Multiple Ways of Looking:

Learning from The Experience of Montréal's Transcultural Seminars to Foster Cultural Safety in Youth Mental Health Services

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May 2021

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of Doctor of Philosophy in Psychiatry (Social and Transcultural)

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Abstract

In youth mental health services, practitioners are increasingly confronted with complex intercultural situations that require adjustments to their interventions. This may cause feelings of powerlessness and frustration, provoke defensive reactions, and negatively affect the quality of their work. To address this concern, the training of professionals is commonly cited as a solution, but often without unpacking what such initiatives entail and require. This thesis reports on findings from a qualitative study carried out on one such initiative: Montréal's Transcultural Interdisciplinary and Interinstitutional Case Discussion Seminars.

This study's objective was twofold: (1) to explore the lived experience of Transcultural Seminar participants; and (2) to examine the conditions and processes during Seminar meetings that contribute to improved intercultural competence. Over a five-year period of fieldwork (2013-2018), participant-observation of Transcultural Seminars was realized (61 meetings were audio-recorded), along with six focus groups and 26 semi-structured individual interviews. The data was analyzed qualitatively using thematic and narrative analyses. The theoretical frameworks that informed the analyses included the cultural safety paradigm, insights from game theory, the community of practice paradigm, and a politico-psychoanalytical perspective on representations and images.

Results showed that the term *culture* in practitioners' and families' discourse serves as a narrative strategy to mediate clinical interactions. These rhetorical moves can at times reify stereotypes and deflect personal responsibility, while at other times mobilize collective representations toward a common transformative goal (Article 1). Results also indicated that Transcultural Seminars operate under different rules than real-life clinical work, such as placing a high value on diversity and creativity, fostering a process of inclusive dialogue, and considering continuity over time. These rules allow participants to safely apprehend a situation from a different perspective and to negotiate power relationships (Article 2). The need to address local contextual elements in intercultural training was also documented, including the cultural identities of trainees and the local power differentials between groups. These sensitive elements can be addressed through supportive and reflexive group-based

initiatives such as Transcultural Seminars, a form of Communities of Practice that brings together practitioners on a regular basis and provide them with a *culturally safe enough space* (Article 3). Finally, results indicated that the attention paid to images – mainly verbal and mental images - during Transcultural Seminars can enable practitioners to adopt a different way of *looking* at the families they work with. Results suggested that working with images in intercultural training is more productive for a transformation of the colonial gaze than the sole enunciation of general theoretical statements that can be experienced by trainees as judgmental (Article 4).

This study deepens our understanding of conditions and processes that are required to increase intercultural competence among youth mental health practitioners, without simplifying current anthropological knowledge. The results also warn against the danger of applying tools and protocols without proper training. Finally, with the aim to improve children's and youth's mental health and wellness, while supporting practitioners and protecting minority families from systemic discriminatory processes, this study calls for the adoption of reflexive, decolonial, and locally rooted approaches to intercultural training.

Résumé

En santé mentale jeunesse (SMJ), les praticiens sont de plus en plus confrontés à des situations interculturelles complexes exigeant des ajustements à leurs interventions. Cela peut entraîner de l'impuissance, de la frustration, provoquer des réactions défensives et nuire à la qualité de leur travail. Face à cette difficulté, la formation des professionnels est souvent présentée comme une solution, mais souvent sans préciser ce que ces initiatives impliquent et exigent. Cette thèse présente les résultats d'une étude qualitative réalisée sur l'une de ces initiatives, à savoir les Séminaires de discussion de cas transculturels, interdisciplinaires et interinstitutionnels (ST) de Montréal.

L'objectif de cette étude était double : 1) explorer l'expérience vécue des participants aux ST; et 2) examiner les conditions et les processus qui, au cours de ces réunions, contribuent à améliorer leur compétence interculturelle. Pendant un terrain de cinq ans (2013-2018), de l'observation-participante a été réalisée (61 réunions enregistrées), ainsi que six groupes de discussion et 26 entretiens individuels semi-structurés. Les données ont été analysées par analyses thématiques et narratives. Les cadres théoriques utilisés incluent le paradigme de la sécurité culturelle, des éléments de la théorie des jeux, le paradigme des communautés de pratique et une perspective politico-psychanalytique sur les représentations et les images.

Les résultats ont montré que le terme *culture* dans le discours des praticiens et des familles sert de stratégie narrative pour médier les interactions cliniques. Ces pratiques rhétoriques peuvent tantôt réifier des stéréotypes et détourner d'une responsabilité personnelle, tantôt mobiliser des représentations collectives vers un objectif commun de transformation (Article 1). Les résultats indiquent également que les ST fonctionnent selon des règles différentes de celles du travail clinique régulier, telles qu'une importance accordée à la diversité et à la créativité, la mise en place d'un processus de dialogue inclusif et la prise en compte de la continuité dans le temps. Ces règles permettent aux participants d'appréhender en toute sécurité une situation sous un angle différent et

de négocier des relations de pouvoir (Article 2). La nécessité d'aborder des éléments contextuels locaux dans la formation interculturelle a également été documentée, notamment les identités culturelles des participants et les inégalités de pouvoir entre les groupes au niveau local. Ces éléments sensibles peuvent être abordés lors d'initiatives groupales de soutien et de réflexion, telles que les ST, soit des communautés de pratique qui réunissent les praticiens de façon régulière et leur offrent un espace *suffisamment sécuritaire sur le plan culturel* (Article 3). Enfin, les résultats indiquent qu'une attention portée aux images - principalement verbales et mentales - lors des ST peut permettre aux praticiens d'adopter une façon différente de *regarder* les familles avec lesquelles ils travaillent. Les résultats suggèrent que de travailler avec des images dans les formations interculturelles est plus productif pour une transformation du regard colonial que la seule énonciation d'énoncés théoriques généraux qui peuvent être vécus par les participants comme une forme de jugement (Article 4).

Cette étude approfondit notre compréhension des conditions et processus nécessaires pour accroître la compétence interculturelle des praticiens en SMJ, sans simplifier le savoir anthropologique contemporain. Les résultats mettent également en garde contre l'application d'outils et de protocoles sans formation adéquate. Afin d'améliorer la santé mentale et le bien-être des enfants et des adolescents, tout en soutenant les praticiens et en protégeant les familles minoritaires de processus systémiques discriminatoires, cette étude plaide pour l'adoption d'approches réflexives, décoloniales et enracinées localement en matière de formation interculturelle.

Acknowledgments[1]

Contrary to what the myth of individualism may lead us to believe, this work is certainly not the result of my efforts alone. There are many people I wish to thank here, and there are many others for which I won't be able to recognize the contributions. The content of this thesis is just as much the result of their thoughts and experiences as it is of mine. It is a co-creation, but a co-creation for which I am the one who holds the power of the pen. Hence, I am aware that in interpreting events and experiences and in writing about them, I am choosing to mention some things and not others. In doing so, I also give a fixed and clear form to what is ambiguous and in perpetual transformation. Keeping this in mind, I still hope that my efforts to understand my world and our world will contribute to building a better world, at least one that is more comfortable for all of us to live in, no matter what social categories we fall into.

I dedicate this thesis to those who trusted me, invited me to share their reality, and confided in me. First and foremost, this work is for the people who *make* Transcultural Seminars. Although for reasons of confidentiality I cannot name them here, this work is for the practitioners who took part in seminar meetings between 2013 and 2018, and who accepted my presence among them. Some of them even pushed their generosity to the point of sharing their intimate thoughts, feelings and wishes with me. I thank them very much. It goes without saying that I am also infinitely grateful to the facilitators and organisers of Transcultural Seminars, amazing people that I had the pleasure of spending time with during my fieldwork. Cécile Rousseau and Garine Papazian-Zohrabian, of course, for whom this thesis can be seen as a tribute to their work as clinicians and educators. My gratitude also goes to Marie-Hélène Rivest, Anousheh Mashouf, Zaïa Ayoub, Karine Hamel, Anne-Marie Richard, Marie-Pier Desage, Christian Savard, Astou Niane, Nathalie Otis, Hayette Boubnan, Olivier Lacroix, Julie Mercure, Colette Boulanger, Karine Hippolyte, Mélanie Issid, Marie-Claude Cyr, Sophie Hamann, Amélie Mercier, Danielle Roy, and all the others that I may forget to name but who made the ritualistic magic of

[1] Please note that in an effort to bring knowledge out of the academic ivory tower and to counter Anglocentrism, most parts of this thesis are also available in French - including the introduction, the discussion and the abstracts of the articles – using the following link : https://janiquejohnson-lafleur.com/doctorat/.

Transcultural Seminars possible during that period of time. This work is also dedicated to Ana Gomez-Carrillo, Yann Zoldan, and all the future Seminar facilitators who bring me hope about the unknown of what tomorrow holds for us.

I would also like to use this occasion to warmly thank the members of my advisory committee who guided me during this doctoral journey. First, I wish to express my gratitude to Cécile Rousseau, my PhD supervisor, who taught me so much since I became familiar with her work more than two decades ago, and who inspired me even more so since I had the chance of crossing paths with her about a decade ago. It goes without saying that all the writings in this thesis would not be of the same quality without her wise advices. Her very own way of zooming out to look at the big picture and identify a guiding thread in the midst of my swarming and chaotic thoughts was of tremendous help. Cécile also acted as a mentor since we began working together as she gradually and gently challenged me over the years to help me get to where I am today. I thank her more than she knows for using her magic and making my first name now rhyme more with *ludique* than with *panique*. My thanks also go to Lucie Nadeau, for whom I will always be grateful for introducing me to the infinite beauty of Nunavik. Not only did she offer me a way to make a living by inviting me to collaborate on her inspiring projects with youth mental health workers and Nunavimmiut artists, but she also offered me the opportunity to "learn on the job" the delicate craft of doing research. The improvement in the quality of the two manuscripts for which she is co-author is also to be acknowledged. Her great ethical rigor will always serve me as a compass for the projects I will undertake in the future. I would also like to thank Lisa Stevenson whose work inspires me and obviously influences mine. My participation in her doctoral seminars played a central role in my development as an anthropologist and led me to notice how much pleasure there can be in thinking and creating together. It is Lisa who introduced me to the works of Walter Benjamin, Kaja Silverman and other great thinkers of the image, thereby awakening the artist in me. I will always be grateful to her for getting me to write more, with flow and without shame, and to rely on the power of writing to clarify – or even transform - what I think and what I feel. I would also like to acknowledge Laurence J. Kirmayer's influence on the development of my thinking. I am deeply indebted to all his work on which mine has been able to borrow and build on. To be able to describe complexity with such clarity is something I can only aspire to. My thanks also go to Mélanie Vachon.

My participation in her qualitative research workshop helped me clarify my epistemological posture and inspired me to continuously improve my scientific rigor as a qualitative researcher. I simply could not have had a better thesis advisory committee.

Several colleagues and collaborators have made possible the writing of the manuscripts contained in this thesis. First, I am thinking here of colleagues and friends at Sherpa University Institute. Zoé Richard-Fortier, Diana Miconi, Prudence Caldairou-Bessette and Annie Pontbriand conducted interviews that were used in the first manuscript. I am indebted to them for that. The same goes for my accomplices from the Sherpa publications seminar who made a detailed reading of the second manuscript and whose comments greatly improved its quality. I am thinking here of Annie Jaimes, Christina Klassen, Gil Labescat, and Vanessa Lecompte. Lucie Nadeau also provided judicious comments on an earlier version of this manuscript. I also want to thank members of the ANTH611 ethnographic writing group at McGill University who gave my fourth manuscript a generous reading, and especially Lisa Stevenson who was the organiser of the seminar, and whose comments on the first drafts of the manuscript guided me to transform it from a ball of clay to an elegant raku bowl. My gratitude goes to Alonso Gamarra Montesinos, Malcolm Sanger, Ferran Pons Raga, Naim Jeanbart, Jonathan Wald, Vincent Laliberté, and Adam Fleischmann, who were all so supportive when I decided to “kill some of my darlings” and who assisted me when I needed to clarify and refine my ideas. I am also indebted to the meticulous work done by Christina Klassen in her revision of the English language for the second and third manuscripts, and to Michaela Field for editing the other parts of this thesis. Not only did their work enhance the quality of the thesis, but it also improved my knowledge of written English, which will serve me greatly in the future. The list would not be complete without mentioning the phenomenal work done by Chantal Lemire, who painstakingly translated into written text the words she heard on the audio recordings of numerous hours of interviews and Seminar meetings. A comment she made about the pleasure she finds in listening to the Transcultural Seminar meetings because of the suspense they contain also added to my reflections. It is thanks to a student grant given by Sherpa University Institute that I was able to obtain her assistance for this tedious task. Funds for carrying out this project were also provided by Fonds de recherche du Québec – Société et culture (FRQSC 198690), by McGill University (Grad Excellence Award-00259 and GREAT Award-00259-MD),

and by Cécile Rousseau's operating research funds. This work could not have been possible without this financial support.

Finally, the journey of writing this thesis would not have been the same without the company of my family and friends who helped me keep my balance in the rocking boat of Academia. My mother and stepfather, Jeanne d'Arc Johnson and Roland Bourneuf. My brother and nephew, René-Pier Johnson-Lafleur and Alix Lafleur. My uncles, aunts, and cousins who are so numerous that I cannot all name here. You and stays in *Gaspésie* will always be my existential anchors. My long-time partners in crime, Émilie Santerre-Ayotte, Annie Cloutier, Marie-Claude Béland, and Élaine Bourque. I want to thank you for existing and thus for preserving my faith in humanity. The chats and Friday *apéros* on Zoom calls with you during the pandemic made it possible to continue living and writing without going crazy. All the other friends I do not name here. I hope you recognize yourself and know how precious your presence in my life is. At last, more than anything else, I want to thank my two loves, Arnaud and Frédéric, for what matters most, for everything that really counts. My work is also yours. I could not have done it without you.

Prologue: *Mise-en-scène*

The first time I attended a Transcultural Case Discussion Seminar was in the fall of 2013. It was Cécile Rousseau, the facilitator of this Seminar, who had invited me to join the group, even though I was not a member of one of the clinical teams that could take part in these meetings. If my memory serves me well, it was after I told her about my love of fieldwork that she invited me to coordinate an evaluative study on these Seminars, a project that involved attending the meetings for at least two years. I remember thinking to myself that this was a dream job, as I was going to be spending work time listening to stories. I recall sharing my enthusiasm with Cécile. "It will be a pleasure to work together," she replied. I don't know if she had any idea it would last that long.

I remember the feel of the moment as if it happened yesterday. I still see the light coming into the room. It was not a morning light, but rather a light that had been there a while, that already had events in its wake. A light that wasn't as fresh as the one you have at the beginning of the day. The atmosphere in the room did not carry a morning energy either. At the back of the room, some people were making themselves a cup of coffee and it was not a morning coffee. It was an afternoon coffee. A coffee that helps you digest the first part of the day and find a second wind to get to the end of it. As I write about it now, I don't have a clear memory of the person or team that presented a case to the group at that meeting. Nor do I have any recollection of the story that we were told and the ideas for interventions that we worked on as a group. What I do remember however is the setting in which the meeting took place. The beige of the room and the uncomfortable chairs that reminded me of schoolchildren's chairs. I also remember the retractable wall, beige also, and dirty, that was used for the occasion to divide this large room in two, so that another group could have a meeting in the adjacent space. The type of accordion wall that you can stretch to create a partition and then push back in its wall pocket to restore the room to its original size. There were no pictures on the walls either, no decoration, and no color, except for the red of the emergency exit sign. In short, I remember the uninviting feel of the room, with only small windows at the top of the back wall that allowed a bit of the outside light to come in. In contrast to this lack of life in the place, to this boring environment, the energy present in the group was palpable. People seemed happy to see each other. Some were

arriving from outside and had red noses and frozen speech. Others were clearly working in the same building, as evidenced by the absence of coats hanging from their forearms. A pleasure to take part in this meeting was obvious. I had already heard about Transcultural Seminars. I had already understood that they were dear to practitioners, but I had never had the opportunity to experience them from the inside.

I tend to be uncomfortable when I join a new group and this time was no exception. When I glanced at a few people who had already taken a seat at the tables set up in a rectangle for the occasion, I realized that I was possibly not the only one who was not a regular. I could see their attempt to give themselves some composure while waiting for the meeting to begin. This woman reading a document. That man writing a note and trying to look busy. Were they really uncomfortable, or was I lending them my feelings? Maybe they were just not that interested in being there? I also vividly remember the moment when someone closed the door and when people's attitude went from intimate nonchalance to professional seriousness. The door closing and the cacophony of conversation slowly fading away seemed to echo the classical *mise-en-scène* of anthropological fieldwork. The dinghy departing from the shore and leaving Malinowski on the beach. This felt to me like such a moment. I remember my heart racing when I heard Cécile propose to go around the table to find out who was going to take part in the discussion that day. I remember how I felt like an impostor, seeing myself among people who have a front-row seat to people's suffering and who accept to get their "hands dirty" (Rousseau, Nadeau, & Measham, 2008) in spite of the inevitable complicity with structural violence involved in professional clinical work, all the more so when working with minority families. I remember feeling that my hands were just as dirty as a researcher, but that their dirtiness was not as visible. And what I remember just as much is the feeling of relief brought by Cécile's gaze, a gaze that clearly signified the legitimacy of my presence in the room. I remember feeling that the bet she was making by entrusting me with what I now consider to be important ethnographic fieldwork – in this day and age of a populist denial of systemic racism and of "cancel culture" that reminds us of the ghosts of other times – this trust in me revealed by her smile that could be seen by the whole group, was in fact opening me a door to this world. In retrospect, the most important thing that I retain from that first meeting is the feeling that I was invited to join a group of professionals who shared a concern

for understanding the complexity of human experience. To this day, I consider that this warm introduction allowed me to start developing a bond of trust with the practitioners taking part in Transcultural Seminars. And it is in fact this bond of trust that has endured over time that has allowed me to carry out the doctoral project that I am going to talk about in this thesis.

Note: Contribution of Authors

As per McGill thesis regulations, I confirm that I was the principal investigator on this study and that I am the first author of the four manuscripts included in this thesis. For the co-authored manuscripts, I wrote the first draft of the papers, while the co-authors gave comments and feedback and edited the first versions.

Introduction

> *Because the situations are so… so complex. When I listen to a situation, I tell myself, "How are we going to get out of this? Is this family okay? Is there a solution?" But in the end, I find that with the discussions, the suggestions, and so on, there is still a glimmer of hope. And we're here to plant those seeds of hope in families. And then I think, "Okay, if we were able to find solutions for that family, then that means it's real, it's possible." So, that's one of the things I find interesting about Transcultural Seminars. I need to know that I can offer hope [to families from cultural minorities], that I can create hope in a family. Because I tell myself that I'm there as an ally for change with the person. We're going to work together to change things. If I lose that side of me as a practitioner, I tell myself that maybe my place is no longer there. I come to nourish myself in Transcultural Seminars. It allows me to be able to continue in my profession.*

In our contemporary world of globalized population movements and local demographic changes, encounters between people with diverse cultural backgrounds are becoming more and more frequent. In the field of mental health care, thanks to a plethora of studies conducted over the last decades in transcultural psychiatry and medical anthropology, it is now acknowledged that culture *does* matter in clinical encounters and plays a major role in mental health problems' manifestations and care (e.g., Bibeau, 1997; Good, 1993; Jenkins et al., 2004; Kirmayer et al., 2014; Kleinman, 2008). However, despite the role of culture in mental health services being *offically* recognized (American Psychiatric Association, 2013), actually taking culture into account remains a challenge for many practitioners, even for those who are committed to doing so and who are aware of the complexities that may arise.

This doctoral thesis reflects on such complexities and on the challenges that emerge when teaching mental health and psychosocial practitioners how to integrate and account for culture in their professional interventions. Several elements contribute to this complexity, the first, being that culture is a processes-based, ubiquitous, multidimensional, dynamic, evolving, and often contested

phenomenon. Secondly, the fact that cultural processes are in permanent interaction with other social forces makes it impossible to consider culture as an isolated or static "factor" or "variable". Finally, the very definition of *culture* is an elusive one. Not only is the concept being ceaselessly reworked and questioned theoretically, but its very analytical usefulness is constantly being debated in anthropology; notably, due to its association with the colonial enterprise. Bearing this in mind, the posture adopted in this thesis is that teaching professionals to consider culture in their interventions is preferable to not doing so, as long as this education is conducted in a way that avoids an essentialist perspective, which further stereotypes, stigmatizes, and harms cultural minorities. This thesis will thus explore the challenges inherent to such educational initiatives and how thinking through these issues and considering their practical implications may help avoid the above-mentioned pitfalls. These considerations will be reflected upon by looking at a specific training model, known as the Transcultural Interdisciplinary and Interinstitutional Case Discussion Seminars, as they unfold in practice in Montréal, Québec, Canada. I will argue that the approach advocated in Montréal's Transcultural Seminars, and more broadly the decolonial approach to youth mental health care inspired by contemporary critical anthropology, proposes another way of understanding and assisting. Another way of caring. Another way of looking.

Attending to Culture in Professional Mental Health Practices

Understanding the influence of culture on the experience, expression, and treatment of psychopathology is a long-standing concern in the mental health disciplines. This interest has its historical roots in the colonial period and has grown out of the encounter between Euro-American psychiatrists and "other" populations. The initial approach to such considerations for culture was largely based on a colonial and exoticizing view; however, the field of transcultural psychiatry has continuously evolved, with its efforts aimed at responding to the mental health needs of culturally diverse populations without this "othering" perspective (Anderson et al., 2011; DelVecchio Good et al., 2011). More recently, with the transformation of colonization and the acceleration of globalization, the focus has shifted from studying "the culture of the patient" to studying the cultural dimension of psychiatric practices and their theoretical foundations through a renewed dialogue between psychiatry

and anthropology (Kirmayer & Minas, 2000). This was made possible by the influence of a group of thinkers, notably in North America by members of the Harvard school in the United States who, since the 1970s, have developed a large body of literature around the cultural meaning and subjective experiences of mental health problems and services (e.g., Good & DelVecchio Good, 1981; Kleinman, 1980), as well as by a network of scholars and clinicians in Montréal who were devoted to the study of culture and mental health. Indeed, around the mid-1960s, the city of Montréal was considered as "the center of cultural psychiatry" (Bibeau, 2002). A few years earlier, in 1955, the section of Transcultural Psychiatric Studies was created at McGill University by Eric Wittkower and Jack Fried. Over the years, members of what became the Division of Social and Transcultural Psychiatry in the early 1980s conducted studies on the cultural variations of psychiatric disorders, healing practices, and attitudes towards mental illnesses (Prince, 2000). Thanks to the contributions of the above-mentioned thinkers, it is now acknowledged that culture matters in the clinical space, as evidenced by the inclusion of the Cultural Formulation Interview (CFI) in the American Psychiatric Association (APA)'s DSM-5 (2013). The CFI is an interview tool that was developed as a way to further operationalize the work initiated in DSM IV's "Outline for Cultural Formulation" (APA, 1994) regarding the collection of cultural elements in the context of patient assessment and their integration in treatment plan elaboration (Lewis-Fernandez et al., 2015).

Nowadays, McGill's Division of Social and Transcultural Psychiatry is under the scientific direction of Laurence J. Kirmayer and includes a network of scholars and clinicians who continue to carry out research, and clinical and training activities on culture and mental health. In Montréal and Québec, the contribution of the *Groupe interuniversitaire de recherche en anthropologie médicale et en ethnopsychiatrie* (GIRAME) has also been significant. This network, which was founded in 1974 by Guy Dubreuil and H. B. M. Murphy, operated during several years under the leadership of anthropologist Gilles Bibeau. The overall objective of the GIRAME was to study and disseminate research results on the interface between health, illness, and sociocultural elements (Bibeau, 2002). Currently, the SHERPA University Institute, led by Scientific Director Jill Hanley, is dedicated to the development, evaluation, and dissemination of primary care interventions and prevention practices adapted to multiethnic contexts. SHERPA is located in a community health and social services center (CLSC) in Parc-Extension,

one of the most culturally diverse neighbourhoods in Montréal. SHERPA also works in collaboration with the Research and Action on Social Polarizations team (RAPS), under the scientific direction of Cécile Rousseau, to address the growing polarization of societies – including Québec's – around identity and inter-community issues. This phenomenon has a definite impact on the mental health of both cultural minorities and majorities, as well as on current prevention, training, and intervention initiatives, such as the one examined in this thesis.

Cultural Competence, Cultural Safety, and Anthropological Critiques

Practitioners and health systems commonly refer to *cultural competence* when considering the importance of culture on mental health concerns and care. Overall, the goal of cultural competence is to develop "the capacity of practitioners and health services to respond appropriately and effectively to patients' cultural backgrounds, identities and concerns" (Kirmayer, 2012). It is commonly held that this requires addressing both knowledge (*savoirs*) and practices (*savoir-faire*), as well as attitudes (*savoir-être*) towards cultural differences (Sue, Arredondo, & McDavis, 1992). It may also involve the development of both generic and specific competencies to address a range of practical issues in intercultural work (Fung & Lo, 2017; Lo & Fung, 2003). Specific cultural knowledge and strategies are particularly meaningful if care is provided in settings with easily identifiable ethnocultural groups, such as Indigenous communities (Wendt & Gone, 2012), but less so in environments that have been labelled as culturally "shattered" or "hyperdiversified" (DelVecchio Good & Hannah, 2015). In Québec, interestingly, the term *intercultural competence* is preferred to that of *cultural competence*, both in the literature and in practice, as the use of the *inter* prefix has the advantage of underlining the dynamic aspect of interpersonal encounters, and the fact that they take place at the confluence of multiple cultural worlds.

Criticisms of cultural competence have warned against a simplification of anthropological fundamentals, notably a lack of understanding and confusion of the concepts of culture, ethnicity, and race. Questionable elements of certain cultural competence models include a misunderstanding of culture as a static entity, treating culture as a variable, emphasizing cultural differences to the detriment of structural power imbalances, overlooking intra-group diversity, and not recognizing biomedicine as a cultural system itself

(Carpenter-Song et al., 2007). Thus, a major challenge remains of finding the right balance between two extremes when it comes to training and developing the cultural competence of practitioners. On the one hand, “cookbook” approaches are based on culturalism and may further stereotype, stigmatize, and harm cultural minorities, while on the other hand, individual-centered approaches may be read as “cultural avoidance” in the sense that “one size does not fit all” (Alegria et al., 2010).

To avoid such oversimplifications of culture or its complete disregard, other approaches such as *cultural humility* and *cultural safety* have been proposed to complement cultural competence. *Cultural humility* emphasizes the importance of a reflexive and humble posture in intercultural care (Tervalon & Murray-Garcia, 1998), while *cultural safety* tends to address issues of power and discrimination in health service delivery (Anderson et al., 2003; Papps & Ramsden, 1996; Ramsden, 1992). The cultural safety approach will be further presented in the first chaper of the thesis, but I would like to add a side note on its application in the local context of the present study, that is in French-speaking Québec. About thirty years ago, the notion of cultural safety (*kawa whakaruruhau* in Māori) was developed in New Zealand (*Aotearoa*) to account for the hurtful experiences of Māori people in the health care system. Originally, the intention was to challenge culturalism and unveil systemic racism in health services by addressing the issue of coloniality and power relations in the clinical encounter (Papps & Ramsden, 1996). Over time, the cultural safety approach has been reworked and applied to other discriminatory situations, with LGBTQ communities for instance, while in Canada it is still mainly associated with the health care provided to Indigenous Peoples. In Québec, this approach is increasingly popular, but it is difficult to find an equivalent in French to the expression “cultural safety”. In general, only the word *sécurité* is used to translate both the word “safety” and the word “security”, although these two English terms do not have quite the same semantic scope. Thus, the expression that was chosen by the actors involved in the fight against inequalities in the health system is that of *approche par sécurisation culturelle* (Blais, 2020), which roughly translates back to “approach by cultural securing”. Although at first glance anecdotal, this linguistic shift nevertheless reveals once again a fundamental misunderstanding of the concept of culture as understood in contemporary anthropology. While the word “securing” can indeed be defined by the action of reassuring and building trust, it can also refer to the action of stabilizing a situation or protecting a place in the face of

a potential danger, such as erecting a barricade. Yet, all the richness of cultural worlds lies specifically in the idea that they are open, heterogeneous, fluid, and never fixed systems. Moreover, far from always representing a danger, intercultural encounters can on the contrary be sources of great learning and creative processes. Unfortunately, this expression is now enshrined in the literature and in practice, and since words have an affective range that influences us deeply and often unconsciously, the use of this vocabulary may have the unfortunate effect of increasing confusion as to the dynamics of culture in the clinic, or even hinder the intercultural dialogue from which an allyship towards a decolonization of practices could emerge.

Finally, it is important to stress that to reduce disparities and inequities in the health status and care of cultural minorities, there is a need to improve both the cultural competence and "structural competence" (Metzl & Hansen, 2014) of professionals and of health systems. Underlying processes that lead to such disparities need to be thought of and addressed globally, from the intimacy of the clinical encounter to the systemic and political levels. As such, intercultural training initiatives can only be successful if they are accompanied with other actions at the institutional level. These can include better accessibility to interpreters, increased consultation time, intercultural training of non-clinical or administrative personnel, partnership with ethnocultural community-based organizations, and increased cultural diversity among staff (Pouliot et al., 2015). Inequities in the health status and care of cultural minorities also highlight the fact that taking into account cultural elements in mental health services raises complex ethical and political issues relating to the use and distribution of collective resources, which are further framed by local representations of alterity (Johnson-Lafleur, 2016). That being said, this will not be the main focus of the present thesis which will instead dive into the intricacies of a specific group-based training modality and explore the trainees' perspective and experience with it.

