatly, in terms of background, roles, degree of institutional integration, and level of professional expertise. Categories of individuals who may act as culture brokers include the following: health practitioners, such as social workers, nurses, or psychologists, who can function as culture brokers by virtue of their bilingual/bicultural identity or direct knowledge of a specific community; social scientists, such as anthropologists or sociologists, who may be called upon to act as culture brokers because of their scientific knowledge; or individuals drawn from community groups such as voluntary organizations and religious institutions. Other terms used to refer to persons who are employed in health care institutions to mediate cultural

differences include "patient advocate," "intercultural mediator," and "cultural interpreter."

The roles of culture brokers are defined by localized health care and social systems but are influenced by the dominant models of national integration and regimes of citizenship. For instance, culture brokers were introduced in North American health care settings in the late 1960s, following the recognition of serious inequalities in health care access for underserved ethnoracial groups and, subsequently, for new immigrants. The use of culture brokers needs to be situated in relation to the sociopolitical changes of the late 1960s, which marked a shift from an emphasis on assimilation to a diversity paradigm. Stemming from the battles of the civil rights movement, the diversity paradigm focuses on appreciating and valuing differences between individuals and groups. Multiculturalism policy in Canada is one reflection of this shift toward acknowledging diversity.

Culture brokers are often highly educated immigrant women, and the trajectories of migration have influenced the availability and role of culture brokers (Gentile & Caponio, 2006). For example, Gobbo (2004) provides a portrait of a Roma cultural mediator in Italy whose professional identity allowed her to capitalize on her marginal state of being "between communities." In an article on immigrant health services in France, Sargent and Larchanche (2009) described the different stages of the professionalization of culture brokers through the life history of a woman migrant who started as an interpreter in the mid-1980s. Despite the clear connection between life trajectories and professionalization among culture brokers, in the health care field, culture brokers have been conceptualized less in terms of the knowledge and skills acquired through the experience of migration than as a type of expertise that can be added to already established professions including nurses, social workers, and community interpreters—any of whom might function as a culture broker.

Culture brokers may also be professionals already engaged in health delivery. In the UK, the Nafsiyat model (Kareem, 1992) focused on the psychotherapist as a culture broker and integrated process-oriented supervision of the therapist on issues related to racism and discrimination. As culture broker, the clinician examines the impingements of ethnicity, racism, and the therapist's own ethnoracial identity on clinical assessment and psychotherapeutic process. Cultural mediation through the use of culture brokers has been recommended in the treatment of Black, minority, or ethnic (BME) patients in the UK to address issues of institutional racism (Fernando, 1995, 2002).

Defining the Position and Roles of Culture Brokers in Medical Settings

The ways in which institutions approach cultural difference largely determine the nature and function of culture brokers in health care services. For instance, within the cultural competence model of health care, which is now dominant in the USA, each health care provider must be able to mediate cultural meanings with their patient. This model requires training of practitioners on issues of cultural difference. In the cultural mediation model, more common in European settings, the culture broker is an "expert on culture," whose roles are to facilitate clinical encounters, prevent conflicts, and act as agent of social integration.

Bischoff (2006) distinguishes two approaches to culture brokering based on different ideologies of social integration and power relations. The first approach aims at assimilating the immigrant's point of view to that of the health care system as part of the larger society. The professional or institution decides when to include a culture broker, whose main role is to convey information to patients in order to enhance their adherence to treatment. In this approach, the patient's point of view is rarely taken into account. This one-directional approach often functions as a sort of institutional protection against possible legal repercussions, for example, insuring informed consent for diagnostic procedures or treatment. The second approach involves a more inclusive two-way exchange in which there is a significant level of trust and where the opportunity for each

participant to understand something of the other's point of view is increased by providing real negotiation options and empowerment strategies. In practice, the position of culture brokers is usually situated between these two poles. At the level of working alliance, culture brokers tend to fluctuate between three basic roles: (1) as agents who work for public institutions and professionals, (2) as advocates who represent the interests of the ethnocultural and immigrant communities, and (3) as mediators who take a nonpartisan stance and strive to be "neutral" (Cohen-Emerique, 2004). Through these basic roles, culture brokers have proved to be useful participants in efforts to improve underserved communities' access to health care services and to build mutual trust between ethnocultural communities and health care institutions.

Countries with a longer history of multicultural practices such as the USA, Canada, Australia, United Kingdom, and New Zealand were the first to organize culture broker programs, specifically to reach indigenous groups in Canada and Australia and underserved groups such as Afro-Americans and Latinos in the USA. These interventions provided a way to ease some of the historical mistrust that many racially, ethnically, and culturally diverse minorities have in relation to health care institutions. The risk inherent in this approach is that culture brokers may be perceived as acting on behalf of the dominant culture and therefore falling into the paradigm of domination and marginality. For instance, in colonial and postcolonial settings, indigenous nurses have been trained in Western medical knowledge to act as culture brokers between the traditional healing system and the biomedical one. They have managed to mediate different understanding of illness, yet their professional affiliation pushes them to value the biomedical knowledge over the traditional healing system (Barbee, 1986; 1987; Kahn & Kelly, 2001; Marks, 1997), becoming an instrument of the colonial policy to replace the "indigenous health care systems." The role of culture broker is particular relevant in situations of conflict arising from divergent views of health and healing, which bring to the forefront the incommensurability of cultural values over issues such as informed consent and end-of-life decision making (Kaufert & Koolage, 1984; Kaufert & O'Neil, 1998; Kaufert, Putsch, & Lavallée, 1998).

The Training of Culture Brokers

While informal or ad hoc culture brokers are found in many different milieus, some countries facing persistent gaps in health service access and delivery have made efforts to develop and use formal culture brokers in their health care systems. This has especially been the case for indigenous populations in settler societies. In Australia, for example, Aboriginal health workers (AHWs) have been actively involved in community mental health (Soong, 1983; Trudgen, 2000; Willis, 1999). In remote and rural Aboriginal communities, Aboriginal paraprofessionals act as culture brokers and work in tandem with non-Aboriginal health professionals. Aboriginal community workers have received training through specific programs and certification to work in specific jurisdictions. For example, they may function as community health representatives, mental health workers, or alcohol and addiction program workers. The overarching purpose of the training is to produce paramedical professionals who can promote health education within their communities. Mental health workers, for instance, may be trained specifically to help community members with grieving and loss of relatives and friends through violent death or suicide. In Canada, Aboriginal medical interpreters have been trained to bridge both linguistic and cultural diversity and have received some official recognition (Burgess, Herring, & Young, 1995). Of course, the creation of a new type of paraprofessional raises issues for jurisdiction and collaboration; further, these interdisciplinary teams may fail to work effectively due to a lack of understanding of roles between non-Aboriginal health care professionals and Aboriginal paraprofessionals (Minore & Boone, 2002). This failure may occur because of a lack of preparation among professionals to work with interdisciplinary teams (especially

with paraprofessionals) and a lack of clarity of the duties of the culture broker.

