Vulnerability in Relation:
Homelessness, In-Betweenness, and Socio-Medical Interventions in Marseille, France

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ABSTRACT / RÉSUMÉ

In recent decades, it has become common for medical practitioners and researchers to refer to patients from certain marginalized backgrounds (low socio-economic status, homeless, etc) as 'vulnerable.' But what does vulnerability entail in these contexts? In the particular setting of socio-medical interventions with homeless individuals, who is actually vulnerable? The service users? The professionals? Both? Based on three months of ethnographic fieldwork with two different socio-medical organizations offering services to homeless individuals in Marseille (France), this thesis situates vulnerability in-between different theoretical concepts, social relations, and social policies. I first explore how vulnerability suspends professionals (intervenants) and service users (usagers) in a particular form of time -- a constant tri-temporality, in which neither past nor future are open for movement, leaving individuals in an often directionless present. Second, I present how vulnerability is not just a feature of life circumstances external to the socio-medical system, but a form of relation that circulates between, and affects both, intervenants and usagers alike, albeit with different consequences. This thesis is fundamentally an invitation to rethink socio-medical interventions with so-called "vulnerable" individuals through a different ontology of the self – a relational ontology. In this perspective, vulnerability happens in-between; in-between individuals (whether intervenants or usagers) in relation to one another, and in-between individuals and their particular socio-political contexts. In this way, vulnerability extends beyond a simple category of individuals. It stems neither from individual fault nor from fixed social categories: it circulates, rather, within/through a system of vulnerability. Vulnerability is therefore a relational ontological form of existence shared by all of those living and working on the margins of society.

Depuis de nombreuses années déjà, les professionnels de la santé et les chercheurs décrivent certains patients issus de différents contextes marginaux (faible statut socio-économique, itinérance, etc.) comme étant "vulnérables". La question se pose toutefois : Qu'implique la notion même de vulnérabilité dans ces contextes précis? Ainsi, lors d'interventions médico-sociales avec des personnes en situation d'itinérance, qui est véritablement « vulnérable »? L'usager? L'intervenant? Les deux? Basé sur une ethnographie d'une durée de trois mois dans deux organismes de Marseille (France) qui offrent des services médico-sociaux à des individus en situation d'itinérance, ce mémoire positionne la vulnérabilité dans un entre-deux; entre différents concepts théoriques et entre de multiples relations individuelles et politiques sociales. Tout d'abord, je présente la manière dont la vulnérabilité affecte la notion même de temporalité, tant pour les usagers que pour les intervenants. Cette vulnérabilité les maintient dans une tri-temporalité constante, où le passé lourd et le futur incertain jouxtent un présent souvent sans grande direction. Par la suite, j'explore le concept de vulnérabilité non pas comme une catégorie propre à des individus, mais comme une relation. Ce cadre relationnel présente donc une vulnérabilité qui circule de façon commune entre les intervenants et les usagers, au sein d'un système médico-social précis, le tout avec des conséquences différentes pour l'un ou pour l'autre, certes, mais négatives pour les deux. Ce mémoire se veut donc une façon de repenser les interventions médico-sociales avec des populations dites « vulnérables » à l'aide d'une nouvelle ontologie : une ontologie relationnelle. Dans cette perspective, la vulnérabilité se situe dans les entre-deux; entre les individus en relation (qu'ils soient intervenants ou usagers, au-delà de leurs rôles) et entre les individus et un système socio-politique particulier. La vulnérabilité n'est donc plus qu'un simple statut ou une catégorie d'individus marginalisés; elle révèle une ontologie relationnelle pour tous ceux et celles qui évoluent, vivent et travaillent en marge de la société.

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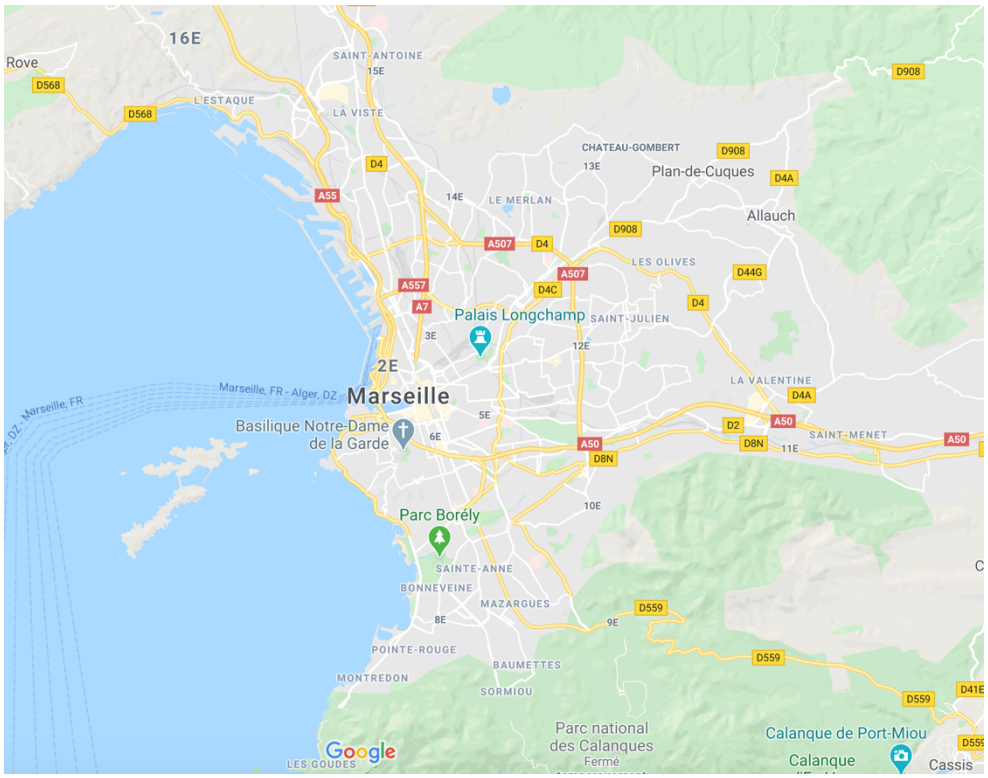
NOTE

Throughout this thesis, the names of individuals and places have been changed in order to protect confidentiality.

On translation: Unless otherwise noted, all translations have been done by professional translator, Jim Kroening.

MAPS

Source: Google Maps 2020



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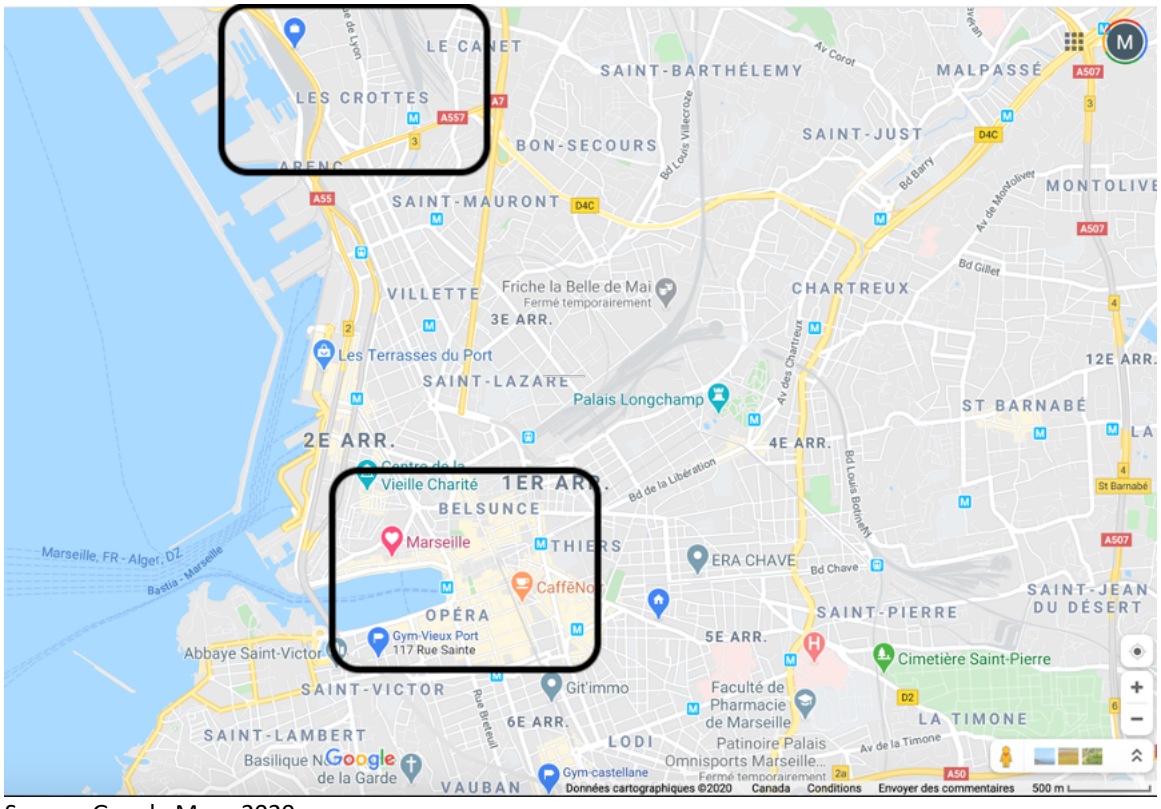

Source: Google Maps 2020

INTRODUCTION

Vignette: Le Mistral

The wind often blows hard in Marseille. It has a different name depending on from where it blows. The Sirocco is a wind blowing from northern Africa across the Mediterranean. It often brings colder weather and, at times, tiny sand particles from the Sahara. During these days, the cars in the city sometimes get covered with a thin, rusty layer of sand coming from far away.

The Mistral is another wind that blows through Marseille, often the strongest one. It is a powerful, dry wind that blows from the north of the European continent toward the Mediterranean, funnelling through the Alps. During the summer, it clears the sky, allowing the sun to shine very strongly on the city - almost burning it at times.

Mr. Tonev has been living in the emergency shelter for a very long time. He had a stroke many years ago that left him severely handicapped and has made walking extremely difficult for him - only possible now with a walker. He was born in Bulgaria, and nobody really knows how long he has been in France, or how exactly he ended up homeless. In La Maison Frédéric though, he has been there for quite a few years, making him one of the earliest residents. La Maison Frédéric is one of the emergency shelters for homeless men in Marseille. Mr. Tonev is part of the furniture at La Maison Frédéric, yet he is still one of the most discrete residents. He is always either sitting on his walker by the medical building under the shade, with his torn Monoprix cap on, or he is eating slowly in the cafeteria, often coughing between bites because of the stroke that left him with a severe swallowing impairment. If you don't find him in one of these two locations, you will most probably find him in his room, lying on his bed. Travelling between these three places is always a journey in itself for Mr. Tonev.

The Mistral is blowing strong today. It makes the 38-degrees-in-the-shade somehow bearable under the highway where the shelter is located. I have been sitting at the picnic table between the cafeteria and the medical building since I arrived this morning, about two hours ago. A few residents have been stopping by for quick chats, a handshake, a few questions, or a coffee. Another resident, Mr. Najar, a resident of Algeria, who came to France from Algeria on a tourist visa hoping to be cured of his prostate cancer, asks me for the fourth time this week when his appointment with the oncologist would be. For the fourth time, I tell him I do not know. Every week it seems like his belt needs to be tightened a bit more. His pants are baggier while his face has become sunken and grey. The look of death. "You know, I am really sick," he tells me. "I know, sir. I know," I tell the man for more than the fourth time since the beginning of the summer. Health care, including oncology and palliative care, is not covered in France for people entering with tourist visas.

So much constantly happens here; so many intertwined realities, so many people with their stories that feel somehow strange and difficult to capture.

I watch Mr. Tonev in the middle of the alley. He started making his way from his room towards the cafeteria about 15 minutes ago with his walker. He has almost completed the 20 meters that separates his room from the cafeteria. One foot after the other, he slowly progresses toward his final goal for this morning. He moves sluggishly with his severely curved back, his trembling arms supporting him on his walker, his swollen cracked legs, and his usually neutral face of concentration—or boredom—or worry. I cannot tell.

Suddenly, a strong gust of wind—le Mistral—makes my fieldwork notes fall to the ground. As I bend down underneath the picnic table to pick them up, someone starts yelling—about three meters behind me, Mr. Tonev is lying on the pavement, in silence now, his walker standing at his side. The wind took him down. Lying there on the ground, I see his face a bit less neutral this time, somewhere between pain and shock? I get close to him, making sure he is all right and not severely injured. A resident goes looking for the nurse who was already inside the cafeteria waiting for Mr. Tonev to arrive. In fact, a nurse always needs to supervise him during his meals to make sure he does not choke on his food. Another resident comes to help me get Mr. Tonev back on his feet. This resident stays behind him and his walker as his feet try to move forward, hesitantly. “Come on sir, you can do this,” the resident says, while on his knees, using his own hands to move Mr. Tonev’s trembling feet over the two-centimetre doorstep to the cafeteria. The nurse is holding the door open for them while she tries herself to stand and remain stable in the wind. She looks at me, sighs, shakes her head, and in front of him she tells me: “He doesn’t belong here. It’s dangerous. I don't have time to be everywhere checking only on him.”