Practitioners' Experiences and Perspectives in Intercultural Training

In youth mental health care, the clinical assessment of a presenting situation is influenced by different elements, many of which are of a cultural nature; notably, the family members' and practitioners' potentially diverging views on the problem at hand and the course of action that should be taken

(Kirmayer et al., 2008). Although such elements seem easy to integrate when considered from the comfort of a theoretical distance, when in the field and during intimate clinical encounters, professionals are sometimes confronted with complex situations that require adjustments to their tools, protocols, and "practice as usual" interventions. Indeed, results from a study conducted in the Québec health and social services network indicated that cultural differences are often put forward by practitioners to explain clinical difficulties and impasses (Pouliot et al., 2015). Cultural misunderstandings have also been reported to cause feelings of powerlessness and frustration in practitioners, sometimes even unconscious ones (Daxhelet et al., 2018), which may provoke defensive reactions and adversely affect the quality of their work. Thus, to close the gap between what is advocated in the literature in transcultural psychiatry and the reality encountered in day-to-day practice, the training of professionals is often presented as a solution. However, more often than not this solution is offered without necessarily unpacking what such initiatives would entail and require. It has been argued that intercultural training cannot solely rely on content-focused curriculum, as the training requires practitioners to reflect on their cultural identities and social positionings, as well as to become more aware of their internalized cultural assumptions (Kirmayer et al., 2020). Training guidelines also highlight the importance of hands-on clinical experience under the supervision of clinicians trained in intercultural care (American Psychiatric Association, 2013); however, the availability of supervisors with the capacity to provide such support is rather limited, particularly in youth mental health care and outside major urban centers (Rousseau & Guzder, 2015). To overcome this challenge, group approaches have also been proposed.

The object of this thesis is one such initiative known in the literature as Transcultural Interdisciplinary and Interinstitutional Case Discussion Seminars (De Plaen et al., 2005; Rousseau et al., 2005; Rousseau et al., 2018), although the professionals who take part in it use the simplified expression "Transcultural Seminars" to refer to these meetings. Since the late 1990s, this training modality has been gradually developed at the request of primary care practitioners who worked in Montréal neighborhoods with a high degree of ethnic diversity. Initially, they were only attended by practitioners working in community health and social services centers (known in Québec as "CLSCs") who wanted to improve their intercultural competency, but nowadays, the Transcultural Seminars also welcome child and

youth protection employees (commonly called “youth centers”), and professionals from the school milieu. These monthly, three-hour meetings bring together about twenty practitioners to discuss a complex clinical case in depth. A case that is said to involve “cultural” or “intercultural” issues is brought to the group by a participant or a team for discussion, including misunderstandings between families and caregivers, therapeutic impasses attributed to cultural elements, difficulties of collaboration, and so on. Thus, the training is based on real-life experiences, and the discussions are imbued with the emotions and cognitions of the practitioners who present a situation, as well as by the reactions of those who receive the stories and assist their colleagues to expand their understanding of the case and develop an intervention plan. These meetings are conducted under the supervision of one or two clinicians with extensive work experience in intercultural contexts. The Montréal’s Transcultural Seminar model will be further described and explored in each of the articles that make up the thesis.

Methodology and Research Objectives

The intention of this doctoral thesis is to report on the analysis of Montréal’s Interdisciplinary and Interinstitutional Case Discussion Seminars or “Transcultural Seminars”, a training modality for practitioners involved in the field of youth mental health to support them in their intercultural work. The general objective of the study was to better understand this professional practice by observing it unfold across different contexts and reflecting on its conditions of possibility and its various effects. The research’s aim was to examine the processes taking place in Seminars and their transformative effects. To do so, a qualitative methodology was selected, as it allowed for an exploration of these impacts and processes, both in terms of group dynamics and of the participants’ lived experience, and in terms of their manifestations in discourse and in non-verbal performances.

The epistemological perspective that was taken for this study was an interpretive constructivist approach – which posits reality as multiple, and meaning as constructed (Ponterotto, 2005) –, the most suitable paradigm to study the lived experience of research participants. Additionally, since this thesis also seeks to “disrupt and challenge the status quo” (Kincheloe & McLaren, 2011, p.285), a critical stance was adopted in an effort to consider the importance of the researcher’s role and of power

relations in the scientific enterprise and in the production of knowledge (Creswell, 2003). Overall, the research posture that was adopted during this project was characterized by an attitude of openness, listening and decentering, and reflexivity, rather than being based on the idea of creating "expert" knowledge; thus, resulting in knowledge that was co-created as a result of encounters. My scientific approach is based on a vision of human beings as being both the objects of study and remaining thinking, acting, and feeling beings with a legitimate perspective on their own reality. In this respect, to combine the strengths of the emic and etic perspectives, the writings produced for this thesis have been reviewed by both people involved in the professional practice and who are the object of this study, and by external reviewers who are less – if not at all – familiar with its content (Creswell & Miller, 2000).

In terms of methodology, it is important to note that this doctoral project, which began in the fall of 2015, is a continuation of a previous evaluation research conducted between 2012 and 2015 on the impact of Transcultural Interdisciplinary and Interinstitutional Case Discussion Seminars. This previous study was directed by Cécile Rousseau, my PhD supervisor, and I was in charge of coordinating the research activities. As such, the first two papers in the thesis are based on analyses that included data from the research program "Collaborative Care in Youth Mental Health", a program that was co-directed by Cécile Rousseau and Lucie Nadeau (2012-2018), and that included the aforementioned research on Transcultural Seminars. Although this evaluative study documented the positive contributions of the Seminars in terms of improving the intercultural responsiveness and general clinical competence of practitioners (Rousseau et al., 2018), one of its limitations was the reduced access to the lived experiences of Seminar participants, as the data collection was conducted through observations and group interviews. Thus, to gain a deeper understanding of the processes unfolding during Transcultural Seminars and to take a more intimate look at the experiences of the people involved in the meetings, an ethnography of Seminars was pursued until the spring of 2018 and turned into a doctoral project.

During the period of the doctoral fieldwork *per se* (2015-2018), four different groups of Transcultural Seminars, located in four Montréal neighbourhoods, met once a month during the academic year, that

is from September to May with a break during the summer period. Of these groups, three of them obtained official authorization from their institution (locally called a "certificate of convenience") to participate in the present study, allowing for the possibility of their members to take part in research activities. A multi-centric certificate of approval from the Research Ethics Board was obtained from *Le CIUSSS du Centre-Ouest-de-l'Île-de-Montréal* for conducting the study.

As a whole, the writings produced for this doctoral project reflect on a five-year period of ethnographic fieldwork that consisted of taking part in the meetings of the Transcultural Seminars and discussing them with the people involved. This thesis is divided into four chapters, with each chapter presenting a scientific paper that addresses a different aspect of the practice. Since each paper is intended to be a stand-alone product, these articles all contain specific research questions and an account of the methods used, as well as the literature providing a backdrop for the analyses. The theoretical frameworks that informed the analyses included the cultural safety paradigm, insights from game theory, the community of practice paradigm, and a politico-psychoanalytical perspective on representations and images. This literature will not be reproduced here, in order to avoid redundancy and to make the thesis less weighty. However, to provide an overall picture of research activities, the different data sources and research questions for each article are presented in the Appendix (see Appendix A).

With hindsight, I realize that this thesis takes the form of a *montage* of theoretical perspectives in order to better understand a complex phenomenon – Transcultural Seminars – by observing it from different angles, with different conceptual tools. In this sense, one can say that the complexity of the object of study and its multiple layers of processes and meanings call for a multiplicity of analytical lenses. This is why I like to say that this manuscript-based thesis uses the power of "montage" (Suhr & Willerslev, 2013), in that each article presents a different perspective on the complex reality of intercultural training as it unfolds during Transcultural Seminars, with the combination of these perspectives providing an overall better understanding of the phenomenon, while leaving a part of the "unknown" and "invisible" existing between the cracks. In this respect, the writing style used in certain parts of the thesis – in particular the fourth chapter – can be unsettling for some readers who are more

accustomed to a “scientific”, “factual” or “detached” tone in which the author and their creative work hides behind the use of the third person. This methodological choice was intended to make the reader experience the destabilizing effect of changing language and *genre* to look at situations of suffering and their professional care. This is the same feeling that people who are not used to Transcultural Seminars may experience when they first participate, as they are asked to move from “chart talk” – a clinical language that enumerates a list of symptoms and procedures – to a more storytelling approach that uses language to narrate events and emotions, including those that affect them closely (Mattingly, 1998). In this sense, I hope the form of the thesis echoes well the object of its content.

Chapter 1: On Using the Word *Culture* in Youth Mental Health Services (bridge)

In this first chapter, I address the issue of the use of the word *culture* in the context of youth mental health care. I present the findings from the thematic and narrative analysis of discursive material collected with families and youth mental health practitioners. The cultural safety paradigm was used to explore how different operationalizations of the notion of culture may affect families' and clinicians' experience of services. The findings reflect a diversity of understandings of the term and its uses, including essentialist views and critical decolonial perspectives. At times, these rhetorical moves serve to "make other" and stereotype or to deflect personal responsibility; however, the culture concept is also used as a tool to mobilize collective representations towards the development of a transformative goal throughout the clinical follow-up. Therefore, I argue that culture can be seen as a mediator of dialogue between clinicians and families, either as a way to engage in an authentic dialogical encounter and install a sense of cultural safety, or as a way to avoid or reject such dialogue. These findings are reported in the following manuscript, and were also presented at the 39th annual meeting of the Society for the Study of Psychiatry and Culture (SSPC) (Johnson-Lafleur et al., 2018) for an audience of practitioners and researchers, as they provide insight into how the concept of culture is understood and used in the discourses of those who are involved in youth mental health services.

Johnson-Lafleur, J., Nadeau, L., & Rousseau, C. (submitted). Families' and Clinicians' Use of Culture in Youth Mental Health Services: A Double-Edged Sword.

Abstract

Over the last few decades, a large body of theoretical and clinical writings in medical anthropology and cultural psychiatry have documented how collective representations shape individual experiences and perceptions of mental health problems and care. This literature has emphasized the salience of cultural representations in the clinical encounter, whether they be explicitly acknowledged or implicitly embodied by patients and practitioners (Good & Delvecchio Good, 1981; Kirmayer et al., 2014; Kleinman, 1980). However, despite research conducted in these fields demonstrating the importance of culture in the clinic, it is not always clear what is actually meant by using the concept of culture in mental health care. In this article, we will describe how various understandings of culture are used by clinicians and families in youth mental health (YMH) services in Montréal (Québec, Canada) and apply a cultural safety paradigm to analyze how different operationalizations of the notion of culture may affect families' and clinicians' experience of YMH services. We will argue that the concept of culture and its use in the clinical realm can be viewed as a double-edged sword, in that it can be used as a tool to reify stereotypes and inequalities, or as a process of mobilizing representations towards cultural safety and transformative practices.

1. Introduction

Over the last few decades, a large body of theoretical and clinical writings in medical anthropology and cultural psychiatry have documented how collective representations shape individual experiences and perceptions of mental health problems and care. This literature has emphasized the salience of cultural representations in the clinical encounter, whether they be explicitly acknowledged or implicitly embodied by patients and practitioners (Good & Delvecchio Good, 1981; Kirmayer et al., 2014; Kleinman, 1980). However, despite research conducted in these fields demonstrating the importance of culture in the clinic, it is not always clear what is actually *meant* by the use of culture in mental health care. In this article, we will describe how various understandings of culture are used by clinicians and families in youth mental health (YMH) services in Montréal (Québec, Canada) and apply a cultural

safety paradigm to analyze how different operationalizations of the notion of culture may affect families' and clinicians' experience of YMH services. We will argue that the concept of culture and its use in the clinical realm can be viewed as a double-edged sword, in that it can be used as a tool to reify stereotypes and inequalities, or as a process of mobilizing representations towards cultural safety and transformative practices.

2. Culture: a central yet ambiguous and debated concept

Even in anthropology, the discipline devoted to understanding and attending to cultural differences, the definition of *culture* and what the term encompasses when in use remains hotly debated. It is commonly held that the first formal anthropological definition of culture is attributed to Edward Tylor, as he wrote in his book *Primitive Culture* (1871), "[Culture] is that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society." Conceptualized as a discrete and bounded entity, culture was understood then as a *system* and as belonging to a *people* characterized by a list of specific traits and behaviors. At the time, cultural evolutionism was an important school of thought in anthropology, a theoretical orientation that was imbued with ethnocentrism and went hand in hand with European imperialism and colonialism. Thus, according to Morgan's (1877) staging classification of human cultures, "primitive cultures" would stand on one end of a continuum of evolution, and on the other end would be Europe – notably industrial England and the United States – as the epitome of "civilized cultures". With time and the contributions of thinkers from within the field of anthropology, as well as in other disciplines, contemporary anthropology has abandoned this view of culture, moving instead towards more critical, nuanced, and process-oriented understandings and definitions. According to Wright (1998), there was a shift in the way culture was approached in the anthropological discipline during the second half of the 20th century, when older definitions of culture as a bounded entity with shared, specific, and fixed characteristics, gave way to new understandings of culture as a dynamic process of meaning-making and contestation, neither closed nor coherent. Interestingly enough, while anthropology's birth can be associated with the colonial encounters between Europeans and native people in Africa and the Americas, it is also the colonial enterprise that can be associated with major changes in the discipline

and in the definition of its core concept; although, this time with the end of European colonialism and the rise of postcolonial and critical studies. Today, while no consensus regarding the definition of culture exists, a few elements that are typically agreed upon by anthropologists include: (1) culture should not be conflated with other categories such as ethnicity, nationality, religion or race; (2) culture is process-based, experience-grounded, ubiquitous and multidimensional; (3) culture is dynamic, constantly transforming and often contested; (4) intra-group variations with regard to cultural beliefs and practices is what should be expected; (5) individuals are at the crossroads of and belong to multiple cultures; and (6) cultural processes are in constant interaction with other social forces, making it impossible to consider culture as an isolated or static phenomenon (Asad & Kay, 2015; Carpenter-Song et al., 2007; Gregg & Saha, 2006; Singer et al., 2016).

In retrospect, the difficulty in delineating the concept of culture is nothing new. In 1952, Kroeber and Kluckhohn wrote a review of the different ways anthropologists defined culture, resulting in a list of 164 different definitions (Wright, 1998). Instead of adding to the list of already existing definitions, this paper will draw upon three broad ideas with regards to the culture concept. First, we will consider Clifford Geertz's (1973) definition of culture as "a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life" (p. 89) and his proposition to look at culture as a *complex web of significance and meanings*. Also, we will borrow from Arthur Kleinman's (1998) idea of culture as *what is at stake in local moral social worlds* and refer to his approach to culture, which addresses the political dimension in meaning-making: "[Culture] is closely connected with political and economic processes and changes in relation to them; it is both shared and contested; it is differentially distributed across the divisions of class, ethnicity, religion, gender, and age cohort; it is realized in local worlds yet extends beyond them; and it contains coherences and incoherences" (p. 361). Finally, we will borrow from Lila Abu-Lughod's (1991) idea of culture as a *political tool for making other*. Our analyses will draw upon her suggestion that "despite its anti-essentialist intent, 'culture' tends to freeze differences like 'race' used to do" (Abu-Lughod, 1991, p. 470).

3. Attention to culture in mental healthcare: the cultural safety paradigm

In mental health services, it has been documented that ignoring cultural elements in clinical practice can lead to low-quality care, such as incomplete evaluations, diagnostic errors, inappropriate treatment plans, and non-compliance by patients and families (Adeponle et al., 2012; Alegria et al., 2010; Hansson et al., 2010; Kirmayer et al., 2007). As such, when faced with the necessity to take full account of cultural influences on mental health problems and care, practitioners and health systems attend to culture in terms of *cultural competence*. Although often well-intentioned, some approaches to cultural competence tend to take the form of "cookbooks" that describe and attribute mental health beliefs and behaviors to specific ethnocultural groups. By minimizing intra-group variability and overlooking clinicians' cultural representations, such approaches tend to reify and essentialize culture, leading to stereotyping entire communities and decomplexifying the role of culture in clinical practice (Kirmayer, 2012; Kleinman & Benson, 2006). To avoid oversimplifications of culture, other approaches to the consideration of cultural diversity in healthcare have been proposed, such as *cultural humility*, which describes a lifelong process of approaching cultural diversity from a humble position and impossible mastery of cultural knowledge (Tervalon & Murray-Garcia, 1998), and the postcolonial notion of *cultural safety,* which addresses issues of power and discrimination in health service delivery (Anderson et al., 2003; Papps & Ramsden, 1996).

In the late 1980s and early 1990s, *cultural safety* was coined by Māori nurse leaders and educators as a new approach to healthcare (Ramsden, 1990). One of the main leaders, Irihapeti Ramsden later developed this concept further in her 2002 doctoral thesis (Brascoupé & Waters, 2009). Stemming from the sociopolitical context of Aotearoa/New Zealand where significant health disparities existed between Māori and European descendant populations, an important contribution to the conceptualization of cultural safety was the introduction of a critical perspective on the use of culture in the health sector (Papps & Ramsden, 1996; Smye et al., 2010). Whereas "Māori culture" was often used as an explanation for the poor health statuses of Māori communities, the cultural safety approach brought back into focus the important influence of historical, political, and socioeconomic contexts on health and healthcare (Ramsden, 1990). Also central to the cultural safety approach is a shift in power

in terms of determining the outcome and success of a healthcare intervention. In the cultural competence paradigm, clinicians and organizations are responsible for assessing the quality of care, whereas in a cultural safety paradigm, it is the person receiving services that has the last word (Ramsden, 2002; Robinson et al., 1996). Focus is also less on the benefits of culturally competent care and more on the risks of culturally unsafe care, making the cultural safety approach less based on the ideas of knowledge, competence, and expertise, and more concerned with the establishment of trust, respect, and equality (Brascoupé & Waters, 2009). Lastly, although some authors view cultural safety as the last stage in a continuum of approaches to the consideration of culture in healthcare services; a continuum that would start with cultural awareness then extend to cultural sensitivity, cultural competence, cultural humility, and cultural safety, others consider that cultural safety constitutes a paradigm shift in intercultural care, as it completely reverses the top-down approach to attention to culture in healthcare (Brascoupé & Waters, 2009). According to Brascoupé & Waters (2009), these differing views of cultural safety could be explained by the fact that when approached as a concept, cultural safety represents an outcome and a distinct shift of paradigm and departure from that of cultural competence. However, when it is applied in practice, cultural safety appears as a continuity and an addition to the learning process of health practitioners. In sum, the goal of culturally safe care is to ensure that the person or family receiving services feels welcome and accepted, does not feel discriminated against, and is not put at risk of cultural harm by both acknowledging and legitimizing culture differences, and valuing diverse cultural identities (Smye et al., 2006; Papps & Ramsden, 1996; Williams, 1999). The objective of the article is to explore what understandings of culture circulate in YMH clinicians' and families' narratives, how culture is used in their discourses, and to what extent this use is embedded in a framework that might provide or hinder a feeling of cultural safety for families accessing services.

4. Methods

4.1. Research setting and data collection

This article is based on research findings from the qualitative strand of a large multisite and mixed methods research program on collaborative care in YMH conducted in Montréal in socioeconomically and culturally diverse neighborhoods. Two sets of data will be solicited for this paper: (1) narratives from families and clinicians involved in YMH follow-ups in first line health and social services centers (Study I); and (2) narratives from clinicians about their experience of a specific intercultural training modality (Study II). Starting in 2012, data was collected from youth and children receiving care (4 to 17 years old), their parents, and their principal health care workers to study the relationship between collaboration, types of interventions, and quality of services. All practitioners working in the participating sites were invited to take part in the project and to inform families about the study. Before deciding whether they would like to join the project, families who agreed to be contacted were provided additional information by the research team regarding participant involvement and study aims. The research team met with participating parents and their children either at home, in the clinic or in a research office, according to their preferences. 217 families participated in the quantitative strand of the research and were contacted at three points in time to complete questionnaires: at the onset of services (T0), 6 months later (T1), and 1 year later (T2). A sub-sample of participating families (n=44) also agreed to take part in semi-structured interviews at T1 and T2. Research assistants obtained informed consent from participants and assent from children when 14 years or older, and then conducted interviews in French or English based on the participants' preferences. The assistance of a professional interpreter was provided when needed. Research was conducted in compliance with the ethics board of the participating sites. A total of 205 interviews were conducted between April 2015 and April 2017, and covered the following themes: reasons for consulting, explanatory models of problems, trajectory of services, experience with care, and cultural adaptation of services. This article draws upon the qualitative component of the larger mixed-methods study (Study I).

Study II concerns practitioners' narratives about a specific training modality in intercultural YMH called Transcultural Interinstitutional and Interdisciplinary Case Discussion Seminars (TIICDSs). For more than two decades, these Seminars have been held in Montréal as a way of enhancing the intercultural competence of practicing YMH professionals and trainees. TIICDSs bring together professionals (approximately 25 participants per group) from various disciplinary backgrounds and institutions,

including primary health care, social services organizations, youth protection services, and the education sector. Four different Seminar groups hold monthly meetings in four different neighbourhoods in the city of Montréal. Three of these four groups took part in the study, as one organization declined participation. TIICDSs consist of in-depth clinical case discussions lasting approximately three hours. Sessions are structured around an initial presentation made by one or more professionals involved with the family (either intra- or inter-institutional colleagues), followed by a group discussion on the case and recommendations to the presenters. During the Seminar, the group actively participates in case formulation and treatment recommendations, with a senior transcultural mental health clinician acting as facilitator and resource person. As part of the research program on collaborative care in YMH, a two-year evaluative study was conducted to document the impact of TIICDSs. Building on results from this study, semi-structured individual interviews were conducted with a sub-sample of Seminars participants to deepen our understanding of participants' experience in training. Twenty-six participants agreed to be individually interviewed. Research was conducted in compliance with the ethical board of the participating sites. Interviews were conducted between May and September of 2017 and covered the following themes: reasons for attending TIICDSs, participants' cultural identities, and participants' perception and experience of Seminars.

4.2. Data analyses

Data collected during Study I and Study II was analyzed qualitatively. All audio material was transcribed verbatim. Transcripts were then read, and interviews were synthesized in brief summaries and overview tables. Using the qualitative data analysis software *NVivo* (version 10), a thematic analysis of the transcripts was conducted to elicit the presence of culture in the narratives. This analysis emerged from an iterative process between the data, pre-existing codes, and emergent ones. A text-search was also conducted with the character sequence cultur* to ensure nothing was omitted during the previous coding phase. The third step of the analysis consisted in exploring how participants' narratives around these understandings of culture were articulated in more or less coherent discourses. By going back and forth between the transcripts and field notes gathered throughout the research process, the idea of using culture as a differentiated way of approaching dialogue slowly emerged. Three broad

categories to qualify this mediating process were then developed, namely: engaging in a dialogical encounter, avoiding dialogue, and rejecting dialogue. The final step of the analysis was to document the contexts of production and enunciation of these discourses by making analytical notes on elements, such as the identities of interlocutors, their attitudes, the time and place of enunciation, as well as the broader social, historical, political, and institutional contexts of the encounter. A narrative approach was favored, as a focus on participants' use of language hints at shifts in perceptions and assumptions around various subjects, as well as identifies the negotiating mechanisms in power relationships (Blommaert & Bulcaen, 2000). Using discourses as a window onto situated beliefs, knowledge, values, and attitudes, our analyses examined what participants considered as cultural and, by extension, as culturally different and how it should be attended to. Finally, throughout the analysis process, meetings were held among the research team to discuss findings and ensure the most systematic and transparent analytical process possible. In this paper, some parts of interview extracts were altered to preserve participant confidentiality; for instance, changing or removing the names of families' countries of origin or the professions of clinicians.

5. Results

5.1. Characteristics of participants

A total of 112 participants were interviewed during Study I: 39 parents, 48 children or youth, and 29 practitioners. Most participants were met at two points in time (T1 and T2), for a total of 205 interviews. For Study II, 26 practitioners were interviewed once, at the end of the TIICDS year. As shown in Table 1, families who participated in Study I presented a large degree of diversity in terms of geocultural regions of origins (based on parents' country of birth), as 43.2% of families had two migrant parents and 15.9% had at least one. The majority of families were from North America (54.5%), including two from Indigenous backgrounds. Concerning the geocultural areas of origin, two elements are important to note. First, the fact that 6 families were of mixed origins, combining more than one geocultural area; but most importantly, the idea that these categories are derived from the United Nations' statistical divisions and that they are far from representing culturally homogeneous

entities. Also, of note is the high level of education of participating parents, with 65.9% of families having at least one parent with college or university degrees, which is most likely attributable to a sampling bias through self-referral for participation in the study. In addition, 8 out of 10 participating parents were mothers, and 56.4% were born in Canada. Concerning the children and youth, 58% were boys and 42% were girls. Their ages ranged from 4 to 17 years old, and the mean age was 11 years old.

Table 1: Characteristics of Interviewed Families

	Study I (N=44)*	
	N	**%**
Child Gender		
Girl	18	40.9
Boy	26	59.1
Child Age at T0		
4 - 7 years	11	25.0
8 - 11 years	17	38.6
12 - 14 years	8	18.2
15 - 17 years	8	18.2
(M = 10,9 years*; SD = 3,5)*		
Child Born in Canada		
Yes	31	70.5
No	13	29.5
Parent Gender (Interviewee)		
Female	35	79.5
Male	4	9.1
Missing	5	11.4
Parent Born in Canada (Interviewee)		
Yes	22	56.4
No	17	43.6

If not, number of years in Canada (M = 12,0 years; SD = 9,0; range 1-49 years)		
Parent Highest Level of Education		
Secondary or less	9	20.5
Professional or college	5	11.4
University degree	24	54.5
Missing	6	13.6
Family Income		
Less than 20 000$	9	20.5
Between 20 000$ and 40 000$	10	22.7
Between 40 000$ and 60 000$	2	4.5
More than 60 000$	16	36.4
Missing	7	15.9
Migration		
Non-Migrant Parents	18	40.9
Mixed Parents	7	15.9
Migrant Parents	19	43.2
Geocultural Areas of Origin**		
Caribbean	5	10.4
Central and South America	3	6.3
East and South-East Asia	3	6.3
Europe	2	4.2
Middle East	11	22.9
North America	24	54.5
Sub-Saharan Africa	1	2.1
South Asia	1	2.1

*Certain cases did not consist in a complete parent-child-clinician triad; thus, 5 youths participated by themselves, and 4 parents participated without their children. Additionally, 4 families had 2 children who participated instead of 1.

**Six families were of mixed origins so combined more than one geocultural area; therefore, the total exceeds 100%.

As shown in Table 2, practitioners who were interviewed for Study I and II were mostly working in local health and social services centers (100% and 65.4% respectively). However, Study II also included professionals from youth protection services (26.9%) and from the school milieu (7.7%). The most represented domains of practice in both studies were social work (31% and 61.5%), psychology (27.6% and 19.2%), and psychoeducation (20.7% and 15.4%). In addition, a large majority of participating practitioners were female (89.7% and 84.6%) and were born in Canada (72.4% and 80.8%). Twelve professionals from Study I were also TIICDSs participants (41.4%), and one of them also took part in Study II.

Table 2: Characteristics of Interviewed Practitioners

	Study I (N=29)		**Study II (N=26)**	
	N	**%**	**N**	**%**
Gender				
Woman	26	89.7	22	84.6
Man	3	10.3	4	15.4
Age				
20 - 29 years	1	3.5	2	7.7
30 - 39 years	7	24.1	12	46.2
40 - 49 years	2	6.9	9	34.6
50 - 59 years	4	13.8	3	11.5
60 and more	2	6.9	0	0.0
Missing	13	44.8	0	0.0
Born in Canada				
Yes	21	72,4	21	80,8

No	3	10,4	5	19,2
Missing	5	17,2	0	0,0
Organization				
Health & Social Services	29	100,0	17	65,4
Youth Protection	0	0,0	7	26,9
Schools & School Boards	0	0,0	2	7,7
Domain of Practice				
Social Work	9	31,0	16	61,5
Psychology	8	27,6	5	19,2
Psychoeducation	6	20,7	4	15,4
Art Therapy	5	17,2	0	0,0
Other	1	3,5	1	3,9

5.2. Talking about culture

When questioned about whether or not YMH practitioners took their cultural background into account, certain parents and youths from Study I replied with ambivalent answers, stating that culture was "not important", while also providing illustrations of concerns on cultural issues elsewhere in the interview. Some participants also identified an ambiguity in the use of the term, as illustrated below:

> *[Interviewer: Do you feel that she [the clinician] took your culture into account?] We don't have any cultural… We really don't care about that. I don't know. I can't really answer that question because we never… When you say culturally, being religious-wise or ethnic-wise? I don't know. (Parent)*

> *Culture… What do you mean by that? (Youth)*

> *[Interviewer: Do you feel that the cultural aspects of your background were taken into account?] No, it didn't matter. There was no cultural background that needed to be*

handled. […] Because I grew up here so there wasn't much of a cultural issue. […] But my parents are overprotective with me. […] It could be just my parents. But I know there are cultural differences. My parents behave differently with the kids, depending whether it's the boy or the girl. (Parent)

Amongst a number of recurrent themes that arose during our analysis, the idea of culture as being linked with territoriality or space, and by association with place of birth, place of living and nationality, emerged as a dominant theme. As illustrated in the following extracts, some participants also mentioned the culture of a region, a city, or a neighbourhood.