The culture broker approach has proved to be useful in other areas of health care, including nursing (Jezewski, 1990) and social work (Jackson, Graham, & Jackson, 1998 [1995]). Jackson describes the training of Interpreter Cultural Mediators (ICM), bilingual and bicultural people who are familiar both with biomedical practices and American societies and with the cultural practices of the minority group to which they belong. Their training includes basic knowledge of biomedical health care and institutions, with an emphasis on issues of prevention, child-rearing, and pregnancy. Through role-playing, they learn how to communicate with health practitioners and how to review cases. They work as part of a team composed of a nurse supervisor, community advisors, a program administrator, and medical directors, as well as other health and social services employees. Over a period of time, the ICM follows a family or a patient, visiting them at home to explore the family's needs, problems, and strengths, which are presented to the health providers to help develop a common strategy for care. The ICM thus combines cultural mediation with case management.

Culture Brokers in the Field of Mental Health

In mental health care, the term "culture broker" was introduced by medical anthropologist Hazel Weidman (1975) in the development of a community mental health program for the inner-city population in Miami, Florida. The goal of the program was to train participants to adopt a transcultural perspective in the delivery of health care to patients from multiethnic background. The term "culture broker" was adopted to describe an intermediary who worked with therapists from the mainstream culture and clients from a different culture; the broker's roles were to act as a facilitator of negotiation, understanding, and meaning-making. The culture brokers were anthropologists or social scientists who could clarify the needs of the ethnic groups to health professionals and put them in contact with appropriate resources. The relationship between the ethnic group and the health care system was framed as symmetry or equivalence between two cultures. For Weidman, the practice of cultural brokering was an intervention strategy, combining research, training, and service; it substantially affected the service providers, who initiated a process of transformation geared to highlighting issues of cultural difference and health equity (Van Willigen, 2002).

In mental health settings, the key requirement for a culture broker is a thorough "knowledge of mental illness as conceived and perceived by the individual seeking the services as well as by the mainstream culture" (Singh, McKay, & Singh, 1999, p. 5). This requires the ability to understand patients' idioms of distress, as well as cultural dimensions of clinician–patient interaction, including nonverbal communication. The culture broker aims to sensitize the clinical practitioner to the patient's system of belief and also helps the patient understand and trust the health care system or institution. As a go-between, the culture broker makes explicit to both patient and clinician aspects of the cultures of both participants that are relevant to specific health care issues and helps patient and clinician negotiate the hybrid realities that characterize the lives of immigrants and other cultural minorities. Following this perspective, at the CCS, culture brokers often are asked to comment on how a patient's behavior would be perceived and understood and whether it would be considered usual or acceptable in his or her culture or community of origin.

Cultural Mediation in Europe

Although culture brokers are widely employed, they are not yet well integrated into mainstream health care in the USA or in Canada, where their profession remains informal and unregulated. In some European countries, however, culture brokers are increasingly recognized as professionals.

The *cultural/intercultural mediation model*[1] has been adopted in Europe to address the service needs of the growing migrant populations. This model emerged from a situation in which rapid changes in population caught service providers unprepared. Health practitioners soon realized that addressing linguistic barriers through interpreters was not sufficient in clinical situations which involved culture differences (Minervino & Martin, 2007). Culture brokers (or intercultural mediators) became a crucial resource to respond to the resultant "emergency." Starting in the early 1990s, cultural mediation services were set up in Spain and Italy and soon spread across the European Union. These services, which comprise both interpreters and intercultural mediators, are located either in hospitals (Belgium, Sweden, Switzerland) or in outpatient clinics (Italy).

Although there is a wide range of approaches to the implementation of intercultural mediation services across national contexts, there have been efforts within the EU to encourage collaboration and to organize pilot projects for exchange of methods and best practices and the setting of common standards of quality in relation to code of conduct and training (Bischoff, 2003; Molina, Gailly, Gimenez Romero, & Guest, 2001; Krajic et al., 2005). These processes of collaboration and exchange have encouraged the professionalization of cultural mediators, despite cross-national variations in training and curriculum (Pöchhacker, 2008).

[1] In communication studies and related disciplines, many terms have emerged to point to the process of communication between culturally diverse parties, including *cross-cultural*, *intercultural*, and *interdiscourse* communication. Although they often are used as synonyms, they imply distinct concepts of culture. Cross-cultural communication implies that there are distinct cultural groups and looks at their interaction comparatively. Intercultural communication starts from the assumption that there are distinct cultural groups but studies their communicative practices in interaction with each other. Finally, interdiscourse communication sets aside any a priori notion of group membership and identity to investigate how and in what circumstances concepts such as culture are produced. The interdiscourse perspective, therefore, looks at the context of communication and interaction as relational process.

Cultural mediators are often immigrants themselves who have a good grasp of the two systems of reference, but effective work as a culture broker requires training. A project entitled *T-learning to Improve Professional Skills for Intercultural Dialogue* in five European countries (Italy, France, Austria, Greece, Poland) developed training for cultural mediators using new information technologies (Halba, 2009). The curriculum included issues relating to multiculturalism and interculturalism, national and European policies in the field of immigration, and questions relating to the integration for migrants (housing, education and training, access to employment and health). Given the heterogeneity of European health care systems, however, translating good practices into common policy has been difficult.

In recent years, Belgium and Italy have been among the more active countries in the development and employment of cultural mediators in health care settings. In Belgium, implementation started in the field practice and became eventually a national policy program (Verrept, 2008). The government is taking an active role in developing a code of conduct for cultural mediators. In Italy, an immigration law was passed in 1996 in which the "auxiliary" profession of culture broker (*"mediatore culturale"*) was recognized in institutional settings (such as schools, hospitals, mental health services, police offices); as a profession, it is available to immigrants who have taken a vocational training course (Fiorucci, 2007). Despite this law, there is no national program for the participation of *mediatore culturale* in the national health care system. The employment of *mediatore culturale* remains very fragmented, with large variations across regions.

The literature on cultural mediators in Europe indicates that they are mainly employed in obstetrics and gynecology departments. In the general hospital of Liege, Belgium, the cultural mediator provides information and support before and after clinical encounters for the whole duration of the hospitalization (Fossi, 2004; Gentile & Caponio, 2006). A similar approach is taken at several hospitals in Italy. In Bologna, for instance,

the culture broker plays a central role at the Health Centre for Migrant Women and Their Children, founded in 1992 within the structure of the Santa Orsola Hospital. The consultation takes place in several stages. Female cultural mediators welcome the immigrant women, and in a preliminary talk, they elicit the reason for they visit. The mediators stay with the patient during the clinical examination intervening in case of linguistic/cultural misunderstanding. After the clinical encounter, the mediator discusses the visit alone with the patient, providing a space to express questions and concerns.