As they get inside and I see the white door of the cafeteria closing behind them, I see in the nurse’s eyes something resigned or tired - I am not sure. -Something that felt heavy. During my fieldwork, this nurse and all the other professionals I followed shared with me a different yet common form of experience in their work, something the vast majority considered to be a sense of powerlessness, exhaustion, and suffering, no matter how much they valued their roles.

The wind keeps blowing hard as I sit back at the picnic table. It will be like this for the rest of the day and the next few days. I get my field notes and I start writing. I wonder, where do this man, the other residents, and the nurse actually belong? What is actually happening here?

I started this anthropological journey wondering how anthropology could help a family medicine resident better understand homelessness. My research questions arose directly from my clinical practice. I

worked then—as I still do—as a family physician in a neighbourhood community clinic in downtown Montreal that serves a diverse urban population.

Given the location of the clinic in the centre of the city, my colleagues and I regularly work with people identified as "vulnerable." In inner-city medicine, professionals often have pre-conceived notions about the vulnerable populations with which they work, based on specific categories: homeless men and women, drug users, or sex workers. In the healthcare literature, multiple papers have been published on the specific health and social issues these vulnerable populations face (see Clark and Preto 2018; Palmer et al. 2018; Russell, Kunin, Harris, et al. 2019; Sklar 2018). Particularly, by virtue of the various physical and mental health conditions and psychosocial difficulties they face, homeless populations are referred to as "vulnerable populations" in many publications (American Journal of Managed Care 2016; McInnis et al. 2013; Pierce 2016; Strehlow and Amos-Jones 1999). Therefore, in everyday usage and the medical literature, the association between homelessness and vulnerability has become almost automatic and categorial.

Vulnerability has become a much-discussed concept, focusing medical attention on a specific set of personal and lifestyle characteristics, which increase the likelihood that an individual will experience negative health outcomes of some sort. However, the portrait is somewhat more complex, and aspects other than individual "risk factors" are to be considered when thinking about vulnerability. On this topic, the American Journal of Managed Care (2006) writes:

> "Vulnerable populations include the economically disadvantaged, racial and ethnic minorities, the uninsured, low-income children, the elderly, the homeless, those with human immunodeficiency virus (HIV), and those with other chronic health conditions, including severe mental illness. It may also include rural residents, who often encounter barriers to accessing healthcare services. The vulnerability of these individuals is enhanced by race, ethnicity, age, sex, and factors such as income, insurance coverage (or lack thereof), and absence of a usual source of care. Their health and healthcare problems intersect with social factors, including housing, poverty, and inadequate education." (AJMC 2006, S 348)

These so-called vulnerable populations are, therefore, more than simple categories of individuals facing consequences related to individual conditions and choices. They are also caught in particular webs that combine inequalities along with socio-economic and political realities. Yet, as I will present throughout this thesis and in this introduction, vulnerability was more than this in my fieldwork. It was much more than a passive signifier or a simple label. Vulnerability presented itself as a deep and encompassing personal and social relation, a relation that became impossible to ignore.

Initially, I intended this master's thesis to focus on homelessness and how this so-called vulnerable population was navigating the socio-medical system. I was interested in understanding how homelessness was seen and dealt with somewhere else, away from home and away from my own professional practice. At the time, I was not planning to focus on vulnerability per se, as I saw it simply as a terminology referring to this population in which I was interested.

I landed in Marseille in the south of France in June 2017, hoping to take a step back from my work in Montreal and reflect on homelessness in a different clinical context. I wanted to analyze the socio-medical institutions and services in place to deal with homelessness in Marseille. I was mostly interested in exploring how medical institutions understood homelessness as a social phenomenon and how they dealt with it. Additionally, I was interested in the experience and the reality of men and women in situations of homelessness and specifically how socio-medical services were offered to them.

From June to September 2017, I conducted my fieldwork in two different organizations in Marseille; a homeless shelter for men only, located in the northern part of the city, that has a socio-medical clinic on-site (La Maison Frédéric); and a mobile hospital team (l'Oasis) that works with homeless people in the streets (men and women) who present with mental health problems. The French legal system for

emergency shelter is based on the principles of universality and unconditionality. Therefore, at La Maison Frédéric, anyone is to be offered a bed, if there are enough beds. An important majority of the men present were coming from outside the European Union, most of them on migration trajectories after having crossed the Mediterranean. At l'Oasis, the realities of migration were also present, though in different proportions. These two field sites and their specificities are presented in more detail in the corresponding sections of the thesis.

The more time I spent in the field, though, the more I sensed I was paying attention to something other than homelessness; as if homelessness was a pretext, an angle to approach and study something bigger and deeper. Throughout the field notes I wrote and the journal I kept during my fieldwork, a phrase constantly came up when referring to the interventions I was observing and participating in: what is actually happening here? By this, I meant, what is it that is happening here and that resonates so strongly within the walls—physical and abstract—of these organizations dealing with homelessness? What is this particular "thing" I feel so heavily when observing daily tasks and professional interactions? I was looking at socio-medical interventions with homeless individuals, but something else was emerging from so many of these situations -not only for the homeless men and women, but also for the professionals working with them. It was vulnerability. Vulnerability emerged as a pervasive experience, suffusing the social fabric. Vulnerability emerged in interactions between the users, between the users and the professionals, between the professionals themselves, and between all these individuals and a given socio-political system. It was as if vulnerability was a "condition" emerging from life itself within this given context and affecting people as a common experience, yet clearly with different consequences.

I can clearly remember the moment when I became aware of the omnipresence of this vulnerability. One evening, during the early weeks of my fieldwork, as I was about to leave the shelter, I heard rumbling noises coming from the entrance. Behind the large metal gate that separates the street from the large courtyard of the shelter, I could see a group of men shouting at one another in the street, while others were watching the scene from inside through the metal bars. The tension was high. One of the employees managed to retreat inside the shelter, visibly shocked. He had apparently been attacked by a man who had just been denied a bed that night for various reasons, and who had run away. That man apparently had a knife with him but did not use it on the employee. I remember leaving the shelter and crossing the gate that evening feeling so little. The noisy crowd was still outside, and I had to make my way through them and the palpable tension that was still all around. A resident of the shelter told me to be careful as the man might still be present. As I walked toward the metro in the dimly lit streets that evening, I remember feeling uncomfortable and vulnerable. Something had just hit me—not so much the scene of violence I had just witnessed, but the ordinariness of it. I got home that evening without seeing that man, but his presence followed me.

Throughout my fieldwork, I asked myself what it means to be vulnerable in these particular socio-medical contexts related to homelessness, and what the word vulnerability truly entails. But most importantly, I walked home so many nights wondering who is vulnerable in these contexts. The homeless people? The professionals? The anthropologist? Like the wind that hit us all in the opening vignette of this thesis, something appeared lived and experienced by all, different in form, yet common. It was vulnerability, as a concept, that disrupted the simple category of so-called vulnerable individuals. But it was also something inherent to living, working and being in the margins of the city, in the margins of life.

However, the more I followed the different workers and professionals and focused on their everyday tasks and experiences, the more I sensed it was also important to look at their realities. Could these workers, responsible for helping the homeless - so-called vulnerable individuals - be vulnerable themselves? The focus of my attention, therefore, became the dyad between the professional (*intervenant*) and the service user (*usager*).[1] Looking at this particular dynamic opened up new forms of analysis where vulnerability is not only centred on the user, but also on the provider, and circulates in between them. In this regard, vulnerability is not only reserved for the homeless person, but shared by all the professionals and providers.

Before continuing, I want to address an important point. I have mentioned that I was struck by the commonality of the experience of vulnerability in my fieldwork, while saying the consequences were different depending on whom it affected. I really do want to stress this point. Obviously, the consequences were different. I said I was hit by this vulnerability when walking back home in the dimly lit streets after the attack, but I was returning to a comfortable bed in a safe house while being able to choose what restaurant I would eat at before going home that night. The intervenants, no matter how overwhelmed and powerless they felt, had a paycheque at the end of the month (even if small). They did not have to wait in line to grab a meal in a shelter cafeteria like the usagers who had been able to secure a bed that night instead of sleeping in the train station. Nonetheless, no matter how different the consequences were, I witnessed a shared difficulty in these socio-medical relationships between the usagers and the intervenants. I am trying to make the relationality of vulnerability explicit, without erasing or ignoring notions of class, privilege, or socio-economic status. The challenge becomes to find a

[1] From now on, I will keep using the French term intervenant to refer generically to all the workers and professionals I encountered during my field work. They include nurses, caseworkers, welcoming staff, physicians, social workers, street workers, etc. Similarly, the term usager will be used to refer to users of services in a given organization. At times, depending on the situation, they might also be referred to as patients (if encountered in a clinical context), résidents (longer-term users of the shelter), or hébergés (temporary users of the shelter).

"juste milieu" (a middle ground) in presenting this commonality. Similarly to what Mitchell (2019) says about vulnerability, "the question, then, is how to acknowledge the serious limitations of how 'vulnerability' is operationalized in social policy without losing sight of the genuine vulnerabilities to which social policy responds?" (Mitchell 2019, 226). By focusing on the relationality of vulnerability, I am therefore questioning positionality. I am trying to present an alternative voice with which to reflect on vulnerability in socio-medical interventions - one that disrupts the vision of care in the Western world, where an individual in a position of supposed weakness is helped by another individual in a supposedly professional and more secure position. I want to show that professional positions and roles do not spare one the experience of vulnerability. I present these interventions as moments when intervenants and usagers become a unit, merging and trying to move somewhere together, away from the suffering, the difficulties and the impossibilities. Yet, this is a difficult task to do. This thesis is an attempt to describe and make explicit this powerful, profound and destabilizing encounter.

This thesis is structured in the following way. First, I will present the literature review relevant to this thesis. I will explore the concept of vulnerability through its associated terms that need to be exposed so to grasp the meaning of vulnerability, and then explore different writings and concepts related to homelessness and medicalization. Second, I will present the different field sites in which I conducted my research, including the city of Marseille and the two main organizations that welcomed me (La Maison Frédéric and l'Oasis) for my fieldwork. Third, I will spend time detailing the ethnography, the qualitative methodology I used for this anthropological project. Fourth, in the two main chapters of this thesis, I will address the notion of temporality related to vulnerability and the fundamental relationality that is part of vulnerability, respectively. I will conclude with some reflections on ways to rethink and reconcile the notion of vulnerability with the way socio-medical services are offered.

LITERATURE REVIEW

Vulnerability

Multiplicity

In the healthcare literature, the notion of vulnerability was first introduced in the context of human research subjects, and the need to establish protections for these subjects (Belmont 1979). It was later extended to healthcare contexts generally. Various definitions of vulnerability have appeared in this domain, among which the common denominator in definition appears to be an "(in)ability to protect one's own best interests" (Clark and Preto 2018) and a certain predisposition to harm (Hurst 2008; Public Health Agency of Canada 2015). In an article published in the Canadian Medical Association Journal, 'vulnerable populations' are defined as "those that experience adverse health outcomes compared with the general population by virtue of both internal and external factors [… with] focus on groups for whom an additional factor—e.g., poverty, isolation, discrimination, social disruption—renders them vulnerable through inadequate delivery of effective health care" (Patrick, Flegel, and Stanbrook 2018, E307).

There is, then, this vague sense of agreement about the proper usage of this term among readers of medical literature, but there is no clear, common, and shared definition of what vulnerability represents in either the medical or social science literature. The concept itself may strike at something familiar, a concept whose point of reference medical professionals may intuitively understand, yet it is hard for many to pin it down precisely in words (Appleton 1999). Vulnerability is, therefore, a multi-conceptual notion[2] (Thomas 2010) that exemplifies the semantic void that surrounds it (Clément and Bolduc 2004). Vulnerability, therefore, becomes a notion that is "vaguely defined or undefined," and that asks "who is vulnerable, why they are vulnerable, and what they are vulnerable to" (Katz et al. 2019, 4).

[2] une "notion éponge" (Thomas 2010)

The concept of vulnerability is, therefore, multiple. It exists in a complex semantic field, where it lies entangled with a range of other concepts that help to define its meaning (for example, poverty, exclusion, precarity, and risk). Indeed, as my fieldwork revealed, in order to fully grasp the concept of vulnerability and its multiple ramifications, we need to go beyond simple categories of so-called 'vulnerable' individuals and look at processes that underlie this concept.