[I think culture] can change a few little things. […] In [my father's country of origin], people don't react the same way. (Youth)

It might be because of our culture. […] There are things we don't do in Japan. (Parent)

There was a case presentation that was typically from Verdun [a Montréal neighbourhood]. Yes, [it was representative of] the culture of Verdun. (Clinician)

Temporality was present in participants' discourses about culture, such as the idea of cultural differences being attributed to another era or time period and, by association, to another generation. In addition, when issues of ruptures experienced through the passage of time or through displacement and relocation were addressed, participants elaborated on intergenerational cultural differences, interculturality, and on the culture of migration per se, as illustrated here:

As soon as she [my daughter] arrived here, she got piercings, tattoos. At home, in Algeria, it's very rare that we do that. […] Many times we talked about how it's different [culturally] here. […] It's difficult also to have ideas and principles your whole life, and then… […] Maybe with time they [my children] will understand. They will have children and they will see how difficult it is. (Parent)

She [the clinician] understood my family, but she did not understand my grandparents, they are too old. (Youth)

Like most immigrant parents, he [the father] must have a best interest in his children succeeding in this culture and succeeding in this context. (Clinician)

The theme of difference was also central in participants' discourses on culture. Differentiated ways of perceiving, thinking, and acting, linked to differences in collective values, beliefs, mentality, norms, practices, and customs were attributed to culture by participants. Processes of differentiation and of othering were also present in our results. Participants' discourses sometimes presented the idea of "being cultural" as that of "being different". Culture was sometimes understood as belonging to the *other,* and some clinicians from Project II who were members of the ethnocultural majority were taken aback by a question about their own cultural identity. The following extracts exemplify these ideas:

We're not used to be asked about that [our cultural background], as a White person from here. […] I'm from a background that was very White, francophone, with a majority of people coming from France at the time. […] I find my background is very… dull. […] You make me more aware of the notion of the Other with the big O. […] As if I'm the norm and the Other is… (pause) So when you ask me about my cultural identity, I must admit I don't really know what to say. (Clinician)

In my culture, this disease doesn't exist. People would just say: this child is bizarre. This child is crazy. (Parent)

My father [is from another country and he] is more authoritative. But my mother, [she's from here, and] she'll be like: if you want to do it, do it. As long as you don't hurt yourself. (Youth)

In line with this idea of culture as a differentiated way of experiencing the world, some participants attributed to cultural differences the fact that certain situations, attitudes or actions could be felt as incomprehensible, baffling or irrational. The following extracts convey this idea:

> *Sometimes I feel like sharing with colleagues and say: Listen, I don't understand this community. They did this or that thing. Is this cultural or is it only specific to this family? (Clinician)*

> *We don't have the same culture. We don't have the same manner, with the rules, than Canada. So it's a little hard for them [clinicians] to understand […] why my father reacts like that to certain things. But it's just because it's like that in our culture. (Youth)*

Another important theme present in participants' narratives was the idea of "anchoring", whereby a culture provides a sense of belonging to a collective that is linked by identity. Hybridity in cultural identities was also mentioned by a few participants as was the idea that affiliations and identities can be assigned or claimed, and can range from small groups (e.g., a family or a work team) to larger ones such as ethnic groups, religions, linguistic communities or professions. Here are a few examples of this finding:

> *I have children and they have three cultural identities. I speak French. English, not really, [but my husband does.] And of course, we also hear Spanish at home because my stepmother and my husband, they're really bilingual with Spanish. (Clinician)*

> *At home, we're not religious at all. We're Muslims by identity. But my husband is an atheist. Myself, I believe in God, but I'm not religious. (Parent)*

When addressing the question of culture, and especially of cultural identities, certain parts of participants' narratives contained generalizations and stereotypical elements. Oftentimes, these were

attributed to members of out-groups, but also sometimes to one of the participant's own cultural affiliations. Negative representations of culture and cultural identities could also be found in participant narratives; for instance, by equating the "cultural other" with the idea of not being "open" or "modern", as illustrated in the extracts below:

> *[The difficulties during the clinical follow-up] were not really cultural. They [the parents] are very open-minded, and they've been here [in Canada] for a long time. (Clinician)*

> *There wasn't really a cultural gap [between the clinician and my family] because we're quite modern and Canadian. So, we're not really like real Arabs. We have modern ideas and all that. (Youth)*

> *Maybe it's our culture. We are not... let's say affectionate between parents and children. In the sense that… I really like to give hugs to my children, but you don't see that in China. (Parent)*

> *The way authority is perceived is different in certain cultures, some sort of submissiveness, where the expert is the expert, and it's the doctor. […] [This Vietnamese family] wanted the expert. (Clinician)*

Finally, it is also worth noting that the narratives of certain participants were filled with nuanced views on culture, evoking its complexity, heterogeneity, and fluidity.

> *I think [as a clinician working with culturally diverse families], you always need to put yourself into question. Because cultures are not fixed; it changes all the time. And so do we, as people; we change. (Clinician)*

I can reject the values that don't really suit me, either the ones from Canada or the ones from Morocco. […] I think cultural diversity is enriching for everyone. (Parent)

I don't mind if you're from a different culture. I think it depends on the way you live it (Youth).

5.3. Working with cultural elements: mediating dialogue

In addition to the many different and sometimes contradictory definitions of culture that are present in participants' discourses, our results suggest that the use of the term culture varies and can be situated on a continuum that ranges from *engaging in a dialogical encounter* to *avoiding dialogue,* to *rejecting dialogue*. In some instances, participants would talk about culture by presenting cultural differences as a way to enrich single and narrow perspectives, and as a source of creativity to co-create new meanings and solutions. In one case, a Muslim mother wearing a *hijab* who recently migrated from the Middle East reported that during her family's YMH follow-up, the clinician's attitude was essential in establishing a trustful relationship, especially given the current social context of suspicion in regards to Islam, including certain practices such as wearing the veil. She stated that by her respectful and welcoming attitude, the clinician was able to let her know she was safe with her in a social context where this might not always be the case. This allowed for a climate of cultural safety to be established and for the beginnings of a trustful dialogical relationship to be fostered wherein sensitive issues could be addressed. The following extracts illustrate how culture was sometimes operationalized in participants' discourses as a way to engage in a respectful dialogical encounter:

The clinicians, they really understood me. Because I see they are really unbiased. And they accept our values and things like that, as long as it's for the good of the child. So they don't care if I'm from another culture. […] Wherever you go, you take the good things and you reject the bad ones. So why no learn [from each other]? (Parent)

[Interviewer: Did you feel your way of thinking and of being, culturally, was respected?] Yes, she [my clinician] was never against me or against my opinion with something cultural or norms or values. She never said "this is bad" or something. She just respected everything. […] She was not like… racist or discriminatory or something like that. (Youth)

A lot of professionals that attend Seminars, they have an interesting cultural diversity. And that is very enriching because of this marriage of values, of different ways of doing things… It is incredibly rich. And the beauty of all this lies in the complementarity, in everything one can bring to another in these exchanges, be that related to pitfalls, to values, to customs, to rites, and so forth. […] And there's a climate of trust. We feel that everyone is open and respectful. (Clinician)

On other occasions, research participants would use culture in their discourse as a way to avoid dialogue. In some cases, participants reported instances of "cultural camouflage", which consisted of bringing the cultural dimension to the forefront to protect another aspect of the situation from being recognized and addressed. In other cases, participants reported on instances of feeling stereotyped in their experience of services, while also at times using stereotypes themselves. Therefore, by presenting a fixed, simplified, and essentialized view of oneself or the other, both clinicians or families could avoid taking part in an authentic dialogical encounter; hence, limiting the possibility of transformation. Here are a few illustrations of this operationalization of culture:

People will say, 'You know, in my country, it's like that'. And you realize that you know other people from this country, and it's not like that. […] So the mother was often using the argument that 'You know in Vietnam, bla bla bla…' And I was finding it hard to accept this kind of argument. (Clinician)

Arabs and Lebanese people, they're emotional, that's all. It's normal. (Youth)

With the Greek mother, we don't talk about emotions. You do something and you move on. It's very engrained in their way of being. (Clinician)

Another use that could be made of culture is that of rejecting dialogue, which negates the value of the cultural other and their perspective. In the extreme, this position could lead to dehumanisation and violence; however, in our study, this usage of culture typically emerged when parents reported incidents where they felt judged or disrespected based on their cultural beliefs, practices, and identities during the clinical follow-up, as expressed in the following extract:

My partner is from Lebanon. His way of raising the children is different than mine, and together we developed a compromise. But the lady [the clinician], she had a way [of seeing things] that she learned or… I don't know. […] So from the very beginning, I had the impression there was a judgment. (Parent)

Finally, in a similar way as a few parents who expressed feeling judged concerning cultural differences, some clinician participants from Study II expressed the same type of non-dialogue experience; however, in this case, this experience was related to other cultural identities, such as those related to a profession or an organisation, as illustrated below:

I'm the only one from the school milieu [in the Seminars]. I feel a lot of judgment from the other organizations. About us. Against us. Sometimes I think there's a lot of missing information and people are quick to make a judgment. (Clinician)

6. Discussion

6.1. Culture as a situated conceptual montage framing the encounter

Our research results suggest that neither families nor clinicians hold a single, unified, and articulated definition of culture, but rather resort to different and even sometimes contradictory understandings

of the notion in their discourses. Multiple conceptualizations of culture coexist and are called upon according to the context and content of the encounter. As such, the notion of culture, as present in our research participants' discourses, tends to take the form of a complex conceptual montage rather than that of a consistent and integrated understanding. This multifaceted understanding of culture was reflected in both clinicians' and families' narratives, which at times could be simplified representations of specific populations, while in other instances convey a nuanced and fluid understanding of cultural representations and identities. Typically, a stereotypical utterance would be made on a cultural group and would be followed by the addition of a comment pointing to intra-group variability.

From an anthropological point of view, this conceptual montage of culture includes both outdated and more recent conceptualizations of the notion. In clinicians', parents' and youth's narratives, we can still feel the influence of this idea of culture as a "thing" or "bounded entity" characterized by clear cultural prescriptions and proscriptions which impact all dimensions of life. This evolutionism-era definition of culture as an "organizing system" or as this "complex whole", which includes universal phenomenon that is inherited or acquired by all humans as members of a collectivity is salient in participants' discourse. It is also important to note that such a view of culture was more often attributed to the "different other", especially when cultural elements were considered in an unfavorable light. This use of culture and the othering process it creates is also reminiscent of the hierarchy that was implied in cultural evolutionism, whereby "Western cultures" were considered as the most "advanced" and "civilized" cultures and are now thought of as more "rational", "open", and "modern". One example of this notion is how some participants from cultural minorities would distance themselves from assigned cultural identities in front of external attributions. Additionally, as some participants confided in the interview, to be questioned about one's culture and cultural identity could be experienced as offensive. Our observations also converge with those of Taylor (2007) who noted that *culture* was often considered an impediment to health interventions; however, in our study, the cultural backgrounds that were considered were those of the minority and migrant families and not those of clinicians. This points to the idea of culture as a defensive conceptual tool that can create distance between oneself and the different other when pain, suffering, and powerlessness become overwhelming.

In combination with this reified understanding of culture, our results indicate that a conceptualization of culture as a process of forming representations and meaning making with the role of framing thoughts and actions was also present in participants' discourse. A few participants, mainly clinicians, would hold such a Geertzian perspective of culture which acknowledges the constant transformation of cultural representations and their political embeddedness. Unsurprisingly, this anti-essentialist perspective on culture was adopted by a few professionals with a longstanding participation in TIICDSs and years of experience in intercultural care. Some of them also had previously completed studies in the field of anthropology and had experienced many intercultural encounters in their personal lives. In these instances, culture was operationalized as a means to generate creativity and fruitful exchanges.

In sum, both fixed and dynamic perspectives on culture could be found in a participant's discourse, sometimes even alternating in the same sentence, rather than certain participants holding one view over the other. This sort of come-and-go movement between generalizations and specifications seems to parallel the human ambivalence about the desire to explore the unknown and the desire to seek refuge in the familiar, as well as the desire to attend to the other's experience and the desire to distance oneself from it and center on the self. This movement also evokes the ambivalence towards the desire for change that an encounter with a "different other" could bring about and the desire for stability that can be ensured by keeping it at bay. Thus, culture in the clinic can be viewed as a double-edged sword, as it can be a way to defensively perpetuate stereotypes and colonial views of the other, while also being a process in which to politically embed notions that can be solicited to mobilize individual and collective modes of expression, as well as to explore the complexity of human nature, and to demystify and uncover oppressions.

6.2. Dialogical relationships and transformational practice

The fact that participants resort to a multiplicity of understandings of culture in their discourses cannot be dissociated from another set of findings indicating that culture serves as a narrative strategy to mediate clinical encounters, either by engaging in a dialogic relationship, or by avoiding or rejecting it.

Engaging in a dialogue implies recognizing and negotiating points of sameness and points of difference. It also entails that both patients and clinicians will be impacted by the dialogical encounter (Qureshi, 2005). For interlocutors to engage in a dialogue, and therefore take part in a truly transformative practice, all involved parties must – at the very least – agree to acknowledge the others' perspectives. This minimum requirement of acknowledgement allows the interlocutors to work towards finding a common ground from which they can move forward together on. As documented in our study, such a decentering and negotiation process can be impacted by contextual elements of the encounter. Illustrations from Study I highlight that clinicians' social and cultural identities can help modulate families' feeling of cultural safety and that these must be looked at on a case-by-case basis, as both proximity and distance between interlocutors' identities can be either desired or feared for a diversity of reasons. During Study I interviews, the importance of the clinician's attitude in establishing a climate of trust for which a dialogical relationship could emerge was often mentioned by parents and youth and was deemed as key in influencing what could be said and addressed in the clinical encounter; thus, creating a fruitful working alliance. When cultural representations and clinical issues are explored respectfully, a hybrid cultural space can be developed, allowing for a creative and transformative practice. Similarly, in Study II, TIICDSs participants from different disciplinary backgrounds and organisational affiliations must try to momentarily withhold their judgments against other theoretical orientations and work environments and negotiate a common understanding of the clinical situation – even if only partially – to decide on an appropriate way to tackle it. This process of collective meaning making that occurs during TIICDSs also reveals the cultural, constructed, and fluid aspects of case formulations, which are neither "expert truths" nor "purely subjective creations". They are situated knowledge that emerged at a specific moment in time, at a specific place, and within a specific set of relationships (Rousseau et al., 2018). Again, this highlights the fact that the context of the elocution of discourses includes multiple levels, not only the dialogical level but also the social, cultural, and political ones.

In light of our results, the use of culture in participants' discourses appears as situational and is focused on *what is at stake* in the encounter when interlocutors resort to it (Kleinman, 1998, p. 360; Ware & Kleinman, 1992, p. 547). In some cases, when cultural elements were presented as fixed in a discourse,

it pointed to a defensive narrative strategy to prevent dialogue. This needs to be looked at in context to understand what is at stake in the encounter. When one resorts to cultural camouflage and confuses a situation or symptom with a cultural element presented as consensual, this might indicate a narrative strategy to avoid tackling a sensitive issue that might bring about too much suffering. When one makes use of stereotypes and of culture as a way to essentialize and freeze differences (Abu-Lughod, 1991), then attending to the complexity of individual experience and other layers of reality is deflected and the potential for clinical change is reduced. Cultural differences can be brought to the forefront and be part of both clinical and political resistance during YMH interventions. A parent might wonder: "Why are these changes proposed to me? And what are the possible consequences for my child, for my family, or for my community?" What makes this quite complex is that *what is at stake* encompasses psychological, relational, and sociopolitical processes. It can be very difficult to discern which dimension is mobilized, all the more so as these processes occur both consciously and unconsciously. In our findings, in the absence of cultural safety, participants expressed their fears and lived experiences of being judged or disrespected due to their outlook of the situation, perhaps even blamed for the issues being addressed. In such instances, families' defensive strategies can take the form of withdrawal and identitarian closure triggered by cultural harm, hence ruling out any possibility of dialogue and giving way to stereotypical and negative representations of the "cultural other". This has serious clinical implications because it can lead to disengagement from the therapeutic process, absence of clinical outcomes, and dissatisfaction with care. Incidentally, the literature in YMH reports an underutilization of services by cultural minority families (Freedenthal, 2007; Kataoka et al., 2002; Yeh et al., 2003). Other findings from our research program also indicated that migrant families show a lesser degree of engagement in the clinical process compared to non-migrant families (Bolduc, 2017).

6.3. Aiming at cultural safety to improve quality of care

In light of our research findings, it appears that aiming at cultural safety in the clinic is a nonlinear work in progress. As reported in their discourses, when clinicians, parents, and youths address cultural differences by resorting to various operationalisations of culture, they go back and forth between avoiding, rejecting, and engaging in a fruitful dialogue with one another. Our results suggest that

minority families' experiences of YMH services may be improved with three types of initiatives: (1) raising awareness of the importance of culture in YMH services; (2) supporting training initiatives in intercultural care; and (3) promoting an ongoing reflective practice enabled by a supportive environment.

Acknowledging the salience of culture in YMH interventions may be the first step in making YMH services culturally safe and shifting away from the phenomena of cultural blindness. Raising clinicians' awareness of their own cultural representations is key, as it allows them to use the cultural elements that emerge in the clinic as an opportunity to engage in a respectful and non-judgmental dialogue. It has been proposed that resorting to universalism, or what has been called "minimization strategies", is quite common among mental health professionals (Hammer, 2011). Indeed, as some parents and youths mentioned during the interviews, certain clinicians do not ask questions about culture or cultural differences and are not attuned to the way culture is present in the clinic. This attitude lacks the awareness of *what matters most* and *what is at stake* for families in YMH care and may represent a protective form of avoidance, preventing the engagement in an authentic dialogue. Dialogue, as understood from a Bakhtinian perspective with its emphasis on better understanding rather than consensus, is a major contribution to any positive therapeutic change, especially in YMH (Seikkula & Trimble, 2005). Therefore, if clinicians or family members avoid or reject engaging in dialogue for "cultural reasons", then transformative practice is compromised. Hence, clinicians need to elicit and navigate both their own avoidance strategies, as well as those of the people they provide care to. On the one hand, if avoidance or rejection narratives about culture are employed by a person or family seeking care, then the clinician is responsible for understanding their rationale and purpose in order to gently open up a dialogue. On the other hand, if these discursive strategies are employed by clinicians, this would demonstrate their cultural blindness and their lack of intercultural competence; in this case, this would need to be addressed through appropriate training and supportive work conditions.

The issue of training in intercultural care is very complex, as it implies not only the acquisition of knowledge and skills but also the development of attitudinal competences (Sue et al., 1992). Addressing practitioners' attitudes is a major challenge because it implies exploring the trainees' own

cultural representations and identities. Although this can be addressed through direct clinical experience under the supervision of experienced intercultural clinicians, the relative lack of experienced supervisors represents a major obstacle to complying with this training objective, a concern that is particularly visible in YMH care (Rousseau & Guzder, 2015). In Montréal, TIICDSs were implemented to respond to this challenge. Results from an evaluative study indicated that these Seminars could help participants better capture the complexity of the cultural and social experience of the families they meet and decrease the reliance on cultural formulations that essentialize culture (Rousseau et al., 2018). In line with these results, our findings indicate that this training modality can also positively impact clinicians' attitude, as longstanding TIICDSs participants used culture in their narratives mostly to engage in dialogue. Our results indicate that a key aspect of this training modality is for trainees to feel culturally safe, thus facilitating their awareness of their own cultural representations and biases. In addition, parents and youths who were being followed by trained clinicians all mentioned feeling culturally safe in their presence and none of the cases reporting on non-dialogue came from clinicians having attended TIICDSs. This outcome on families' experiences of YMH services supports the implementation and pursuit of such training initiatives to increase cultural safety in care.

Another layer of complexity in intercultural training lies in the difficulty of transmitting both generic and specific types of culturally informed knowledge and skills (Lo & Fung, 2003). In other words, it is difficult to find the right balance between the extremes of "cookbook" approaches to training, which tend to reinforce stereotypes and essentialize culture, and person-centered approaches, which could also be read as "cultural avoidance", meaning telling clinicians to treat service users with empathy and respect is not sufficient when training them to be culturally sensible, safe, and "competent". In line with Fung and Lo (2017)'s work on culturally competent psychotherapy, we consider that various "generic" cultural issues may arise at each phase of YMH follow-ups that can be addressed through open and respectful dialogue, and note that specific cultural knowledge can guide their resolution. Intercultural training can also help clinicians learn how to collect cultural information in a sensitive and respectful way and how to make intervention propositions that can be negotiated and reframed in

culturally acceptable ways. Thus, ways to alleviate individuals' and families' suffering can be tackled with countercultural, neutral, culturally congruent or reinforcing approaches (Fung & Lo, 2017).

Finally, it is important to stress that cultural safety also needs to be addressed at the systemic level, as in its absence, professionals can be caught in a double bind between being at odds with their organization and work environment and being at odds with their ethical and professional judgment (Johnson-Lafleur et al., 2019). The sources of support that organizations can offer to their personnel working with culturally diverse populations include adequate access to interpreters, access to intercultural training, additional time for complex interventions, and access to clinical discussions spaces.

Our research results have limitations, which mainly derive from the specificities and fieldwork settings of our studies. First, many interviewees in Study I were clinicians working in culturally diverse neighborhoods for many years, while all participants from Study II were clinicians involved in intercultural training. As such, our research participants are likely to be more interested in issues of culture than other professionals in the health and social services system, to hold less stereotypes and more nuanced views of culture, and to highly value cultural diversity and social inclusiveness. If the research was to be conducted again in another context, it is likely that the use and understanding of culture by clinicians would be distributed differently on our continuum of dialogue mediation. It is also important to note that the analyzed narratives in our paper are not discourses that emerged *in situ* during clinical encounters but rather in the context of research interviews. This needs to be considered since the presence of researchers has a definite influence over what narratives will be produced and shared by participants. This highlights the importance of establishing a climate of trust and cultural safety not only in clinical practice but also in research; especially, if the goal is to move away from defensiveness, social desirability, and self-silencing of participants, as well as to gain access to other layers of reality.

In addition to our study limitations, it has to be said that the cultural safety paradigm also presents limitations. Because it focuses on power, social inequities, and the vulnerabilities of families, the

notion of cultural safety puts a lot of emphasis on the possibility for the practitioner to harm (Kirmayer, 2012) and less on the possibility of cultural norms and practices to do so. Also, in a cultural safety paradigm it is the person receiving services that holds the power of determining the success of an intervention (Ramsden, 2002). However, because of a multiplicity of factors, from clinical to relational or political ones, the person receiving care is not always in the best position to define if an intervention was culturally safe or not, although neither is the clinician. A combination of perspectives appears as more promising to reduce biases and to promote more equality and shared responsibility in mental health services. Finally, by overemphasizing culture, focusing on cultural safety runs the risk of "fixing" differences, for a diversity of political purposes and orientations, in a way similarly as race used to (Abu-Lughod, 1991). This is why it is imperative to maintain an intersectional and critical approach to cultural safety, as Anderson et al. (2003) clearly demonstrated.

Future research could explore how patients can impact the cultural safety of clinicians and how clinical issues and sociopolitical contexts frame patients' perceptions of cultural safety. It would also be important to study the issue of cultural safety in research. Future studies could examine how researchers' understanding of culture and of cultural safety can influence the formulation of research questions and the development of methodological tools, such as questionnaires and interview guides, which in turn frame participants' narratives, researcher's analyses, and research results. As suggested by our findings, ideological and political agendas are present at every level in clinical practice and research, and they are implicit in the way culture is used. When agendas are guided by a quest for more equity and social justice and less social suffering, then culture is used as a source of joint creativity towards social change. When normalizing forces are at play, culture is used to identify and reduce differences with the intent of assimilating cultural minorities into the majority. However, when othering forces are at play, culture becomes a conceptual tool to exercise power by making other (Abu-Lughod, 1991) by maintaining differences and excluding groups assigned as "cultural"; thus, reinforcing social inequality.

7. Conclusion

Our research findings indicate that culture is present in research participants' discourse as a complex montage of different implicit definitions. Both clinicians' and families' understandings of culture seem to be influenced by definitions of the concept that existed in different periods of anthropological thought, including early 20th century stereotypical and fixed representations, as well as more recent nuanced, fluid, heterogeneous, politicized, and process-based understandings of culture. Our results also suggest that culture can be used as a narrative strategy to mediate clinical encounters, either by engaging in an authentic dialogue, or by avoiding or rejecting it. Thus, culture as a conceptual tool in the clinical realm can be seen as a double-edged sword, in that it can be used to both reify stereotypes and inequalities, as well as mobilize representations to establish cultural safety and enable transformative practice. Our research results highlight the fact that the context of the production and enunciation of participants' discourses around culture is important and includes multiple dimensions, not only the dialogical one but also the social and political ones. Strategies to improve cultural safety in YMH services need to be addressed at the level of professional practices in terms of clinicians' training and working conditions, both of which stress the importance of involving the organizational and systemic levels.

Chapter 2: Trust, Temporality, and Ritualized Play in Intercultural Training (bridge)

In the previous chapter, I demonstrated how both practitioners and families use the term *culture* in their discourse as a narrative strategy to mediate clinical interactions. At times, the term is used to install a sense of cultural safety, but it can also be employed to stereotype minority families; thus, hindering the creation of a working alliance. Interestingly, uses of the concept of culture that revealed a non-essentialist perspective were more common among professionals taking part in Transcultural Seminars. In this second chapter, I now look at the conditions and processes that take place during Seminar meetings, and how they can contribute to increasing the intercultural competence of the participants, as revealed in their discourses. To do so, I use insights of game theory and propose to look at Seminars as "games", at participants as "players", and speech as "moves". I then perform a discourse analysis of the practitioners' narratives, which unfolded in the context of Seminar discussions and during focus groups on this practice. The results notably show that the rules of the game are not the same in Transcultural Seminar meetings as in institutional practice settings, and that these rules invoke an atmosphere of non-evaluation that allows practitioners to learn to shift their perspective and "play" with representations of situations and people. These results were the subject of a poster presentation to an audience of clinicians and researchers at the 5th congress of the World Association of Cultural Psychiatry (WACP) (Johnson-Lafleur, & Rousseau, 2018). They were also published as a scientific paper with a stronger focus on interprofessional collaboration, as presented below.

Johnson-Lafleur, J., Papazian-Zohrabian, G., & Rousseau, C. (2019). Learning from partnership tensions in transcultural interdisciplinary case discussion seminars: A qualitative study of collaborative youth mental health care informed by game theory. *Social Science & Medicine*, *237*, 112443.

Abstract

Although collaborative care was adopted in several countries, including Canada, to improve the health and social services system, partnerships are often experienced as challenging. In many cases, transformative partnership remains a political rhetoric rather than a practical reality. This article presents an analysis of partnership relationships in youth mental health (YMH) using insights from game theory and a qualitative analysis of interactions during transcultural interinstitutional and interdisciplinary case discussion seminars (TIICDSs). Drawing on the analysis of 40 seminar sessions and six focus groups with seminar participants conducted in Montréal (Canada) between October 2013 and April 2015, this article interrogates the conditions and processes present in TIICDSs that contribute to building and strengthening YMH partnerships, examining how tensions among TIICDS participants are attended to. Research results indicate that TIICDSs can be seen as a game operating under different rules than real-life clinical work. They are characterized by the establishment of a climate of trust and respect, a high value placed on diversity and creativity, a concern for affects and power dynamics, a process of inclusive dialogue and negotiation, and a consideration for continuity. The game rules allow participants to safely apprehend a situation from a different perspective, a key competence in intercultural and collaborative YMH care. Results also indicate that participants complexify their representations by playing with divergent perceptions of people and situations and that enhanced case formulations are collective game outcomes. In light of our findings, tensions in collaborations can be seen as constituting both obstacles that can be counterproductive if not attended to, as well as powerful and useful learning tools that, under certain conditions, can support the clinical process and contribute to partnership building. Some clinical and partnership impasses may be overcome through clinical case discussions that allow partners to address these tensions and negotiate power relationships.

1. Introduction

"Partnership" and "collaboration" are two terms that are increasingly used in the field of health and social services delivery. Commonly understood as a structured relationship between partners with mutually defined goals, partnership was adopted as an approach to public services delivery in several countries, including Canada, as a promising avenue for the successful resolution of organizational problems and to improve the performance of the health and social services systems (Hutchison et al., 2011; Masotti et al., 2006). On the field, however, a lot of challenges and questions emerge when partnerships are experienced, since services coordination and delivery operate through collaborations between institutions, administrators, and professionals with different mandates, agendas, and power statuses, inevitably bringing about tensions in these partnerships. In the domain of mental healthcare, although the World Health Organization emphasizes the necessity of a comprehensive and coordinated response to the populations' needs and the importance of strong multisectoral partnerships in this response (2013), some argue that, in many cases, real transformative healthcare partnership still remains a political rhetoric rather than a practical reality (Aveling and Martin, 2013).

This article presents an analysis of partnership relationships in youth mental health (YMH) using insights from game theory and a qualitative analysis of interactions during transcultural interinstitutional and interdisciplinary case discussion seminars (TIICDSs). In these seminars, clinical case discussions can be seen as a window on the partnership practices among different disciplines, institutions, and sectors. Using the terminology of game theory, the questions that will guide the analysis are the following: What kind of game are TIICDSs? What are the rules of the game? What are the disputed resources? What strategies do players resort to? And, what are the potential individual payoffs and collective game outcomes?

Using game theory as an analytical framework and TIICDSs as an illustration, we will argue that tensions emerging in clinical case discussions are indicators of power issues, differences in mandates, and cultural gaps between institutions and professionals. As such, tensions in collaborations constitute both an obstacle that can be counter-productive if not attended to, as well as a powerful and useful

learning tool that, under certain conditions, can help the clinical process and contribute to partnership building. We will also argue that a gap persists between true partnership and partnerships experienced in practice because, in practice, addressing tensions is avoided for two main reasons. First, due to fear that, by overtly acknowledging tensions, an escalation of conflict may occur and relationships among partners, which are oftentimes fragile, may be impaired or even ruptured. Second, because of fear that, by addressing tensions among partners, power structures may be exposed and powerful partners may lose secured privileges. The interest in using insights from game theory is that, by picturing TIICDSs as a type of "game", it allows for an understanding of collaborations neither solely in terms of hierarchical power relationships, nor through solely naive or politically correct rhetoric. Game theory offers an alternative perspective that helps one to understand the importance and the dynamics of trust, temporality, and ritualized play involved in TIICDSs. This explains why this practice allows partners to address tensions rather than negating or avoiding them, since "players" are aware that even though in a game some may "win" and some may "lose", not only will the relationships between "players" not be endangered, but some playful engagement might even be experienced along the way.

The purpose of this article is to interrogate the conditions and processes that structure the participants' interactions in TIICDSs and that may contribute to building and strengthening YMH partnerships, with a particular focus on the way in which tensions among participants are handled and the role they may have in the learning process.

2. Healthcare and social services partnerships: the contribution of game theory

In healthcare and social services, the partnership approach has burgeoned over the last decades and is presented by governing bodies as a key strategy for improving the performance of the public sector. The growing popularity of this paradigm must be situated within the broader historical context of the transformation of the role of the state in healthcare and social services delivery, notably the perceived failure of the welfare state and shortcomings of large and complex bureaucratic structures in providing appropriate and effective healthcare to local populations (Miller and Ahmad, 2000). Contrary to market and neoliberally-oriented approaches, partnership is argued to improve the efficacy and

responsiveness of systems by empowering service users rather than by treating them as mere consumers (Aveling and Martin, 2013). As set out in theory, partnership in healthcare and social services is effective because it brings together everybody's strengths for the resolution of increasingly complex problems to the benefit of service users. In practice, though, the shifts in power relationships associated with partnership and new roles for professionals and their institutions can become a source of significant tensions (Nadeau et al., 2012).