As an emerging profession, culture brokers face many of the problems encountered by community interpreters, including: difficulty in having their role adequately recognized by other professionals and administrators; the dilemmas of balancing "neutrality" with advocacy; the precariousness of their positions, which are seldom guaranteed continuity and consistent funding; and the lack of psychological support when dealing with challenging cases (Augusti-Panareda, 2006; Minervino & Martin, 2007).

Cultural mediation can contribute to a patient-centered approach in which culture is seen not as a fixed entity but as a process framed and negotiated in the context of the clinical encounter. However, because of power dynamics in the institutional settings that employ them, and often their own social vulnerability as recent migrants themselves, culture brokers tend to align themselves with the institution even when health practitioners may encourage them to align with the patient (Augusti-Panareda, 2006). Another risk is that culture brokers may tend to overemphasize the role of culture in the patient's point of view as a way to reinforce their role as experts on "the patient's culture." As Eric Wolf pointed out, culture brokers strategically use their knowledge and position of "in-between" in order to consolidate their expertise. Finally, the professionalization of the culture broker may mask policies of integration that sustain practices of "othering" by keeping newcomers with professional skills in this marginal role. Considering the immigrant by default, a "cultural other" tends to essentialize diversity and institutionalize racism.

Models of Ethnopsychiatric Consultation and Cultural Mediation

Several types of mental health consultations in Europe which follow an ethnopsychiatric or transcultural psychiatric approach employ cultural mediation as part of their therapeutic practice: in France, for example, at the Centre George Devereux and the Bobigny School at Avicenne Hospital, and in Italy, at the *Centro Frantz Fanon*. In these programs, mediation either may be viewed as a shared and diffused role within a multidisciplinary team group that co-constructs knowledge and practice or can be assigned to a particular person who takes the role of cultural expert; the two approaches can also coexist. The cultural mediation approach also extends outside the medical/therapeutic setting in that the culture broker acts as a liaison between different institutions and the patient and his or her family, in order to promote social and legal dimensions of the patient's well-being.

In the context of multidisciplinary team groups, the culture broker is generally a therapist who undergoes training in clinical psychology and anthropology or who belongs to a minority ethnic background. In these settings, culture is used as a therapeutic lever which, according to the specific consultation model, can be invoked and negotiated to create a space where the immigrant patient's suffering can be voiced and understood.

The Centre George Devereux

The Centre George Devereux was founded by psychologist Tobie Nathan in an attempt to bring together anthropological knowledge with clinical and psychoanalytic thinking (Freeman, 1997; Streit, 1997). Nathan introduced the concept of culture in healing practice, going against the grain of the French ideology of citizenship that is based on the republican value of universality and civic integration in which expressions of culture are downplayed in public and confined to the private sphere (Corin, 1997; Kirmayer & Minas, 2000).

Nathan approaches clinical consultations as moments of intercultural interaction that are played out in a symbolic intrapsychic space. His model has played an influential role in the development of ethnopsychiatry in France and abroad. Ethnopsychiatric consultations conducted by Nathan's team employ a model of large group settings comprised of the leading therapist, the interpreter, and the patient with family members as well as various co-therapists from diverse backgrounds (Nathan, 1994a, 1994b). In this particular setting, culture brokers are co-therapists, who may intervene by explaining how the patient's difficulties are viewed from their own particular cultural group (Zajde, 2011). Critiques of Nathan's work have noted the value of group settings for African immigrants and other groups, while raising questions about the extent to which this approach reifies culture and tradition in ways that may be inconsistent with migrants' experience of hybridity (e.g., Andoche, 2001; Corin, 1997; Fassin & Rechtman, 2005; Sargent & Larchanche, 2009).

At the Centre George Devereux, a group of expert therapists who are trained in anthropology have been called "ethno-clinical mediators." Ethno-clinical mediators are co-therapists who share a similar ethnic background with their patients and participate in the group therapy, taking the lead when needed by providing specific knowledge of a particular healing tradition. Besides his or her role in the group setting, the culture broker is given a proactive liaison role; that is, he or she can see the patient and family alone and may accompany the patient to different administrative and therapeutic appointments. Because the service is not fully covered by the National Health System, it is not accessible to individuals who do not have the means to assume the cost of the service.

The Bobigny School at Avicenne Hospital

The Bobigny School, led by psychiatrist Marie Rose Moro, is a referral medical consultation at the Avicenne Hospital (Sturm, Heidenreich, & Moro, 2008; See also Chapter 4). The consultation is part of the health care system and therefore fully covered by the National Health System. Its aim is to forge liaisons with social services of different kinds (schools, refugee agencies, child protection services, community, or work social services). Moro has integrated Nathan's model of ethnopsychiatry setting within a less prescriptive vision of culture, which considers *métissage* (hybridization) and identity as process-oriented and relational constructions (see Moro & Real, 2006; Sturm et al., 2008; Sturm, Nadig, & Moro, 2011). The consultation works with first- and second-generation immigrants; it offers individual and group setting therapies taking a psychodynamic approach in which the idea is not necessarily to "match" the patient's culture. Moro's approach emphasizes issues of positionality and power, namely, "who has the power to define the client's culture in therapy?" (Sturm et al., 2008). The patient is seen as the expert of his or her own culture. The concept of culture is applied in the therapeutic setting on two different levels: at a cultural-anthropological level in which the patient's emic view is elicited and at a psychoanalytic level through the notion of universal signs.

Therapists are trained in psychology, psychiatry, and anthropology. In the group setting, co-therapists present etiologies from different cultures in order to encourage patients to reflect on etiologies from their own cultural background and create a dynamic point of view. There is no need to have a "specialist" from the patient's culture; instead, the co-therapists play with universal logics of causation (jealousy, magic, sorcery, contagion, possession, etc.). There is always an interpreter in the patient's mother tongue, who may at times be asked to give some culture-specific inputs. Rather than resting on a prescriptive notion of culture, as is the case with Nathan's approach, "culture" becomes a tool that can be shared by the team with the input of all team members.

The Centro Frantz Fanon

In Italy, the *Centro Frantz Fanon* in Turin, headed by Roberto Beneduce, was the first center in Italy to develop an ethnopsychotherapy intervention strategy based on cultural mediation and an ethnopsychiatric approach to mental illness

(Giordano, 2011). The *Centro* is a psychosocial and psychotherapeutic institute associated with the Turin Local National Health Service Zone and receives funding from diverse institutions (province, local government, European Union), which give social, psychological, and psychiatric assistance to immigrants. The center offers referral consultations and therapies to both regular and irregular (or "illegal") immigrants without distinction according to their status, as well as provides training courses for various health practitioners and social workers who work with immigrants. Specifically, the center aims to train cultural mediators, who in the Italian context are immigrants themselves. The center's therapeutic and political stance draws from three main influences: Tobie Nathan's French ethnopsychiatric tradition, Franz Fanon's critique of colonial relations and their entrenchment in identity formation, and the Italian tradition of social psychiatry linked to the deinstitutionalization movement of the 1970s (Giordano, 2006, 2011; Pandolfi & Bibeau, 2006). The *Psichiatria Democratica* (Democratic Psychiatry) Movement led by psychiatrist Franco Basaglia showed how social, economic, and political variables are intrinsic to the construction of the mentally ill and to their "confinement" within mental institutions. This movement focused on the subjective experience of the mentally ill and aimed to close mental institutions. It led to Law 180, passed in 1978, that sanctioned the closing down of the asylums and brought about the organization of community mental health services.