Various authors have written about the concept of vulnerability (See Brown, Ecclestone, and Emmel 2017 and Han 2018 for more extensive reviews). A number of definitions have, therefore, been put forward to conceptualize vulnerability in the social sciences. In their book, Lévy-Vroelant, Joubert, and Reinprecht (2015) insist that 'vulnerability' is a polysemic term that shows contradictions in terms of definitions and meanings (18). For them, the category of vulnerability addresses issues of hardship.[3] Brodiez-Dolino (2016) presents the etymology of the term, pointing at the combination of a crack and an injury[4] (Thomas 2010) and to the possibility of being hurt[5] (Soulet 2005). For Spini, Hanappi and Bernardi (2017), the concept of vulnerability is a form of legitimacy to describe any situation of weakness, whether of personal or social origin.[6] Particularly, they present vulnerability as encompassing multiple spheres (family, work, health) and affecting different types of capital (material, social, cultural, health).

Lévy-Vroelant, Joubert, and Reinprecht (2015) also insist on the importance of carefully differentiating between the different uses of the term vulnerability, as theories (Castel 1991; Soulet 2005), public action categories (Frigoli 2009; Muller 2000; Soulet 2005) and everyday uses. Sociologist Valérie Becquet (2012)

[3] "une nouvelle sémiologie d'appréhension de la vie sociale, formulée en termes de publics en difficulté et de leurs problématiques" (Lévy-Vroelant, Joubert, and Reinprecht 2015, 19)
[4] "conjonction de la fêlure et de la blessure" (Thomas 2010)
[5] "potentialité à être blessé" (Soulet 2005)
[6] "toute situation de faiblesse au cours de la vie, qu'elle soit d'origine sociale ou individuelle" (Spini, Hanappi and Bernardi 2017, 70)

also presents how vulnerability has been used in different professional and academic domains, resulting in a certain ambiguity regarding what the term actually means. Sociologist Emma Mitchell (2019) also presents the two main ways vulnerability is being used and understood as "both a cultural script that shapes how social problems are understood and experienced and a socio-material phenomenon and condition of human life" (Mitchell 2019, 228).

Poverty, exclusion, precarity and risk

Vulnerability is as a term/concept, therefore, multiple in its usages. Yet, it also presents multiple theoretical anchorages. These include poverty, social exclusion, precarity, and risk (Roy 2010). For sociologist Shirley Roy (2008), the notion of vulnerability is part of a dynamic construction in close association with two other concepts; poverty and social exclusion. The notion of poverty has been explored by a number of scholars (Frerer and Vu 2007; Paugam 1996; 2005). Poverty is often considered exclusively through an economic lens, but scholars have critiqued this approach for its heavy reliance on certain numerical measures/indicators and thresholds that are somewhat arbitrary. These thresholds often fail to capture the full experience of people living in socio-economic poverty.

Social exclusion, on the other hand, is a concept that has been present in the social sciences for about 30 years, preceding the extensive use of the term vulnerability (Castel 1991). The concept of social exclusion raises questions about the way social relations have evolved over the past few decades and have become more individualized. Individualism is, therefore, an important theoretical concept related to social exclusion. Individualism appears as a founding principle of our (neo)liberal society (Cheshire and Lawrence 2005). Anthropologist Tejaswini Ganti (2014) presents neoliberalism under two main scopes. She says: "anthropologists have most commonly understood neoliberalism in two main ways: as a structural force that affects people's life-chances and as an ideology of governance that shapes

subjectivities" (Ganti 2014, 89). Many theorists argue that (neo)liberalism forwards individualism as the foundation of contemporary social relations (Roy 2008, 24). In this perspective, individuals have primary responsibility for their self-realization, autonomy, and success or failure. Roy also mentions that the de-collectivization and the individualization of social relations that we have seen over the past decades have created a new social matrix into which each individual must try to fit. The individualistic paradigm presupposes minimal intervention from the state, favouring individual rights over collective rights and values. In this analysis, with neoliberalism as its lens, it is those individuals who lack the tools to integrate into an individualistic social matrix who become vulnerable. However, an apparent lack of individual "tools" can obscure the role of larger processes related to poverty, class, and socioeconomic status. This context of individualism also brings a common encompassing structural vulnerability[7](Soulet 2005), where society becomes a permanent context of difficulties and challenges all of us must face (Martucelli 2005). Altogether, this can weaken social networks and social links between groups and individuals, leading to social exclusion (Erhenberg 1998). Therefore, social exclusion, like vulnerability, presents itself as an emerging condition resulting from changing social relations, with individualism at its heart.

The term precarity also needs to be explored. For anthropologist Clara Han (2018), it can be analyzed under two different main foci. The first one is a "bounded historical condition," related to "intermittent casual forms of labor" (Han 2018, 332). It refers to the conditions that were imposed on workers following changes in state protection under a globalizing market (Han 2018; Lévy-Vroelant, Joubert, and Reinprecht 2015). The second focus of precarity refers to a "common condition of ontological precarity" and the related ways in which "vulnerability appears within forms of life" (Han 2018, 332). Similarly, Judith Butler (2004) presents precarity—and precariousness—as "a form of embodied commonality experienced by all, a common ontological condition of exposure and interdependency that seems to be

[7] "un univers de vulnérabilité [structurelle] pour tous" (Soulet 2005)

independent of forms of life" (Butler 2004, 20). I will return to this concept of commonality later, as it will be central to my thesis, and to the way vulnerability appeared and emerged in my fieldwork.

The notion of risk is also associated with the concept of vulnerability. Economist Nicolas Sirven (2007) describes risk as the probability that a given event happens and that the consequences are known and usually negative (71). Spini, Hannapi and Bernardi (2017) argue that vulnerability is related to the risk of being exposed and lacking the tools to face a given threat that has materialized itself (71). Vulnerability could then be seen as a form of exposure to risk (Lévy-Vroelant, Joubert, and Reinprecht 2015, 23). Citing a variety of sources, Brodiez Dolino (2016) explains how many occidental societies have recently entered an "anthropology of vulnerability" through the notion of a "risk society" (Beck 2001) and an "increase in uncertainties" (Castel 2009). Regarding this "anthropology of vulnerability," philosopher Mark Coeckelbergh (2013) says:

> How can we benefit from the insights that (1) risk and vulnerability somehow belong to the human, that (2) our experience of risk and vulnerability matters, and that (3) risk and vulnerability are relative to the social and natural environment, without ending up with a view that risk and vulnerability are either entirely subjective or entirely objective, in the latter case perhaps supposing that there is a risk-in-itself? (Coeckelbergh 2013, 42)

This anthropology of vulnerability - using risk as a mediator - therefore, questions whether vulnerability could be common and contextual to human life. Referring to anthropologist Michael Jackson's use of personal narratives in his writings, Coeckelbergh presents this embedded personal approach of risk as an approach to address and reflect on vulnerability. He says, "Perhaps we need fewer risk reports and risk assessments and more narratives that help us cope with risk and vulnerability" (Coeckelbergh 2013, 57).

The notions of risk and social inequalities are also associated with one another. For anthropologists Vinh-Kim Nguyen and Karine Peshard (2003), "risk is the primary mechanism through which social inequality is

embodied and is visible in different prevalence of diseases and outcomes between different social groups" (457). They further say:

> For anthropologists, the inequality/disease relationship is a form of violence enacted through cultures and rationalities. A distinction has been made between social relations, where the violence of inequality is most often expressed in ritualized form, leaving visible traces on the body, and those where the violence of inequality is transcribed into the body as biological difference and expressed as "risk" to be managed through techniques of government. (Nguyen and Peschard 2003, 448)

Using Foucault's notion of governmentality (Foucault, 1977-1978), O'Malley sees risk as a "technology of government" in which risks "are not regarded as intrinsically real, but as a particular way in which problems are viewed or 'imagined' and dealt with" (O'Malley 2008, 5), including how certain populations are targeted, governed and managed.

In-betweenness and relations

Vulnerability can, therefore, be situated in an in-betweenness, somewhere amongst poverty, exclusion, precarity, and risk. I have presented these different theoretical concepts that underlie and overlap with that of vulnerability. Further, vulnerability can be situated somewhere between a constructivist approach (vulnerability as emerging from natural processes, social relations, etc.) and an essentialist approach (vulnerability as nature, a form of destiny, a structural fact) (Jousset, Boles, and Jouquan 2017, 10). Referring to Laugier (2012), Lévy-Vroelant, Joubert, and Reinprecht (2015) argue that vulnerability is a common condition potentially affecting everybody. A common condition, but one which does not affect everybody in the same way. Vulnerability then is much more than a simple category of "vulnerable" individuals or groups facing situations of hardships. Vulnerability allows for an integration of various characteristics of an individual's life, but more than that, it allows for an integration of the important role of social processes in shaping the life experience of so-called vulnerable individuals (Lévy-Vroelant, Joubert, and Reinprecht 2015).

Regarding this, sociologist Marc-Henry Soulet (2008) calls for a broader approach to vulnerability. He refuses to take the "vulnerabilized" individual[8] as the centre of analysis of vulnerability (Soulet 2008, 65). He calls for a broader systemic reading of the condition. He asks for three things: 1) to see vulnerability beyond a lack of material goods or services; 2) to not assign an inherent vulnerability status to a group or a population simply because of their risk status, and; 3) to not conceptually situate vulnerability as an intermediate state between integration and exclusion (Soulet 2008, 65). The social context within which people evolve can, therefore, be vulnerabilizing for the individual. In fact, social dynamics can weaken both the self and the relations of that self in one's environment. Similarly, anthropologist Raymond Massé (2017) argues that vulnerability is much more than a social or medical category; it is a social, moral, epidemiological, and political construct (85).

Finally, going back to an important concept, vulnerability is fundamentally an in-betweenness for Becquet[9] (Becquet 2012). Citing Robert Castel (1995), she portrays vulnerability as an unstable intermediate zone because of the precarity of the workforce and the fragility of social support where individuals find themselves in a floating state (Castel 1995, 17). Becquet (2012) is therefore critical of the notion of separation between the "us vs them" when reflecting on vulnerability, especially when trying to differentiate the protected population from the excluded ones. She calls for an analytical posture that focuses on the "porosity of situations" and how "vulnerability circulates between them" (Becquet 2012, 53). Therefore, when exploring vulnerability, the focus of analysis lies somewhere between the individual and the socio-political context, in-between human beings in relation to one another.

This question of relations is fundamental when addressing vulnerability. I will treat it in a summary manner now and will continue to revisit it through the rest of this thesis. Levy Vroelant et al. (2015) open

[8] "l'être—ou la catégorie—vulnérabilisé" (Soulet 2008, 65)
[9] "La vulnérabilité est tout d'abord une notion d'entre-deux" (Becquet 2012, 52)

their book about vulnerability stating that the exploration of vulnerability fundamentally questions the notion of social relations. Similarly, Roy and Chatel (2010) put social relations at the forefront of their analysis of vulnerability.[10] These social relations, and how vulnerability circulates within them, were fundamental in my fieldwork.

As I will argue, vulnerability becomes a form of relation between individuals and society, and between professionals and patients; therefore, circulating among all of them. A vulnerability that goes beyond a simple category of individuals and becomes a relational form of existence between individuals and society; a relational ontology that I will later explore. As Raymond Massé (2017) argues, vulnerability has in itself a social life. He says:

> I suggest that social sciences cannot analyze vulnerability simply as a passive form of identity unilaterally assigned from outsiders to certain groups. Vulnerability is neither a passive nor a definitive status; it often has an intense social life of its own.[11] (Massé 2017, 85)

It is precisely this social life that this ethnography pays attention to; an intense social life that happens in a constant in-betweenness.

Homelessness

This thesis is not really about homelessness per se. My initial questioning regarding interventions with so-called vulnerable populations led me to look at homelessness, yet mostly as an angle from which to study vulnerability. As I will present in the coming chapters, I was in two different organizations dealing,

[10] "elle répond simplement au souci d'inscrire la thématique de la vulnérabilité dans ce qui la déborde et ce qu'elle interroge, à savoir la question du lien social" (Roy and Chatel 2010, 3)

[11] "nous proposerons que les sciences sociales ne puissent plus aborder [la vulnérabilité] comme une identité simplement assignée unilatéralement, de l'extérieur, à certains groups considérés comme passifs face à ce processus d'étiquetage. La vulnérabilité n'est pas un statut passif ni définitif: cette étiquette possède une vie sociale souvent intense" (Massé 2017, 85)

yes, with homelessness, but I was looking at something larger in the form of vulnerability. This ethnography is, therefore, not an extensive study and review of homelessness in general, although it remains nonetheless an important concept that needs to be explored.