When partnership tensions are addressed in the literature, competition and conflicts between partners are considered as inevitable and depicted as challenging obstacles that need to be overcome or reduced in order to achieve real partnership (Darlington et al., 2004; Scott et al., 2009). Factors that underlie partnership barriers can be regarded as cultural, referring to divergences between institutional and professional norms, values, and practices (Holtom, 2001; Reich and Reich, 2006). Potential clashes of professional identities, interests, and judgment, on the one hand, and different institutions' roles and mandates, on the other, are usually placed at the forefront as possible obstacles to partnership that need to be worked on. Professionals may have unequal status and power and operate within differing levels of autonomy and authority to act. When conflict is instead viewed as an opportunity to deepen understanding and when differences are apprehended as assets for effective collaborative processes and outcomes, then tension can become an interesting tool for positively influencing decision-making processes and transformative partnership can be experienced, as opposed to domination by one or more partners (Gardner, 2005). Although highly promoted, a gap between theory and practice persists in partnership, because integrating various perspectives in the decisionmaking processes often implies going against a deeply internalized hierarchy of professions and institutions which favors maintaining the status quo of the system rather than taking the risk of transforming it (Miller and Ahmad, 2000).

Since healthcare and social services partnerships operate in a competitive and potentially conflicting environment, they fall within the compass of game theory. Game theory is a theoretical framework that originated in the field of mathematics in the 1920s and was further refined to take into account the complexity of human actions and socially interactive decisions-making processes (Colman, 2013).

Game theory studies models of strategic interactions, that are called “games”, which involve at least two decision-makers, called “players”, who all have a set of possible actions to choose from, called “strategies”. A strategy is a plan of actions made by a player, depending on what happens during the game and with respect to their knowledge at the time of action. Players receive a payoff based on the outcome of the choices they make. The rules of the game specify what actions are available to each player, how these actions are taken, what information is available to players to make their move, and which outcome is associated with which combination of decisions made by all the players (Myerson, 2013). By using models to study complex real-life situations, game theory can serve to illustrate the potential for and risks associated with competitive and collaborative behaviors among potentially distrustful partners, as well as the potential for partnership to produce mutually beneficial outcomes. For instance, game theory makes a distinction between games where players can all benefit from the situation or all suffer together, referred to as non-zero-sum games, and games where, if one player gains something, then another loses it, called zero-sum games.

Game theory is also a promising framework in which to think about temporality and continuity because this approach allows for a distinction between single-episode games and repeated interactions (Fotaki et al., 2005). Models can also be built to illustrate the impact of different levels of information on players' strategies and payoffs. As such, game theory offers an interesting perspective on the dynamics of trust involved in interactions, notably in professional contexts. It can help with investigating partnership processes and bringing about useful insights and alternative understandings of diverse partners' motivations and expectations (Lumby and Morrison, 2006). Just as in any social context, tensions and conflicts in healthcare and social service delivery can be apprehended as conflict over resources, particularly when resources are perceived as scarce and unevenly allocated. Disputed resources can be purely material such as access to funds, time, space, professionals, etc., but can also be symbolic, such as access to reputation, status, belonging, or identity. The identification of disputed resources and a better understanding of how people are fighting over them facilitates the development of solutions leading to better collaboration (Guerin, 2002). In interprofessional healthcare research, game theory has been used to analyze the processes of power relationships

among partners (e.g. Lingard et al., 2004) but less so to investigate playful engagement among partners and its outcomes.

3. Methods

3.1. Setting

For more than two decades, TIICDSs have been held in Montréal, Québec, as a way of enhancing the cultural competence of practicing YMH professionals and trainees, given the high cultural diversity in neighborhoods serviced by the TIICDSs partner institutions. Each month, TIICDSs bring together professionals from youth protection services, primary care health and social services organizations, and the education sector. Sessions consist of in-depth clinical case discussions lasting approximately 3 h and they are held alternately in the premises of participating institutions to ensure an equitable representation of partners and utilization of resources. Seminar sessions are structured around an initial presentation made by one or more professionals involved with the family, either intra- or interinstitutional colleagues, followed by a group discussion on the case. Seminar attendees actively participate in the construction of knowledge by asking questions and sharing their own experiences, perceptions, and expertise during the case discussion. Although they were initially created to enhance the clinical and cultural competency of participants, evaluations have shown that TIICDSs contribute to partnership building and promote better collaboration by clarifying partners' various roles and mandates, with their corresponding strengths and weaknesses (Rousseau et al., 2018; De Plaen et al., 2005). In addition, TIICDSs are particularly cherished by participants, who can experience isolation in their institutions and distress linked to discontinuities created by numerous administrative changes (Rousseau et al., 2005).

Starting in 2005, a broad governmental reform took place in Quebec, Canada, in the field of mental health. The main goal of this reform was to improve accessibility and quality of services. To achieve these objectives, primary care resources were strengthened through transfer of funds and professionals from hospital-based structures to primary care ones, and the networking of the system's

different players was promoted. On the field, this complex transformation based on a partnership approach implied a redefinition of roles and mandates for professionals and their institutions, which questioned traditional power relations and often brought tensions between partners. In the wake of this reform, clinicians once again expressed a strong need for discussion spaces and face-to-face meetings with colleagues and partners (Nadeau et al., 2012).

3.2. Protocol

In 2013, a research evaluation was initiated to document the impact of TIICDSs on partnership, on clinical, practice and on the subjective experience of participants. Between October 2013 and April 2014, and between September 2014 and April 2015, three different groups held monthly seminars for a total of 45 sessions (15 meetings for each group). One-hour focus groups were also held with a sub-sample of participants at the end of each year to explore their perception of the impact of TIICDSs on clinical practice and collaboration. Recruitment was done on a voluntary basis and without incentive, creating a convenience sample of 58 participants. Focus groups were facilitated by the first author who also carried out participant-observation during TIICDSs meetings throughout the study period. Of the 45 meetings, five were not included in the dataset. In all three groups, the first session of the year was not audio-recorded. It was used to inform participants of the research protocol and obtain the group's consent to audio-record the subsequent sessions. Additionally, two meetings that did not consist of clinical case discussions were not included in the dataset. A total of 40 TIICDS sessions and 6 focus groups were audio-recorded, transcribed, and analysed. Ethical approval was obtained from the participating organizations (Centre Intégré Universitaire de Santé et de Services Sociaux (CIUSSS) du Centre-Ouest-de-l'Île-de-Montréal, CIUSSS du Nord-de-l'Île-de-Montréal, and CIUSSS du Centre-Sud-de-l'Île-deMontréal) and consent from seminar attendees. To ensure the confidentiality of research participants, all information that could result in identifying a professional, a specific institution, or a family was slightly modified. In addition, since most participants were female, the pronoun “she” will be used in the text to avoid identifying male participants. Quotes were translated from French to English for publication purposes.

3.3. Analysis

The data was analysed qualitatively. First, a thematic analysis of focus groups was conducted to explore participants' subjective experiences of TIICDSs and to identify the conditions they considered crucial to make these discussions successful in terms of clinical work and partnership enhancement. By going back and forth between the transcripts, a priori and emerging codes, and field notes, a codebook was generated and applied to the dataset by the first author. The final set of themes was reviewed by coauthors who are familiar with the data in order to check that themes accurately reflected the content. Second, a narrative analysis of TIICDSs sessions' transcriptions was conducted to identify occurrences of partnership tensions, defined as “a state of latent hostility or opposition between individuals or groups” (n.d.). A narrative analysis was used because it allows for a detailed exploration of relational aspects of the negotiation between partners, as narrated by participants. Participants' narratives are central to the way they view and imagine their professional practices and collaborations, and narrative strategies provide insight into negotiating mechanisms in power relationships (Blommaert and Bulcaen, 2000). The subsequent analyses focused on defining narrative strategies employed during negotiation processes occurring around these events. The last part of the analysis involved describing and categorizing the processes leading to tensions resolution during TIICDSs. Field notes were also consistently consulted to enrich the analyses and integrate non-verbal elements into the body of data. The first author conducted this analytical process and the results were collaboratively produced, refined, and interpreted among coauthors.

4. Results

4.1. The players

Throughout the duration of the research project, 154 professionals attended TIICDSs and the vast majority of those participants were females (89.0%) in their 30s (35.8%) and 40s (24.5%) (see Table 1). Their principal domains of practice were social work (55.2%), psychology (17.5%), and psychoeducation (13.6%). They were either affiliated with community health and social services organizations (66.9%),

youth protection services (25.3%), or the education sector (schools and school boards) (7.8%). Among TIICDS attendees, 58 participated in focus groups, either at the end of year 1 (36.2%), at the end of year 2 (53.4%), or in both years (10.4%). The majority of focus group participants were also female (93.1%) in their 30s (34.6%) and their 40s (25.0%). The focus group sample primarily included social workers (48.3%), psychologists (24.1%), and psychoeducators (12.1%). These participants were affiliated with community health and social services organizations (70.7%), youth protection services (19.0%), and the education sector (10.3%).

Table 1: Characteristics of TIICDSs and Focus Group Participants

	TIICDS Participants (N=154)		**Focus Group Participants (N=58)**	
	N	**%**	**N**	**%**
Gender				
Woman	137	89.0%	54	93,1%
Man	17	11,0%	4	6,9%
Age				
20 - 29 years	30	19.8%	8	13,8%
30 - 39 years	55	35.8%	23	39,7%
40 - 49 years	38	24.5%	13	22,4%
50 - 59 years	19	12.3%	9	15,5%
60 and more	12	7.6%	5	8,6%
Organization				
Health & Social Services	103	66.9%	41	70,7%
Youth Protection	39	25.3%	11	19,0%
Schools & School Boards	12	7.8%	6	10,3%
Domain of Practice				
Social Work	85	55.2%	30	51,7%
Psychology	27	17.5%	15	25,9%
Psychoeducation	21	13.6%	8	13,8%
Other	21	13.6%	5	8,6%

4.2. The players' roles and moves

Our observations of TIICDSs show that players have four types of actions to choose from, depending on the role they occupy during the game. Potential roles include being a presenter, a resource-person, and an attendee, either active or passive. Although most players are regular attendees, some participate occasionally or only attend one specific discussion to provide additional information to the presenters. Players can choose among the following moves: speak and make an affirmation, comment on someone else's affirmation, ask a question, or choose to remain silent if they are not a presenter or a resource-person.

4.3. The game and its rules

Findings from our analyses indicate that TIICDSs can be seen as a game of case formulation co-construction and that specific conditions are needed to ensure seminars are clinically useful and conducive to partnership building. The establishment of a climate of trust and mutual respect among players was often mentioned as the sine qua non condition for the positive value of TIICDSs. Three broad elements were identified as essential to the establishment of this safe space: 1) group composition, 2) specific characteristics of the resource-person, and 3) continuity and time.

4.3.1. The composition of the group: stability and diversity are key

A stable and mid-sized group, no more than about 25 people, was described as ideal by interviewees who also stressed the benefit of diversity in group members to enrich interactions, as illustrated in the following extracts:

> *Now the group is more stable. But there was a time when it varied a lot. It was more difficult to engage, to take risks. It's quite something. It takes a certain amount of humility to expose our weaknesses.*

To be able to share with different professionals, from different environments, I find it very enriching

Diversity of the group was seen as a source of strength, but the importance of a common element among participants was also expressed, such as interest in intercultural intervention or clinical humility and openness:

I think we need to have a common interest. It's either transcultural intervention […] or openness to other ways of thinking or intervening. I think it's important.

It takes a lot of maturity to be part of what's going on here [in TIICDSs]. […] It can challenge us on many levels, intellectually of course, but also socially and personally. […] So I find that people who come here need to be psychologically strong and, I would say, they need openness. I don't know if you feel like that? (Group agrees). We could end up killing each other otherwise (laughs).

4.3.2. Specific characteristics of the resource-person: expertise and attitude

Various characteristics of the resource-person were identified as crucial to the success of TIICDSs, notably a combination of professional expertise and attitudinal competence. As described by interviewees, the ideal resource-person is a knowledgeable senior clinician who understands group dynamics and is flexible, open, empathetic, and tactful. Such professional and personal characteristics form a certain way of being which helps establish a climate of trust and respect in the group while still ensuring a certain level of leadership. Interviewees appreciated the resource-person's non-judgmental attitude and horizontal way of seeing expertise. They mentioned that when a resource-person shows humility and empathy, not only towards patients and their families but also to practitioners, this plays a role in creating a safe space and in building trustful relationships within the group. These elements are exemplified in the quotations below:

I think that she [the resource-person] succeeds in finding the right balance between sharing her enormous pool of knowledge while still leaving us space to discuss. If she took more space it would become a lecture or a conference. And we could fall into everyone bringing their little contribution without any direction.

She [the resource-person] truly has a human approach, really broad, really respectful, and I think it sets the tone for our meetings and we can explore issues together without the fear of being judged.

4.3.3. Continuity and time

Many focus group interviewees named the passage of time as essential to the establishment of trust among TIICDSs participants. Repeated encounters with the same people allow players to predict each other's attitude based on previous experiences, such as being listened to with respect and empathy. The following extract illustrates this needed condition.

It's almost always the same people, so it feels good to have such a space, like a safe space, where we can truly say things.

4.4. Tensions during TIICDSs: what resources are players fighting for?

Results from our narrative analysis indicate that tensions during TIICDS sessions can emerge in three types of situations. First, they can arise when participants feel challenged in their identity and self-worth, notably with regards to their professional competence or personal morality. Various identities can be solicited during TIICDSs, some more related to individual qualities, and some more linked to collective identities such as belonging to a profession or an institution. These multiple identities can be assigned, adopted, or rejected, and are traceable in the use of specific pronouns and rhetoric (e.g., we, at youth protection, think that …). Second, tensions can be experienced when participants are at odds

with the way another person or collectivity is depicted during the seminar. Finally, tensions can occur when participants disagree with the way a situation is evaluated or described, especially if it comes in dissonance with their personal, professional, institutional, or cultural norms and values. As such, our findings indicate that representations are what players fight for. On the one hand, they may argue about specific representations and sometimes negotiate a hybridization of their perceptions. On the other hand, whatever the representations are, they struggle to preserve a certain level of certainty, resisting the relative confusion that a critical reflection may introduce. In the following extract, tension arises when a presenter seems to feel threatened in terms of their professional competence. Since the resource-person is challenging a claim she made and is then asking a question she cannot answer, the presenter may think her intervention is being called into question, in this case the fact that since an interpreter was not used with the mother then important information might be missing for the evaluation.

-Presenter: She [the mother] speaks English.
-Resource-person: She must speak Mandinka?
-Presenter: I don't know what language she speaks.
-Resource-person: But English is not her mother tongue. Have you ever seen her with an interpreter?
-Presenter: [In a defensive tone] I don't remember if I've seen her with an interpreter. It's been such a long time. I've seen too many people.

Under such circumstances, players can resort to narrative strategies to assert their legitimacy. In the situation described above, the presenter uses contextual justifications to preserve her identity and self-representation as a competent clinician by stressing that she is doing a lot and is overburdened, traits that are nowadays valued institutionally.

4.5. Narrative strategies to negotiate through tensions

When players are involved in tense interactions, either personally or because of their professional, institutional, or cultural affiliations, they often try to portray themselves as legitimate speakers by using the "knowledgeable" identity associated with the theme being discussed. Different legitimacies are associated with specific identities: acknowledged professional training and expertise, experience in an organization or community, personal and sociocultural origins, interdisciplinary hierarchies, institutional mandates, and so on. Access to relevant information is also linked to the feeling of legitimacy and choice of strategy. One might prefer to stay silent if they do not feel knowledgeable enough about the topic being discussed. We identified different types of narrative strategies that can be deployed to defend a claim when tension arises. In these cases, speakers can resort to empiricism, rationalism, power statuses, lived experience, and distancing.

4.5.1. Empiricism

When players resort to empiricism, they bring examples to the discussion that will support a claim they make or challenge someone else's. These reports of observations are brought to the table to contradict or foster a particular representation of a person or a situation, in the hope that this additional information will make the player's claim more trustworthy. In the following extract, two seminar participants challenge the presenter's depiction of a young man discussed during the seminar. They stress the possibility of this youth to act out or even to be homicidal. In this case, the tension is not centred on professional or institutional norms or values, but around divergent representations of an individual person.

> *-Presenter: And he [the young man] never told me that he wanted to kill someone else.*
> *-Participant A: [What about] his cousin … and the boy at school when he was bullied.*
> *-Participant B: And the worker in the staircase.*

4.5.2. Rationalism

Another narrative strategy adopted around tensions is when players make use of rational arguments to address an issue being discussed. They do not resort to observations but to logical reasoning. In some cases, the reasoning falls flat and another perspective is brought to the forefront. The next quote illustrates such a situation during which a participant, a trainee from youth protection, commented on the resource-person's discourse and conflated the notion of confidentiality with that of secret keeping. In this case, the resource-person gently challenged her reasoning with additional information. When she uses the pronoun “we”, she puts herself in convergence with the position of the presenting team (the school team) who agreed with her suggestion of creating a therapeutic space in school for the child wherein what would be expressed would be kept confidential, even though youth protection services were involved in the case.

> *-Participant: I would be careful concerning the confidentiality issue. […] Maybe it could be difficult for this child. There are secrets at home; there are secrets at school … And [this could challenge] the collaboration between the school and youth protection …*
>
> *-Resource-person: I understand your comment and what you're saying is very interesting. Theoretically, it's important. But at the same time, in this specific case, because of the story, this child needs to be able to talk about her distress without her having any consequences at all. […] It's in this sense that we stress the importance of confidentiality.*

4.5.3. Power status

Resorting to power statuses during group discussions is another strategy players can use. When a proposed representation they disagree with is being discussed, they can turn to power statuses to support their point of view, such as power provided by acknowledged expertise, access to restricted

information, specialized training, or the law. In the following extract, which concerns corporeal punishment, a seminar attendee working in youth protection services reacts to other participants who mentioned frequently encountering such situations in their practice in migrant neighborhoods and only referring cases to youth protection when they have a clear impression of abuse. Here, personal and institutional identities are clearly delineated and some practices are presented as potentially dangerous because of being based on inadequate knowledge. In this case, the player's legitimacy is asserted in relation to her specific training and expertise. The use of the “we” and “you” pronouns points to these collective identities.

> *In fact, in the article of the law on physical abuse, there are “unreasonable educational practices”. There are many things that we need to evaluate to see if the complaint will be sustained or not. I understand that you hear that every day and all that but it could become dangerous if we give the responsibility to each worker in their office to say: “I will report this situation or not”. Because it becomes so subjective that it can become dangerous. Us [at youth protection], we had referrals where we wouldn't understand why it wasn't reported before, because there had been previous verbalization in the school milieu or in the health and social services center and all that, where children have had marks. It was out of good faith each time. But the law exists, and [youth protection] evaluation workers are precisely trained to see what we will retain and what we will not.*

4.5.4. Lived experience

Another narrative strategy often used around tensions is one that involves sharing lived experiences with the group to assert one's legitimacy as a speaker who “knows things from the inside”. Players can also add strength to their utterance by mentioning temporal elements related to the experience, such as duration (I have known this lady for a long time now and I can say that …) and repetition (It frequently happens at our community clinic that …). In the following extract, the resource-person resorts to the lived experience of another player to question the normality of a behavior in terms of

gender roles. The legitimacy of the player who responds is accepted by the group, based on her ethnocultural identity and personal experience in another sociocultural context.

> *-Resource-person: This is a discordant action. A man wouldn't do that. [Turning to the participant] I don't know if this happens in [country].*
>
> *-Participant: You're right. It's very unusual. Normally a father could ask a woman within the family to talk with the girl, to inquire about that, to explain things.*

4.5.5. Distancing

While some strategies involve players positioning themselves in proximity to the situation discussed by sharing intimate lived experiences, another strategy consists in players distancing themselves from the tension in the discussion. Humour is typically used to contradict or oppose another player's claim, to defend oneself, or to create a necessary distance when tension emerges. Resorting to contextual justifications such as time constraints or institutional mandates is another strategy players can use to distance themselves on a personal level. The following extract illustrates how humour was used to express powerlessness and navigate a tense exchange. By using humour, not only does the presenter challenge the supposed simplicity of putting into action another player's representation of a situation, but she also creates a space where the group can meet her as she distances herself from the shame that can be experienced when one's professional identity is shattered by “not knowing what to do”. And indeed, the group laughs with her and collectively holds her powerlessness.

> *-Participant: She [the patient] needs to cool down and examine her suffering so it can finally be digested, instead of turning it into some sort of theater that everybody strongly reacts to.*
>
> *-Presenter: [In a humorous tone] And how do we do that? (Group laughs)*

4.6. The game individual payoffs: affect and identity

When players choose to make a move by speaking their minds and sharing their perspective with the group, tensions can occur and bring about the use of narrative strategies. Both personal and collective identities, such as those associated with institutions and professions, are solicited during these moments, and depending on the way in which the players present react to narrative strategies, individual and collective payoffs will be determined. When a representation proposed by a player is endorsed or rejected by other players, and especially by the resource-person, then the payoff can be an improvement or loss of status as a legitimate and valuable player. Payoffs can be attributed both individually – to the player who made a move and spoke for instance -, or collectively to all the other players who share an aspect of this player's identity or simply agree with the proposition. For instance, a comment on specific professions or institutions can stimulate a response from other players who identify with these groups. Payoff attributions are typically accompanied by pleasant or painful affects, such as pride, shame, joy, or anger. They can also bring feelings of unsettledness, the mourning of a perception, or a sense of flow, creativity, and belonging. In the following quote, a focus group interviewee expresses experiencing such a difficult affect when she was a presenter, but she also mentions being able to come out of this tension with something very instructive.

> *When you're the presenter and you're asked a question. And you go: "Why didn't I think about that?!" And as a young professional, your sense of competence goes awhhh … But that's it. It lasts five seconds. You breathe and you say to yourself, "Ok, I'm here, so let's go". And all the other times, you ask that question! (Group laughs)*

This last extract also highlights the impact that experiencing the role of presenter, for which the stakes are higher, can have on increasing empathy toward other colleagues presenting a case and additionally emphasizes the importance of the benevolent and trustful ambiance of seminars.

4.7. The game collective outcome: an enhanced case formulation to inform future action

Another finding from our study is an observation that tensions can be fruitfully managed through inclusive dialogue. The role of the resource-person is crucial in establishing this framework of a non-zero sum game beneficial for everyone and in ensuring that certain powerful and assertive players do not dominate the game and frame it as a zero-sum game. Although this role is at times also endorsed by senior TIICDSs players, the resource-person is usually the one who establishes this ambiance of inclusive dialogue by valuing all players' moves, by normalizing their difficulties (the clinical situation you describe is very difficult and tiring …), and by holding their painful affects when a proposed representation is rejected. Our analyses also indicate that temporality is crucial in this process. TIICDSs participants express themselves more openly at the end of the meeting than at the beginning, and at the end of the seminar year compared to the first meetings. Once an ambiance of inclusive dialogue is established, a collective case formulation can be gradually developed by addressing any tensions that emerge among players.

Our research results point to four types of tension resolution processes during TIICDSs: 1) the transformation of certain players' representations, 2) the construction of new representations, 3) the peaceful coexistence of different representations, and 4) the holding of a lack of coherent formulation. In the first case, the role of the resource-person is to gently challenge a representation while preserving the player's sense of belonging in the group so that she, as well as any other silent players who might have identified with her, will feel safe to speak up at another moment. In order to do this, the resource-person can provide additional information in the hope of changing a player's representation that is in opposition with endorsed theoretical assumptions (psychodynamic, ecosystemic, and anthropological). To facilitate such a transformation, this must be handled in a particular manner. The resource-person usually resorts to narrative strategies that leave space for uncertainty and non-closure (maybe … I don't know) and give time to integrate a new perspective (this is not necessarily the case. We'll come back to that later). She needs to avoid being too assertive and potentially creating resistance. The following excerpt illustrates how the resource-person tries to transform a player's representation and complexify a polarized perspective on a clinical situation.

-Player: It's a woman who's been suffering physically for many years. And with all the rejections she experienced in the health system, it's as if we don't take her pain seriously. And her anger contributes to her pain. I think she genuinely feels pain.

-Resource-person: Yes, totally. The idea is not to delegitimize her anger or the reasons why she intends lawsuits. The question is to ask ourselves if it's enough to explain all that [the clinical impasse]. Are there other things to be understood? There is true pain. There is real injustice. But at the same time, we get the impression that there is something else that makes us feel trapped and stuck.

In the second type of process, players bring pieces of information to the discussion, and fragmented but complementary perspectives can be put together to produce a new representation. In the third case, the final formulation includes a coexistence of diverging representations. By acknowledging the presence of uncertainty and a multiplicity of meanings, these formulations are not consensual but they open up the possibility of a respectful dialogue and negotiation process. More specifically, it can take the form of clinically testing a first hypothesis and if the results are not satisfactory or if subsequent information changes the formulation, then the clinical team can try working with another hypothesis. Finally, in some rare cases a formulation cannot be reached and the game outcome consists of collaboratively holding the powerlessness and uncertainty of presenters.

Finally, many participants reported differences between partnership relationships unfolding during TIICDSs and those experienced in their work environment. Some expressed feeling a disconnect between what was developed during seminar sessions and what could be transposed into their institutional contexts and accomplished on the field, both in clinical and partnership terms. While creative action plans are worked on collectively during these meetings, their implementation in practice was sometimes seen as rather difficult and so created a sense of pressure and distress in certain players, even a painful lack of meaning in their professional lives for some, as expressed in the following quotes from focus group interviewees.

I find it difficult to bear the complexity of the case alone afterwards. [My superiors say:] "This case was discussed at the seminar. We've seen the recommendations. You can't do that. We don't agree. We don't understand." And I don't have the group's power anymore. Not everybody has transcultural perspectives and competence.

It reminds us of our own powerlessness when the proposed solutions are not realistic and deliverable.

5. Discussion

5.1. Playing with representations

If we look at TIICDSs through a game theory lens, the combination of the perspectives of focus group participants and of the narrative content of seminar sessions indicate that these seminars present the features of a game during which players co-construct a case formulation in a spirit of partnership and playful involvement. TIICDSs are partially decisional in the sense that players decide on a case formulation with its implication for intervention, although the ultimate decision will be made by the institutions' decision-makers. To ensure these conditions and the playful and creative feel to the seminar sessions, the resource-person is key in creating a ritualized space and time marked by benevolence and trust rather than evaluation and blame attribution. Under such circumstances, participants can position themselves as players in the sense that they maintain some, but not excessive, emotional distance from the issue at hand. When participants do not keep enough distance, they tend to focus solely on what could and should be done, thereby hampering creative thinking. On the other hand, if they maintain too much distance from the story being told, they run the risk of not adequately dealing with the emotions involved and the real-life barriers that need to be considered.

TIICDSs are based on the idea of bringing together a group of people who will share their clinical experiences and expertise through narrative actions, either by presenting a case to be discussed with

the group, or by asking questions, commenting, and providing recommendations to the presenters. Seminar participants need to translate their theoretical background and professional principles into specific situations and explicit case formulation. The framework of TIICDSs, which favors the presence of a multiplicity of identities, forces participants to address areas of difference or disagreement between reference systems and negotiate a minimal common understanding of the case (Rousseau et al., 2005). As such, the legitimacy of TIICDSs attendees is asserted and claimed via difference, which can at times bring tension to the meetings. Representations of the self and of the other, either on an individual or on a collective basis, and representations of situations can be identified through participants' narratives. Our results suggest that representations of clinical situations and of the people involved are what participants play with and fight for. Representations are crucial because they shape experience and local moral worlds (Katz and Alegría, 2009; Kleinman, 1998). They influence clinical practice, such as preferred interventions and the distribution of roles among partners. But representations are not fixed. When tensions arise during TIICDSs and reveal what is at stake for participants in their local moral worlds, representations can be acknowledged and mobilized. That being said, certain conditions specific to TIICDSs, or “rules of the game”, are essential to foster play, creativity, and negotiation, and to ensure that tensions between partners don't impede dialogue, collective work, and ultimately the relationships among partners.

TIICDSs sessions can be seen as game episodes because of the way the discussion unfolds. With time, participants know there will be “winners” and “losers” when the group works collectively on a case formulation and intervention plan. In this sense, the way inevitable tensions are acknowledged and managed is specifically what makes TIICDSs helpful for the clinical process and for partnership building. As expressed by focus group interviewees, when TIICDSs are conducted in a “safe enough space” and characterized by diversity, inclusive dialogue, and negotiation, they take the form of a benevolent and creative type of game. This kind of game allows for the demystification of others (professions, institutions, cultures …) and for the exploration, negotiation, and transformation of power relationships among partners, mediated by cultural representations. Small shifts in representations and positionalities are what make TIICDSs a powerful tool for resolving partnership difficulties and working through clinical impasses.

Clinically, a lot can be learned through the analysis of moments of tension in partnership because they are information-rich events that point to gaps and complexity in stories, and to inter-subjective and intra-psychic dynamics. They reveal what is at stake at the systemic and structural levels, such as power relationships between institutions, professions, cultures, family members, and other categories of actors. For instance, when the group adopts a polarized representation of a person in a story, this can inform participants as to what is happening in the family. Additionally, cases with families from cultural minority backgrounds can become a magnifying lens, revealing divisions and polarizations in society and acting as a catalyst for recognizing issues of alterity. Envisioning TIICDSs as a mixed-motive game allows for the realization that partnerships are not based on duality but are rather characterized by convergences and divergences of perspectives and motivations at multiple levels (disciplines, teams, institutions, sociocultural groups). Disputed representations of people and situations, which are formulated through personal, professional, sociocultural, or political lenses, are traceable in the TIICDSs participants' discourses. These are especially important because they inform action. Ultimately, these representations have a stake in what will become of suffering children and families, but also of clinicians who wish to alleviate the pain of those who come to them for help, while at the same time being sometimes caught in double-bind situations in their institutions.