From its inception in 1996, the *Centro Frantz Fanon* had among its founders psychiatrists, psychologists, medical anthropologists, and culture mediators who had previously worked together in a project on migrants' health (Beneduce, Costa, & Favretto, 1994). The cultural mediation model is organized around a multidisciplinary group setting where diverse expertise, including that of the patient, is taken into account. Each participant in the therapeutic encounter is engaged in a form of mediation with therapeutic effect. In this setting, the role of the culture mediator is fundamental in translating from one etiological system to another. The center aims to provide a clinical space for mediation and therapy and acts as a liaison with other institutions outside the clinic.

Consultations take place in either individual or group settings. When appropriate from a linguistic and/or cultural perspective, cultural mediators participate in therapy sessions and are active in the consultation process. During the consultation, the cultural mediator is given room to freely engage with patients in order to elicit their life histories in a way that allows them to use to different vocabularies and etiologies, rather than conforming to the hegemonic discourse of psychiatric diagnostic criteria (Giordano, 2008). Further, the roles of cultural mediator extend beyond the clinical setting; there are instances in which the cultural mediator interacts on behalf of the patient with institutional services on matters of housing and immigration or plays a pedagogical role in cultural mediation training. In this work, the cultural mediator must translate between different cultural materials and work with the epistemological uncertainty and conflicts that characterize the immigrant experience. Cultural mediators must to be aware of their own migratory experience in order to grasp the stakes of intercultural communicative experiences. They must manage the difficult transference at play in the encounter with other immigrants and Italian mental health practitioners/or ethnopsychiatrists (Beneduce, 1999).

The Cultural Consultation Service Experience

In contrast with the European settings, in Canada, while professional associations for psychiatry and psychology have embraced the cultural competence model, there are no national guidelines for the use of culture brokers or mediators in mental health care settings. Clinicians who wish to work with culture brokers must draw them from immigrant or indigenous community members and professionals with expertise about specific patient cultures. There is no formal training for culture brokers. There also is a lack of policy, ethical guidelines, professional standards, or mechanisms for training, assessing, and

monitoring the quality of culture brokers in Canada (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003; Ng, Popova, Yau, & Sulman, 2007).

The CCS is one of several Canadian services where culture brokers are extensively used. The CCS has a pool of about 70 culture brokers who are employed on a case-by-case basis. They are often health professionals (mainly psychologists and social workers) who share a similar ethnic background with the patient or, less often, anthropologists with specialized knowledge of a particular geographic region or ethnic group. Culture brokers are identified by members of the CCS team. They are provided with a manual that outlines their tasks and provides an outline for the cultural formulation to organize their information gathering and reporting (Chapter 3).

About 50 % of cases seen by CCS employ a culture broker (see Chapter 2). In some instances, the consultant psychiatrist, who shares ethnocultural knowledge or background with the patient, plays this role. In other cases, the interpreter also acts as culture broker, while in about 15 % of cases, a separate culture broker is employed in addition to the interpreter. The CCS culture broker database contains a list of psychologists who are bilingual, psychiatrists, social workers, and community workers operating in the Greater Montreal area, as well as anthropologists and sociologists who are selected on the basis of their knowledge not only of migrants' cultures of origin but also of their local communities.

The CCS Process and Setting

A typical consultation at the CCS, involving a culture broker, takes place in three stages: initial intake when the need for a culture broker may be identified; one or more clinical interviews with the patient and their family which may include a CCS consultant psychiatrist, a culture broker, students, other clinicians, or case managers (social worker, psychologist, or family doctor); and a case conference during which the CSS team, including the culture broker, discusses the case to provide a response to the referring clinician's original requests and develop recommendations, treatment plan, or guidance for the patient's future care (see Chapter 3 for more detail).

Typically, the CCS clinician briefs the cultural broker prior to the first interview. Culture brokers may also consult the patient's medical file at the CCS office. This file includes the intake form with basic demographic information and reasons for referral as well as any medical reports that have been received and, in some cases, the patient's migration documents, such as the Personal Identification Form in which refugee claimants write up their story and the justification for their refugee claim (see Chapter 12).

Although the CCS clinician leads the interview, culture brokers have some freedom to intervene during the process. Most often, the culture broker will ask further questions or will pursue a line of questioning aimed at clarifying specific issues of culture and sociohistorical context. The culture broker's interventions in the interview process may also involve attempts to clarify the situation for patients and make them more comfortable. Similarly, interventions on the part of the cultural broker may also be oriented toward the bringing the CCS psychiatrist and the other case workers toward a better understanding of the patient's experience. For example, adolescent or young adult patients may use trendy urban expressions that may be misinterpreted as indicating pathology. In order to prevent or resolve miscommunication, the culture broker will verify the meaning of ambiguous expressions with the patient and then explain the meaning to the clinical team. Similarly, the culture broker may reframe questions that are likely to seem senseless to patients or suggest alternatives to address the basic clinical question. For example, instead of asking a depressed African single mother explicitly whether she is "able to care for her child," the culture broker may suggest an exploration assessment of other behavioral symptoms that may interfere with care giving such as difficulty sleeping, weakness, fatigue, or other somatic symptoms.

After each clinical interview with the patient, the CCS clinician debriefs the culture broker, discussing issues related both to relevant psychiatric

conditions and sociocultural contexts. They discuss a tentative diagnosis, the stressors involved in the patient's situation, and issues that need to be verified or broached with the patient or others during additional clinical interviews. At this time, the culture broker may provide a first interpretation of the contextual elements that may be significant to understanding the patient's predicament. These elements may relate to political dynamics in the country of origin (including war, ethnic tensions, forms of public oppression, dictatorship); the history of colonization; the racialization of social relations in the country of origin and in the post-migration context of Montréal; religious beliefs and practices relevant to the country of origin; issues relating to gender, age, and social class; and so forth. Elements relating to the experience of migrants of similar origin may also be highlighted by the culture broker. The culture broker may offer a tentative analysis of the significance of the cultural idioms employed by the patient to express his or her predicament and distress. For instance, in some cases seen at the CCS involving patients of African origin, patients use idioms that refer to contemporary expressions of witchcraft, such as "feeling the wind pass," "having something eat at one's stomach," and "hearing the voice" of someone. The culture broker may raise these issues and suggest that they be explored further in a second interview. In the meantime, culture brokers, particularly those that are trained as social scientists, may review the relevant anthropological, sociological, or political literature, especially in cases where they are familiar with the region where the patient comes from but not with the exact ethnocultural group, village, or with recent political events.