Various academic writings have been published over the years on the topic of homelessness (Burnes and Dileo 2016; Bridgman 2006; Cohen and Sokolovsky 1988; Dehavanon 1996; Foscarinis 1996; Glasser 1994; Glasser and Bridgman 1999; Hombs 2011; Hopper 2003; Howard 2013; Ravenhill 2008; Susser 1996; Wasserman and Clair 2010). Most of these writings address homelessness as a complex and multiple reality with poverty as a central focus. Yet homelessness exists not only in relation to poverty, and becomes difficult to isolate from the other realities with which it is often in relation. Different authors have tried exploring homelessness through specific angles, such as race, incarceration, veteran status (Dereck et al. 2019; Jones 2016; Henry et al. 2018), gender (Pasaro 1996; Sidel 1992), mental health problems (Hopper 2003; Koegel 1992; Lovell 1997), and drug usage problems (Bourgois and Schoenberg 2009).

Defining and explaining homelessness can be challenging; it goes beyond not having a place to sleep. I mentioned earlier how the concept of vulnerability is often referred to as something familiar, a concept that medical professionals may intuitively understand without being able to put it precisely into words (Appleton 1999). The same is true of homelessness. It might be easy to identify a person in a situation of homelessness on the street, yet it becomes harder to capture fully the realities and mechanisms behind homelessness. Mary-Ellen Hombs is clear that “there is no single, generally accepted definition of homelessness” (Hombs 2001, 6). Definitions are important because of their impact on policies. Anthropologists Irene Glasser and Rae Bridgman (1999) mention how any definition of homelessness will have ‘‘a tremendous impact on the numbers and characteristics of the people included in the definition’’

(Glasser and Bridgeman 1999, 3). These numbers and characteristics will, in turn, have an impact on programs to address homelessness (Kingfisher and Pace 2001). Therefore, beyond a simple category of individuals with their own individual characteristics, homelessness is also a window into the evolution of socio-economic policies and social relations.

When reflecting on homelessness, the question of causes becomes particularly challenging. The literature reflects this difficulty, presenting the constant alternation between individual characteristics and societal structures and relations, when addressing causes (Fitzpatrick 2005; Somerville 2013). Are people homeless because of individual characteristics and flaws, or because they are in a social system that permits, creates and maintains such a reality? Glasser and Bridgman (1999) take an in-between approach, using "ecological models" that consider "not only the individual, but also the community, institutional, organizational, and cultural contexts of poverty and homelessness" (Kingfisher and Pace 2001, 91). Similarly, sociologists Shirley Roy and Roch Hurtubise (2007) argue that the different stories of people in situations of homelessness tend to present homelessness as an endpoint to a process of exclusion and marginalization, a process resulting from a combination of both individual and structural factors. Therefore, when addressing homelessness, it becomes important to explore the phenomenon through different angles, both individual and relational, as I am about to present in this section and throughout this thesis.

Social processes and relations

One of the angles from which to study homelessness is that related to social processes and relations. This angle allows us to see beyond an "epidemiological approach" to homelessness with individual "causal variables" and "risk factors" (Sommerville 2013). Regarding this, Megan Ravenhill (2008) sees homelessness not as a category of individuals, but as a web of relationships "that encompasses

individuals' relationship with themselves, their peers, the community as well as the employment and housing markets" (Ravenhill 2008, 13). Similarly, sociologist Julien Damon (2012) presents the *Sans domicile fixe* (SDF) (homeless) population in France not through the lens of the individual, but through the "entire system of relations and interdependence that define how homelessness is managed and how homeless individuals become categorized as such" (Damon 2012).

Systemic poverty

One of the factors that homelessness is in relation to, is that of poverty. For anthropologist Ida Susser (1996), homelessness is first a window into the economic reality of a given society, saying that "studies of the homeless in the United States address how poverty is represented as well as how the poor are treated and the way they live their lives" (Susser 1996, 412). Looking at poverty, therefore, involves looking at larger conditions and social inequalities that affect all members of society, yet with obviously different consequences. Referring to the phenomenon of homelessness in New York, specifically, Susser (1999) says:

> It is analytically misleading to view 'the homeless' as a category separate from other poor people in New York City. To categorize a person as 'homeless' carries the implication that this is a permanent characteristic rather than an experience through which s/he is passing temporarily. Like the use of the term 'underclass', such an approach leads to static analyses of 'the homeless' as a reified group. It fails to further our understanding of the processes that lead to loss of a home and the ongoing problems of poverty faced by both 'homed' and 'homeless'. (Susser 1999, 70)

Poverty, beyond homelessness, then becomes a much larger systemic relational reality, one of social processes that affect both the "homed" and the "homeless"- to repeat Susser's words.

Looking at homelessness through the prism of poverty also raises important questions about the evolution of the workforce and the consequences on housing. In this way, homelessness could be a manifestation of larger societal transformations and reveal an end-process of "deindustrialization and

the shift to a service economy" (Susser 1996). Specifically, in the United States, the progressive deindustrialization of the country in the 1980s and the associated creation of low-paid jobs created a specific context contributing to homelessness (Hopper, Susser, and Conover 1987). Regarding this, Desjarlais (1996), referring to Timmer, Eitzen, and Talley (1994), presents the roots of homelessness as "rang[ing] from a growing shortage of affordable housing in urban settings to a decline in jobs that keep many families and individuals above the poverty line" (Desjarlais 1996, 420).

Homelessness as a social reality is, therefore, multiple in its causes, often rooted in poverty, though not a poverty of individuals, but rather a systemic poverty. Regarding this, Hopper et al. (1985) mention how "the roots of homelessness are found in the economic restructuring of the city" and that by focusing on certain individual characteristics of homeless individuals rather than systemic aspects, there is a "failure to make [the] link in the past" (Hopper et al. 1985, 183). This systemic argument raises the important notion of neoliberal governance. Anthropologist Vincent Lyon-Callo (2008) argues that two factors need to be examined to understand homelessness, namely: 1) the impacts of neoliberal social and economic practices, and 2) how people have and have not responded to associated social restructuring. Various dynamics are present with homelessness in general. One of them is how the various attempts at responding to systemic inequalities are often a combination of "punitive legislation with support for normalization efforts" (Lyon-Callo 2008, 153). Another major dynamic is related to the deviancy hypothesis, where "discourses of self-help and bio-medicalization are combined to reproduce a conceptual framework within which homelessness is understood as the result of shortcomings within homeless people" (Lyon-Callo 2008, 154). Under this vision, thoughts and actions are therefore often "aimed at fixing and normalizing homeless people" (154).

Health and medicalization

Another angle from which to study homelessness is through its consequences on physical and mental health. The health problems that homeless individuals in particular face are often multiple and chronic. The medical literature in Canada, France and elsewhere presents a sombre portrait: severe cardio-pulmonary conditions, frostbite and other skin problems and infections, nutritional deficits, musculoskeletal problems, poor oral hygiene, podiatric problems, and sleep issues (Association Canadienne de santé publique 1999; Manes and Khan 2014). As a population, homeless people have a significantly greater tendency to present with mental health issues (Guirguis-Younger et al. 2014; Institut canadien d'information sur la santé 2007), along with substance-use disorder, whether it is alcohol or other psychoactive substances (Fazel 2014; Grinman 2010). They also present with premature aging that comes with symptoms of early dementia (Brown 2016; Grenier 2016), and they present mortality rates up to four times higher than the general population (Gouvernement du Québec 2014).

The medical consequences of homelessness are well known, yet the way the medical institution sees homelessness is also important to explore. Through the process of medicalization, homelessness becomes viewed as a medical condition. Medicalization refers to "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad 1992, 209). It is also a "process whereby more and more of everyday life has come under medical dominion, influence and supervision" (Zola 1983, 295).

It is important to understand that medicalization is a process that extends beyond the medical institution and its workers. Referring to Foucault's "The Birth of the Clinic" (Foucault 1975), Deborah Lupton (2005) explains how medical paradigms have evolved into widespread systems through which we interpret not only our bodies and sicknesses but also social relations. Regarding this, she writes:

> [f]rom this perspective, medical power may be viewed as the underlying resource by which diseases and illnesses are identified and dealt with. This perspective fits into the broader social constructionist approach in understanding medical knowledge not simply as a given and objective set of 'facts' but as a belief system shaped through social and political relations. (Lupton 2005, 194)

These social and political relations are therefore influenced by the medical institution in the way it conceives problems through a medical lens. Therefore, medicalization can become a powerful political tool where medicalization becomes a "social phenomenon," as the pathological extends beyond the clinical world (Fassin 1998).

The medical institution is, therefore, far from neutral and objective. As Fassin (2011) says:

> This is certainly what medicalization is about. It is not just an exportation of objects from the social world into the clinical domain, from commonsense to scientific knowledge. The clinical realm is itself permeable to the influence of the social world. It is built on scientific knowledge but also on commonsense. Medicine is far from being the pure intellectual activity of producing diagnoses and dispensing treatment. It is particularly porous to moral categories and moral judgment. Contrary to what has frequently been written, in particular about deviance, medicalization does not erase moralization: it develops new moral forms, less visible, more subtle. (Fassin 2011, 90)

The medicalization of homelessness sees and consequently treats homelessness as a disease. As I have just presented, the medical institution might look at homelessness and see the inequality of the distribution of resources within a community. It might not fault the victim for their life circumstances, but it still considers homelessness as an individual problem. Anthropologist Arline Mathieu (1993) explores how the medicalization of homelessness can divert focus from the social to the individual. She presents a case study of a community in New York, from the 1980s, in which the city directly associated homelessness with mental health issues and, therefore, responded to homelessness through the lens of the medical institution. She explains that "[t]his medicalization was used to divert attention from the socioeconomic roots of the problem and to justify the removal of homeless people from the public" (Mathieu 1993, 170). She goes on to say that "although some homeless people were also mentally ill, most people were not and had become homeless because of decreased low-income housing, declining

real wages, unemployment, and cuts in government benefits" (Mathieu 1993, 170). It can, therefore, be easy at times to reduce complex socio-medical realities, such as homelessness, to a purely medicalized analysis - as though the medical lens is sufficient to explain and offer specific recommendation and orientations. Referring to anthropologist Kim Hopper's Reckoning with Homelessness (2003), anthropologist Brett Williams invites us to put the medicalization of homelessness into perspective, especially regarding mental health. She says:

> Contrary to the conventional narrative, Hopper, who is widely respected in mental health circles, argues that mental illness did not make people homeless. He has made versions of this argument over and over to his colleagues in mental health, advocacy, and anthropology: homeless men bear the brunt of social changes that batter the nearly homeless as well. When their families can no longer provide the care that government should, families have to triage. Homelessness is less a personal journey, he argues, than a social slot for redundant people. (Williams 2013, 130)

Lyon-Callo (2000) describes how the move towards a disease model of homelessness has had various and sometimes conflicting consequences. While many institutions in the late 1990s were approaching homelessness through criminalization, a few communities in the United States chose instead to address homelessness with a "continuum of care approach" (Lyon-Callo 2000). In this method, communities can "treat" conditions that "cause" homelessness, while shelters provide what is necessary for people to get or maintain a form of housing. Nonetheless, although homelessness is seen as a condition afflicting the victims rather than a fundamental defect within the individual, homelessness is still seen as a disease. Lyon-Callo (2000) also insists on the political consequences of the medicalization of homelessness. He says, "Through their experiences in the shelters, many homeless people are thus produced (and reproduced) as political subjects who are more likely to engage in self-blame and self-governing than in collective work against structural violence" (332). "When homelessness is individualized and medicalized," Lyon-Callo concludes, "those concerns [of looking for more systemic causes of homelessness] remain peripheral to the central work of normalizing perceived shortcomings or deviancy within homeless people" (330). Focusing simply on a purely medicalized homeless body is, therefore, not only insufficient to understanding and addressing homelessness, it is detrimental.

The way discourses and terminologies are used to represent such a complex social reality is also important. Anthropologist Catherine Kingfisher (2007) describes how discourses on homeless individuals orient public policies, particularly when they are presented as a subject category instead of recognizing homelessness as "fundamentally political and power laden" (Kingfisher 2007, 94). Focusing on homelessness as an extra-ordinary reality can divert attention from the ordinary, away from the ordinariness of poverty and precarity in certain communities. Again, referring to Hopper (2003), Williams says: "[Hopper] worries that he and his allies have created a special class of pet poor people by ignoring the nearly homeless—the desperately poor families and communities from which they have come" (Williams 2013, 130).