5.2. Partnership building: from rhetoric to reality

Our research results highlight the fact that although partnership tensions are inevitable, under certain conditions, they can be overcome to reach successful collaborations. In line with Aveling and Martin (2013), we consider that an analytical distinction must be made between instrumental and transformative healthcare partnerships, and that only the latter can deliver the unique clinical and managerial advantages set out in theory. These authors conceive these two kinds of partnerships as ideal types corresponding to the poles of a variety of partnership configurations. At one end of the continuum, instrumental partnerships are structured in a way that serves to perpetuate asymmetries in power relationships where those in powerful positions dominate decision-making processes and the definition of priorities and criteria for success. This type of partnership works by excluding or

marginalizing the perspectives of certain partners; collaboration is instrumental and oriented towards the interests of the powerful. In this case, 'partnership' serves as a rhetorical strategy for obtaining political and popular support, thereby legitimating the priority given to the perspective of those in superordinate positions, such as governing bodies and managers, which are typically more concerned with economic and administrative issues than clinical ones. At the other end of the continuum, transformative partnerships operate by pushing for the involvement of all partners, particularly those who have traditionally been silenced. In contrast to instrumental partnerships, transformative ones tend to challenge traditional hierarchical power relationships since the knowledge and interests of subordinate partners are genuinely taken into account. The specific advantages of transformative partnerships stem from their openness which can generate new understandings and creative approaches to conflicting situations. In addition to such problem-solving opportunities, this kind of partnership makes room for the ethical argument for taking into account marginalized perspectives, for instance by including family members in the decision-making process. While real partnership allows for conflicting situations and impasses to have clear transformative potential, there remains the danger that health and social services institutions will instead adopt rhetorical and instrumental partnerships.

As documented in this study, clinicians are often aware of the rhetorical camouflage overlying governments' discourses on partnership, in the sense that the partnership paradigm is invoked and used as a smoke screen to obscure other patterns of interaction and to normalize hierarchical power relationships. Subaltern partners are particularly aware of and concerned with this double discourse. There is a clear disconnect between the discourse which emphasizes the imperative of partnership and the action of making ruthless cuts to the funding and human resources needed to make real transformative partnership possible. At the scale of TIICDSs, our results suggest that when a minimal level of comfort for all players is not established, then partnership remains at the rhetorical level because subaltern partners will not bring their perspectives to the discussion. Participants do not dare share their vulnerabilities, their failed interventions, and their cultural representations as openly when they do not know how it will be received. As such, partners need more than opportunities to meet and discuss, they also need the time and guidance of competent resource-persons present during these

encounters to help them move away from defensive posturing and empathetically take into account other experiences and perspectives. The passage of time and repeated positive interactions are needed to establish trust among participants. Then, creative solutions can emerge, be they clinical or related to organizational issues. Closure and defensiveness of participants can result in something like a dialogue of the deaf, but it can also mean powerful partners silencing subaltern ones. To make matters worse, when political correctness depicts instrumental partnership as real transformative partnership and thus dialogue is no longer possible because of the rhetorical camouflage of power hierarchies, then players can 'opt-out' and polarize their positions, radicalize their views, and become unresponsive to what the other partners experience and say.

A pitfall to be avoided is the simplification and idealization of partnership. When collaborative relationships are idealized, tensions are difficult to address, but it does not mean they do not exist. Our results suggest that in practice, transformative partnerships are experienced in marginalized contexts that are difficult to transpose to more official contexts. Although official discourses present partnership in healthcare and social services as a non-zero sum game by arguing that even if there are less resources for the whole game, partnership will still benefit everybody - including administrators, service users, service providers, and the community as a whole -, the experience of professionals suggests otherwise. Our research results point to current partnerships as a zero-sum game in which less powerful players suffer the consequences of cutbacks in funding and resources. As such, our results align with previous research that documents how transformative partnership implies taking risks and mourning old ways of doing things, thus challenging traditional power hierarchies, roles, identities, responsibilities, and sense of ownership (Aveling and Martin, 2013; Lingard et al., 2004; Milewa et al., 2002).

It is important to bear in mind the differences experienced by research participants between TIICDSs, which represent a specific type of interdisciplinary interaction, and the heterogeneous realities of the teams and institutions in which they will subsequently try to implement the recommendations. When TIICDSs participants become aware of the complexity of clinical situations, they may sometimes experience tensions when they attempt to initiate a decentering process in a team or institution that

has not followed the same reflective process. This may create disillusion and a feeling of relative failure. In those situations, the modeling of the resource-person and the holding of the group can help to create a space where these concerns can be expressed and where participants can share strategies for initiating a slow institutional transformation, while also mourning their expectations about rapid shifts in their work environments. As such, TIICDSs can be seen as a valuable source of support for participants who can, at times, experience powerlessness in real-life practice.

This study has a number of limitations. First, the study was conducted in a collaborative YMH setting in multiethnic neighborhoods. As such, research participants were professionals who were familiar with intercultural, interdisciplinary, and interprofessional work. This specificity of our study setting frames our participants' perspectives and likely impacts our results. It would be necessary to replicate this study in other contexts with lower levels of professional and cultural diversity in order to understand in which way partnership tensions emerge in such environments and if TIICDSs under these conditions would follow the same processes. Second, the study methods included focus groups but lacked the input of individual interviews. Although focus group interviewees shared their perceptions of TIICDSs and partnership relationships with the research team, they might be more inclined to divulge divergent cultural representations when not in the presence of other partners, which could help us deepen our understanding of communication and tensions in collaborative YMH care partnerships.

6. Conclusion

Because of an increasingly complex, diverse, and interconnected world, the need for partnership among professionals and organizations was stressed by researchers and endorsed by governing bodies, notably in YMH. The rhetoric used by governments and institutions positions partnership as an end in itself, without further elaboration on the conditions necessary for its existence, nor provision of the means to its implementation. If the goal is to promote real transformative partnership, then insights from game theory show that tensions need to be further explored as useful sources of information instead of negated through political correctness and rhetorical camouflage. Our research results suggest that denying and ignoring the necessary conditions for real transformative partnership while

still calling it partnership simply adds insult to injury to those whose voices remain marginalized or even silenced, notably clinicians who have an increasing work load and deteriorating working conditions.

Previous research showed that TIICDSs contribute to establishing and strengthening YMH partnerships and the purpose of this article was to interrogate the conditions and processes that contribute to that. Our results indicate that TIICDSs are a relevant tool for revealing partnership tensions and for negotiating power relationships in such a way that clinical and partnership impasses can be overcome. The conditions and processes that allow for these transformations are face-to-face group discussions conducted within a diverse but safe enough environment, characterized by inclusive dialogue and negotiation. Continuity is also key in this transformative process, but it is important to note that repeated interactions alone do not guarantee a successful partnership per se. It is repeated positive interactions combined with the reasonable expectation of future positive interactions that can create the dynamic that is needed to secure trust among professionals, to deconstruct stereotypes about one another, and to develop and/or strengthen partnership relationships. Under such circumstances, partners can playfully engage with a human story, share their insights, and collectively create possibilities for alternative endings.

Chapter 3: Trainees' Cultural Identities in Tense Times (bridge)

In the previous chapter, I presented an analysis of the conditions and processes in Transcultural Seminars that allow participants to decenter themselves and consider different perspectives on the situations discussed during the meetings. The manuscript focused on issues related to interprofessional collaboration, for instance, cultural differences in terms of professions and organizations, and demonstrated how addressing these tensions also contributed to participants' improved intercultural competence with respect to other types of cultural differences, such as those associated with ethnic groups or other communities. While the discourses studied in the previous chapter were collected during Seminar meetings and research focus groups, the next chapter reports on an analysis of participants' narratives that were expressed in a more intimate context through one on one interviews with me. In this third chapter, I focus on the participants' lived experience of the Seminars, notably the verbalizations of their cultural identities and the affects and cognitions that the meetings invoked. The context of the analysis is local and rooted in issues of social polarization as expressed in Montréal, Québec, Canada; however, the findings can translate to other contexts. The manuscript documents the benefits of a Community of Practice approach, as seen in these Transcultural Seminars, which help support practitioners who are increasingly facing tense social contexts, including those related to cultural identities and inter-community relations. The provision of a *culturally safe enough space* during Transcultural Seminars makes it possible to address these sensitive issues. Similarly, the *culturally safe enough space* of the interviews allowed for the sharing of difficult experiences, making it possible to identify "misconceptions and a wish for reciprocity in cultural safety" as a central theme in intercultural training. It is likely that this sharing occurred because of the proximity in terms of cultural identity between interviewer and interviewee. Additionally, it is interesting to note that some of these disclosures concerned situations that took place during Transcultural Seminars; thus, in the presence of colleagues concerned with these issues. However, this result echoes what I have also been given to experience and observe as a researcher – instances of being othered myself, as a woman and as an ethnolinguistic minority – even among cultural psychiatry experts. This highlights that no one is immune from being the target of stereotyping or discrimination or from using it themselves, including those who work in the field of interculturality.

Johnson-Lafleur, J., Nadeau, L., & Rousseau, C. (2021). Intercultural Training in Tense Times: Cultural Identities and Lived Experiences within a Community of Practice of Youth Mental Health Care in Montréal. *Culture, Medicine, and Psychiatry*. doi: 10.1007/s11013-021-09720-x.

Abstract

This article presents an analysis of the lived experiences of youth mental health practitioners taking part in Transcultural Interinstitutional and Interdisciplinary Case Discussion Seminars (TIICDS), an intercultural training initiative developed in Montréal (Québec, Canada), while considering the current context of increasing social polarizations. Using insights from the Community of Practice (CoP) framework and drawing on the analysis of 21 Seminar sessions and 26 semi-structured individual interviews, this article examines the relationship between local sociopolitical contexts, the participants' verbalization about their identities, and the affect and cognition evoked by the training. Results indicate that TIICDSs present several features of a CoP and that intercultural training needs to build on both theoretical and experiential knowledge, while considering local contextual elements. These include historical and contemporary social representations and power differentials between groups, the cultural identities of trainees, and the institutions and sociopolitical structures in which clinical practices take place. These elements, we argue, are sensitive and potentially conflictual; however, they can be addressed through supportive and reflexive group-based initiatives such as CoPs, which bring together practitioners on a regular basis and provide them with a *culturally safe enough space* in which they can learn to complexify their understanding of clinical situations.

1. Introduction

Despite the increasing recognition of the central role played by culture in mental health problems' manifestations and care (Kirmayer et al., 2014), taking into account cultural dimensions in clinical practice remains a challenge for many practitioners who are sensitive to the complexity of social and cultural phenomena. As for those who do not find it difficult, this does not necessarily mean that they are aware of the ways in which a cultural gap may impact their alliances and interventions. To address this issue, training is often proposed as a solution. The literature suggests that pedagogical initiatives with such goals cannot solely rely on content-focused curriculum, requiring the practitioners' cultural

identities and social positionings to be addressed, as well as an awareness of internalized cultural assumptions to be elicited (Kirmayer et al., 2008). Less attention has been paid to the fact that the trainees' cultural identities and social positionings are dynamic and may evolve in response to the rapid social transformation of our world. The ways in which intercultural training may interact with those processes, destabilizing, transforming, or even shattering trainees' cultural identities and social positionings, is still largely unknown. The overall aim of this paper is to explore the lived experiences of professionals taking part in intercultural training in youth mental health, while taking into account the context of this experience, currently one of increasing social polarizations worldwide, including in Montréal (Québec, Canada). In examining the trainees' perspectives, the relation between the local sociopolitical context, the trainees' verbalization about their identities, and the affect and cognition evoked by the training is analyzed.

2. The Québec context

With a 78% Francophone population, Québec is the only province where French is the most spoken language in English-speaking Canada (Lussier et al., 2019). This linguistic specificity, combined with the province's sociopolitical history, shapes the context for the relations between the Francophone majority and other cultural minorities. Historically, Québec's territory was inhabited by First Nations and Inuit people for centuries before the arrival of French and English settlers, and then by newcomers from various parts of the world. Although Québec's population has never been homogeneous, its ethnocultural diversity has rapidly increased over the last decades as a result of a globalization of migration flows. Nowadays, about 45 000 people immigrate to Québec each year, representing about 20% of all newcomers to Canada. Additionally, whereas by the turn of the twentieth century the majority of immigrants arrived from Western Europe, current migration flows are much more diverse, with people mainly immigrating from Africa (in particular the Maghreb), Southeast Asia, the Caribbean, and Central America (Gouvernement du Québec, 2017). In terms of settlement locations, the city of Montréal continues to receive about 80% of all immigrants to the province, despite governmental policies that were put in place in the 1990s with the goal of increasing the immigration rates outside of Montréal (Vatz Laaroussi, 2005).

The historical relationship between the two colonizing peoples is also decisive in the Québec context. As indicated by Potvin (2010), the asymmetrical power relations between the French and English settlers in Canada have influenced relations between ethnic groups and the expression of hostility towards minorities. As a counterpoint to current official governmental discourses and inclusive policies, Potvin (2020) points out that tensions do remain between communities, and that hostile discourses targeting minorities still circulate in the Canadian and Québec social spaces, describing them as bearers of pathological differences, and thus socially inferior. Potvin (2010) argues that in Québec, this anti-minority phenomenon is linked to "the recent transition of Francophones in Québec from a minority status (French Canadians) to a majority status (Quebecers or *Québécois*)", and the "fragile status of Francophone Quebecers as a majority group and their attachment to the gains of 'modernity' in Québec—the secularization of institutions, movements toward gender equality, and the entrenchment of French as the common public language" (Potvin, 2010, pp. 273, 269). The majority/minority paradoxical stance of Francophone Quebecers in Canada can make ethnic minorities an easy target at which to vent fears and frustrations, especially when they are portrayed as a threat to the above-mentioned achievements in the media or by populist politicians. In English Canada, these othering discourses and "racist slips" are also directed at Quebecers (Potvin, 2000).

Outside of Québec's complex colonial history and current coloniality, in which Quebecers are both colonizers and colonized, and the minority status of French in Canada and North America, it is also important to consider the dominant role that the Catholic Church played in the province's history which led many *Québécois* to perceive religion as highly suspect and as a means of people's subjugation, control, or even abuse, especially towards women and children. It is hardly surprising that in recent years, when there have been heated debates around the degree of accommodation Québec's institutions should concede to requests based on cultural diversity, they have been mainly around elements that are sensitive to Québec's Francophone population, namely religion, language, and gender equity.

In fact, numerous studies conducted over the past three decades on intercommunity relations in Québec and internationally have documented the deterioration in the quality of relations between

ethnocultural majorities and minorities (Heath et al., 2020; Ragazzi, 2016; Rousseau et al., 2011). Since 9/11 and the "War on Terror" launched in its wake, an increase in discrimination and in occurrences of hate crimes and incidents has been observed (Cair-Can, 2002; ADC Research Institute, and Ibish, 2003). In Québec, a series of social events have been considered as turning points in the evolution of majority-minority intergroup tensions. These key moments include the so-called "crisis" around the issue of reasonable accommodations that led to the Bouchard-Taylor Commission in 2007-2008, the debates around the "Charter of Québec Values" in 2013-2014, the attack at the Great Mosque of Québec City in 2017, and the tabling of Bill 21 in the Spring of 2019 that bans religious symbols among public workers (Hassan et al., 2019; Potvin, 2010; Rousseau et al., 2019). These public debates and their instrumentalization by politicians and the media alike have enflamed the social space and damaged intercommunity relations. Harsh discourses have depicted minorities as a threat to social cohesion and xenophobic statements have become common on social media platforms (Potvin, 2017).

In the clinical realm, impacts of such divisive social events on practitioners serving populations with a high level of ethnocultural diversity were also documented. Results from a pilot study carried out at the time of the Charter of Québec Values indicated that this debate made not only minority communities more vulnerable, but also individuals within the majority. The practitioners reported an increase in the psychological distress of their patients and in the experiences of discrimination their patients reported, as well as a weakening of intercommunity relations and a distrust of public institutions. They also reported feeling shaken by the hostility experienced by their patients and, as a result of this experience, many felt at odds with their social environment (Johnson-Lafleur et al., 2016).

More broadly, results from a study conducted in the Québec health and social services network indicated that cultural differences are often put forward by practitioners to explain clinical difficulties and impasses (Pouliot et al., 2015). Cultural misunderstandings have also been reported to cause feelings of powerlessness and frustration and can provoke defensive reactions from clinicians (Daxhelet et al., 2018). These feelings of powerlessness may stem from challenges experienced on an interpersonal level but may also on a social level be associated with the particular dynamics of majority-minority relations in Québec.

This paper presents an analysis of professionals' experiences in intercultural training using insights from the Community of Practice (CoP) model and an analysis of interviews conducted with participants of Transcultural Interinstitutional and Interdisciplinary Case Discussion Seminars (TIICDSs), a professional development initiative implemented in Montréal to enhance the intercultural competency of youth mental health practitioners. As TIICDSs bring together people who share a common professional practice on a regular basis so they can share, exchange, and learn from each other, these Seminars present several features of a CoP (Wenger, 1998; Wenger et al., 2002). The CoP framework offers a fruitful perspective to better understand the challenges of intercultural training since it addresses not only the issue of knowledge transmission but also the role of group dynamics, contextual elements, identity, and social positioning in learning.

The paper examines the participants' perspectives on the processes and dynamics present in TIICDSs. The following three broad questions will guide the analyses: (1) What is the place of cultural identities and of the local context in intercultural training?; (2) What are the participants' perceptions and lived experiences of TIICDSs in terms of cognitions, emotions, sense of belonging, and relations to otherness?; and (3) What elements do participants consider as key in their progress towards a greater sense of intercultural competence? Using concepts from the CoP framework and the reported experiences of TIICDSs participants as an illustration, we will explore the learning process in intercultural youth mental health care from the trainees' perspective and argue that fruitful training initiatives requires the combination of both theoretical and experiential knowledge, while also taking into account local contextual elements. Considerations of these local contextual elements include historical and contemporary social representations and power differentials between groups, the cultural identities of trainees, and the institutions and sociopolitical structures in which clinical practices take place. We will also argue that these elements are sensitive and potentially conflictual; however, they can be addressed through supportive and reflexive group-based initiatives such as CoPs. These can bring together trainees on a regular basis and provide them with a *culturally safe enough space* in which they can learn to decenter themselves and complexify their representations of families and their understanding of clinical situations.

3. Methods

3.1. Setting

The study took place in Montréal, the most populous, multicultural, and multilingual city in the province of Québec. The research participants were professionals attending TIICDSs. For more than two decades, such meetings have been held in Montréal as a way of enhancing the intercultural competence of practicing youth mental health professionals and trainees. TIICDSs bring together professionals from various disciplinary backgrounds – mainly social workers, nurses, psychologists and educators – working in community health and social services organizations (Québec's CLSCs), youth protection services, and the school milieu. During these meetings, which are attended on a voluntary basis, a clinical case is presented by a clinician or a team and is followed by a group discussion. During the discussion, which is facilitated by a senior clinician with experience in intercultural care, the TIICDS participants actively contribute to the creation of an enhanced case formulation by asking questions and providing comments and impressions to the presenters. After a coffee break, during which professionals can network and pursue more informal discussions on the case, the group reconvenes to provide recommendations to the presenters.

Previous research on TIICDSs documented their positive impacts in terms of enhanced clinical competence in intercultural context (Rousseau et al., 2018) and highlighted the conditions under which such practice can lead to increased intercultural competence and interprofessional collaboration (Johnson-Lafleur et al., 2019). That research included focus groups but did not document the individual perspectives of the trainees. Through the present project, participants' lived experiences of TIICDSs, including their awareness of the transformation of their representations and affects, could be explored in a safe and more intimate context facilitating the expression of more socially sensitive content.

3.2. Recruitment and data collection

Four different TIICDS groups located in four Montréal neighbourhoods hold monthly meetings and three of these groups took part in the present study. Ethics approval was obtained from the *CIUSSS du Centre-Ouest-de-l'Île-de-Montréal* and all but one of the four health and social services institutions that were solicited for the project agreed to take part in the study and allowed for members of their staff to participate in a research interview.

Between October 2016 and April 2017, seven TIICDSs were held in each participating group for a total of 21 meetings. In October 2016, at the beginning of the first meeting of the year, the study was presented by the first author to the professionals in attendance to obtain the group's consent to audiotape the meetings and conduct participant-observation. Consent forms were distributed and included an option to agree to be contacted for an individual interview. TIICDS participants could also indicate if they did not want to take part in the research project, in which case all collected data concerning them would be discarded for the analyses. At this meeting, the DSM-5's Cultural Formulation Interview (CFI) – a set of 16 questions and supplementary modules that may guide practitioners in their collection of person-centered cultural information – was also provided to participants and presented as a tool from which they could draw inspiration and use in their work. All meetings' attendees (N=75) allowed for the research project to proceed, with 37 agreeing to be contacted for an individual interview. At the end of the Seminar year, all potential informants were contacted and 26 remained available to take part in an interview with the first author.

Semi-structured individual interviews were conducted with 26 TIICDS participants between May and September 2017. Interviews were conducted in French and lasted between 34 and 94 minutes, for an average of 56 minutes. The interview guide included questions on the participant's professional background, their cultural identities, and their perception and experience of TIICDSs, such as their motivation to participate, expectations, satisfaction with, and perceived impact of TIICDSs. A short sociodemographic questionnaire was also completed at the end of the interviews. In addition to interviews, participant-observations were also conducted throughout the project. Observational field

notes were taken during TIICDS sessions and reflective audio notes were collected throughout the duration of the research.

3.3. Data analysis

TIICDS meetings and individual interviews were audio recorded and transcribed verbatim by a professional transcriber. The material was analyzed qualitatively following three broad stages. First, semi-structured individual interviews were analyzed using a phenomenological approach. To explore participants' personal perspectives and the meaning they attribute to their experiences, verbatim of interviews were read at least twice by the first author to foster a phenomenological immersion in the data, accompanied by inductive analytical notetaking. Second, a thematic analysis of interviews was conducted with the help of *NVivo* (version 10) to organize the data using pre-existing categories (interview questions) as well as emerging ones. By going back and forth between the transcripts, analytical notes, and both *a priori* and emerging codes, a saturation of categories was reached, resulting in a codebook generated by the first author, validated by the third author, and applied to the material. Finally, summary tables were created to synthesize the major thematic and discursive content of the material, while always considering field notes that documented the context of the participants' narratives. The first author conducted this analytical process, and the results were collaboratively produced, refined, and interpreted among coauthors.

In order to preserve the participants' confidentiality, some details of the interview excerpts presented in the results section have been altered, and quotes were translated from French to English by the first author.

4. Results

4.1. Participants' cultural identities: self-awareness, belonging, and personal experiences

Of the 26 professionals interviewed, the majority were female (22) and spoke French as their native language (25). Four participants were brought up in multilingual family environments. Participants were either born in Québec (20), in another Canadian province (1), or were first-generation immigrants (5). In terms of professional background, over half of the interviewees were social workers (16), and other fields of practice represented in the sample included psychology (5), psychoeducation (4), and criminology (1). Nearly two-thirds of participants worked in a first-line health and social services institution (17), while others worked in the youth protection sector (7) and in the school milieu (2). In terms of length of time attending TIICDSs, although the largest portion of participants had been attending for between 4 and 9 years (9), some were in their first year of participation (6) or had been attending for 2 or 3 years (7). Four participants had been TIICDS participants for at least 10 years (see Table 1).

When research participants were met for an individual interview, the first moments of the encounter consisted of explaining the research project and answering their questions. Then, following an opening question on their professional role and status, the interviewer proposed using the DSM-5's CFI question on cultural identity to ask them about their own cultural background. Most interviewees knew the interviewer well, and a climate of trust was palpable during the encounters. Indeed, all interviewees agreed to answer a question they are rarely asked, which, for some, elicited reactions they did not expect. While all interviewees found being asked about their own cultural identities unusual yet "very interesting", a few also found it unsettling and difficult to answer, or even annoying and intrusive. These participants, who had a shorter experience of attending Seminars, considered that being asked this question was an intervention in itself, since it made them reflect on the complexity of their own cultural identities. Some participants also highlighted how this type of question is rarely asked to members of the ethnocultural majority, indicating that "being the other" is rarely experienced among members of majorities.

> *What is so interesting with your question is that you make me aware of the notion of Otherness with the big O. The Other is not me. It's the Other. And I, I am the norm. So*

when you ask me to talk about what describes me and about my identity, I must say I'm a little bit speechless. I don't wake up in the morning thinking: Oh yes, this is me!

We are so not used to talking about that as Whites and Québec-born, in quotation marks. I think these are questions we don't ask ourselves often enough.

Table 1: Characteristics of Research Participants

	Individual interviews (N=26)	
	N	**%**
Gender		
Female	22	84,6
Male	4	15,4
Age		
20 - 29	2	7,7
30 - 39	12	46,2
40 - 49	9	34,6
50 - 59	3	11,5
60 +	0	0
Place of birth		
Québec	20	76,9
English Canada	1	3,9
Outside Canada	5	19,2
First Language		
French only	21	80,7
French and other	4	15,4
Other	1	3,9
Domain of practice		
Social work	16	61,5

Psychology	5	19,2
Psychoeducation	4	15,4
Criminology	1	3,9
Experience in domain (years)		
Less than 1	1	3,9
1 - 5	4	15,4
6 - 10	5	19,2
11 - 20	13	50,0
20 and more	3	11,5
Organization		
Health & Social Services	17	65,4
Youth Protection	7	26,9
Schools	2	7,7
Experience in Seminars (years)		
1	6	23,1
2-3	7	26,9
4-9	9	34,6
10 and more	4	15,4

When participants started to elaborate on their own cultural identities and affiliations, probed by the suggestions listed in the CFI question (ethnicity, place of origin, religion, social class, gender, and sexual orientation), they elaborated on the places and experiences that marked their childhoods and on their roles as parents, clinicians, and members of various groups. Most of them considered themselves as belonging to multiple cultural worlds and embraced their hybrid identities. A few were married to immigrant partners, while others had migrated themselves. Some talked about their attachment to a particular region of the province of Québec, others said they needed to live with one foot in the city and the other in the country. About two thirds of participants mentioned being born and growing up in a very homogeneous milieu and that they had strived for more diversity by moving to the city. Some

also mentioned deliberately choosing a work environment specifically for its embeddedness in a culturally diverse neighbourhood. What is clear is that all the people interviewed shared a definite interest in and some personal experiences with cultural diversity: intimate relationships with people from cultural minorities, long stays out of the home country, and studies in anthropology.

Aside from talking about open-mindedness and interest in people, when interviewees were asked about what defines them the most, the majority of answers pointed to being a woman with a commitment to gender equity, speaking French as a native language, and being open-minded and respectful of differences between people and cultures while promoting inclusiveness and social harmony. The following extract illustrates this finding:

> *I am quite concerned by social inequalities and I would like the world to be a fairer and more egalitarian place, a more inclusive place finally.*

Concerning participants' ethnic identities, some mentioned belonging to more than one ethnic group and were appreciative of these multiple affiliations, while others talked about belonging to the majority. In this regard, one participant explained that their ability to be open and interested in others and to appreciate cultural differences lies in their self-knowledge and in the acknowledgement of the positive and negative aspects of any cultural background, including their own, while also taking into account the influence of local and global sociopolitical and historical contexts in people's lives.

> *I'm a big fan of diversity. I really like to be different and to learn from others. I like to know where people come from, their culture. It has always been enriching for me. And what makes me want to understand the other person is because I know where I come from, who I am, and I'm quite comfortable comparing the pros and the cons of who I am and of where we come from. [...] I'm also interested in international politics and history because it helps to understand some current sociopolitical issues and the choices some people make. Even at the Canadian level, when we understand our history, then we understand why it's always the same issues over and over...*

Finally, another participant highlighted how it became difficult to find a term to describe their ethnic identity as part of the majority in Québec, as the terms traditionally used to do so have been appropriated by both right-wing nationalism and Québec-bashing discourses.

> *Actually, I'm a 'Québécois de souche'. We're having trouble finding a term now... My ancestors are mostly of the French-Canadian type.*

4.2. Misconceptions and a wish for reciprocity in cultural safety

Another notable theme in participants' narratives concerned the social context of their professional practices, which could be tainted by intercommunity tensions and social polarizations that are increasingly present both in Québec and worldwide. These tensions, which tend to crystalize around issues of collective identities, were alluded to by participants who depicted situations in their professional practice where misconceptions of both ethnocultural minorities and the local majority have been expressed. An example of this sense of misunderstanding concerns language and the ability of *Québécois* (Quebecers from French Canadian origin) to express themselves in English. As mentioned by a few interviewees, there is an idea that seems to be circulating among some non-Francophone professionals and families suggesting that all *Québécois* are bilingual and that some refuse to speak English. An explanation given for this lies in the significant differences between the Montréal region, where *Québécois* are mostly bilingual, and the rest of the province.

> *Some teachers at school don't speak English because they come from the regions, from all over the province. And they speak gibberish in English, they struggle, so they hold the parents' meetings in French with the possibility of having an interpreter. [...] One day a father was very angry after a parents' meeting and he told me: "Quebecers do not speak English on purpose!" I tried to explain to him, "That's not true, not all Quebecers speak English." But he said, "We are in Canada", and I said, "Sir, you are in*

Québec, and it is French". I don't think this English/French reality is known among immigrants.

I grew up in the countryside and I still find that it's so different from Montréal that I joke and say that I'm a bit of an immigrant myself. I speak French. My English is not perfect but it's not that bad. Sometimes I look for my words.

The fact that the cultural specificities and fears of the ethnocultural majority are not discussed or taken seriously was also mentioned, notably the vulnerability of French:

In the Seminars, we talk about cultures, about immigrants. But the question of English and French in Québec has never been discussed.

I think I have the fear that one day our French doesn't exist anymore. […] We say: "it's important the survival of their language [minorities]" and all that. I don't know if it's recognized that we [the majority] are afraid too. Is there anyone who says, "Yes, that's important too?" I don't know.

The thorny issue of religion in Québec was also raised by some participants, although openness to religious diversity was not presented as problematic but rather as a source of tension with older people in their entourage; thus, revealing a generational gap.

My father, I think like a lot of baby boomers, is very against the Catholic religion. For him, it's very emotional. There are things that I can't talk about with my father, for instance that I'm trying to make veiled women feel comfortable in Québec. It's a huge source of friction with my father. […] I think he tries, but he's becoming more rigid. […] He would freak out in a Seminar.

Finally, some interviewees considered the content and the tone of the TIICDS discussions to be "in line with their personal and professional values", which reinforced their motivation to attend TIICDS sessions. However, one participant recalled that stereotypes have sometimes been expressed towards *Québécois* and other ethnic groups during meetings, and that they would no longer attend if this was to continue and if the facilitator would not comment on these words. Taken as a whole, the participants' discourses suggest that sensitive and divisive issues emerge during Seminar sessions, despite overall being perceived as a *culturally safe enough space* that is sufficiently protected from stereotyping and othering processes.