The second clinical interview, when needed, follows a similar sequence to the first one. However, in some cases, the culture broker may take more of a lead in the interview process. The second interview may focus more on aspects of the patient's life trajectory that do not directly relate to the moment of migration, such as his or her life context before migration, plans for the future in Canada, as well as local and transnational family and social networks. In some instances, the culture broker may see a need for further interviewing to clarify specific issues, and this can be negotiated with the CCS clinician.

In the cultural consultation process, culture brokers may assume varying degrees of initiative: acting as silent observers, intervening in the interview process, or even conducting their own interviews. The appropriate role depends on the complexity of the clinical situation, the culture broker's relationship to the patient's culture of origin (as a professional expert or as someone with the same background), and the familiarity of the consultation team with the patient's sociocultural context.

Roles Played by Culture Brokers at the CCS

Many CCS clinical encounters use both interpreters and culture brokers; in some cases, the primary clinical consultant acts as a culture broker or interpreter (see Chapter 8); in still other cases, the culture broker also acts as an interpreter. However, the specific tasks of culture brokers are complementary to those of the medical interpreter. As opposed to the interpreter, who is present just for the clinical interviews, the culture broker usually is involved at several points in the assessment process and may come to know the case in depth. Thus, the culture broker may initiate questions directed to the patient, as well as to clinical case workers and family members, if present. If the patient is in the care of a multidisciplinary team, the culture broker acts as an advisor to the team members, the patient, and the family.

In addition to participating in the data collection phase of clinical assessment, the culture broker prepares a cultural formulation report, which informs the final clinical summary and recommendations given to the referring clinician. The culture broker also provides cultural input at the CCS clinical case conferences where relevant issues are discussed by members of the CCS and referring teams, who may pose additional questions to the culture broker.

The written report provided by the culture broker and presented during the case conference follows the outline for the cultural formulation developed originally for DSM-IV. The CCS uses

an expanded version of the DSM-IV Outline for Cultural Formulation (Chapter 3). Although not all culture brokers at the CCS are initially familiar with the cultural formulation format, they are asked to follow it, and most find it provides an easy way to organize information that helps situate the patient in relation to both their cultures of origin and the host culture (Kirmayer, Rousseau & Lashley 2007). The cultural formulation includes attention to the clinician–patient relationship, which should include the culture broker's own relationship to clinician and patients. However, culture brokers tend not to write about the interpersonal and intercultural dynamics of the clinical encounters, perhaps because these require specific psychodynamic and systemic training to observe. Also, process observations may be awkward to document because they may pose challenges to the professionals involved (Dinh, Groleau, Kirmayer, Rodriguez, & Bibeau, 2012).

To a large extent, the mediating functions of culture brokers at the CCS involve three main tasks. First, culture brokers aim to make sense of the different narratives relevant to the patient's predicament in the context of the clinical interviews, during the case conference, and through their reports. These narratives include the stories told in the setting of the clinical interviews, which involve patients' illness experience, life trajectories, traumas, and migration history. Case workers or others present during the evaluation also supply narratives that require cultural interpretation, and there usually are also written narratives contained within official documents such as the PIF, medical records, and reports provided by the professionals. A second basic task of culture brokers is to clarify aspects of the health care system, migration process, work, and other social matters for patients and their family members. This may include administrative and practical issues. In some cases, for example, patients have difficulty navigating the administrative structures of government institutions or are confronted by challenges related to their migration status that require specific knowledge about the Quebec and Canadian context. Finally, culture brokers may be involved in negotiation of divergent viewpoints or conflicts between the patient and health care providers. In many cases, this is framed as an opposition between a biomedical interpretation and particular cultural interpretations.

To illustrate the tasks performed by culture brokers at the CCS, we present several brief case vignettes. These cases illustrate the ways in which culture brokers can influence the clinical encounter to bring to the surface issues and dynamics not readily accessible to or easily understood by the clinician.

The process of making sense of the multiple narratives that surround a patient's predicament or ailment is often the first challenge for the CCS consultant. The case of a young woman from Nigeria, who had migrated to Canada on her own, illustrates clearly how the culture broker provided the patient's treatment team a radically different view of the patient's predicament.

Case Vignette 6-1

The CCS was called for an emergency consultation at an outpatient maternity clinic. The staff were seriously considering the separation of a newborn baby from her mother. Child protection services had been involved in the dossier. According to the treatment team and the woman's social worker, the woman did not show appropriate attachment to the baby, and they interpreted this as a response to the fact that the child was the result of a multiple rape in Nigeria. According to the maternity clinic staff, the first signs of "non-attachment" started to appear during prenatal care, when they found the patient was not adequately preparing for the arrival of her baby by purchasing baby clothes, furniture, and other items. As well, she missed many clinic appointments. After the child was born, they closely scrutinized her maternal behavior and found many problems, including that she was not following written instructions on how to take care of the baby and displayed aggressive behavior toward the staff. In one instance, they found the baby unattended and with a blanket over her head.

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These and other signs of apparent neglect made them believe that the mother was not fit to keep her child. There was concern that the mother had an intellectual disability as well as possible psychotic symptoms. Before removing the infant from the mother, they called for an emergency CCS consult. The culture broker, an anthropologist with long research experience in West Africa, attended the consultation interview along with a CCS psychiatrist.

It was apparent from the beginning of the conversation that the young mother was not speaking standard English, but a West African Pidgin. This linguistic difference could account for her difficulty following instructions and her perceived lack of intelligence. As the interview proceeded, the woman disclosed for the first time that she was not able to read and was therefore unable to follow the instructions given to her. She also explained to the culture broker and the consultant psychiatrist that her baby was a gift from God. She had epilepsy and had been ostracized as a youth in Nigeria by both her family and the larger community. She thought that she would never marry, still less have a child. In this conversation, it became clear that her interpretation of her pregnancy was framed in relation to her experience of epilepsy, in contrast to the impression of the treatment team who saw it only in relation to the enduring trauma of the rape that resulted in her pregnancy.

The culture broker pointed out that the mother's aggressive behavior could be understood as a defensive strategy against the perceived threat of the staff. Moreover, for many Nigerian women, especially highly religious individuals like the patient, preparing a nursery and buying clothes and items for an unborn baby are considered to be "presumptuous" and potentially dangerous, as it is likely to bring about bad luck, even the death of the baby. Therefore, "nesting" in preparation for childbirth as it is commonly understood and practiced in North American contexts is to be avoided. The information provided by the culture broker was essential to avoid a potentially catastrophic intervention: separating mother and baby based on an incorrect assessment of her maternal capacity.