Professionals

As I have described, a lot has been published on individuals living in situations of homelessness, marginality and precarity. Some literature has also been published on "the vulnerability" and the reality of the providers and frontline staff working with "vulnerable" individuals. Their working conditions and the impact of those working conditions need to be addressed. These workers face stressful and demanding situations at work, and they tend to have lower salaries and little training and supervision (Mullen and Leginski 2010; Olivet, McGraw, Grandin, and Bassuk 2010). They also have access to fewer opportunities for self-care. They tend to face tension between these stressful aspects of their work and the parts they find rewarding (Kidd 2003). All these difficulties can lead to different negative feelings, such as a lack of accomplishment (Miller, Birkholt, Scott, and Stage 1995) emotional drainage (Kidd, Miner, Walker, and Davidson 2007), compassion fatigue, emotional exhaustion, and motivation to leave their job (Morse et al. 2011). As explored by Waegemakers Schiff and Lane (2016), "For individuals new to the homeless-serving sector, working with complex clients often leads to disillusionment, erodes their

idealism and diminishes their sense of self-efficacy and accomplishment (Collins & Long, 2003). This, in turn, can lead to high turnover, burnout, and less effective work (Lloyd, King, & Chenoweth, 2002)" (8).

Therefore, no matter how rewarding the job can be, no matter how trained they are, professionals working in the homelessness sector are confronted daily with difficulties that appear inherent to this particular professional context. This thesis explores this inherent reality.

FIELD SITES : BEYOND PLACES

> Marseille est une ville selon mon coeur. C'est aujourd'hui la seule des capitales antiques qui ne nous écrase pas avec les monuments de son passé. Son destin prodigieux ne vous saute pas aux yeux, pas plus que ne vous éblouissent sa fortune. […] Ce n'est pas une ville d'architecture, de religion, de belles-lettres, d'académie ou de beaux-arts. […] Aujourd'hui elle paraît embourgeoisée et populacière. Elle a l'air bon enfant et rigolarde. Elle est sale et mal foutue. Mais c'est néanmoins une des villes les plus mystérieuses du monde et des plus difficiles à déchiffrer.
>
> Blaise Cendrars, L'Homme foudroyé, 1945

I landed in Marseille a bit by chance. After different exploratory readings and discussions with colleagues and mentors, Marseille appeared to be a good place for this fieldwork. In fact, given the short period of time available to do this Master's thesis fieldwork (about three months) and in order to ease my integration into my field site and make myself rapidly available mentally for the work, I wanted a field site that allowed for a balance of critical distance from and similarity to my Montreal context.

Marseille offered a similar context in a number of ways. First, being a native French speaker going to France, sharing a common language with the majority of the people I met throughout my experience was certainly an advantage. Second, I wanted to be in a health and social services structure that resembled

the Canadian context in its strong publicly funded component and the various public socio-medical programs and laws that exist for the protection of so-called "vulnerable" populations. I wanted to navigate and explore the socio-medical interventions in another context where, broadly speaking, people did not have to pay to access services. Finally, homelessness is also a widespread reality in Marseille, in terms of the number of individuals living in a situation of homelessness (as I will present shortly) as well as the extensive network of community organizations and programs that have been created over the years to address homelessness.

But the city of Marseille is much more than simply the city where my field sites happened to be. The city became a crucial element through which to better understand the way vulnerability appears and unfolds during socio-medical interventions. Exploring Marseille and its unique socio-political aspects unveils a canvas onto which particular events during my fieldwork are drawn, a canvas also framed by social policies that France has put in place over many years in order to deal with precarity, poverty, homelessness, and immigration. I will, therefore, explore this important background context before presenting my two field sites in more detail.

The City: Marseille

Marseille is the second-largest city in France by population, after Paris, with approximately 870,000 residents as of the last census count in 2016; about 1,500,000 if we consider the entire metropolitan area (INSEE 2016). Located in the south of the country, next to the Mediterranean Sea, its history can be dated back to 600 B.C.E., when Greek colonists from Phocaea founded a colony called Massalia. At the time, and for years, it was a major Mediterranean seaport, the operations of which fuelled a booming economy. Today, the portrait of Marseille is different. Its modern history includes major socio-political

and economic transformations, as well as multiple crises. Marseille, therefore, carries different images in the country's collective imagination, some images that are not always accurate, as I will present now.

One image of Marseille is certainly one of lightness and celebration, an image that goes beyond the superficial delights of *pastis*, *pétanque* and *l'Olympique de Marseille* (l'OM) - the local soccer team. In 2013, Marseille was designated as the European Capital of Culture, shedding new light on the city. Numerous cultural events happened all around town. Many former factories and port installations have been transformed into concert halls or exhibition spaces for contemporary art and performances. The construction of the *Musée des Civilisations de l'Europe et de la Méditérannée* (MUCEM) in the Old Port was, at the time, the first state-funded national museum outside of the Paris region. That same year, the New York Times ranked Marseille as the second-best city in the world to visit, after Rio de Janeiro (New York Times 2013).

Another image of Marseille is one of complexity and crisis. In 2006, anthropologist Michel Peraldi and journalist Michel Samson published *Gouverner Marseille*, in which they explore the complex and subtle political history of the city. They present the overlap of politics and social life, and how social life has influenced politics over the past decades in the city. Their analysis starts with the image of crisis often associated with Marseille, because of the various economic, demographic and political crises that happened over the years, as I will present shortly.

This image of crisis has dominated local and national French media depictions, and the collective imagination (Peraldi and Samson 2005, 9) from the end of the Second World War until the mid-1980s, making Marseille the symbol of dysfunctional cities[12] in France (Mongin 2013). Still today, this image is

[12] " le symbole des villes défaillantes" (Mongin 2013)

pervasive, yet the reality of the present so-called crisis is questionable. Although many sectors of the city are not necessarily booming economically, Peraldi and Samson (2005) argue that things are somewhat different and more subtle than the popular image of disaster. They use trade (*le commerce*) as an example. Contrary to the image of pervasive generalized economic standstill, *le commerce* in Marseille is functioning well today, but not in the way it used to. In fact, they argue that commerce now involves networks of informal trades among poorer and excluded members of society, or trades among big national and international companies, with almost nothing in between (Peraldi and Samson 2005). This image of crisis, therefore, calls for more nuanced analysis.

Beyond the reality of it, or the intensity of it, the image of a so-called crisis is nonetheless powerful, and it remains an interpretative reference for many[13] (ibid). This image prevailed throughout my fieldwork, no matter what reality it was based upon. So many times during observations and interviews, people would tell me about certain situations that involved one form or another of crisis. They would then stop and tell me, "you know, it's always like this in Marseille," rolling their eyes or nodding their head, almost laughing. The history and the current life of Marseille were therefore often perceived and interpreted as a perpetual crisis - true or not - and unfolding on multiple levels: economic, demographic and political.

The first level of this crisis is economic. Internationally, the period from the end of World War II until the oil crisis in the mid-1970s was marked by globalization. In Marseille, in particular, the resultant increase in global competition resulted in the closure of many local industries and factories, leaving scores of individuals in situations of precarity and poverty. The port of Marseille was forced to reduce its industrial activities drastically, while also facing the decrease in maritime travel for passengers, following the end of the colonial economy and the associated movements of independence among former colonies

[13] "Cette crise n'est évidemment pas une légende. Mais elle est néanmoins une trame des légendes que les acteurs urbains se fabriquent pour se rendre intelligible la ville d'aujourd'hui" (Peraldi and Samson 2005, 18)

(Peraldi, Duport, and Samson 2015). This port, which was once the lifeblood of the city[14] (ibid), a major economic hub in the region, and the glorious symbol of the city - became a deserted, empty area. Today, a significant proportion of Marseille's population lives under the poverty line, as I will address in a moment (ibid). It is a city under major state funding, closer to the reality of a banlieue than a prosperous urban centre (ibid). Indeed, as summarized by Peraldi, Dupont, and Samson (2015), Marseille is an economically dead star that still continues to shine.[15]

The second crisis is a demographic one, and consequently, a social one as well. With the succession of major job losses and the consequent high rate of unemployment, people started to leave the city after World War II, and Marseille's population continued to decrease, for almost 30 years. This trend began to reverse only at the end of the 1990s. Over the course of this significant decline in population, two main social categories of individuals started disappearing from Marseille; the wealthy bourgeoisie involved in trades and industries,[16] and *le monde ouvrier*, the working class (Peraldi, Duport, and Samson 2015). The bourgeoisie either physically left the city (along with the different industries that relocated to other parts of France and Europe), or stayed in Marseille and changed class identity, becoming dissolved within the middle class. The other main group, *le monde ouvrier*, faced high rates of unemployment and were at the time—and are still—demoted to a reality of precarity and poverty.

The third crisis is political. The way politics is conducted in Marseille has been the focus of various books, articles and even a Netflix series.[17] The city is generally depicted as a world in which personal

[14] "le poumon économique de la ville" (Peraldi, Duport, and Samson 2015, 9)

[15] "Marseille est une étoile économiquement morte dont la lumière continue de briller" (Peraldi, Dupont, and Samson 2015, 3)

[16] "les grandes bourgeoisies négociantes et industrielles" (Peraldi, Duport, and Samson 2015, 5)

[17] The plot of the Netflix series Marseille is in itself revealing. Consider how the show has been depicted in its entry on Wikipedia: "After 20 years as mayor of Marseille, Robert Taro […] enters into a war of succession with his former protégé turned rival Lucas Barres […]. Both men are members of the "UPM" party, based on the centre-right UMP (Union for a Popular Movement). A betrayal ignites a bitter war between a master politician and his

relationships forged on the basis of political longevity, loyalty, and corruption appear at the heart of political functioning - although it is not clear how much of this is unique to Marseille compared to the rest of the country. Marseille has a veneer of political durability. During the time of my fieldwork, it has only had three elected mayors since 1953: Gaston Deferre, a lawyer who ruled the city for 36 years from 1953 to 1986; Robert-Paul Vigouroux, a neurosurgeon who served as mayor from 1986 to 1995; and the current office-holder, Jean-Claude Gaudin, who worked as a teacher, and has been ruling Marseille since 1995. Only three different mayors, and all connected to one another - as the first one trained the other two (Peraldi, Duport, and Samson 2015, 42). Yet beneath this apparent image of political stability, the political process is far from a calm perpetuation. In fact, the political analysis of the city is more revealing of chaos and hunger for power. The image of an apparent equilibrium on top of chaos[18] (Peraldi, Duport, and Samson 2015) was an important image during my fieldwork, as I will present throughout this thesis.

Poverty

Material and economic poverty are pervasive realities in Marseille. It is particular in its distribution among the population. Rather than isolated to a small proportion of residents within specific groups, poverty seems to be more widely distributed all across the city. In 2009, up to 26% of the population lived under the poverty line (compared to 16% for Paris and 15% for Lyon) (INSEE 2009). A bit more than half of the population earns less than 1,370 euros per month (Langevin 2013). The city also has a high rate of unemployment, low levels of high school graduation and a high proportion of single-parent households, mostly headed by women (Peraldi, Duport, and Samson 2015, 12). Even the public sector, usually a bastion of stable and well-compensated employment, is unreliable in Marseille. Around 18% of the economically active population of Marseille works for the public sector—about twice as much as in

hungry young protégé in this sweeping tale of corruption, seduction and revenge. Then, the battle for the heart of Marseille heats up as right-wing nationalists gain power and a shadowy conspiracy targets the city's beloved soccer team" (Wikipedia 2019)

[18] "l'équilibre sur le chaos" (Peraldi, Duport, and Samson 2015, 33)

Paris (INSEE 2010) - and a significant proportion of them still live a precarious financial life, although above the poverty line (Peraldi, Duport, and Samson 2015).

This diffused precarity was a reality I witnessed throughout my fieldwork. In the various neighbourhoods I explored or lived in, and through the interviews I conducted, I noticed greater proximity with precarity and poverty among the population at large; a certain ease of cohabiting with it. That is, there were moments of violence and tension toward people living precariously, but also a certain kind of acceptance and protection. At l'Oasis, a few of the *maraudes* (the organized walking rounds around the city to go meet people living in the street) during the summer were spent trying to find Guillaume, a man with severe mental health problems living in different squats around le Panier, one of the disadvantaged neighbourhoods of the city. At times, Guillaume was either chased or ostracized by people of the neighbourhood; at other times, he was protected by these same people, as though he really belonged to the neighbourhood. One of the intervenants once told me about Guillaume that people are either kind with him or they chase him. Within the same week, a group of young men had tried to attack Guillaume in his squat while another group of teenagers of the neighbourhood were very suspicious of us asking questions of his whereabouts, "what do you want from him?", they asked us in a very defensive tone. Another citizen, an elderly lady in the neighbourhood, gave us her phone number so we could reach her to get news from Guillaume since her small apartment was close to his main squat. Another similar example involved Joseph, a man who always "worked" at the same place and at the same time in front of *Les Réformés,* a major church of the city. His "work" was to beg on the same street corner, asking for money from car drivers and passengers when the traffic lights were red. The man from the small pizza kiosk right across the street always checked on Joseph and gave us information about his state, at times giving him a slice of pizza for free while he tried to sell other slices to passersby from his small and boiling kiosk. "Well, you know, he's slightly strange but he's not mean," this man once told us.