4.3. Motivation to participate in TIICDSs and expectations

The motivation for becoming involved in TIICDSs was explored with participants. The main reason cited was to acquire knowledge and develop their professional skills to better understand how to take culture into account in their professional practice. A longstanding interest in working with refugees, asylum seekers, and immigrants was also stressed as a motivation to take part in Seminars, as well as a wish to have access to both up-to-date research-based information and analytical tools to deepen their understanding of complex clinical cases. A feeling of incompetence and powerlessness in the face of situations deemed "particularly difficult", such as those of "honour-based violence", was also mentioned as a motivation to seek out intercultural training opportunities such as TIICDSs.

> *Honour-based violence. I feel a little uncomfortable with that. I mean… It's inconceivable to me. It's something that makes me react. Then I said to myself that maybe there are things I could work on [in TIICDSs] that will allow me to calm myself down internally. And to go and get the right information.*

Other elements that were named included obtaining clinical support, engaging in a reflective practice on their work, and having the opportunity to collaborate with various colleagues while learning from their respective expertise. Although a few participants said they did not have any specific initial expectations of TIICDSs, most of them expressed expectations of having a time and space to hear

about, reflect on, and discuss intercultural issues in the clinic. To be told about different cultures and gain cultural knowledge in general and to increase their awareness of cultural differences was also mentioned, “Sometimes, you don’t even know certain things exist.”

4.4. Perceived impacts of TIICDSs: Containing, questioning, exploring, and giving hope

Several types of impacts were reported by interviewees when they thought about their participation in TIICDSs. It is important to note that these impacts were not simply restricted to their professional practice, but also concerned their personal lives and presented an existential depth. An increased awareness and acceptance of cultural differences was mentioned, along with a broader analysis of clinical cases with less focus on symptoms and diagnoses and more on contextual elements and the families’ stories. One way participants had of describing the global impact of TIICDSs was to see them as a “bulwark against automatic defensive reactions” and against the “tendency to polarize people and situations”. Such a lack of nuance and cautiousness in clinical work was seen as paving the way towards intervention missteps, and such missteps were seen as possibly triggering long-term negative repercussions. Participating in TIICDSs, some interviewees said, helps them to remain vigilant, keep questioning themselves, and to “stretch your open-mindedness”. Moreover, they shared that it helps them think and reflect more before acting and to adopt a humbler stance and an ability to say, “I didn’t think about that.”

Aside from impacting their practice, interviewees also stressed the fact that attending TIICDSs gave them a vital moment to pause, take a step back, and reflect on their professional life and its meaning. Many said these meetings represent an important source of support and professional resourcing, and that they help them overcome the solitude and powerlessness experienced in certain clinical follow-ups through a collective holding of difficult situations. Another impact mentioned was to humanize colleagues and to be less judgmental of them by having access to the challenges they face and to their perspective on situations. Finally, some interviewees expressed that their participation in TIICDSs brought them a sense of “existential soothing”. By witnessing the caring and devotion of fellow

participants, they felt more at peace and it gave them hope that "there is still good in this world", as illustrated in the following extract:

> *Seminars are a space for reflection. A space that gives you access to your humanity by having access to your emotions and being able to process them. We don't only think with our heads. […] This is a space where we can still meet as humans and exchange in a nuanced way; a place where we can speak about real emotions without being afraid. And this gives me a lot of hope. Especially now with the polarized social surrounding environment. The fact that this Seminar exists gives me an anchor point. Not everyone adopts a black and white view. There are people who preserve this dialogue.*

While interviewees brought up many positive impacts of participating in TIICDSs, a few critiques on the training modality were also voiced. First, it was observed that clinicians who attend the meetings are typically the ones "who need it the least", and that those who would benefit the most from the training "are not there". Finally, it was suggested that a "systematization of teachings" would be welcome and could produce more results, with additional readings, theoretical summaries, and references to clinical tools cited as examples. In that regard, although the CFI was presented and distributed at the beginning of the TIICDSs year, some interviewees said that despite being initially enthusiastic about the tool, given their increasingly tight-scheduled working conditions, they did not have the required time and mental space to explore its content and integrate it into their practice.

4.5. Lived experiences: the place of emotions, indignation, and a fear of judgment

From the narrative material gathered during the interviews, it became clear that not only cognitions but also a range of emotions was experienced by participants during TIICDSs. When interviewees were explicitly asked if they felt emotions when they were listening to the case presentations or taking part in group discussions, all of them acknowledged that they did. Participants recollected feelings of anger and sadness while listening to stories of suffering, injustice, and trauma undergone by children, youths,

and families, and discussed feeling powerless, discouraged or even hopeless. Some interviewees mentioned being outraged by the violence and discrimination experienced by some people, with this indignation not only being directed towards experiences of sociopolitical or family violence, but also felt when hearing about insensitive interventions and the rigidity and discontinuities of the health and social services system. This excerpt exemplifies this idea:

> *Every Seminar is moving because every session is the representation of a case of suffering. Then very often there is more than just one suffering. There is the suffering of a family that is in a difficult situation. Sometimes the family's situation with the system is difficult, in addition to the situation being difficult between them. Then there is the suffering of the clinicians, either with that family or with the system. […] The main emotion it will bring is powerlessness. […] And the hardest thing is when it's institutional violence. Because the clinician has less chances to make things move.*

In addition to these difficult emotions, a range of positive affects were experienced during TIICDSs. A few interviewees said they felt immersed in a sense of beauty and hope when the stories depicted a trusting relationship created between youths, families, and clinicians. Stories of fruitful collaborations between clinicians also touched them and often evoked a feeling of empathy for the case presenters. Participants mentioned an "agreeable feeling of belonging and connectedness" with fellow participants when the group was working on solutions to improve a clinical situation and alleviate a family's suffering. Notably, some participants said they left the meeting feeling emotionally heavy and had to process their affect outside the meeting with a partner, friend, or colleague. However, most interviewees said that the unfolding of the discussions had the effect of transforming their painful emotions into an overall lighter and more positive affective state, as illustrated here:

> *When the clinician was telling the story… and when we were talking… progressively… while the Seminar was passing, I felt like… more and more serene. Because you could feel everything was not lost.*

Another theme that emerged as key in the narratives about the lived experience of TIICDSs revolved around the question of judgment. Although many interviewees said they felt they could express themselves during the meetings without the fear of being judged, a few others remarked that they were afraid to talk and present a case to the group over fears of being confronted, contradicted, and ultimately judged. In this regard, the illusion of a complete absence of judgment was also brought up, and some interviewees said they were well aware that saying something "out of place" during a meeting could be noticed and remembered by colleagues. One interviewee summed up this sense of *good-enough* comfortable and non-judgmental space by saying:

> *It's a respectful ambiance and there's room for everyone to express their point of view without being judged. But at the same time, we like to be reframed by someone with an analysis and who we like to listen to.*

Indeed, interviewees were asked if they occasionally felt disconsonant with what was stated during TIICDSs, and the main reasons for disagreeing concerned instances of judgmental and blaming words being directed at a parent, a practitioner, or an entire community. The importance of someone reframing these discourses during the discussions, either the facilitator or another participant, was also stressed as crucial for TIICDSs, and some participants said they would not attend the meetings if this was not done in a diplomatic way. The following quote illustrates these ideas:

> *It's not so much that I disagree sometimes, but that I find that there are shortcuts or quick judgments. But at the same time that's what the Seminar is all about. It serves to undo that. It serves to bring nuances, because everything is only nuances and hypotheses. I think it serves to bring wisdom. Are we more in reaction mode or are we thinking about what will bear fruit and what we want to achieve?*

In fact, one aspect of TIICDSs that was appreciated was the fact that "it is not ideological", as one interviewee stated, in the sense that the approach to case formulation neither adopts a culturalist stance nor does it adhere to universalist assumptions and cultural blindness. If this was the case, many

interviewees said they would then be at odds with the training orientation. On the contrary, many mentioned that attending TIICDSs helped them to become culturally sensitive clinicians by continually striving to find a balance between multiple perspectives and needs, such as the differences between the parents and their children, the school milieu and the family unit, the majority and the minority, and so on.

5. Discussion

The aim of this paper was to explore the experiences of TIICDS participants in terms of cognitions and emotions, as well as the place of cultural identities and local context in the training process. A further objective was to investigate the learning process in intercultural youth mental health care from the trainees' perspective.

Our research results document the fact that youth mental health practitioners operate in an increasingly tense social context, making the training of practitioners in intercultural care even more sensitive and difficult. These intercommunity tensions, which are experienced and felt at the local level, must also be situated in the larger context of increased social inequities worldwide, a global climate of growing hostility towards immigrants and members of religious and cultural minorities, and an exacerbation of identity conflicts (Grim, 2012; Heath et al., 2020; Ozer, 2020). The results indicate that the range of local cultural norms and values, as embodied and enacted by trainees in their discourses and emotional reactions during group discussions, need to be acknowledged, respected, and handled in a non-judgmental way, rather than dismissed or ignored, and that this is key to the success of the pedagogical endeavour.

To interpret our research findings, it is thus necessary to highlight a few contextual elements that are important to consider when studying phenomena occurring in present-day Montréal, such as issues of language, gender equality and religion, all of which are affected by inter-community and inter-generational tensions. Hence, it is not surprising that the clinical cases that yield the most emotional reactions for TIICDS participants are those that lie at the intersection of religion and gender issues. For

example, some interviewees reported that situations labeled as “honour-based violence” have created circumstances in which they felt that they had professional limitations requiring intercultural training and that also led to the creation of intervention protocols in their institutions.

5.1. Cultural identities as sensitive, potentially conflictual, and a source of ambivalence

Referring to “those aspects of our identities which arise from our 'belonging' to distinctive ethnic, racial, linguistic, religious and, above all, national culture” (Hall, 1992, p. 274), the concept of cultural identity is equivocal and contradictory. Although pragmatically useful, the concept is also problematic because referring to any cultural identity, such as *Québécois* for instance, does not point to a monolithic conceptual category, despite this being precisely what the “language of identity” connotes, namely the ideas of “boundedness, groupness and sameness” (Brubaker and Cooper, 2000). Anti-essentialist critiques of the concept have shown that with the globalization process, the way we identify with our cultural identities has become more fluid and politicized. However, for lack of a better theory, the concept of cultural identity is still valuable for thinking through these subjective and discursive phenomena that bear political consequences, while bearing in mind that such identities are in constant transformation, as influenced by history, culture, and power dynamics (Hall, 2011).

In the present study, this ambiguity in terms of belonging to specific groups was in fact alluded to on several occasions in the participants’ discourses. We also observed that interviewees from the ethnocultural majority oscillated between a sense of themselves as a minority or within the majority, depending if they were thinking of their relation to minority families or to the place of French-speaking Quebecers vis-à-vis Anglophones. Indeed, because of the historic background of Québec and contemporary sociopolitical considerations, the identity of the ethnocultural majority can be perceived, assigned, or experienced as both a threatening identity and a threatened one. In our study, most participants were women from the majority who expressed that a commitment to gender equity, being a native French speaker, and working towards more social justice were key elements of their identities. Contrary to what might be expected from research conducted with general populations of clinicians, our results do not indicate any major differences between the discourses of majority and

immigrant trainees as to the importance they attach to culture in their practice. Incidentally, it has been suggested that at high levels of intercultural training, the state of intercultural awareness is similar between minority and majority trainees (Chao et al., 2011). Our findings support the idea that the attitude of trainees towards intercultural care may be influenced by their relationship to their own ethnocultural identity – that may be influenced by the experience of reflecting on it among long-time Seminar participants – and by the positioning of this identity vis-à-vis other ethnic groups in the social space. As such, the common experience of being a minority can lead to a greater understanding and sensitivity towards the experiences of minority families in practitioners who are from minority communities themselves and have also experienced being othered and unsettled by power relations. However, a common experience of discrimination can also lead to a defensive reaction of denial or minimization in minority practitioners to keep a sense of humiliation at bay. Furthermore, denial and minimization can also be used in a more or less conscious way by majority practitioners with the intention of reducing a sense of guilt or shame that might be associated with a privileged position. In this regard, it is interesting to note that a fear of judgment was present in the discourse of the interviewees. This fear, which highlights all the ambivalence of the relation to oneself and to the other, is perhaps linked to the tension between the desire to assert one's specific identity and the desire to accept the other who is different, which can be destabilizing or even disturbing, by potentially calling one's values into question. In fact, this directly addresses the value of "openness to the other" which many participants mentioned as a central feature of their identity.

Finally, several participants expressed that their past experiences related to their sociocultural identities influenced their decision to work in an intercultural context and their wish to contribute to the improvement of majority-minority relations. Interestingly, many from the majority reported experiences of feeling different when growing up in a socioculturally homogeneous milieu and striving for more diversity and inclusiveness. Echoing this point, some minority participants mentioned that this trait of their fellow TIICDS attendees – in contrast to the cultural blindness, ethnocentrism, and increasing social polarizations prevailing in the social space – is what helps them maintain a posture of hope for the clinical situations experienced by minority families and for a more inclusive future. In sum, the participants' discourses indicate that the attribution of cultural identities, both to oneself and to

others, can be complexified and made more flexible by participating in TIICDSs as well as by one's intimate experience with minority/majority issues, such as being a woman, being from an ethnocultural minority, having an immigrant spouse, or having lived abroad.

5.2. Trainees' orientation towards cultural differences

Much like the concept of cultural identity, the notion of intercultural competence is highly complex. Indeed, the ubiquity of cultural processes and the multidimensionality of culture make it difficult to document, understand, and assess the processes and impacts of intercultural training. The trajectory of trainees towards greater cultural sensitivity and responsiveness is very difficult to pinpoint. The acquisition of knowledge and skills in intercultural care and the transformation of attitudes do not solely rely on educational initiatives. Although the contributions of training are undeniable, "learning comes from all kinds of other experiences and personal baggage", as one interviewee accurately pointed out. Practitioners who grew up in a very homogeneous milieu – Québec's rural regions for example – had less access to other cultural worldviews during their socialization process. It may therefore be more difficult for them to develop intercultural awareness and sensitivity, which are the prerequisites for intercultural competence. To conceptualize the trajectory of trainees towards an increasing ability to address cultural differences, Bennett (1986, 1993) posited the Developmental Model of Intercultural Sensitivity (DMIS). This framework proposes a progression of posture or orientation towards cultural differences that offers the potential for increasingly refined intercultural experiences. The DMIS model identifies three ethnocentric orientations, where one's cultural world is experienced as "central to reality" ("denial", "defense", and "minimization"), and three ethno-relative orientations, where one's cultural worldview is experienced in the context of other cultures ("acceptance", "adaptation", and "integration"). In the present study, the sample consisted of practitioners working in culturally diverse neighbourhoods who chose to participate in the TIICDSs on their own initiative. For this reason, it is not surprising that most of the time, the interviewees' discourses are not at the beginning of Bennet's continuum in the ethnocentric orientations of denial and defensiveness but are rather mostly in line with ethno-relative orientations. This characteristic of our participants clearly shows that training for all is not the same as training for those interested in

intercultural care and who show a minimum level of knowledge about cultural differences. Although both basic training and specific training is necessary, they do not pursue the same objectives. While basic training aims to increase the cultural awareness and sensitivity of practitioners, specific training such as TIICDSs is more focused on supporting intervention practices and is oriented towards a more complex integration of cultural issues in practice (Pouliot et al., 2015). Moreover, TIICDSs adopts a critical and reflective approach. For such types of training, a Community of Practice (CoP) model offers several benefits.

5.3. The community of practice approach: holding multiple identities, belonging, and learning from complexity

Results from this study indicate that TIICDSs are a type of training that present the characteristics of a CoP. As a counter-discourse to individualistic and cognitivist theories of learning, the notion of CoP was coined by Lave and Wenger (1991) who defined it as "a system of relationships between people, activities, and the world; developing with time, and in relation to other tangential and overlapping communities of practice" (Lave & Wenger, 1991, p. 98). Wenger specifies that the CoP notion refers to a "social process of negotiating competence in a domain over time" (Farnsworth et al., 2016), which entails a process of identification with a given field of practice. He further argues that CoPs are characterized by meaning negotiation and identity formation through participation and reification processes. By taking part in recurrent collective activities, participants in a CoP end up giving shape to group-based lived experiences via the production of a shared repertoire of resources, such as representations, routines, concepts, symbols, and tools (Wenger, 1998). Thus, the group-based approach of TIICDSs offers a modality of training where the group provides access to shared and locally embedded experiential knowledge and to potential collaboration and support networks among participants. Indeed, while these Seminars are based on the state of knowledge in the social sciences and the mental health disciplines, they also create new knowledge by the likes of stories, rituals, and intervention ideas that take the local context into account. Our results have shown that while working on collective case formulations, the reification of the group's creation provides participants with a

repertoire of locally embedded knowledge and resources, as well as with a sense of belonging to a support group.

Another facet of the field of intercultural training that benefits from the literature on CoPs is the importance of co-presence in learning. This highlights the emotional anchoring of personal transformations which applies not only to people in a therapeutic process but also to practitioners in training. The co-presence of different identities, knowledges, and sociopolitical orientations during TIICDSs brings implicit cultural representations and social positioning to light while the group works on a common story. In doing so, TIICDS participants challenge, reinforce, transgress, and negotiate certain representations and norms. Colleagues, by their presence in the flesh, act as representatives of the "others", and their emotional reactions to certain discourses reveal what is at stake in a given cultural representation by making it real, dense, and present. The lived experiences shared by research participants suggest that training initiatives such as TIICDSs, which take the form of a CoP of practitioners characterized by a challenging yet *comfortable-enough* and *safe-enough space*, can help trainees decipher these issues while also feeling supported in navigating these uncomfortable moments. The emotional experiences shared by interviewees showed us that learning about the limits of concepts and theories to grasp the clinical reality of families can be very unsettling, just as learning to restrain from dichotomous thinking and judging to push away difference can be uncomfortable. As expressed by some participants, the process of learning in intercultural care requires openness, leading to potential discomfort; however, openness presupposes emotional safety, which is linked to personal and collective identities, and therefore necessary to achieve cultural safety. What is more, some participants expressed that being part of TIICDSs brought them hope that one day discriminatory social structures, as rooted in institutions, will be transformed to become more socially equitable and inclusive. Thus, our results suggest that intercultural training requires attending to both cultural and structural elements that are linked to power differentials between groups. At the practitioner's level, this implies addressing both intercultural competence and "structural competence" (Metzl and Hansen, 2014), which cannot be done without addressing inequities at the organizational and social levels.

Finally, our results highlight the importance of social and historical contexts in intercultural training that the CoP model can address. In the present era of the early 2020s, the social context is more tense than it was over the past decades when several of the studies in the literature were conducted. In Québec, although the ethnocultural identities of members of the majority may have been even more "unthought-of" than they are today, intercommunity relations were experienced as more mutually enriching at that time, making clinical work with minority families easier to navigate. Identity issues are increasingly heightened now, hence the even greater interest of a CoP to reduce the sense of isolation of practitioners who strive to provide culturally safe care in an increasingly tense context. As one participant put it well, "The Seminars comfort me in my way of thinking."

In sum, our results indicate that what allowed trainees to increase their intercultural competence and to complexify their representations was to feel respected in their identity-related concerns, while also being gently challenged by someone they trusted and to whom was attributed a sound analytical frame and fair clinical judgment (e.g., "I understand your comment, this is a difficult situation, but at the same time…"). One of these cultural identity-related concerns pointed to a fear of a gradual disappearing of Québec's cultural specificity, notably the use of the French language in the face of the hegemony and powerful attractiveness of English in this globalized world. Although this sentiment was only shared with some hesitation, often at the end of the interview, it appears that the ability to do so was likely due to a sense of trust and cultural safety between interviewee and interviewer. Similarly, our results indicate that, in order to learn how to provide culturally safe services, trainees need to feel culturally safe themselves. Yet, not completely. It seems that it is the oscillating movement between comfort and discomfort that contributes to the creation of an inhabitable *safe-enough* and *comfortable-enough space*, and that it is in such a space that trainees can learn to approach situations from different angles and think creatively on ways to ease suffering and build resilience in the face of the discrimination, inequalities, and violence which are growing in the present polarized sociopolitical context.

5.4. Limitations

This study has a few limitations stemming from the specificity of its field work. First, the research was carried out in Montréal neighbourhoods with a high degree of sociocultural diversity. Research participants were professionals who were familiar with intercultural work and open to diversity. They are not representative of all practitioners so results cannot be generalized. It would be necessary to replicate this research in more culturally homogeneous environments or with practitioners with less intercultural experience to explore how sensitive issues would emerge in such settings and if TIICDSs under these conditions would follow the same processes and dynamics or if they would need to be adapted. Second, practitioners involved in youth mental health are more accustomed to interdisciplinary and interprofessional work and thus to the integration of multiple perspectives. Therefore, it would be important to explore whether TIICDSs would present the same dynamics in less interdisciplinary settings such as in adult mental health care. Third, the research methods included individual interviews with a convenience sample of participants who agreed to take part in the study. As such, it is important to bear in mind that the discourses of TIICDS participants who did not take part in an interview may differ from that of those who were interviewed, and that some self-selection bias may be present in our results. Future studies could also look at the role of trainees' personality traits in the acquisition of intercultural competence, which this study did not consider.

6. Conclusion

Previous work on TIICDSs has shown that prolonged participation in this type of practice induces in participants an ability to complexify the identities attributed to members of the families with whom they work and the clinical situations they face (Johnson-Lafleur et al., 2019; Rousseau et al., 2018). The results of the present study support this assertion and the idea that intercultural training induces a complexification of self-awareness of one's own cultural identities, particularly for members of the majority who have been socialized in culturally homogeneous environments. To take trainees “where they are” with regard to their orientation towards cultural differences is thus key in intercultural training if the goal is to avoid denial and defensive reactions. That could mean to listen to their fears

without judgment, even when these relate to the mourning of loss of privileges as members of a majority.

To be effective, intercultural training needs to include the transfer of both theoretical and experiential knowledge, as well as the consideration of local contextual issues. These include the cultural identities of participants, their potentially divergent cultural representations, and the power differentials between groups that operate in the social space. Although sensitive and potentially conflictual, our results support the idea that these elements can be addressed through supportive and reflexive CoPs that bring together trainees on a regular basis and provide them with a *culturally safe enough space* in which they can learn to decenter themselves and complexify their representations of families and of themselves. With a deeper and more complex understanding of clinical situations, practitioners can work more efficiently on the development of culturally acceptable interventions, thereby improving the trust relationship with families and their compliance with clinical suggestions. To do this, the facilitation process is crucial in creating a space in which the ethnocentrism of trainees will be both normalised and tactfully reframed. This centering, decentering, and re-centering movement is made possible by the work and attitude of the facilitator who, by showing empathy towards the trainees and using tact when reframing their discourses, allows for a temporary suspension of their judgment and a decrease in their emotional response and cognitive rigidity when they face destabilizing cultural differences. Attempts to transform attitudes typically encounter confirmation bias, in that more information will not necessarily lead to a change in perspective (Bohner & Dickel, 2011). To counter this, the affective and relational anchoring of learning needs to be considered. Our results indicate that when trainees feel respected on both individual and collective levels and when they have a minimal degree of trust in the facilitator's judgment and analysis, they can learn to think clinical situations through with less defensiveness and come to adopt an attitude of respect and inclusivity, and even value differences. Combined with this work on attitudes, teaching intercultural care through a CoP such as TIICDSs allows practitioners to learn how to identify cultural elements in cases and integrate them into their interventions, with the support of colleagues who can share their locally grounded strategies that take into account local cultural issues and organizational barriers.

Chapter 4: Imagistic Thinking and Worldmaking (bridge)

While the first three chapters of the thesis dealt with discourses and their analysis, so with what is *said*, this last chapter now addresses the question of *the unsaid* – yet experienced and performed – through an analysis of the images that circulated during Seminar meetings, mainly verbal and mental images. This last manuscript brings to the forefront the importance of imagery, imagination, and affects in intercultural training. It also emphasizes the centrality of the body with respect to training and to clinical and psychosocial work in intercultural contexts, as even when we just speak, we do so with our socially differentiated bodies. The writing style employed, that dwells on details of an ethnographic scene, also reveals the importance of the lived experience of the researcher when conducting qualitative research. These findings demonstrate that through the production and encounter of a certain type of images – what I propose to call *living images* – the trainees' orientations towards cultural differences can be transformed from an essentialist and colonial view (what Bennett (1986, 1993), would qualify as "denial", "defense", and "minimization" ethnocentric orientations, as discussed in Chapter 3) to a more critical perspective that seeks to create a more just and inclusive world. This production of alternative images during Transcultural Seminars have the particularity of avoiding the reiteration of institutionalized violence by not dwelling on ethnoracial stereotypes or blunt clinical diagnoses – or what I propose to call *dead images*. These *living images* that are at times produced during Transcultural Seminars are images with a Barthian *punctum*, that is a detail that attracts our attention, interrupts us, and stimulates our imagination to explore other directions and dimensions.

Johnson-Lafleur, J. (submitted). Looking Again and Beyond: The Power of Images in Intercultural Training in Youth Mental Health Care.

Abstract

This article explores the role of images – with a focus on verbal and thought-images – in intercultural training in youth mental health care. That is, it addresses the place of images in a deliberate effort to bring an anthropological approach to professional care, a stance that acknowledges the singularity and the aliveness of the "culturally different" other, thereby momentarily resisting the impulse to "fix" them in place through clinical discourse. Drawing on five years of ethnographic work conducted in Montréal with practitioners taking part in Transcultural Interdisciplinary and Interinstitutional Case Discussion Seminars, this article discusses how the presence of images during these meetings and the attention paid to them can enable practitioners to adopt a different way of looking at the families they work with. To do so, I draw from the writings of thinkers of the image who have reflected on how images work and the power they can have over us. I turn first to the notion of *punctum* developed by Roland Barthes, and then to Kaja Silverman's argument (1996) on the role of the aesthetic object in "educating our look" to develop an ethical and non-violent relation to the other. Through an ethnographic vignette, I describe how images flow during a Seminar meeting and impact the people present, including myself, and argue that working with images in intercultural training is more productive for a transformation of the colonial gaze than the enunciation of general theoretical statements that can be experienced by trainees as judgmental.

1. Setting the Scene: Send in the Ghosts

It was a cold Thursday afternoon in Montréal. The day was far from over, but you could sense it would soon begin to get dark. We were gathered in a meeting room, an unwelcoming semi-basement room, waiting to hear about the case that we would be discussing at this month's Transcultural Seminar meeting[2]. The woman making the presentation arrived a little before the others to draw on the green

[2] These are meetings during which a clinical case is presented by a clinician or a team and discussed with the group to complexify the understanding of the situation. In the literature, this training modality is known as Transcultural Interdisciplinary and Interinstitutional Case Discussion Seminars, but these meetings are simply called Transcultural Seminars by those who participate in them. They will be further described later in the text.

board a genogram[3] of the family she was going to talk about. Other people were gradually arriving, some preparing themselves a coffee in the corner of the room, others grabbing a cookie in the package that had been brought by a group member for the occasion. People seemed happy to see each other. Some participants arrived from outside, while others only had to walk down one or two flights of stairs to take part in the meeting that was held in their organization's building this month. When the time to start the meeting arrived, someone closed the door and the sound of conversations gradually decreased. We all took a seat around the tables that were set up in a large rectangle so that everyone could see each other. As usual, the meeting began by going around the table so that participants could introduce themselves and to identify the organisation they worked in. This part of the meeting is sometimes skipped when people already know each other, but not this time as a few participants were not regulars. There were about twenty people around the table, mostly social workers and nurses, but also psychologists, doctors, and psychoeducators, along with Catherine[4], the meeting facilitator and senior mental health clinician with many years of experience in intercultural care. There were no executives or managers from the organizations represented at this meeting, only practitioners with more or less professional autonomy in their work. And I, as an anthropologist doing research in the same lab as Catherine, was the only one who was not a practitioner. This time, I also noticed that we were all women around the table and that there was no one from the school milieu, only youth protection employees and workers from what we call “CLSCs” in Québec, those community health centers scattered throughout the province.

After Catherine made a few remarks on the importance of keeping the details of the story confidential, Alicia, a woman working in youth protection, began the presentation. At first, she seemed a little nervous, her rapid speech flow and shortness of breath revealing her emotion. But she gradually began to speak with more confidence, encouraged by a colleague who had introduced her and praised her work. The situation was about a 16-year-old girl and a family from Pakistan. The first sentences of the

[3] A genogram is a drawing of a family tree using symbols to represent individuals and lines to indicate relationships. It can include different types of information – births, deaths, ages, genders, marriages, immigrations, diseases, etc. -, and span over several generations.

[4] In order to preserve the confidentiality of the family and of Seminar participants, certain details of the ethnographic vignette were modified as well as the names of the protagonists. The participants' words were also translated from French to English, which hopes to further protect the privacy of those involved in the story.

presentation revolved around the legal aspects of the case, the "grounds for endangering situations" as she told us in a legal jargon all people present understood, me included. The words used by Alicia to describe these *reasons* were quite blunt. She spoke of the "risk of sexual abuse through forced marriage," and of "physical and psychological abuse from the father". We were told that the girl was hit because of her bad grades in school, had trouble sleeping, and that she was very anxious, even suicidal.

The presentation conjured up a series of difficult images. I saw a young girl being hit and denigrated by an unloving father, assisted by an equally cruel and inhumane older brother. I imagined her locked up in the family house and promised to an unwanted marriage in the home country. Probably to an older rich man, I figured. I could not *not* think about the Shafia case[5], a story that has deeply shaken Québec society a few years ago, and particularly youth protection workers who failed to prevent a family tragedy that resulted in the murder of three young girls and their mother-in-law. I felt the presentation started out with some brutal images, and indeed, the people present were listening intently.

Alicia's narration continued on the same note, painting the portrait of a family situation that required our attention and concern, emphasizing the rigidity of the father and his desire to maintain a firm grip on his daughter. "He is *very* controlling", she said. And then, little by little, as the story unfolded, we were gradually provided with little snapshots of ambiguity, that is with details of the story that made the situation at stake increasingly complex. We learned that the girl was being hit not so much in relation to her school grades, but more so about behaviours that could be seen by her family as transgressive. Not coming home at the required time, for example. We also found out that the marriage in question was one that the young girl described as "arranged" or "suggested" by her parents rather than forced. We were also told that the girl panicked when she was informed that her parents would also be questioned about the information she'd just shared. By the end of her interview with Alicia, the girl just wanted to go home and didn't want to pursue this process. Alicia then told us that later that day, the young girl was escorted by the police, to a rehabilitation centre for an

[5] The Shafia family killings took place in 2009 and the conviction of those responsible for the murders – the father, the mother and the eldest son of the family – was obtained in 2012. The family was Muslim and of Afghan origin (The Canadian Press, 2012).

emergency placement. She said she *had* to initiate a "48-hour immediate protective custody", as obviously, the girl sitting in front of her was scared out of her mind. Catherine glanced at me furtively.