In the work of the CCS, both during clinical interviews and during case conference discussions, the culture broker provides insights into the clinical encounter by highlighting the macro-social dynamics of the patient's case, moving from the individual to interpersonal and sociocultural levels. The culture broker emphasizes social and historical dynamics that may help the clinician understand the patient's life trajectory and current predicament, such as the changing role of family dynamics, the patient's migration experiences, religion, and social, economic, and political contexts of the country of origin. Ideally, the culture broker also supplies cultural context for understanding "idioms of distress," to help differentiate normative cultural and linguistic modes of expressing distress from psychiatric signs or symptoms. This specific cultural knowledge adds clinically important information about the patient's lived experience that goes well beyond cultural stereotypes. This task requires a capacity to articulate the patient's shifting (sometimes inconsistent or conflicting) narratives while considering multiple, relevant frames of interpretation. This includes taking into account the impact of the different sites or settings where patients' narrate their experience. Successful culture brokering depends on the capacity to move beyond a culturalist perspective that tends to offer a stereotyped view of patients as exemplars of their "cultures of origin," while reducing the culture to a series of cultural traits. It also requires avoiding the trap of opposing cultural interpretations to a biomedical model. For many patients, these regimes of interpretation are not mutually exclusive.

A further case, in which the tension between cultural and biomedical idioms of distress played out differently, highlights the intricate tasks of cultural brokering.

Case Vignette 6-2

A young man from Rwanda was referred to the CCS by his social worker because the patient's claim for refugee status had been refused and he was entirely passive in proceeding to apply for legal status in Canada on humanitarian and compassionate grounds. In this case, the culture broker was an anthropologist with knowledge of contemporary African societies and the African migrant communities in Montreal.

At the time of the CCS assessment, the young man was living at a shelter for the homeless. However, he arrived for the interviews properly dressed and clean and was clear and articulate in his speech. Despite being homeless, he managed to organize his life by setting up a system to receive phone calls and renting locker space where he kept his belongings. The most striking aspect of his account was his emphasis on religion, more specifically his reliance on Jesus, to make sense of his situation. He stated that his will was being tested by Jesus. He had to accept this religious trial and wait for a sign from Jesus before taking steps to try to get work and complete the appropriate papers to advance his application for status in Canada on humanitarian grounds. This strong reliance on spiritual idioms and reasons for inaction was in tension with his legal and economic situation, which both demanded quick and decisive action.

After the first clinical interview, during a discussion of the case with the CCS consulting psychiatrist and the social worker, the culture broker proposed that, despite the high likelihood that there was a component of mental illness, with either a psychotic or post-traumatic syndrome, it might help the clinical alliance and the assessment process to accept the patient's worldview and to frame the interaction during the second interview in terms of the patient's religious interpretation. By doing so, the culture broker hoped to clarify whether the patient's homeless lifestyle and his strong spiritual beliefs (which, in themselves, were not so unusual for a young man from Rwanda) were culture-based ways of coping with the trauma of the Rwandan genocide and his current predicament in Canada or whether his passivity simply was due to psychiatric illness. In fact, in African cities, many young adults who are students at colleges or university, which had been the case of the patient, live in conditions that are similar to those at the homeless shelter: sharing a room with other students; not having private space to leave one's belonging; spending much time outside of one's room; needing to be autonomous to arrange for food, communication, and laundry; and so forth. Further, as is the case of a number of contemporary African societies, Rwanda has experienced a significant wave of religious revival over the past 30 years, with great impact on the religiosity of young Africans. The second interview, in which the culture broker played an active role, posing numerous questions and entering into direct dialogue with the patient, focused on the patient's capacity to project himself outside of his state of inertia by asking, for instance, what could constitute a sign from Jesus? Had Jesus given him a sign already? Could someone, such as a pastor, help Jesus give him the sign he needed to take action? In the course of this conversation, the delusional nature of the patient's thinking became more clearly apparent.

In this case, rather than reframing the patient's experience within the expected discourses of biomedicine and modernity, the culture broker validated the patient's frame of reference, hoping that this might find common ground for mutual understanding between the patient, the CCS psychiatrist, and the social worker. However, in this case, the cultural "acceptability" of the patient's established lifestyle and intense spiritual experience did not emerge in the discussion, and the patient's illness became more explicit.

Although the aim of culture brokering is to create shared understanding or a "fused horizon" in interpretive frames, the culture broker's interventions may also make the differences between actors' points of view more stark and obvious. The case of a young woman from Haiti illustrates how the culture broker may bring issues into the open in the clinical interview and, at times, "force" patients and others present to confront the potential contradictions between divergent accounts and interpretations that play a part in the patient's life situation.

Case Vignette 6-3

A migration lawyer, puzzled by the behavior of his client, a young Haitian woman who was facing deportation but refused any contacts with her family and any legal actions to prevent the deportation, contacted the CCS for a consultation. The patient did not seem to be aware of the gravity of her predicament. At the consultation, the psychiatrist soon recognized that the young woman suffered from psychosis, most likely schizophrenia, which had remained undetected for a long time both by the legal system and by her family. She was in need of further psychiatric assessment and care. However, the young woman was very resistant to her lawyer's request to contact her family. Both the psychiatrist and the lawyer hoped that the culture broker could encourage the patient to allow them to contact her family and to receive treatment.

The culture broker, a middle-aged woman from Haiti, tried to establish a rapport with the patient, by speaking Kreyol and asking a series of culturally appropriate questions, but the young woman did not speak Kreyol and did not respond to this effort. The culture broker creatively followed the cultural formulation template of the CCS inquiring about the patient's migration trajectories, her contacts with her host country, and whether she maintained links with Haitian culture. She inquired about religion and Vodoun. However, the young woman did not provide any details on these matters, and as a consequence, the culture broker started to be visibly uneasy, as she failed to establish a connection by mentioning various cultural themes and practices.

At one point during the consultation, the culture broker got up, walked up to the client telling her to get up as well. Raising her voice, the culture broker reached out, shaking her hands at the level of the patient's shoulders, and spoke in an animated manner, almost shouting. There was a striking shift in register from modulated professional talk to a sort of colloquial and authoritarian speech. The culture broker started to speak in a style of French incorporating Haitian expressions, diction, and rhythm:

"We are not working for Canadian Immigration. Canada does not give a damn about you [*s'en fiche de toi*]," she said. "It is not important to us if you committed those crimes, but you need to allow us to help you. Do you know what Haiti does to criminals, my daughter?" she asked, closing her fists and moving both arms in a gesture of emphasis.

"No," replied the patient, staring at her.

"You will be put in prison. It is nothing like here. Prisons there are filthy, dark and crowded. You will sleep on the floor, no bed, and you cannot complain. They don't give you food. You need someone from outside who brings you food, and your family is here in Canada. And when they will eventually release you, no one will want anything to do with you, you will become a pariah. In their eyes, you had a chance to go to a rich country and you messed up. You could not regulate your own behavior…."