Poverty in Marseille is geographically specific. It is mainly concentrated in two different areas of the city: the very centre, and les *Quartiers Nord*[19] (Peraldi, Duport, and Samson 2015).[20] It is precisely where my two field sites were located. Contrary to other Western cities, where the downtown area is commonly populated by the elite and organized around tourism with museums and boutiques, at the centre of Marseille. - in the three arrondissements that form the city centre (1er, 2e, 3e) - the poverty rates ranges from 43% to 55% (Compas 2013). In fact, the 3e arrondissement is the poorest area of the entire country, with about 50% of the population living under the poverty line (Langevin 2013). Les *Quartiers Nords* have a large amount of social housing, around 38-41% of the total housing stock, where many of the recent immigrants from Algeria and the Comoros reside (Compas 2013). The area suffers from similar

[19] Les Quartiers Nords (mainly Arrondissements 13-14-15) are a series of neighbourhoods in the northern part of the city with social realities similar to those of some banlieues of Paris. "The north of Marseilles (the quartiers nord) is an area of oddly named low-income low-rent council estates, inside the city but cordoned off from it as though in quarantine" (Lemoine 2012).

[20] Consider this newspaper chronicle by French economist Philippe Langevin regarding the distribution of poverty in Marseille.

"Au-delà des questions de revenus, les déséquilibres entre différentes parties de la cité s'expriment sur d'autres réalités. Les logements sociaux sont concentrés dans les quartiers nord. L'habitat dégradé et insalubre est celui du centre-ville. Les commerces de détail disparaissent au cœur des quartiers que l'on dit sensibles. Les services publics s'éloignent doucement des habitants qui en ont le plus besoin. On ne compte plus les fermetures des bureaux de poste ou de cabinets médicaux. L'école maternelle et primaire reste le dernier rempart de la République dans le centre et le nord de la ville. D'un côté, la rareté de l'emploi génère une économie de bazar entre petits boulots, " tombé du camion ", travail au noir et trafic de drogue. De l'autre, des ingénieurs qualifiés et des entrepreneurs de talent, qui ne fréquentent pas le marché aux puces, construisent le Marseille de la compétitivité. L'accès au logement social est très difficile. Non seulement l'offre est très insuffisante (le délai moyen d'attente est de 8 ans !), mais elle est très inégalement répartie sur le territoire Marseillais. Le taux de logements sociaux est de 3,4% dans le 6° arrondissement et de 38,1% dans le 15e. Se développe dès lors, notamment au centre-ville un logement social de fait, souvent insalubre et toujours onéreux, dont les évènements récents ont montré la dangerosité" (Langevin 2019).

Note: the recent events the author refers to at the end of this passage are related to the collapse of two apartment buildings on November 5th, 2018 on la Rue D'Aubagne, in the popular neighborhood of Noailles, in the 1er arrondissement. Eight people were killed, and hundreds of people displaced. This tragedy sheds light on the very dangerous state many of these apartments are in, and on the way the city administration dealt with the crisis. Regarding this situation, Le Haut comité pour le logement des personnes défavorisées (HCLPD) published a report in November of 2019 on the housing situation in Marseille, referring to a "humanitarian crisis" pointing at a series of dysfunctions and inactions from the authorities of the city who were well aware of the housing conditions in these populous neighborhoods where people are forced to live in unsafe, substandard and indecent lodging (HCLPD 2019).

rates of poverty as the city centre (Compas 2013). There are certainly wealthy people in Marseille - very wealthy - but they tend to concentrate in small gated communities, mostly located in the 8e and 9e arrondissements. Marseille is, in fact, among the 10 cities in France with the highest income inequality (INSEE 2009; Observatoire des inégalités 2012).

Criminality

The image of Marseille as an unsafe and violent city is persistent. Yet the statistics present a somewhat different portrait. Fassin (2011) has demonstrated how statistics on criminality, in general, tend more so to provide evidence of police activity rather than delinquent acts, per se. In Marseille, the *règlements de compte* (gangland killings) related to the drug trade are certainly a reality, but the statistics between 2012 and 2017 show an overall decrease in this precise type of criminal activity and in other forms of criminality (for example, violent physical attacks, burglary or car theft) (Peraldi, Duport, and Samson 2015; Préfecture de Police des Bouches-du-Rhône 2017). Certain types of crimes (for example, burglary) are even less frequent in Marseille than in Paris (Préfecture de Police des Bouches-du-Rhône 2017).

Even if the statistics may show a decrease in crimes related to drug-trafficking, it is an industry that is nonetheless a reality in Marseille. French Deconnection was published in 2014 by journalist Philippe Pujol. Ethnographic in nature, the book gives a vibrant and intimate portrait of the drug trade in les Quartiers Nord de Marseille. The title refers to the French Connection, a system of illegal heroin trafficking in the 1970s, where the drug was produced in Turkey and sold in the United States (US) via an elaborate system of smuggling and transportation through the Port of Marseille. Pujol's French Deconnection describes how the drug is now produced in Morocco, transported through Andalusia in Spain, and sold in Marseille.

Pujol presents criminality and drug dealing as a consequence of the intense precarity faced by residents of les *Quartiers Nord*, a consequence of the high levels of unemployment plaguing especially the younger generation (18-30 years old). They participate in the drug trade while still living at their parents' houses, unable to afford an apartment on their own. One of his informants, a 25-year-old, describes his life in les *Quartiers Nord*: "People say one cannot enter our neighborhoods, but I'd rather say that one cannot escape our neighborhoods"[21] (Pujol 2014, 95). Pujol presents the feeling of confinement (enfermement) to describe the life situation in les *Quartiers Nord* de la ville:

> Because, in the end, everything is just an issue of confinement, in a city, in a drug network, in an addiction, in unemployment, in one's personal misery or condition. And like all shut-ins, we dream of escaping through drugs, alcohol, food, delinquency, compulsive shopping or ambition. We still don't understand how the people living in working-class neighbourhoods seem to be prisoners of a powerful, though constantly improvised, political control [translation].[22] (Pujol 2014, 13)

Nonetheless, one of the intervenants I met during my own fieldwork, who grew up in les *Quartiers Nord*, once told me she felt much safer in les *Quartiers Nord* than she did downtown. She mentioned how the strict social codes within les Quartiers created a sense of predictability among its residents. One knew exactly what to do and what not to do in order to remain safe.

Clientelism

An important aspect of the political governance of Marseille needs to be addressed here since it is has been part of the socio-political fabric of the city for many years. Governance in Marseille is heavily influenced by clientelism. Clientelism is a form of personal relationship that involves the distribution of public funds outside of proper channels (Briquet and Sawicki 1998) as a form of political exchange in

[21] "On dit qu'on ne peut pas entrer dans nos quartiers, moi je dis qu'on ne peut pas en sortir" (Pujol 2014, 95)

[22] "Car tout finalement n'est qu'une question d'enfermement, dans une cité, dans un réseau de stups, dans une addiction, dans le chômage, dans la misère ou dans sa condition. Et comme tous les enfermés, on rêve d'évasion, grâche à la drogue, l'alcool, la bouffe, la délinquance, l'achat compulsif, l'ambition. Reste, encore, à comprendre comment les habitants des quartiers populaires semblent prisonniers d'un contrôle politique puissant bien que sans cesse improvisé" (Pujol 2014, 13)

which "a politician (i.e., a 'patron') gives patronage in exchange for the vote or support of a 'client'" (Robinson and Verdier 2013, 262), whether in the form of public subsidies, a public sector employment, or subsidized housing (Mattina 2016).

For journalist Philippe Pujol (2014), clientelism involves putting oneself in the service[23] of the patron who has given you a favour. In order to reach the greatest number of people, the *donateur* seeks out individual clients who wield great influence in their respective milieus. French sociologist, Cesare Mattina (2016), has been writing about the urban clientelism in Marseille for years. He mentions the inherent stability of this redistributive system. No matter what socio-demographic or political transformations have taken place in the past decades, it always appears to have been the same groups benefitting from this clientelism. He shows how advantages are distributed almost systematically prioritizing city employees and their families[24] (Mattina 2016), presenting an almost "hereditary" distributive process (Hadj-Belgacem 2017). For example, in *les Quartiers Nord*, clientelism most especially benefits the drug dealing caïd (drug cartel boss), as well as a number of influential families, either because of their size or involvement in a particular aspect of quartier life.

Yet, for Pujol (2014), clientelism goes beyond a simple desire for political influence and power. Fundamentally, clientelism is about material and economic precarity. In fact, he says, "clientelism exists because of the scarcity of resources"[25] (Pujol 2014, 144). When their life circumstances are precarious, people will take what they can find from among what is available around them. Pujol gives a number of examples of this; with housing ("this natural desire to live in a somehow better precarious

[23] "se mettre au service" (Pujol 2014, 143)
[24] "les avantages [sont] octroyés en priorité et de manière quasi systématique aux employés municipaux, à leurs familles et à leurs descendants" (Mattina 2016, 205)
[25] "le clientélisme joue sur la manque" (Pujol 2014, 144)

neighborhood"[26]), and with employment ("because they are so rare, even the worst job becomes attractive"[27]) (ibid, 144). In the end, for Pujol, clientelism becomes a form of opposition between individuals and groups ("clientelism creates ghettos within ghettos and it opposes poor people against slightly less poor people"[28]) (ibid, 135). As I will show later, clientelism, too, made its appearance in my fieldwork.

Immigration, Migration and Refugees

Marseille has long been a *terre d'accueil* (a welcoming land) and a land of passage. Its booming port economy created a system of international commerce and travelling for centuries, before its more recent decline. Different waves of immigration have occurred in the city. Starting in the mid-1850s, Italians arrived in the city to fill many of the industrial jobs. Following World War I, Armenians arrived after having fled the genocide. Starting at the end of the 1950s, in a context of decolonization and culminating with the Évian Accords in 1962 that ended the Algerian War between France and Algeria, an immigration movement started with people from le Maghreb - mainly Algerians, but also Tunisians and Moroccans. In the mid-1970s, another wave of immigration took place with people from countries located around the Senegal River (Guinea, Mali, Mauritania, and Senegal) and the Comoro Islands, an archipelago of islands located off the south-east coast of the African continent. Three of these islands form the independent country of Les Comorres (the Comoros), while the fourth one, Mayotte, is an overseas department of France. Today in Marseille, Algerians form the largest group of people with a migratory background, followed by Tunisians and Moroccans.

[26] "cette volonté naturelle d'habiter dans une cité moins pire" (Pujol 2014, 144)
[27] "puisque qu'il y en a si peu, le [job le] plus minable prend de la valeur" (Pujol 2014, 144)
[28] "le clientélisme crée des ghettos dans les ghettos, oppose les pauvres aux moins pauvres" (Pujol 2014, 135)

Since 2014, there have been waves of massive human migration across the Mediterranean. People fleeing areas of lengthy conflicts, political tensions and deteriorating socio-economic conditions in different African countries and the Middle East have been trying to reach Europe as refugees. The number of deaths at sea has been appalling; in 2017 is it estimated that more than 3,100 people died while trying to cross the Mediterranean while 171,635 arrived alive (International Organization for Migration 2018). Three main migration routes exist: the Western Mediterranean route (with people arriving in Spain after crossing the sea mainly from Morocco or Algeria), the Central Western Mediterranean route (with people arriving in Italy also after crossing the sea mainly from Libya), and the Eastern Mediterranean route (with people arriving mostly to Greece from Turkey by land or water) (European Council on Foreign Relations 2019; UNHCR 2015). At the time of my fieldwork, France - and particularly Marseille - was not a port of arrival for the Mediterranean crossings, but was a final destination or a transitional location for some refugees en route to the United Kingdom or Germany, for example. Most refugees I met during my fieldwork in the homeless shelter were people who had first arrived in Italy using the Central Western Mediterranean route. The majority of them had entered France irregularly, without obtaining the necessary documents from Italy as required under the Dublin III regulation.[29]

Homelessness

Homelessness in Marseille is an ever-present reality. In 2016, about 14,000 people found themselves at least once in a situation of homelessness, visiting either an emergency shelter or another resource for the homeless in the city (Daguzan and Farnarier 2016). Every night, about 750 people sleep in an emergency shelter in Marseille (Castelly 2019). Over the past few years, the city has seen a general

[29] The Dublin III Regulation establishes that only one European Union country can be responsible for the examination of an asylum application on its territory (European Commission 2019). This country is almost always the one where the asylum claim was first made. I will explore this important concept later in the thesis.

increase in the number of people facing homelessness, most especially minors, women and people above 60 and 70 years old (Daguzan and Farnarier 2016).