Listening to this part of the story, other images came to me. I saw a scared girl caught up in a web of control and violence, with an even bigger reason to be scared out of her mind. She must have been wondering, "What have I done?"

I was completely drawn into the story as the suspense grew, eager to know what was to come next. I must say that I also considered myself very fortunate not to be in the role of facilitating this meeting. Catherine, however, had the responsibility to react to the situation and advise this team. I felt very lucky I could simply listen to the story, because thus far, I was not able to think straight. I was not able to imagine what might be *really* going on in this family.

2. Images and Ways of Seeing

In one sense, this article can be read as an attempt to tackle the question of what passes for *reality* and for whom and how this can be critical in the field of youth mental health care. In this domain of practice, the clinical assessment of a presenting situation is influenced by different elements, many of which are of a cultural nature, notably the family members' and practitioners' potentially diverging views on the problem at hand and the course of action that should be taken (Kirmayer et al., 2008). Whereas such elements seem easy to integrate when considered from the comfort of a theoretical distance, in the field and in the intimacy of clinical encounters, professionals are sometimes confronted with complex situations that require adjustments to their "practice as usual" interventions. Situations can be difficult to classify and can seem to resist being captured through conventional conceptual tools. In turn, these situations may cause feelings of powerlessness and frustration, provoking defensive reactions in practitioners, even sometimes unconscious ones (Daxhelet, Johnson-Lafleur, Papazian-Zohrabian, & Rousseau, 2018), which can adversely affect the quality of their work. Thus, to close the gap between what is advocated in the literature in transcultural psychiatry and the reality encountered in day-to-day practice, the training of professionals is often seen as a solution. However,

the way training can help to bridge different experiences and evaluations of a shared *reality* is rarely unpacked.

While it is commendable that more attention is being paid to the place of culture in mental health and psychosocial interventions, it seems, however, that the growing popularity of what is commonly referred to as *cultural competence* initiatives has led to a simplification of anthropological fundamentals, transforming culture into a list of traits, beliefs, and behaviors attributed to members of a given group, typically in terms of ethnicity, religion or nationality. Although often well-intentioned, some approaches to training in intercultural care tend to reify and essentialize culture and can inadvertently lead to further stereotyping minority communities and de-complexifying the role of culture in clinical practice (DelVecchio Good & Hannah, 2015; Kirmayer, 2012; Kleinman & Benson, 2006). However, alternative training modalities, such as the one studied in this article, attempt to adopt a reflective and critical stance, and try to integrate an "anthropological sensitivity to care" (Stevenson, 2020), an approach that allows one to remain in touch with the ambiguous and problematic aspect of the concept of culture. Indeed, previous research in youth mental health care showed that both practitioners and families use the term *culture* in their discourse as a narrative strategy to mediate clinical interactions. On some occasions, these rhetorical moves tend to reify stereotypes and fix inequalities or deflect personal responsibility. At other times, personal and collective representations can be mobilized through the use of the concept of culture, and in doing so, a transformative goal of the predicament can be developed in a dialogical way (Johnson-Lafleur et al., 2018). Either way, to teach clinicians to be culturally sensitive in their practice in a non-essentialist mode requires addressing not only the image they hold of the people they work with, but also the image they hold of the very notion of culture, and gently modify it when necessary.

The training modality that I examine in this article is that of Transcultural Interdisciplinary and Interinstitutional Case Discussion Seminars. These Seminars were developed and implemented over the last two decades in Montréal with the intention of enhancing the intercultural competence of practitioners involved in adult and youth mental health care. Previous research on these Seminars has shown the positive impact of this group-based training modality on practitioners in terms of increased

intercultural sensitivity and overall clinical competency (Rousseau et al., 2018). Other effects of this practice have also been documented, including the important source of support these Seminars represent for practitioners working in both an increasingly difficult professional environment and an increasingly tense social context with regard to cultural identities and inter-community issues (Johnson-Lafleur et al., 2021; Johnson-Lafleur et al., 2019). The required conditions to achieve positive results from this training modality have also been identified; notably, the establishment of a climate of trust and respect and a process of inclusive dialogue and negotiation (Johnson-Lafleur et al., 2019). Although, the discursive and group processes involved during Transcultural Seminars have been explored, the role of images in the course of the meetings has not yet been reflected upon.

Interestingly, Seminar sessions typically begin with an image. The first moments of the meetings are devoted to the drawing of a genogram by the practitioner or team presenting a situation to illustrate the family that they will discuss through symbols and codes. This exercise also represents an opportunity to gather and synthesize all the information collected on a given case: family members, quality of relationships, and important events and dates. Over time, a standard has also been established in the group: it is not seen as proper to present a genogram that only includes the nuclear family. In this way, a genogram can help Seminar participants *see* an important feature of the family, such as meaningful connections between people or intergenerational patterns. Seminar meetings then switch to the narrative mode and continue with the telling of a double story: the narration of events experienced during the clinical follow-up, and the narration of events experienced by the family and its members in their lives. Finally, Seminar sessions are complemented by a group discussion led by a facilitator, a senior clinician in intercultural intervention who tries to bring doubt into the certainties of some trainees with the intention of working on the potential alternative meanings and unfolding of the presented situation. Members of the group also propose intervention ideas to the professional or team in charge of the case.

In this article, I will explore how images and imagistic thinking are involved in the processes at play when youth mental health practitioners learn to take *culture* into account in their work. Drawing on five years of ethnographic work carried out between 2013 and 2018, with practitioners taking part in

Transcultural Seminars, I will discuss how attention to images during Seminar meetings can enable practitioners to adopt a different way of *looking* at the people and families they work with. To do so, I will describe the images produced during a specific meeting and how they circulated among the people present – including myself –, adopt a reflexive stance, and use my embodied experience and my ethnographic self (Hickey, & Smith, 2020) as a window into the reality of the Transcultural Seminars. This article will explore how the presence of images has clearly made a difference in the course of the meeting and potentially in the lives of the protagonists involved in the story. Through an ethnographic vignette, my intention is to try to explore what happens when *something* happens during a Seminar meeting, that is when a certain word or turn of phrase elicits a reaction among participants, or when an example is proposed or a similarity with another case is noticed, generating a shift in the discussion. In these moments, an *image* is conjured up and it clearly affects the people present. I will describe and dwell on these events when an image produces a transformative effect and try to further identify what distinguishes these images from others; specifically, those that produce a feeling of powerlessness, or a sense of *being stuck*.

Before proceeding further, I should note that in what follows, I conceive of the image not in the way that it is understood in everyday language, but as more than a visual entity. I use the word *image* in this text to refer to the concept of the image in the broadest sense, which includes a diversity of imagery, and I am not so much concerned with visual images as with verbal and mental images. Moreover, instead of working from an exhaustive definition of the image, I would like to focus on three characteristics of the image – related to how they work and what they can do – that will serve as an anchor to explore the ethnographic material presented here. First, following W. J. T. Mitchell (1984) when he writes that "an image cannot be seen as such without a paradoxical trick of consciousness, an ability to see something as 'there' and 'not there' at the same time" (p. 509-510), I wish to emphasize that moebius strip-like characteristic of the image. That is, that the image is an entity that is neither solely of the order of the representational – about *something else* – nor solely of the material or *thereness*. It is simultaneously an absence and a presence *in itself*. Also, unlike a clearly formulated interpretation of an observation, an image conveys the ambiguity in meaning of the experience at hand. When commenting on a painting in *Bento's Sketchbook*, John Berger (2011) points out that

occasionally, an accumulation of observations can make an image appear when it is no longer "a heap of signs and becomes a *presence*" (my emphasis; Berger, 2011, p. 8), a presence that can tap you on the shoulder and attract your attention. This *presence* aspect of the image is what charges it with affective intensity. An image can emerge when an encounter takes place between the outside world and one's inner world through the body's sensory organs. The impression left by this exchange can lead to the creation of an image, whether it be a visual, sound, or mental image. This applies as much to objects and people as it does to places, events, and situations. Moreover, when the movement occurs in the opposite direction, that is when we express ourselves, whether through words, bodily gestures or artistic productions, we are also engaged in the creation of images.

The second characteristic of the image that I wish to explore in this article is its capacity to "interrupt us in our thinking" (Stevenson, 2020), and its power to shake up our certainties and make us relate differently. When Barthes (1977) writes about photography in *Camera Lucida* and discusses what makes certain photographs have power over us, he suggests that some images possess what he calls a *punctum*. For Barthes (1977), all photographs have a *studium*, which is graspable by familiarity of knowledge or education, which is of the order of the cultural (1981, p. 25). The *studium* conveys information, what he calls the *first meaning*, but it is also filled with intended and connoted symbolic content, or what he calls the *second meaning* (p. 44). The *studium* can be read, can be decoded, and it generates a moderate affect. By contrast, some pictures have a *punctum*. A detail that defies the *studium* and "pierces us", thus creating something else, a *third meaning* which opens a new reading of the photograph *without* removing the others. Barthes (1981) writes: "[A] 'detail' attracts me. I feel that its mere presence changes my reading, that I am looking at a new photograph, marked in my eyes with a higher value. This "detail" is the *punctum*" (p. 42). Drawing inspiration from Barthes' work, I will explore the ethnographic material presented here by considering different levels of meaning in the images contained in Transcultural Seminars meetings, whether it be a verbal image, a thought-image[6], or the image of a person or of an entire situation. I will focus as much on the informational and

[6] I borrow here from the notion of thought-image (*Denkbild*) in the works of Walter Benjamin. Thought-images are short texts in which the activity of thinking in images is performed in writing in such a way that the dialectic contained in reality and experience is set in motion again with the assistance of a linguistic similitude (Wiegel, 1996 :48). In this article, I use the expression thought-image to name these occurrences when the way an idea is expressed verbally does not resolve the complexity and contradictions in it but rather sets thinking and feeling back in movement.

symbolic aspect of these images, understood as the first and second meanings respectively, but also on the moments when a detail creates a *punctum* in an image and gives way to Barthes' third meaning: the purely imagistic in the image. While images can be read (informational) and can bring a sense of belonging (symbolic), they can also pierce us and shatter what we just thought we saw (imagistic). As such, the word *looking* in this article is used in a broad sense to include the idea of visual perception and other bodily perceptions, such as sensing or having a gut feeling.

Finally, following Foucault (1993) when he claims that the image is a language which "expressed without formulating" (p. 36), I am also drawn to the potential of images to get at what cannot be put into words and at *the unsaid*; thus, opening us to non-discursive and even non-cognitive ways of knowing. Hence, I am curious about what happens during Seminars meetings, but which is not clearly said and formulated. Therefore, my interest in the role of images in intercultural training relates both to their centrality in the lived experiences of trainees, as well as to their use as a powerful tool in rhetoric, that is in discursive moves aimed at convincing oneself and others of a certain way of seeing things by getting our audience to notice certain aspects more than others. I will look at how images are involved in these communication and meaning-making games and explore their power in changing the course of events.

3. The Myth of the Protocol: A Crack in Everything

The moment when Catherine asked Alicia a first question after she completed her presentation was one of those moments when you get a vague feeling that something is happening, or is about to happen: "Is that all you presented to the court or did you have any other information?", Catherine asked in a neutral tone that was impossible to interpret as either judging or congratulating Alicia's work. I felt both surprised and relieved by this question. I also felt the atmosphere in the room change, as if people were starting to breathe again. Until then, the meaning conveyed in the presentation had been that the youth protection team was trying to save a young girl from a dangerous family and that the situation was alarming. Suddenly, with Catherine's question, the possibility of another reading of the situation opened up. With this question, it occurred to me that we knew very little about these parents, this young girl, or this situation. The other participants in the meeting probably realized it too.

In fact, on second thought, there was a piece of information during Alicia's presentation that seemed to indicate the potential for a different perspective on the situation. In her narration, Alicia had mentioned that the day after the emergency placement, when she and the girl met again, the young girl had become very emotional when she read the motion that was going to be discussed in court to decide on the next course of action. In fact, both the girl and her parents were opposed to the placement. On reading the motion, the girl remembered an “I love you” that her father had said to her a few days earlier and started to get very emotional, sharing with Alicia that she felt she had ruined everything. “Still,” added Patricia, a colleague of Alicia’s, “it should be pointed out that the intervention was made in an emergency context.” Ignoring this remark, Catherine took the floor again and explained to us that sometimes we go for help and do not necessarily receive the help we expected. “Seeking protection from government officials against her family can also be seen as a betrayal of her family,” she added. “That’s right,” Alicia replied, “that's not what she wanted. She didn't want to be placed. But we’re at youth protection you know. And I was worried. I had to make sure she was safe.”

At that moment, I felt like I was witnessing a battle between two emerging families of images. Alicia was painting a portrait of the parents, using evocative words such as “concerned about their reputation”, “excessive control”, “law of silence”, “no recognition of the facts”, “rigidity”, and so on. It was as if by using those words, she was trying to fix an image of those parents that we should be worried about. However, instead of reacting to this depiction of the family, Catherine mentioned that we could come back to these issues later and she asked Alicia to tell us about what happened next, after they went to court. “It was a very beautiful reunification at the courthouse,” Alicia said. “The judge ordered that the youth's passport be taken to prevent a marriage abroad and that the family cooperate in a social follow-up, but he did not order a placement. They were very happy. The parents were happy, and the girl was happy.” She added, “But of course, I've since then been dealing with a family that's completely shut down. It's very difficult. The father won't give me access to their story. There's a lack of transparency.”

As the meeting progressed, people started asking questions and we gradually gathered other details. We learned that the mother wore a *hijab*, but the daughter was not forced to do so. We were told an

anecdote about a poor school performance that had strongly affected the girl, but to which her parents reacted with much more flexibility and indulgence than the youth herself. One could also gradually feel that there was a good bond of attachment between the members of this family. As the story of the intervention continued to unfold, probed by both Seminar participants' and Catherine's questions, I could gradually see the potential for violence in the health and social services system and how professionals can perpetrate it. I could see that by positioning themselves as defenders of the oppressed in the light of a given prism, powerful institutions and their agents can also be the bearers of another type of violence that can destroy social and family ties, despite the benevolence of intent.

At that point I felt very bad for Alicia. I knew that Catherine felt that we were dealing with a questionable intervention and I wondered if, little by little, Alicia was beginning to realize it herself. And when Catherine asked Alicia if she considered the situation to be an imminent risk to the youth's safety when she initiated an emergency placement, Alicia justified her actions by saying that she was "not willing to take that risk". "What risk?" I asked myself. She did not say. "Why was the girl placed in a rehab center?" a person in the room asked. And that's when the cat came out of the bag. "We applied the protocol," said Patricia. And after that, a risk defined as "honor-based violence" was brought into the discussion and we were told about the protocol[7] implemented at youth protection to deal with such situations. Finally, the ghost of the Shafia case was brought into the discussion by Catherine – "This was implemented after the Shafia case, right?" This was no surprise to me; indeed, I felt it had been haunting the meeting since the beginning of the presentation.

"The implementation of protocols maintains the myth of zero risk," Catherine said. "It allows clinicians to avoid the activities of thinking and feeling", I thought to myself. "It's the same when we deal with suicidal people," she added. "In fact, when we seek zero risk through coercive measures, we alleviate our anxiety as clinicians, yet we increase the risk that the next time that person will not come for help.

[7] Implemented following the submission of a report on "honor killings" in 2013 by the Quebec's Council on the Status of Women, the protocol in question now obliges youth protection workers to take certain steps when the "signalment" they assess contains elements indicating a potential forced marriage or other forms of "honor-based violence". These steps include consultation with their institution's transcultural counsellors, the prompt and separate conduct of interviews with family members, and emergency placement when the physical safety of the person concerned by the signalment is imminently compromised. The degree of fear experienced by the person was also mentioned as an element of assessment.

It's impossible to do good clinical work without taking risks," Catherine stressed. "It was also to protect us," Patricia replied. "It was very difficult for youth protection workers who acted in good faith in the Shafia tragedy. All the investigation, and so on. It was to make sure nothing bad happens." "It's an illusion that nothing bad will happen if we apply a protocol," Catherine rectified, "I think your institution was traumatized by the Shafia case and so was the entire society."

In mentioning the Shafia case, Catherine showed how certain images can do their work by haunting us and taking up a lot of space in our imaginations, for better or for worse. Certain images can stupefy us, especially those that evoke a lot of violence. They can freeze our thinking. "We often read a story from what struck us at the beginning," Catherine said.

4. Thank You for Not Judging Me

In addition to the Shafia case and the protocol, there are a few other powerful images that circulated during this meeting that I still can recall, even years after the event. One was that of a story used by Catherine to teach the people present about what is known in intercultural care as "the decentering process", that is the capacity to approach a situation from a different angle, moving away from an ethnocentric point of view. Up to this point, I felt the presentation and discussion were going in a circular way, as if we were stuck in the groove of two scratched vinyl records: that of the presenter and that of the facilitator. As if the same things were being repeated over and over again. Even if examples and details were added or different words were used, they were all saying the same thing. Broadly speaking, the message conveyed by Alicia was that the young person was a victim in a dangerous situation; that her family, and more specifically the men of the family, were the source of the problem and they had to be more transparent or else had to be foiled so that they couldn't conspire and contaminate the "real story"; and that the mother could be an ally in the intervention. In short, the family dynamic had to be broken in order to protect this young girl.

When Alicia acknowledged that the issue of academic success seemed very important to the young person and suggested that the mother could be an ally to work on this, Catherine came up with an allegory. "The story of the Wind and the Sun goes like this," she said. "There is a traveler with a coat,

and both the Wind and the Sun want to take his coat off. And so, the Wind starts blowing on the traveler. And blows some more. But the more the Wind blows, the more the traveller clutches his coat around him and the less the Wind is able to take the coat off. And then the Sun makes its appearance and warms the traveler. So, little by little, the traveler is more comfortable, is more relaxed, and eventually, he takes his coat off."

By turning to an image, I felt Catherine wanted to help the presenter *see* and *feel* the situation differently, not only rationally. But she also complemented the image with captions: "It is indeed necessary to put the emphasis on the academic side, but if you exclude the father, you will end up with a system that is even more difficult to change. Whereas if you include the father over something that is important to him, education, then you are going to have a winning card. When your intervention doesn't work, you shouldn't do more of the same, you should do something else."

A few months after this meeting, when I was interviewing Seminar participants for my research, such as Alicia and Patricia, I asked them if there were any cases or pieces of cases that stuck with them. Several people mentioned the notion of "violence-based honor" in their narratives, and even the Shafia case, without me bringing up this subject. The Wind and Sun allegory was also reported to me. In fact, when a person who was at the meeting commented on this case a few months after the event, she said "I remember a story about a traveler who was cold or something; it was very imagistic, and it was done in a respectful way. Those kinds of stories allow us to understand but it is not offensive to our self-esteem as professionals," she added. "Imagistic" (*imagé*), "respectful" and "not offensive" are the words she used to describe her learning experience. Unfortunately, I didn't have the quick wit to ask her how or why she found it less offensive. My guess is that it refers to the possibility for clinicians not to lose face but to be just as challenged when a recommendation is mediated by an image. The facilitator did not say that someone made a bad move, instead she shared a story, an allegory – an evocative yet enigmatic image – to activate the thoughts and feelings of the people present and let them interpret the parable as they saw fit. And if some of them were willing to try the hat on and see if it would fit, then they could. But it is difficult, if not impossible, for practitioners presenting a case in Transcultural Seminars to wear the hat of insensitive and incompetent practitioners. And the parents in

the stories cannot wear the hat of abusive and malevolent parents. These are very uncomfortable or even unwearable hats. In this case, the parents want their daughter to be honorable so she can have a promising future. But the word *honorable* is not just a word in Quebec anymore. Since the Shafia honor killings, it has become a *word-image*[8], and quite a scary one.

At one point during the Seminar meeting, a participant shared her view of the situation. “In fact,” she said, “I'd like to try to look at the situation from a different perspective. I had a very similar case once, and in that case the girl had been promised in marriage by her parents and she had decided to follow the tradition to preserve the links with her family and with the community. And one day, I saw her again in the context of a medical follow-up, and I told her that she could always contact me if she felt in danger and needed help. And she told me, ‘This is the way it is where I come from. Thank you for not judging me.’” “What you bring is important”, Catherine said in response, “it's about the agency of the person, the power of the person. It's about the hard choices that some young girls have to make.”

Thank you for not judging me. This is a strong thought-image which, I hope, marked the participants present at the meeting. Accepting a share of violence, restraining a share of our individual agency to preserve a relationship, to preserve social links, to be part of something bigger than ourselves. We all do that. We don’t like to be shamed for it. And the practitioners who work in the health and social services system are also in shackles and chains in order to be part of their profession, to be part of their institution. What kind of shackles do they agree to? In a way, during the Transcultural Seminars, when clinicians are attempting to explore their egocentric and ethnocentric biases, would they also like to be able to say, “Thank you for not judging me?”

[8] The Benjaminian notion of word-image is inspiring to think the power certain words can have over us. As Lisa Stevenson writes when she comments on the usefulness of Benjamin's writings in order to broaden our conception of the image: “for Benjamin, words themselves can serve as images and draw to them the multiple sensations corresponding to the word” (2014: 11). In this sense, I am not so much interested here in what is *said* by the use of a given word but in *the unsaid* it also carries, in the purely imagistic in this word.

5. Transgressions and Transparency

Following this, a good part of the meeting was devoted to discussing ways to repair the therapeutic alliance with the family by offering non-stigmatizing support. The notion of protection was suggested by a participant to replace that of control. This is a word that often circulates in Seminars, a word-image that Catherine often proposes. It is a powerful image. There are not many parents who would not like to be seen as protectors. “And that doesn't stop you from putting a clear line on physical abuse while helping them find other ways to deal with their daughter's transgressions,” Catherine added. “But you shouldn’t humiliate them in doing so.” “That’s right, images can be very hurtful, even humiliating,” I thought. What parent would like to be seen as malevolent? “But” Catherine added, “the girl must also be taught to transgress without getting into trouble.” And then, when it was suggested that the girl should learn to “transgress in secret”, some participants reacted quite strongly to this idea. As if the idea of *transparency* was dear to them. But why, I wondered? This is not the first time that the image of transparency has been circulating in the Seminars, and more precisely the image of a transparency injunction for families. I wonder if this could be related to the ghost of Catholicism in Québec. A reminiscence of the Christian confession. Of the duty, to be a good Christian, to being transparent before God. Of the need to confess in order for our sins to be absolved. Would transparency before the agents of the State have replaced transparency before God?[9] This quest for transparency can also evoke a tendency to voyeurism, but even more a lost attempt to capture people who are trying to escape.

“Don’t put that on Facebook!” I said in a humorous tone, reacting to the idea of learning to transgress in secret. Some people laughed. And just after I said that another image came to my mind. One that was linked to many other discussions we had in many other Seminar sessions, one about young girls from immigrant families who want to live the “Québec lifestyle”, who mess around, who dress sexy, who go out with boys, and so on. It was an image of stories that end badly. The image wasn't very clear, though. It was like a sketch in my head, so I asked Catherine if she could talk to us about these

[9] In *Les aveux de la chair*, Foucault (2018) discusses the Christian history of confession and its role in the construction of the modern subject. Through the management of desire, “truth-telling” practices have become powerful tools of social ordering, interfering in the daily life of couples and the organization of the family unit. The function of confession is also disconcertingly timely in our era of social networks and new forms of expression of life experience.

situations that sometimes occur. In a way, I asked her to complete and refine my image. “Yes,” she said, “we sometimes see this in our clinical work with families in the neighbourhood. Sometimes young girls, by messing around and transgressing the implicit rules of their community, end up having a bad reputation. In some cases, they would like to come back in their community and have a traditional marriage with someone from the home country, but return is no longer possible. That's when they can become very suicidal,” Catherine added.

“Is it possible that this is what she went through in the youth protection office?” I asked. “That the great fear she experienced was that she was afraid she crossed...” “Afraid she crossed the line?”, Alicia completed my sentence. “Yes, and afraid of losing her family?” I added. And that's when another important image came up during this meeting. “Yes, that was clearly it!” said Alicia. “In court, the girl said something that really struck me. She said, ‘I realized that my parents are more important than friends’. Yes, that was clearly it…” she repeated. “This is very important,” Catherine continued. “And I can see you’re touched,” she added, noticing that Alicia was trying to keep herself from crying. “So, what you're going to work on is the fact that she can both have friends and her family. That she can stay Pakistani and still be a Quebecer. That she's comfortable and that her parents are reassured. That she can have friends and still be honourable. How do you navigate the possibility of being both? It's very beautiful what she told you.”

6. On Being Touched and Moved

I realized that my parents are more important than friends. These words uttered in court by the young girl, this specific turn of phrase that surged up in Alicia’s memory touched her deeply. It moved her. This thought-image seemed to condense the whole situation differently and it opened up a space where her affective consciousness could go. It allowed her to think and to feel from the vantage point of the girl’s world. Alicia was touched and she felt it in her body. She was *moved* to the girl’s world. These words uttered in court is what I consider to be the *punctum* in this meeting for Alicia as they clearly affected her and her way of looking at the situation. A flow of contagious images, of one image leading to another, made its emergence possible. When I was sitting in this meeting room, listening to the story of this young girl and her family situation, the image of a transgression, of a line crossed, the

image of a potential point of no return came to me. As I observed to the participants' reactions, I felt that the idea of letting the girl break the rigid rules of her family – and by extension, those of her community – was dear to them. I hindsight, I realize that by verbalizing with a joke the contradiction contained in the spreading of transgressive and intimate experiences on social media by young girls in similar family situations, my unconscious wish was to put some movement back into this fixed and simplified image of this young girl as being only a victim of her family, and therefore without any agency. When I verbalized this image, it resonated in Alicia. It triggered another image within her, and that image was so powerful that it overwhelmed her, that it *pierced* her.

Barthes' (1977) ideas on photography provide me a way of looking at clinical situations and at learning processes during Transcultural Seminars in an imagistic way. This can help us to think about these details that leave an impression on us, these traces that are difficult to name and that come back unexpected when we are no longer looking. The classification of people and situations by medical and scientific language is a way of looking that dwells on the *studium.* This disciplinary clinical look provides a basis for action, it carries hope grounded in similar stories, in similar *cases*. This way of looking generates an emotional distance which is necessary to prevent practitioners from being overwhelmed all the time. In contrast, the *punctum* that in some instances pierces the *studium*, the element of the singular and the unique that interrupts us in our usual thinking and feeling is, for me, of the order of the *living*. It is not fixed, and it cannot be fixed all and for once. The living is simultaneously of the orders of the actual and of the potential. Of the visible and the invisible. The known and the unknown. The living escapes. It is not completely representable, and it always overflows disciplinary knowledge. As Barthes argued, not everything in an image is purely imagistic. An image with a *punctum*, what one could call a *living image*, can interrupt us in our quest for meaning and gesture toward “something counter logical and yet ‘true’”, a “counter narrative” that tells us something (Barthes, 1977, p. 63). This “interruption” in our looking created by the *punctum* allows for an “anthropological sensitivity” to emerge (Stevenson, 2020), an affective consciousness, a sensibility anchored in the particular and turned towards other worlds which often do not yet exist.

Up to this point in the meeting, until the image of the words spoken in court entered the room, Alicia seemed to understand Catherine's explanations in a rational way. She agreed with the *studium* of the meeting, one might say. She showed a "polite interest" and "average affect" (Barthes, 1981, p. 27) toward what Barthes (1977) calls the *obvious meaning* of the pictured situation. She is stuck in an image that only has a *studium*. It has a first and a second meaning. It is informational and it is symbolic. It conforms to other images we have seen *ad nauseum* and digested. Family violence. Islam. Gender. Honor. The Shafia killings. Dominant stereotypes. These images flow and have the effect of *reproducing*. Reproducing agreed upon ways of seeing, standard ways of knowing, and existing power structures. An image that dwells on a colonial *studium* is what I would like to call a *dead image* as it fixes and does not challenge the established order of things, the current coloniality, heir to the ghosts of history. Alicia may be thinking that Catherine, a reputable experienced clinician in transcultural care, is probably right. She knows that she has to take a different perspective and look at things differently to resolve the situation and get out of the clinical impasse. But you can sense that she cannot do it, that emotionally, it doesn't work. That she doesn't understand *from her guts*. Even when Catherine uses an allegoric story or after the contribution of participants who have dealt with similar situations. These attempts to re-mediate Alicia's way of looking at the situation, or, to borrow from Susan Sontag's writings on photography, to change the "captions" under this situation-image (Sontag, 2003), moving from colonial captions to clinical and anthropological ones, all seem to fail. The intervention ideas that Alicia proposes – her suggestion to refer the girl to an organization for victims of family violence, for instance – show her lack of understanding. And all of a sudden, when the question is asked whether it is possible that the great fear experienced by the young girl is not that her family might abuse her and physically hurt her, but rather that her family might abandon her, then the purely imagistic in the situation emerges in her, the *punctum*; thanks to this interruption, she can finally see further, see differently. The *punctum* in that sense would be like a complexification that took place or an imaginary that opened up, probed by a detail that pierced her. The sentence that forced itself in Alicia's mind created what Barthes (1977) calls a "subtle beyond" in her experience of the situation. It led her to *look beyond*. The *punctum* told Alicia: This girl has a life. This girl has a world. This girl has a family that loves her and that she loves too.

7. Educating Our Look

In her book, *The Threshold of the Visible World*, Kaja Silverman (1996) engages in an analysis of the category of love in what she calls an "ethics of the field of vision, and a psychoanalytic politics of visual representation" (p. 2). While being aware of the contempt that love can provoke when taken as an object of study, she nonetheless stresses its importance in both the psychic and the sociopolitical realms. She proposes to conceptualize love by rethinking the idealization and identification processes and their function, for she claims there is no love without some idealization. She suggests it would be beneficial to review our tendency to see the idealization process with suspicion and rather use it as a political tool capable of cultural transformation. The model she elaborates addresses the difficulty of loving bodies that are both different than our own as well as culturally despised by considering the ego issues at stakes in these processes. When she was interviewed about the temporality of what she calls "the look", which unfolds in time and is played out on two dimensions – the conscious and the unconscious – Silverman argued that "there may be nothing we can do to avoid responding with horror or contempt the first moment we apprehend certain sexually or racially marked bodies, both because those responses are so powerfully culturally overdetermined and because they are activated at a largely unconscious level. Nevertheless, it is within our power to work through and undo these acts of violence retroactively, at a conscious if not an unconscious level" (Hüser & Silverman, 1997, p. 4).