For a moment, the young woman seemed to have appreciated the seriousness of her situation. She asked for a lawyer, agreed to contact her family, and asked for a phone.

Through intonation, choice of words, and bodily posture, the culture broker enacted tacit knowledge (Gadamer, 1987) that she shared with the patient, despite the patient's long detachment from Haiti and her fragmented perception of reality. This conveyed the urgency of the situation, and the patient responded with more appropriate and adaptive behavior.

The culture broker herself was surprised by her action. As she later recounted, "I had the feeling I had to shake her. She was not there. I was not sure she was coming back to reality." In the first part of her intervention, she stated: "We are not working for Immigration Canada… we are here to help you." She marked her allegiance to her, in an attempt to create a space for trust. She then posed the heavily laden question: "Do you know what Haiti does to criminals, my daughter?" In asking this question, she referred to Haiti as powerful authority in relation to the highly stigmatized word "criminals," setting the context for the crude and frightening images that followed. At the same time, by adding the kin term "my daughter" at the end of the question, the culture broker invoked a frame of caring in which she identified her position as mother, which allowed her to adopt this scolding tone.

The literature on culture brokers in other contexts has shown how culture brokers very often act as normative agents of the hegemonic culture, reenacting essentialized traces of the "cultural other." The culture broker in this particular clinical encounter tried to appeal to this essentialized version of Haitian identity, only to realize that for the patient, the Canadian frame of reference was much stronger than that of her distant "home country." Yet, she was able to reach the patient, despite her fragmented reality, by invoking a style of communication and tacit cultural knowledge through a combination of body language, tone, choice of words, and images. While the lawyer and psychiatrist were constrained by an institutional morality and ethics of care rooted in their respective professional codes and discourses, the culture broker was able to provide a more intermediate or transitional space where communication could occur.

Despite such moments of successful communication, the task of mediating between differing and at times contradictory worldviews remains challenging. The success of brokering depends on the culture broker's capacity to render divergent regimes of interpretation meaningful and acceptable to the participants in the clinical encounter.

Case Vignette 6-4[2]

A 45-year-old man from a rural province of China was hospitalized for multiple self-inflicted injuries including an attempt to amputate his left hand. He explained his actions as the result of following instructions given by "celestial entities," who also demanded that he make food offerings to them, which he did by depriving himself of his own food. The patient, who did not respond to antipsychotic medication or electroconvulsive treatment, was referred to the CCS by the inpatient treatment staff who wondered whether the man's psychosis could be framed in the context of his culture of origin.

At the CCS clinical conference, which was attended by the inpatient treatment staff, the CCS psychiatrist, and the culture broker, marked differences in systems of knowledge about illness became apparent. After a short introduction and update on the state of the patient, who was still hospitalized and not responding to treatment by the inpatient staff, the culture broker, a Southeast Asian specialist, questioned out loud, "Could it be demonic possession? I am wondering whether an exorcism can help him?" The referring inpatient staff met these questions with stunned silence and the case conference came to an awkward end.

Here two different worldviews clashed, and communication could not resume. On one side was the culture broker, who did not provide a con-

[2] This case is discussed in further detail in Chapter 14 (Vignette 14-9).

text for his questions and did not clarify the meanings of possession in East Asian cultures. For the culture broker, spirit possession had a symbolic valence related to a wider set of meanings and practices, including the importance of maintaining good relations with the ancestors by food offerings. However, in introducing a point of view so different from the biomedical perspective, the culture broker did not appreciate the impact on the clinicians. For the inpatient treatment staff, the language of spirits and possession was far outside their usual conceptual frameworks and provoked defensiveness and withdrawal. The CCS consultation report which was sent afterward to the referring clinician provided a lengthy account of the missing context needed to frame the "spirit possession" interpretation and how it might be used as a strategy to work with the patient in negotiating his treatment. The offering of food to the spirits and ancestors is a common practice in Southeast Asia. If an ancestor was not properly buried and did not receive the appropriate offerings of clothing and incense and has no descendents taking care of their tomb, their spirit may become a "hungry ghost." This is the cultural context the culture broker failed to provide in her intervention. The CCS report suggested that the inpatient treatment staff negotiate with the patient to make an offering of food and investigate further whether the patient would like this offering to be "officiated" by a religious leader. This strategy was meant to engage with the patient in finding a way through which he could eventually reduce or eliminate the troubling voices.

In the case of a young woman from Morocco, the culture broker managed to bring two initially opposed sets of values together by herself typifying such an amalgamation.

Case Vignette 6-5

The young woman, who had recently immigrated to Canada from Morocco with her family, experienced a clash of cultural values between family and the new society. Her family firmly opposed her relationship with a boy she met at school. The conflict between parents and daughter escalated, and she decided to move out from her parents' house and live with her boyfriend. Soon after the move, she started to have suicidal ideation and felt guilty about having betrayed her family and her own culture. In an attempt to address the conflict, a family meeting was scheduled at the CCS in which a culture broker took part.

The culture broker, a young North African woman, spent time with the family alone in order to identify their concerns and then with the young girl, voicing the reasons and fears of both sides. Through her behavior and interaction with the family, the culture broker managed to be perceived by both parties as a successful example of how it is possible to combine traditional values with adopted ones. In negotiating between the two parties, she cautiously introduced to the girl the importance of respecting the family hierarchy while helping the parents to adopt a more flexible position vis-à-vis the expectations they had for their daughter in a new society. As a successful example of bicultural identity, the culture broker's presence was reassuring to both the parents and daughter and allowed dialogue to be reestablished.

Strengths and Limits of the Culture Broker's Position

These cases illustrate some of the rich potential and complexities of the position of culture brokers in the clinical encounter. Culture brokers may be seen as sharing a common cultural identity with patients, as agents of the health care institution, or as external experts with specific status and affiliations in the ethnocultural community. Their identity and role raises sensitive issues around the power dynamics of the CCS and its cultural consultative process.

Earlier, we referred to Alexander Bischoff's (2006) classification, which highlights two distinct approaches to cultural brokering: an approach that

aims to help the patient assimilate the health care provider's perspective and adapt to the dominant society and an alternative approach that aims for a more inclusive, two-way exchange, in which the cultural broker acts as a mediator and provides a framework for the construction of common ground. The cases discussed here show the ways in which the CCS cultural broker are encouraged to engage in two-way exchanges, which at times becomes a process of advocacy and, at times, a primary intervention. The cases of the young Haitian woman, the new mother from Nigeria, and the young man from Rwanda exemplify the inclusive process of two-way exchange.