Generally speaking, homelessness in France is not a situation of those "who have just lost everything" and suddenly ended up in the street for financial reasons (Noblet 2014). A variety of individual profiles exist, but in very many cases, the users of shelters and other resources for the homeless are recent immigrants to France, or those who have had difficult personal journeys for a long time (Damon 2002; Noblet 2014). Among homeless individuals who have arrived in France recently, most are asylum seekers and those who have entered the country irregularly and do not have legal authorization to stay (Pichon 2014). This reality was an important one during my fieldwork, as I will explore in this thesis. The proportion of migrant men and women living in a situation of homelessness has increased significantly in France over the years, from 38% in 2001 to 52% in 2013 (Yaouancq et al. 2013).

Homelessness in France is, therefore, not a homogenous reality, and there is an overrepresentation of the migrant population. Regarding this, Dietrich-Ragon (2017) wrote about the results of the 2012 French Homeless Survey (Enquête Sans-Domicile), a nation-wide survey that looked more carefully at the population of SDF (*Sans domicile fixe*) in the country. The conclusions are revealing:

> While the origin of homeless people is rarely mentioned in the media, this article shows that housing insecurity disproportionately affects migrants and their descendants. Moreover, access to accommodation provided by assistance organizations is more difficult for migrants than for homeless people from the majority population. Migrant men are more likely to be left out in the street, while migrant women tend to be sent to emergency accommodation, which is less likely to lead to stable housing. (Dietrich-Ragon 2017, 28)

The migrant homeless population is in-itself, also very diverse. Dietrich-Ragon (2017) identifies three main trajectories and subgroups in this population. First, those who have recently arrived in France, often undocumented or with an irregular status, and who rapidly end up in homelessness. Second, those who have been homeless for years living in daily rental hotels or other such institutions until they find a

more permanent form of housing. Third, those who have had a form of stable housing for years but end up in the street after a personal or family crisis that leaves them unemployed and then homeless.

These different subgroups of the migrant homeless population point at different processes and create different categories of homeless individuals with different chances. In fact,

> The heterogeneous trajectories of the three sub-populations of migrants, and their varying legitimacy in the eyes of assistance organizations, create unequal chances of exiting homelessness. […] Women with children take priority, as do migrants who are best integrated into the labour market and those with the most education. Conversely, the most precarious migrants are offered solutions that are themselves precarious, thus reducing their chances of integrating into French society. They will probably continue their trajectories on the margins of society, and some will be lost to observation because they leave France or become extremely marginalized. (Dietrich-Ragon 2017, 29)

There is a particular temporality to systems of homeless assistance in France that must be understood. The systems of assistance for *Sans domicile fixe* (SDF) are often temporary in nature and will focus on providing immediate monetary or sheltering assistance (Pichon 2014; Noblet 2014). More and more, resources providing longer-term assistance and counselling are becoming available (Noblet 2014), but they remain quite limited. For Noblet (2014), this temporariness also raises questions of autonomy and responsibility. A homeless individual will get some temporary help that will sooner or later be taken away if he or she does not succeed at regaining a form of social autonomy.[30]

Various types of resources addressing homelessness are offered in different places in Marseille, scattered around the city. The *centres d'hébergement d'urgence* (centres for emergency sheltering), the *Accueil de jour* (ADJ) (for services and help with different administrative requirements during the day),

[30] "Mais cette aide, quand elle est accordée, ce qui est loin d'être toujours le cas, reste très parcimonieuse. En particulier, elle est temporaire: "je t'offre un toit, mais c'est seulement pour quelques jours ou quelques semaines ou quelques mois ; je t'offre un emploi (un "contrat aidé"), mais c'est seulement un emploi à mi-temps pour quelques mois ; au final, tu dois être autonome pour assumer par toi-même ton existence quotidienne. " Résultat, le système aide la personne, mais, peu après, la punit si elle ne parvient pas à transformer l'aide limitée dans le temps en tremplin vers l'autonomie. Toute la politique d'insertion française est ainsi biface. L'individu obtient une aide, mais l'aide lui est tôt ou tard retirée, même s'il ne parvient pas à retrouver son autonomie" (Noblet 2014, 15)

and numerous soup kitchens and charity organizations form the core of the temporary assistance regime. For healthcare, les *Permanences d'accès aux soins de santé* (*les PASS*)—whether medical, dental, psychiatric or obstetrical— are clinics located in city hospitals that provide health and social services to individuals without health coverage. This notion of coverage will be explored in greater detail later in the thesis. These *PASS* clinics were created nationally in 1998, following a French law to fight social exclusion (*la Loi relative à la lute contre l'exclusion*). Other health services include the *Centre d'accueil de soins et d'orientation (CAS*O) provided by Médecins du Monde; the mobile teams for physical and or mental health, especially les *Équipes mobiles psychiatrie-précarité (EMPP);* the *Centres de soins d'accompagnement et de prévention en addictologie (CSAPA*) for issues related to substance use; the *Lits haltes soins santé (LHSS)* for full-time housing of people presenting with acute medical conditions, but who do not need to be hospitalized; and the *Lits d'accueil médicalisés (LAM)* for homeless people with severe and chronic medical conditions requiring important medical assistance. My two field sites were at a *Centre d'hébergement d'urgence* (La Maison Frédéric), and with an *Équipe mobile psychiatrie-précarité* (EMPP) called l'Oasis.

Conclusion

Marseille is complex and diverse. The city itself exhibits an in-betweenness: a composition of different realities evolving side-by-side, affecting one another, yet not merged as a whole. Marseille exists between the joyfulness and simplicity of the city and the high level of diffused poverty. It exists between a strong social activist movement and a strong level of inequalities, alongside a unique political model of governance. Marseille is complex and fascinating. Pujol (2014) presents this reality of in-betweenness that is inherent to the city:

> Some [people] already know that Marseilles is a beautiful city; a humane place, where you can connect with anyone, at any time, about anything; a composite, with its beaches, creeks, and village centres; joyful, with inhabitants who have mastered the subtle art of exaggeration and self-mockery. [...] [But it is also] a vast city, with no suburbs. A city of neighbourhoods that, like

> elsewhere, are becoming poorer every year, attracting the poorest immigrants, who can be exploited at a lower cost, ghettos made up of school ghettos, groups of children from poor families in establishments that struggle in all this social misery. It isn't conducive to calm study. Ghettos of the unemployed who are ignored by the economic world that turns around them, the under-qualified and, occasionally, a graduate. Ghettos of traffickers who, in the end, find this a good place for a business that constantly adapts to the methods of the police. Ghettos that support the temptation to just rely on oneself, to live in fear of others.[31] (Pujol 2014, 147)

The rest of this thesis explores this in-betweenness that suffuses the city as a whole, but also the lives of the people I followed during my fieldwork.

La Maison Frédéric and L'Oasis

La Maison Frédéric

Vignette: On my way to La Maison Frédéric

> Down the street, on my way to the shelter, I can see the old port, the sea, a few train tracks, the elevated highway, and below it, a small wall made of rocks. The blue water creates a sharp contrast against the beige and grey concrete walls of the surrounding buildings, the broken windows, the holes in the pavement, and the ceaseless presence of trash. As I walk down this long street and get closer to the water, the small wall made of rocks suddenly appears taller, making what lies behind it disappear, including the sea. No more water and no more horizon; only the city, vibrating under the burning July sun.
>
> Against this backdrop, at a distance, emerges the shelter. I am about to arrive. On my left, a new urban eco-development is being constructed. Smartseille, it is called. It is part of the Euromed project, a vast urban revitalization project launched in the 1990s with the goal of rehabilitating the former port area and a number of other parts of the city. The picture sign at the entrance of

[31] "[Il y a] ceux qui savent que Marseille est une jolie ville; humaine, où l'on peut nouer le contact avec n'importe qui, n'importe quand, sur n'importe quoi; composite, avec ses plages, ses calanques, ses noyaux villageois; joyeuse, avec ses habitants maîtres dans l'art subtil de l'exagération et de l'autodérision. […] [Mais c'est aussi] une ville vaste, sans banlieue, des cités dans la ville, qui comme ailleurs se paupérisent d'année en année, accumulant les immigrés les plus démunis, donc exploitables à moindre coût, des ghettos qui se déclinent en ghettos scolaires, regroupements d'enfants de pauvres dans des établissements qui se débattent dans toute cette misère sociale peu propice à l'apprentissage serein. Des ghettos de chômeurs ignorés du monde économique qui les entoure, les sous qualifiés comme les rares diplômés. Des ghettos de trafiquants, qui trouvent là finalement une zone favorable à un business qui s'adapte en permanence aux méthodes policières. Des ghettos qui alimentent la tentation de l'entre-soi, de la peur de l'autre" (Pujol 2014, 147)

the construction site shows the future final project, and it clashes with the present surroundings. On the picture, a large, clean, paved sidewalk lies between the condominium building and a terrace, protected by the freshness and the shade of luxurious trees. “Smarseille, la ville du futur à vivre au présent,” (“Smartseille, the city of the future to enjoy in the present”) it says. The website of the project is clear about its future possibilities.

> “Marseille becomes a metropolis. Facing the sea, different projects are starting to win over the hearts of the city and its citizens. The transformations are just starting. The city has changed. Life in itself is about to change. Smartseille is about life in the future. An active and urban Mediterranean life. A peaceful and easier life within a more intelligent, sober and sustainable city. Smartseille is about living in the first eco district of a wide eco-city, within the center of gravity of the metropolis.”[32]

The cranes are moving slowly behind this sign. No trees are on the horizon. Only bright sunlight, the smell of heat and garbage, and the humming sound of cars on the elevated highway at the end the street. The beginnings of condominium office towers timidly appear on the construction site. A hotel is already standing there, apparently operational. A few times over the summer, as I was walking back home, tourists stopped me on the street to ask for directions to this hotel. They looked puzzled as I pointed to that isolated white building in the middle of the dusty construction site, looking back at their online reservations and wondering whether their GPS was functional.

When arriving in front of the shelter, there are two main entry points to get inside. A small door on the left, and a big rolling metal gate on the right. The small side door is the main entry for residents. It opens starting at 4:00 pm (or at 3:00 pm during Ramadan). Every day, each man needs to line up in front of this door and give their name to confirm the spot they obtained through the central phone system for shelter beds in Marseille. The big rolling metal gate is the other way to get inside La Maison Frédéric. Through the thick bars, you can see the large courtyard with all its surrounding buildings. This gate rolls in and out in order for cars to drive inside, for employees to come in, or for the few residents being allowed to stay during the day to leave and come back as they want. I often wondered during the summer what entry to take when both were open.

When facing the heavy metal gate, you have to ring to get inside the big courtyard. Someone has to come and slide the door open for you. As the bell loudly resonates all across La Maison Frédéric, you stand there, waiting. The cleaning staff may come to you if they recognize you as a

[32] “Marseille devient métropole. Face à la mer, les grands projets gagnent le cœur de la ville et celui des marseillais. Les métamorphoses ne font que commencer. La ville a changé. C’est maintenant la vie qui va changer. Smartseille, c’est la vie du futur. Une vie active, urbaine, méditerranéenne, plus douce, plus facile, dans une ville plus intelligente, plus sobre, plus durable. Smartseille, c’est la vie dans le premier écoquartier d’une vaste écocité, au centre de gravité de la métropole.” (Présentation document of projet-Smartseille 2015, 2)

> member of the team. If not, you have to wait for a welcome staff to come open the door for you. Residents usually continue to mind their own business inside the courtyard, since they are not authorized to open the gate. On certain days, though, you have to ring twice, even three times.
>
> "Eumm, bonjour, je suis l'anthropologue canadien," I would often shout during the first few weeks of my fieldwork, through the bars of the gate, competing with the noise of the cars on the highway right above us. As the summer went by though, there was no more face of suspicion from the welcoming staff, no more talking through the metal bars, but an immediate rapid opening of the gate and a handshake.