To look at the ethnographic material presented in this article, I would thus like to draw inspiration from Silverman's (1996) work when she questions the infinite mobility of the identification process. She writes, "While most of us are, in fact, quite peripatetic when it comes to narrative and structural positionalities, we are considerably less tractable when confronted with the possibility of bodily reconfiguration, especially when it would involve an identificatory alignment with what is socially disprized. Generally, we either cling to our own corporeal coordinates, or aspire to assume ones which are more socially valorized" (p. 2). I would like to borrow this idea and expand it to encompass not only the issue of the body-image subjected to visual aesthetic dictatorships, but also that of bodies with ways of moving, talking, smelling, eating, laughing, crying, affecting, and being affected that are "different", and so that are spontaneously repudiated by cultural majorities. In the case that interests us here, it is as if Alicia spontaneously rejects the bodies of the men in the family because in her

world[10] – and in the world of psychosocial intervention in Québec, which is mostly populated by women of the cultural majority – they are seen as inherently violent and dangerous, and so to be feared. On the other hand, Alicia's look on the bodies of the young girl and her mother seem to trigger an identification process whose idealized object is that of the pure victim. In this sense, it is not surprising that Alicia has mistaken the girl's world for her own, and neither is it surprising that she wanted to protect the girl and, in doing so, protect herself. Alicia's look was spontaneously mediated in a complex and unconscious way both by the local representations of South Asian migrant men who are often construed as aggressors, as well as by defensive psychic constraints that protected her from seeing herself as doing harm to this family, and so of seeing herself as an aggressor. To be able to act as a protector of this young girl, Alicia would have needed to form an alliance with those who love her and want to protect her, her parents – which is what one participant's comment was precisely attempting to help her do – but it was not possible for her to identify with the father, at least not under the unconscious circumstances of the first look.

The message of hope brought by Silverman (1996) is that it is possible to *look again* at despised bodies. It is possible to educate our look by turning to the power of the aesthetic object that provides us with "the terms under which we might idealize and so identify with bodies which we would otherwise reject" (p. 4). This identification process across social categories, mediated with aesthetic objects, allows us to see beauty in divergent bodies, allowing us to challenge the existing system of ideals. Certain images have power over us and bring about affective modes of knowing. The aesthetic charm of these images brings the unconscious tendency of the first look to the conscious level. And the image, contrary to the world and the reality of the other, is under the will of consciousness. The unconscious time of the image is different for everyone on the personal level – one's *punctum* in an image may or may not be the other's – while the conscious time of the information and the connotation is easily graspable by those who share an education and a given cultural world. This meaning is easy to grasp because it is constantly reiterated and "given-to-be-seen" (Silverman, 1996, p. 220). It reproduces fixed idealities and injustices. On the other hand, Silverman's category of the aesthetic object – that I am tempted to juxtapose to Barthes' image with a *punctum,* in the sense that

[10] A world can be defined as a shared image of "what there is to fear" (Stevenson, 2019).

like the work of art, the imagistic image is anchored in the so particular that it becomes universal[11] – points to entities that can act as mediators between worlds, all the while not erasing the uncertainty and the becoming of those worlds. They let the unknown be. Such images can act as "intercessors", to borrow from McLean (2017). They can cross borders and create bridges between worlds. In that sense, thinking with images is perhaps best suited than discourse to complement protocols and counteract stereotypes – *dead images* – in intercultural care. Images are better able to engender new forms of thoughts and help us grasp the unknowable, to assist us in tracing "the contours of an identifiable and knowable social world to evoke the presence within it of that which forever resists the attempt to know and explain" (McLean, 2017, p. 118).

When she discusses the power of images to activate our capacity to idealize – and so to love – divergent bodies, Silverman also warns us against the tendency to introject and project in unconscious attempts to protect the ego. She develops the notion of the "active gift of love" as a "provisional bequest" to underline the elusive and temporary quality of ideality. In other words, by remaining conscious of our own agency in this process of offering love, this stance prevents us from attributing it to an intrinsic quality of the beloved, that is to a fixed essence. It reminds us that the essentially ideal subject does not exist. Educating our look to an ethical and non-violent relation to the other also entails remaining as conscious as possible of the part of violence that belongs to us – as difficult as this is to accept – and is projected on the other, and of the part of beauty that belongs to the other and that we would like to assimilate to ourselves. It implies respecting the otherness of the newly valorized marginal bodies.

At last, to delineate the psychic and social circumstances under which we can look at others and at ourselves in a non-violent way, Silverman turns to D. W. Winnicott's (1974) paradigm of the *good enough*. The concept of the "good enough mother" was coined by Winnicott in his seminal book *Playing and Reality* (1974) to conceptualize the balancing act of the mother who ensures the essential

[11] In line with Silverman's work, what I call the aesthetic object is the image that can be distinguished from the cliché and most of the productions of the entertainment industry. It holds a *punctum*, a purely imagistic element, a specific detail that speaks directly to us. This type of image works by expressing extreme uniqueness and imperfection – thus vulnerability – to which one can identify with on a deep personal level, not just a categorical one. It evokes the beauty there is the unicity of our imperfections.

needs of the child while gradually letting the child experience frustration. Following this principle, the good-enough mother is preferable to the perfect mother because although she ensures the psychic survival of the child, she still leaves room for lack; thus, both desire and further achievement can flourish. In time, the child can learn to deal with the mother's failures and overcome a disillusionment with the world, subsequently relating to it on a more realistic basis. Borrowing from this principle, Silverman (1996) suggests that seeing the others and ourselves through the prism of the "good-enough" allows us to overcome the dichotomies of ideality/abjection and sufficiency/insufficiency. This way of looking opens up a new form of pleasure, a pleasure anchored in the feeling that despite being imperfect, we remain worthy of love. The good-enough is key to look at others in an ethical, productive, and transformative way.

Once Alicia looked at the situation and its protagonists – including herself – through the prism of the good-enough, she was then able to look at the situation in a more nuanced way, simultaneously seeing the reassuring elements in the picture, as well as the more rigid and worrisome ones. The mediation work done by the word-images and thought-images produced by Catherine and other Seminar participants allowed Alicia to complexify the image she held of the father. She now could see a powerless and distressed protector rather than an unloving abuser, while still seeing the violence and suffering experienced by his daughter because of the way he copes with the situation. With this expanded image in mind, she was better equipped to think creatively about interventions that could bring relief to this family.

8. Closing Remarks: Glancing at the Unknown

Clinical impasses experienced by practitioners can trigger a "will to know" (Foucault, 2013) or a desire to learn and understand why people do not always want and appreciate their assistance, and do not always comply with their propositions. They may not understand why clinical and social services interventions may even be experienced by some families as inherently violent. During the Transcultural Seminars, the presenters beg for an alternative interpretation of the situation they are caught in, while they also at times resist it, both consciously and unconsciously.

In this article, I wanted to show how Transcultural Seminars, and more broadly how youth mental health care inspired by anthropology, propose a different way of understanding and assisting. A different way of caring. A stance or a "gesture of care" that acknowledges the aliveness and singularity of the "culturally different other", thereby resisting classification and exceeding conceptual closure (Stevenson, 2020). My intention was also to convey what it can feel like to be under the colonial gaze, especially when this gaze is exercised unconsciously by agents of the state (Fanon, 1971). One can imagine the terror that the young girl experienced in the youth protection office, waiting for the police to take her to a rehabilitation center for the night, and imagining how her parents will feel when they will learn what she did.

I remember when Catherine glanced at me furtively after the police-escorted emergency placement was mentioned. We didn't need to speak. I knew what she thought. And I saw the severe expression on her face. And I was afraid other people saw it too. Afraid they would feel judged by what our glance could mean. Afraid that this should be misread as a way of looking down on Alicia from a moral superiority standpoint. I knew it wasn't about that. That our exchange uncovered that we felt viscerally the hurt caused by the structural violence of the institutional system to which we belong, and of which we are accomplices (Rousseau et al., 2008). And also, in between the lines, that glance meant that we both knew there would be some complex mediation work to do with this story to come to terms with this violence. But would the other Seminar participants get that from our glance? In hindsight, I guess there was even more to our unspoken exchange than that. Perhaps Catherine was also hoping – just as I was – that Alicia would be open enough to complexify the "captions" under the image she had of the situation, but even more so, that she would be sensitive enough to feel its *punctum*.

I once asked Catherine how she was able to maintain a non-judgmental stance during the Seminars when the interventions described are very insensitive, even violent. I remember she replied that she focuses on the vulnerable posture that the clinician agrees to have by volunteering to present a case to the group. *Thank you for not judging me*. I cannot help but see beauty in that.

Discussion

> *The diversity of our experiences is an important and enriching contribution. It is the sum of agreement and disagreement that makes the richness of [Transcultural] Seminars.*

What kind of training can lead a youth mental health clinician or psychosocial worker to offer culturally safe care to minority families? What kind of learning process brings them to modify their ways of intervening so that suffering is alleviated, yet systemic discrimination is not ignored, thus *invisibilized* and reinforced? How can we concretely respond to Kleinman & Benson (2006)'s invitation to transform clinicians into “mini-ethnographers” to avoid the pitfalls of the cultural competence approach in intercultural care? Moreover, since previous research has documented the potential of Montréal’s Transcultural Seminar model to advance towards such goals, then what is it about these meetings that makes it work? In other words, what are the conditions and processes taking place during Transcultural Seminars – both between participants and in their inner worlds – that enable such transformations? These are the major interrogations that motivated the realization of this doctoral study.

At the end of this thesis, the experience of Montréal’s Transcultural Interdisciplinary and Interinstitutional Case Discussion Seminars – as felt, thought, spoken, and performed by those who take part in them – and the transformation they bring about on multiple levels seem to have become considerably clearer. This doctoral initiative, the objective of which was to better understand this professional practice, seems conclusive in that it identified and delineated key aspects of this promising training modality.

First, the results of this study have shown us the importance of transmitting basic notions from contemporary anthropology to mental health and psychosocial practitioners, namely a more accurate understanding of the phenomena of culture and cultural identities. This is fundamental because we have observed how *culture* can be used in youth mental health care, for better or for worse, and often times unconsciously, by both practitioners and families. Sometimes, *culture* becomes a tool to “make

other", and to fix and pathologize difference – as *race* used to do but is less well regarded nowadays (Abu-Lughod, 1991); thus, further hurting cultural minorities. The role of Seminar facilitators and participants who are more knowledgeable about contemporary anthropological knowledge is thus critical to transmitting this perspective to more ethnocentric participants; however, this must be done tactfully. Second, the study findings clarified the framework that should be installed in the meetings to allow participants to be able to consider clinical situations from other perspectives. This framework, or "rules of the game", consists of establishing an atmosphere of trust and respect, clearly orienting the Seminar meetings as a place where judgment is suspended to better support the professionals who bring a case. The constitution of the group is also decisive. A medium-sized group of about twenty people, with a diversity of cultural identities – at least in terms of professional identities – is key to stimulate experiential learning related to the co-presence of a multitude of perspectives. The temporal aspect of continuity to the training is also crucial to establish comfort and trust between the participants. Additionally, the moderation of discussions by experienced facilitators and long-time participants should aim at establishing an inclusive dialogue in which creativity and diversity of viewpoints is valued, while also gently reframed according to current clinical and anthropological knowledge. Facilitators thus serve as role models by transmitting their knowledge and know-how, but above all, by embodying the interpersonal skills associated with intercultural competencies. The necessity to take into account the local context in which the training takes place, and the cultural identities of the participants was also documented by the results of this study. The social dynamics and inter-group power relations originating from local history, as well as the global context of increasing social polarization and inter-community tensions, are essential to consider in order to establish a *culturally safe enough* ambiance during Transcultural Seminars. Ignoring the social sufferings related to participants' cultural identities and social positioning – including dominant ones which imply being positioned as an aggressor – could have the unfortunate effect of making them adopt a defensive posture and not be trusting and comfortable enough to be able to *decenter* themselves, a key competence to be acquired in intercultural intervention. Finally, to help participants integrate the knowledge and know-how of intercultural intervention, as well as to adopt an ethical and non-violent attitude towards the "culturally different" other in their work, paying attention to the unsaid and to the images that circulate in the Seminar meetings seems more promising than just issuing theoretical

statements that can be experienced by participants as judgmental. The creation and provision of alternative images by the facilitators and participants offers the possibility of *touching* co-participants - notably those struggling with the discussed situation – and *moving* their emotional awareness to other ways of understanding and intervening, thereby helping them to get out of their fixed perspective of the situation.

In light of these results, I conclude that the educational approach adopted in the Transcultural Seminars is based on the principle of montage, and that the content implicitly transmitted during the meetings is rooted in a renewed dialogue between the mental health disciplines and contemporary anthropology. This dialogical montage of perspectives is anchored in a more or less articulated reflection on the origins of various ontological and epistemological postures towards the world, including individual, sociocultural and professional stances, but above all, this montage rests on their pragmatic consequences; thus, on the world we intend and contribute to create. These results remind us that the clinical is also intimately political.

The Creative Potential of Montage

> *I've always felt [Transcultural] Seminars as open to ideas that are a bit crazy or a bit out of the norm. There's that openness to talking about* what's there*. And then sometimes, as you go on, you think, is this idea really going to be retained or not so much? or is it going to lead to something else? But there's a principle that we can brainstorm and then we don't have to have a definitive idea right away. It's a 'work in progress' and all suggestions are welcome. Then we'll see what we do with them later, at the end. We will see what we conclude or what we retain from all this. We will see afterwards. It makes it possible to have emotions, images, all that. There's room for that. For something in the order of creation.*

In their introduction to the edited volume *Transcultural Montage*, Willerslev and Suhr (2013) define the principle of montage as "the joining together of different elements in a variety of combination,

repetitions, and overlaps" (p. 1). They write about montage as an "amplifier of invisibility" and argue that the power of montage lies in its capacity to shake up commonsensical views of what we call reality and provoke "generative instability", which results in *provoking*, *suggesting* or *evoking* new ways of perceiving connections. Through juxtaposing and accumulating, the technique of montage allows for "the opening of a gap or fissure, through which the invisible emerges" and, as they justly point out, "the subversive potential of montage lies in its capacity for altering the obvious first sense of an object, image, or perspective by combining two or more elements" (Willerslev & Suhr, 2013, , p. 12).

In the training modality discussed in this thesis, the principle of montage operates on different levels and in several instances. Transcultural Seminars involve and build from the juxtaposition of a multiplicity of perceptions and impressions. The participants produce and offer the group a diversity of representations and images of the people, groups, and situations discussed. How does the school psychologist see this boy's behavior? What about the family doctor who has known the family for so long? Does this social worker from the same part of the world as the family agree with this interpretation? What about this tutor who works closely with the child? Also, what ways of looking, understanding, and caring can emerge from the space created between all these perspectives? What other gazes towards this family can we imagine and integrate to the equation?

During my ethnographic fieldwork among Transcultural Seminar participants, I was given the opportunity to observe that a montage of perceptions can disrupt both the normative space and the disciplinary and cultural certainties of participants, helping them experience the multifaceted aspect of reality. This happens during a singular meeting by the juxtaposition and accumulation of impressions and traces left on people by different bits of a story. However, to deepen the learning process, it seems even more important to experience montage over time, by the accumulation and juxtaposition of different stories involving people we tend to lump together around social and anthropological categories. What is evoked in me when hearing about a family from Iran, after hearing a single story? What about after having heard ten or twenty stories? It is as if intercultural training which aims at the transformation of the colonial gaze on minority families requires – or at least benefits from – a juxtaposition and accumulation of particular situations that form an experiential montage from which

emerges the *invisible*: the complex reality of identities, cultures, psychic life and social phenomena. By way of montage, it is possible to move away from essentialization and let the presence of the invisible emerge and be felt. Montage brings the practitioners to sense an irreducible otherness in the people they work with, an elusive unicity that is impossible to represent in its entirety by existing analytical categories. This awareness can bring participants to experience what Lévinas (1982) called the ethical interpellation of the face of the other – *le visage* – and adopt a stance that acknowledges what Carpenter-Song (2011) identifies as a human need for *recognition* in clinical relationships – a need to first connect on a human level. During Transcultural Seminar meetings, as one of the facilitators put it so well, "We meet people" ("*Nous allons à la rencontre des gens"*). We ask ourselves about who these people are, and we listen a little more and dwell in uncertainty a little longer before trying to regain some form of control by classifying them.

Maintaining the Dialogue between Clinical Practice and Anthropology

The difficulty in witnessing suffering can lead to the spontaneous reaction of wanting to act before understanding, what one might call the "to-do-something syndrome". For youth mental health practitioners, this human response comes with professional responsibility as well. I have noticed in these Transcultural Seminar meetings that new participants tend to want to go straight to the recommendations for intervention immediately after hearing the case, not allowing for a deeper understanding of the situation and the differentiated consequences of the suggested interventions to emerge. I feel that they want to resolve the situation quickly, but at what cost? I have come to understand that what can be destabilizing for them, in these times of speed and urgency, is that Transcultural Seminars force people to *dwell*. To dwell and sense that etiology is not an exact science. To understand that a clinical formulation is a montage of ways of looking. That it is relational and needs to be contextualized in place and time. Seminars bring participants to sense that a clinical assessment is made from *specific* ways of looking and is not *universal*. It is not one, but it is not infinite either. It is rooted in historically constructed systems of signs, meaning, and action (Bibeau & Corin, 1995).

In this thesis, I wanted to show how Transcultural Seminars, and more broadly how youth mental health care open to contemporary theories in anthropology, proposes a different way of understanding and assisting. More specifically, the strength of the Seminars is deployed in two stages. First, by bringing out the *unformulated* through the technique of montage, and then reorganizing this montage of ways of looking according to an ethically anchored orientation. The position taken by the Transcultural Seminar model is that all together, in complementarity, by joining forces and perspectives, we can come to an understanding about how to better intervene. But what does *better intervene* mean? This brings back to the forefront the link between intervening in professional mental health practices and the function of controlling human behavior. Intervening with what objective? Depending on the context, we have seen that the word *better* may have different referents. To maintain the social status quo? To reduce institutional expenses? In Transcultural Seminars, *to better intervene* is understood in terms of finding ways to relieve a family's suffering and distress, while considering both the individual aspirations of its members and the human need for cultural belonging. In the Seminar space, *to better intervene* means remaining aware of the "other" as a person composed of a set of relationships and specific predicaments. During Transcultural Seminars, practitioners learn to remain aware of these tensions and open to surprises; they collectively hold space for these tensions to be explored, even if they are impossible to resolve.

Thus, the experience of Montréal's Transcultural Seminars teaches us two main lessons. First, that the destabilizing and chaotic effect created by a montage of ways of looking is stimulating but must be reorganized to avoid confusion and an absolute relativism that would not take into account the power relations at stake and therefore the consequences of these different ways of looking. Therefore, an absence of organization in the juxtaposition and combination of ways of looking could have the effect of leading to disengaged practitioners, as they may struggle to imagine a future without a clear orientation to refer to. Secondly, what the experience of Transcultural Seminars also teaches us is that this montage of perceptions and evaluations about a situation is a co-construction; moreover, since this co-construction is usually not thought about, formulated, or named, it is typically organized according to the dominant perspectives, biases, and aspirations.

The Cruel Optimism of Tools and Protocols

The results of this study also showed the great usefulness of clinical tools to guide and support practitioners in their work, as tools can help them organize chaos so they can take action. The CFI is especially promising to orient and support professionals when they collect cultural information to perform a "mini ethnography" (Kleinman & Benson, 2006) of the persons they assist. On the other hand, the results also showed the limitations of clinical tools and protocols. They made visible the "cruel optimism" (Berlant, 2011) that exists if practitioners imagine that "nothing bad can happen" as long as they follow protocols and use tools. The results made us aware of the potential consequences of doing without the activities of thinking and feeling. They alluded to the unfortunate impact that can result from applying a tool such as the CFI in an automatic way, without concern for the uniqueness, aliveness, and dignity of the human being facing oneself. Protocols are established by institutions and professionals in positions of authority – managers and doctors for instance – and there is a whole invisible work that needs to be done to adapt protocols to the chaos of daily practices. There is a lot of "tinkering"[12] (Mol, 2009) that practitioners must do to make the illusory predictability of a protocol fit with the erratic reality of a specific body and life; especially, when this life is not consistent with the dominant cultural scripts. In light of the results of this study, it can be argued that Transcultural Seminars help professionals with this tinkering work. It is by accompanying practitioners through the craft of integrating the collected information into cultural formulations and intervention plans of complex cases that learning to be "mini ethnographers" can be achieved by Seminar participants. For some, this is done easily and almost intuitively, while for others, it is more difficult.

Overall, this study's findings demonstrated the need to complement tools and protocols through a practice of dialogue and negotiation. Dialogue and negotiation between individuals, between professions, and between cultural worlds. This ethnographic work illustrated how during Seminars sessions, participants explore worlds – intimate and shared ones – and navigate between them. The study results suggested that meanings can be invented and tried out in a transitional space, between raw affective and corporeal experience, and knowledge contained by cultural mediation and regulated

[12] The link between Annemarie Mol's article and the tinkering work done during Transcultural Seminars was made by Alonso Gamarra Montesinos during Lisa Stevenson's ANTH 611 graduate seminar.

discourse. It appears that Transcultural Seminars are such a liminal space in which participants can momentarily play with the absence of categories, temporarily experiencing without containing and "fixing" (Stevenson, 2020). This way, Seminar participants can collectively use their imagination to create a more habitable world, both for them and for the families they accompany in their difficulties.

Implications, Limitations and Future Research

The implications of these results are differentiated according to the different potential audiences. First, for clinicians who are not particularly familiar with working in intercultural contexts, these results can be disconcerting in that they ask them to move beyond "cookbook" approaches to improving their intercultural competence. Asking them to embrace a humble stance of "I-don't-know" can be particularly painful, much like a double bind, since they are also required to be knowledgeable and experts in analyzing situations. On the other hand, these results can also have the effect of making them feel recognized in the complexity of their work – a work, it must be stressed, that they carry out in a context that is increasingly socially tense and less and less institutionally supportive. I hope that this study, by bearing witness to the fact that some people are working to maintain these spaces for dialogue, will give them a glimmer of hope about the possibility of a transformation of professional youth mental health practices that will be more ethical and humane, both for them and for the families they care for.

Then, as far as managers involved in these practices are concerned, the results of this study may have the effect of reiterating to them the need to support the practitioners under their authority, and recognize their needs in terms of intercultural training and resources, which has become more important in our increasingly diverse world. As showed in this thesis, youth mental health practitioners are important "tools", and it is necessary to take care of them if the goal is to ensure quality services for families and quality of life for professionals. In this sense, maintaining spaces protected from institutional surveillance that offer training, support, and room for collaboration – such as the Community of Practices that are Transcultural Seminars – is essential if the objective is to minimize staff departures due to burnout, the costs of which are not only financial but also human. As such, the

results of this study are equally relevant to policy makers in a position to provide the funding necessary to sustain promising practices such as Montréal's Transcultural Seminars. The message of hope that these results bring is that the expense associated with carrying out this type of professional practice in organizations is rather low when all the benefits that result from it are taken into account; especially in the long term, as these positive effects concern the well-being of children and young people at the dawn of their lives, and therefore impact the well-being of tomorrow's citizens. The results of this study also clearly show that to improve the quality of youth mental health services, it is imperative to pursue a dialogue between research and practice through training. In this sense, the creators and facilitators of intercultural training initiatives will be able to draw inspiration from these results, so as not to reinvent the wheel and avoid foreseeable errors.

For researchers, the implications of these findings revolve around the theoretical contributions on which they can build, as well as the limitations of the study that can be addressed in future projects. Indeed, the specificity of the research field that was conducted among practitioners with an interest in intercultural issues means that a blind spot remains regarding the learning trajectories experienced by practitioners who are less open to cultural differences. It would be interesting to pursue reflection in more socially homogeneous contexts and among practitioners who are more closed to the contributions of anthropology.

Also, a more in-depth study of the impacts of practitioners' intercultural orientations on family experiences and clinical outcomes would be needed, as it was not the specific subject of this thesis. In this regard, a 2018 scoping review of initiatives to improve the cultural competence of health care workers in Canada, the United States, Australia, and New Zealand found a lack of consistency in the definitions of culture and cultural competence in the reviewed studies, as well as a frequent absence of such definitions (Jongen et al., 2018). The review reported on promising mentoring and supervision initiatives, but also identified a lack of focus on issues of racism and language competence in the training initiatives, which are crucial in the field of intercultural intervention. The authors concluded that the wide variety of educational approaches and evaluation methods used in the reviewed studies

made it difficult to compare the outcomes of these training initiatives. In addition, although positive impacts were documented, they were generally based on self-reported outcomes.

In an institutional context that values evidence-based practices, we know that qualitative research has less weight in policy decisions. Therefore, I raise the question of whether it is possible to use more empirical methodologies to study the impacts of this type of training model, given not only the complexity of the processes involved, but also the multifactorial nature of the influences leading to increased intercultural competence – a concern that the study participants themselves pointed out. Even though quantitative methods may be at odds with the on-the-ground realities of the field, in an effort to increase credibility with decision-makers and to draw their attention to the multiple benefits of this professional practice, it may be necessary to embrace mixed-method evaluation approaches and consider quantitative methodologies. What is more, although in the short term this training modality appears to be costly in terms of human resources, it is still important to ask ourselves whether we can afford *not* to maintain it, and consider not only the clinical benefits it produces, but the exhaustion of practitioners and the erosion of social coherence that it also prevents.

Conclusion

Throughout this thesis, I have underlined the incredible potential and richness of the Montréal's Transcultural Seminars model as a practice that allows to apprehend complexity and to decenter oneself. Participants all stated that Transcultural Seminars are a good way to tackle the intricacies of intercultural work and to familiarize themselves with it. Through storytelling and by working from real cases and in collaboration with colleagues who have real bodies and reactions, thus in the presence of a multiplicity of ways of looking at a situation and of reacting to it, Seminar participants experience the possibility of intercultural encounters that unfold in a sensitive manner and foster a respectful cohabitation. However, one must remain careful, as if these Transcultural Seminars are carried out without taking into account the elements identified in this thesis, such initiatives can become a source of conflict, or even of further suffering and harm. Other initiatives not reported in this thesis have shown that the implementation of this type of group-based practice can turn into a blame game. Like

any tool, it can be used to assist or to hurt. To prevent this, this study has deepened our understanding of conditions and processes that are required to install such a trusting framework for experiential learning to occur and to increase intercultural competence among youth mental health practitioners, without simplifying current anthropological knowledge.

Overall, Montréal's Transcultural Seminars provide a way to complement protocols and tools, such as the CFI, by way of the existential practice of transformative dialogue. This group practice, if well supervised, makes it possible to not only address the cultural dimension of care, but also to consider the power differentials that exist between social groups, such as between professions and ethnocultural communities. The Transcultural Seminar modality allows the collective holding and processing of discomfort, which may be associated with imagistic uncertainty, and that that may be associated with being accomplices to structural violence. By engaging in this model, it is easier for practitioners to be conscious of the inequitable structures and coloniality that permeate their professional landscape, and so to work in fostering a sense of cultural safety when working with minority families, eventually trading complicity with advocacy. In sum, with the aim to improve children's and youth's mental health and wellness, while supporting practitioners and protecting minority families from systemic discriminatory processes, this study calls for the adoption of reflexive, decolonial, and locally rooted approaches to intercultural training.

I would finally like to leave the last word to a participant who is tackling the question of worldmaking. Here she is emphasizing the importance of maintaining a dialogue between people who have very different ways of looking at the world to counter social polarizations and build from our common humanity. Below, is what she told me about the role of Transcultural Seminars in this regard:

> *Participating in Transcultural Seminars is very helpful for my work and it leads me to be more open and tolerant towards others in general. It also helps me to explain to friends or family things they're not necessarily used to and that sometimes shock them. To explain the other side of the coin to them, and to take the reflection a little further, which may not necessarily be what I would have done 10 years ago. Because*

sometimes you're afraid of upsetting people. What will they think of me? But I realize that the more we discuss with people, the more it leads to lowering our defenses and being less reactive. And people are less reactive to what they see. On my Facebook, there are relatives who live in the States who are pro Trump, and I strongly react to that. But I also like to see them, because I tell myself that if I see them, they exist; and then I can understand them better. Because your Facebook thread is influenced by what you like: what you don't like, you don't see. So sometimes I have the fantasy to like things I don't agree with just so I can see them more.

I cannot help but see beauty in that.

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Appendix A: Data Sources and Research Questions per Manuscript

Data sources per manuscript:

Study	Data collection activity	Period	Article 1	Article 2	Article 3	Article 4
Collaborative care in youth mental health (Nadeau et al., 2012-2018)	individual interviews with clinicians and families	2015-2017	x			
Formation continue et concertation interinstitutionnelle (Rousseau et al., 2012-2015)	Participant-observation (audio recordings of meetings)	2013-2015		x		
	Participant-observation (fieldnotes)	2013-2015	x	x	x	x
	Focus groups with seminar participants	2014-2015		x		
Considering cultural safety in youth mental health (Johnson-Lafleur - This PhD, 2015-2021)	Participant-observation (audio recordings of meetings)	2016-2017				x
	Individual interviews with seminar participants	2017	x		x	x
	Participant-observation (fieldnotes)	2015-2018	x	x	x	x

Research questions per manuscript:

- Article 1) What understandings of culture circulate in clinicians' and families' narratives? How is culture used in their discourses? And to what extent is this use fostering or hindering a feeling of cultural safety for families accessing services?

- Article 2) What are the conditions and processes that structure the participants' interactions during Transcultural Seminars and how can they contribute to building and strengthening their interprofessional collaboration and intercultural competence?

- Article 3) What is the lived experience of Transcultural Seminar participants, while considering the context of increasing social polarizations worldwide, including in Montréal? What is the relation between the local sociopolitical context, the trainees' verbalization about their identities, and the affect and cognition evoked by the training?

- Article 4) What is the role of images – in the broad sense that includes verbal and mental images – in intercultural training? What kind of sensitivity or ways of caring is promoted in Transcultural Seminars?

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