To the extent that the culture broker is initiating interventions and changing the dynamics of the clinical interaction, these cases raise important ethical issues. At present, there are few professional guidelines governing this work, and the medicolegal responsibility for the quality of care rests with the treating clinician and the CCS psychiatrist. The CCS relies on a group of culture brokers who have been vetted and trained through the process of collaboration on the service. Over time, the skills, areas of competence, and limitations of specific brokers become clear to the CCS clinicians, and they may be given greater autonomy in the assessment process. New culture brokers, however, are monitored closely and sometimes are found to lack crucial skills or to express biases that impede the clinical process. All culture broker interventions are done with the approval and supervision of the CCS psychiatrist. The CCS consultant supervises the culture broker's work and intervenes whenever there is any question or concern about whether their actions are clinically appropriate and helpful.

This is illustrated by action of the consultant psychiatrist in a consultation with a family from Kosovo. A culture broker originally from the former Yugoslavia also acted as interpreter in a consultation with the family. At one point, in translating the psychiatrist's questions, the culture broker spoke at length in a harsh tone of voice. The psychiatrist felt on edge when he saw the family react with fearful expressions to the translation of his very neutral questions. He decided to intervene by continuing the consultation without the culture broker, using French as medium, which the family members could partially master.

There are other instances in which the culture broker attempts to take over the role of the clinician. For example, a middle-aged man from Sri Lanka suffering from PTSD was referred to the CCS for an assessment in order to strengthen the therapeutic alliance with his physician. At the CCS, he was seen by a young female psychiatrist of South Asian origin along with a male culture broker who had practiced medicine in Sri Lanka but, on immigrating to Canada, could not get relicensed as a physician and became a medical technician. In the course of the CCS interview, the culture broker who shared with the patient's ethnic and religious background simply took over the consultation and silenced the psychiatrist. This behavior can be understood as an expression of the culture broker's own efforts to save face in front of his countryman because of the embarrassment of having a much younger female, professional in charge of the consultation. However, it had the effect of undermining the assessment process.

To some extent, all of the cases presented here raise issues of positionality at a second level in terms of the articulation between the roles of the culture broker and his or her own identity. The CCS employs two types of culture brokers who are called upon because of their cultural affinity with referred patients: (1) bilingual or bicultural clinicians who usually work in local medical or social service institutions; (2) non-health care professionals, including anthropologists or lay people from the community, who are recognized for their expertise on a specific sociocultural context, group or geographic region. Both types of culture brokers have strengths and weaknesses in their practice at the CCS. The differences between these two types of culture brokers are reminiscent of the debate in the 1980s and 1990s on "native anthropologists," that is, anthropologists studying their own people. These debates were structured around the epistemological advantages of "insider" and "outsider" anthropologists, where "native anthropologists" were often seen as having access to privileged knowledge due to their "natural" ties with the cultural context studied. This advantage seems to

have been the case in the clinical encounter that involved the young Haitian patient and a culture broker of Haitian origin. While the culture broker assumed a shared Kreyol and Haitian cultural understanding that did not exist between her and the patient, they nevertheless found a common ground through using a culturally distinctive style of communication. On the other hand, in the cases involving the Kosovar family and the Sri Lankan patient, the apparent cultural proximity between the patient and the culture broker did not necessarily bring about a mediated understanding of the patient's predicament, albeit for different reasons. In fact, in these clinical encounters, the cultural proximity between the culture broker and the patients resulted in interpersonal dynamics that were not helpful to the cultural consultation process.

As these examples make clear, gender, education, social class, and other key markers of identity may emerge as crucial elements in the relationship between the culture broker and the patient. Indeed, an external culture broker who does not share an identity with the patient (e.g., a social scientist with knowledge of the culture) may have a more "objective" standpoint. However, the relevance of such a standpoint depends on the specific culture broker's personal style of communication and skill in the clinical encounter.

Clearly, successful culture brokering depends on brokers' critical awareness of their own culture and social positioning and sensitivity to interpersonal and social context. This may emerge out of a shared cultural background or from recognized expertise but requires the additional ability to recognize, tolerate, and mediate between diverging regimes of interpretation. As illustrated by the cases discussed here, successful cultural brokering is not built on cultural stereotypes. Grasping a patient's predicament requires more than an essentialized vision of his or her culture of origin; it implies that the patient's life trajectory be understood in the relevant historical, social, political, and economic frameworks.

Ultimately, the success of culture brokering may also depend on structural conditions that extend beyond the competences of individual culture brokers. While the clinical team at the CCS is concerned to integrate sociocultural context, biomedical and psychiatric knowledge remains central to the consultant's task. When there is uncertainty about a patient's medical and psychiatric condition, biomedical understanding of symptoms and illness experience is prioritized. In these cases, the initial clinical interview necessarily focuses on gathering information related to the patient's symptoms, mental status, medical and psychiatric history, and medication. Information related to the patient's legal situation in Canada, migration history, family history, and so forth are obtained next. Much of the work of culture brokers at the CCS is to convey information about relevant dynamics in patients' countries of origin or to provide a meaningful paraphrase of a patient's idioms of distress to the CCS clinical and treating teams. While in some cases, culture brokers establish some form of interpersonal tie with patients, the fact that the consultation usually is limited to two interviews limits culture brokers' capacity to play a more significant role in the patient's ongoing care.

Conclusion

Culture brokers are essential to the process of assessment and clinical negotiation at the CCS. The CCS experience in working with culture brokers has implications for their selection, training, evaluation, and regulation. In general, culture brokers must be carefully chosen for their interpersonal and communication skills. They should have a basic understanding of mental health issues in both sociocultural milieus (i.e., the patient's place of origin and the local context in which they currently live and receive care). Clinicians also need to learn work collaboratively with culture brokers. Before the first clinical interviews, a discussion between the CCS consulting psychiatrist (or the CCS resident) and the culture broker on the case is essential to establish common goals and plan a rough agenda and trajectory for the interview. It is important that culture brokers understand their own role within the clinical team.

While the culture broker should play an active part in the interview process, he or she should not take over the clinical encounter unless there is an explicit reason that warrants a more active role. In cases where the culture broker oversteps the bounds of their role, the clinician may need to intervene during the interview, especially when the culture broker's attitude or behavior is likely to jeopardize the clinical alliance.

Although the CCS currently recruits, trains, and evaluates culture brokers through ongoing consultation work, there is a need for formal training, assessment, and certification. Culture brokers should be trained systematically and evaluated periodically to maintain their certification. Training and assessment can build on the expertise of experienced cultural consultants, clinicians, and culture brokers who have managed to develop their skills through apprenticeship. In practice, it may be difficult to formally train a group of culture brokers adequate to address all clinical needs, because certain cultural knowledge and skills may be needed only occasionally, especially in settings with a great diversity of patients. Training clinicians to accept the expertise of culture broker and acknowledge their therapeutic role is also a challenge. Finally, there is a need for further research on effective mediation to inform the development of this essential adjunct to intercultural clinical work.

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