Created in 1994, La Maison Frédéric is one of the principal men's emergency shelters of Marseille, hosting about 285 men every night (and more in the winter). There is one other main shelter for men in Marseille, located in the city centre. Shelters for women are located in different parts of the city, one of them run by the same organization that currently oversees La Maison Frédéric. Over the years, though, the responsibility for the administration of La Maison Frédéric has passed between various groups and organizations, an important point that I will explore in greater detail in the chapter on temporality. La Maison Frédéric is located in les Quartiers Nord, far from the centre of the city. One must walk 20 minutes from the last metro station at the end of the line to reach it—or else travel five minutes by bus if one is lucky enough to catch it. This is the journey I depicted just above. I walked this street many times during my fieldwork, on my way to the shelter.

During the three months of my fieldwork, La Maison Frédéric had an occupation rate of about 95%. The rate varies according to the seasons and tends to be higher in the winter months. The shelter hosted a total of 936 different men during my fieldwork, with an average length of stay of 26 days. Some of them left after only three days, while others had been there for years, like Monsieur Tonev, who was taken down by the wind in the opening vignette of the thesis. The majority of these men were between the ages of 26-46 years old, yet 42 of them were above 70 years old. Over the summer, about 74% of these people reported having come originally from outside the European Union, 15% from France and about

5% from another EU country. The rest (about 6%) did not disclose this information. Irregular immigration status was a common reality, as I previously mentioned. In fact, 48.2% were simply sans-papier (without status), and 3.6% were admitted under the Dublin regulation.[33] In terms of social and health insurance coverage, the vast majority (81%) simply had no health or social coverage whatsoever when arriving at La Maison Frédéric.

Each room in the shelter hosts three to eight men, with communal bathrooms and showers. Some of the rooms are located inside the main buildings, while others are in temporary modular outdoor units. A cafeteria on-site serves breakfast and dinner, and there is a storage room (bagagerie) for the men to keep their belongings. One of the buildings hosts the majority of the health and social services offered. On the ground floor are two small offices for the nurses and the aide-soignante (assistant nurse). Nurses offer daily consultations in the afternoons. Doctors come about once a week for consultations. In an office at the side of the same building, social workers offer daily services and consultations. Each new resident, upon arrival, has to meet with the nurse and the social worker for a brief evaluation of their health and social situation and needs.

A variety of workers and socio-medical professionals work in rotation to make the shelter run 365 days a year. At the time of my fieldwork, about 24 *accueillants* (welcome staff) were working day and night to welcome residents and ensure their safety and the overall smooth operation of the shelter. They were accompanied by four social workers, two nurses, one nurse-assistant, three physicians, one director of socio-medical services, two *maitresses de maison* (employees who are responsible for the general wellbeing of residents) alongside various administrative personnel and housekeeping staff.

[33] As I previously mentioned, The Dublin III Regulation establishes which European union country is responsible for the examination of an asylum application on its territory (European Commission 2019). I will explore this later in the thesis.

The main mission of La Maison Frédéric was to offer a temporary roof to people in emergency situations. Laws regarding emergency sheltering in France are based on the principles of universality and unconditionality, no matter what reason brings the person to a shelter (Article L345-2-2 of the *Code de l'action sociale et des familles*).[34] Article L354-2-3 of the same law also states that all persons have the right to accommodation in an emergency shelter and to stay there for as long as one wishes/is necessary until an alternative option is available to them.[35] Therefore, whether you were a French citizen having become homeless or a refugee having crossed the Mediterranean recently, everybody has to be provided a spot.

It is according to this vision that services were to be offered at La Maison Frédéric. Everybody was welcomed and had to be served, no matter what their immigration status, no matter if they had *des droits*[36] (status) or not. Yet the reality was somehow different. In a welcoming session at the shelter, one of the intervenants was clear; the services were temporary, and you should really obtain a regular immigration status in order to have a future in the country:

> "I don't want to give you false hope, but you really need to regularize your status if you want to stay in France and have any kind of future here. Our job here is quite clear: emergency support, shelter, a hot meal, social support. Some medical support. Our role is to get you on another path, not to take care of you."[37]

[34] "[t]oute personne sans abri (…) a accès, à tout moment, à un dispositif d'hébergement d'urgence (qui) doit lui permettre, dans des conditions d'accueil conformes à la dignité de la personne humaine, de bénéficier de prestations assurant le gîte, le couvert et l'hygiène, une première évaluation médicale, psychique et sociale (…) et d'être orientée vers tout professionnel ou toute structure susceptibles de lui apporter une aide justifiée par son état" (Article L345-2-2, Code de l'action sociale et des familles).

[35] "[t]oute personne accueillie dans une structure d'hébergement d'urgence doit pouvoir y demeurer, dès lors qu'elle le souhaite, jusqu'à ce qu'une orientation lui soit proposée" (Article L345-2-3, Code de l'action sociale et des familles).

[36] I will later present in details this notion of droits in France, that is the legal rights people have in the country. Specifically, here, it refers to having (or not) a form of social and health care coverage.

[37] "Je ne veux pas vous donner de faux espoirs, mais il faut vraiment une situation régulière si vous voulez rester en France et avoir moindrement un futur ici. […] Notre boulot ici est assez clair : urgence, abri, repas chaud, accompagnement social. Un peu d'accompagnement médical. Notre rôle est de vous réorienter, pas de vous prendre en charge. "

In order to facilitate the coordination of available spots in all emergency shelters of the city, a telephone service called "the 115" was created in 1998. Le 115 is a free telephone service, administered by the *Service d'aide mobile d'urgence sociale (SAMU social)* of Marseille, a country-wide city-led emergency service providing socio-medical help to homeless individuals and people in social distress. Anybody looking for a bed on a given day may call this 115 number and wait on the line to speak with an agent. Many times though, all the spots will already have been fully assigned by the time a caller reaches an agent. In fact, the number of refusals by le 115 -because of the lack of available beds - increased by 94% between 2016 and 2017, and only about 10% of all calls in 2016 resulted in an offered spot (Castelly 2019).

L'Oasis

L'Oasis is a mobile team composed of a set of different professionals and other employees working specifically with people in situations of homelessness who have mental health problems (mostly schizophrenia), in the centre of Marseille (Sarradon-Eck et al. 2012). The first of these mental health mobile teams was created in France in 1998 (Marques 2010). While it operates outside of the walls of the hospital, the team is officially part of the public hospital system of Marseille, and, therefore, its employees are paid by the hospital and managed by the hospital's administrative rules.

The detailed mission of the team is well explained by Sarradon-Eck, Farnarier and Nymans (2014):

> [t]he mobile team's program of medico-social care has two main objectives: (1) to reach out to the mentally ill homeless and help them engage health and social services; and (2) to provide 'psychiatric rehabilitation care,' including looking for ways to get people off the streets and into a place they can call home. As a hospital unit, the team provides psychiatric and physical consultations (on the street, but also in emergency shelters and in an office), obtains in-patient admissions, prescribes medication (sometimes delivering daily dosages), adjusts medication levels, assesses side-effects, and at times provides rudimentary medical care. Team members also focus on social work, helping the mentally ill homeless access social security benefits, health

> insurance, emergency shelters, permanent housing, residence cards, etc. (Sarradon-Eck, Farnarier and Nymans 2014, 252)

The team I accompanied in my fieldwork consisted of one psychiatrist, one family doctor, one psychologist, two social workers, one coordinator, two educators, one researcher, several pairs of workers and a few interns in social work, psychiatry and public health.

The Oasis office is located in the centre of Marseille, on the first floor of an apartment building that looks entirely ordinary from the outside. At the street level, only a small, half-torn sticker with l'Oasis written on it, affixed to the half-fallen doorbell, tells you that you are at the right place. That doorbell would prove itself important regarding the welcoming of people. Inside, the office looked like a big apartment that had been transformed to have a variety of separate rooms and offices. There was the main meeting room, where staff meetings happened; a collection of offices, a kitchen, and a roof patio with half-broken chairs, ashtrays and plants. One Oasis user would, at times, stop by to water these plants, drinking water from a plastic bottle and then spitting the 'water' all over the plants. "It is apparently better for plants this way according to him," one of the professionals once told me.

METHODOLOGY

Ethnography

Ethnography has a long tradition in anthropology and in other social sciences (Becker 2002; Creswell and Poth 2018; Reeves Kuper and Hodges 2008). It served as the primary research method for this project. Ethnography can be defined as "the study of social interactions, behaviours, and perceptions that occur within groups, teams, organizations, and communities. The central aim of ethnography is to provide rich, holistic insights into people's views and actions […] through the collection of detailed observations and

interviews" (Reeves 2008, 512). Anthropologist Sherry Ortner says that "ethnography has always meant the attempt to understand another life world using the self… as the instrument of knowing… in which the whole self physically and in every other way enters the space of the world the researcher seeks to understand" (Ortner 1995, 173).

Two main ethnographic tools were used during this project: participant observation and semi-structured interviews. Participant observation is accepted as the defining method of the discipline of anthropology (Dewalt and Dewalt 1998; Olivier de Sardan 2008; Savage 2000) and a cornerstone of ethnographic research. Researchers are typically expected to learn about the social practices, relations and worlds of informants by participating in their daily lives and gaining an 'inside' perspective. Participation and observation go hand-in-hand in participant-observation. It is difficult to take them apart and execute them separately: while participating, one will observe, and vice versa. The data obtained by participating and observing are then written in a fieldwork journal (Baribeau 2005; Jaccoub and Mayer 1997; Mills and Morton 2013), which becomes the main source of data.

Semi-structured interviews are another main tool of the ethnographic method (Imbert 2010; Sarah and Nicky 2006). They allow the researcher to obtain more precise and targeted information on certain facts or representations (Ketele and Roegiers 1996). In anthropology, the semi-structured interview takes the form of a conversation and dialogue. The form allows for a certain flexibility in the order of questions and topics within a pre-defined set of larger themes the researcher wants to address. Most importantly, the semi-structured interview is based on a trusting relationship between the anthropologist and the interlocutor that will determine the quality, authenticity and relevance of the collected information (Imbert 2010). In the next section, I will also address the content of these interviews.

Field: description and immersion

What constitutes the "field" in ethnography is an ever-evolving concept during a project. Lederman (2006) describes ethnographic fieldwork as often necessarily "maximally undemarcated," the boundaries of the field are frequently hard to define or to predict before starting the project. When I arrived in Marseille at the very beginning of June 2017, I met with a few individuals involved in research and interventions in the context of social precarity. They helped me to draw a clearer picture of the major actors and organizations involved in the field of homelessness in Marseille. In my initial project proposal, I intended to focus my time on only one institution. After these meetings with researchers and professionals, and after exchanges with several organizations, two offered to host me for my project: l'Oasis and La Maison Frédéric. As the summer went by, the field went beyond the physical borders of the organizations, beyond the walls of l'Oasis offices or the barrier of La Maison Frédéric. The field extended into the streets of Marseille during a walk, or to the main train station, as I was going to catch a train for a personal day trip while keeping an eye open for somebody the team of l'Oasis had been looking for in the previous few days. The field also extended to a big public market in the neighbourhood of La Maison Frédéric, where I would often get my lunch, seeing one of the residents waiting for the shelter to re-open as he sat or stood under the burning sun reflecting off of the pavement and the mountain of garbage bags. The field also expanded within my own mind, for example when one evening I was having dinner in a small restaurant where the owner expelled a homeless person who had come in begging for food. Realizing later that I knew him from La Maison Frédéric, I began to reflect upon the possibilities and limitations of intervention.

I spent a lot of time immersing myself in the field.[38] Immersion allows a researcher to observe and build meaningful relationships with people in the field without the formality of "work" interactions (Fortin 2010; Olivier de Sardan 2008; Pope and Mays 2006). An important part of my fieldwork was spent in this immersive mode, discussing and observing in an informal or casual way. This happened with both organizations that I was based at for my fieldwork, but also in many other situations into which I was invited, or stumbled upon. By walking towards the metro and stopping to watch a demonstration, by sharing lunch with friends of a roommate at a local bistro, or sharing jokes with a neighbour at the local café, I became more aware of the environment I lived in without realizing I was doing "work." The context and interactions of informal everyday life provided meaning and codes with which to interpret events happening in my fieldwork. This immersive phase turns out to be a constant and necessary step. It allows a greater and more subtle understanding of the field than would be possible using formal research interventions alone. It takes time, and it cannot be rushed.

Throughout my fieldwork, I explored vulnerability through the lens of a common vulnerability shared by the intervenants and the usagers. By focusing on the relationships that exist between these intervenants and usagers, I had to pay attention to these interactions. Nonetheless, I also focused extensively on the experience of the intervenants, while still paying considerable attention to the people living in situations of homelessness and using the services of l'Oasis and La Maison Frédéric. This information was not only useful to better understand the reality of those in a situation of homelessness, but also to help me gain a

[38] In his article La politique du terrain. Sur la production des données en anthropologie, Jean Pierre Olivier de Sardan (1995) uses the French term *imprégnation* to describe this immersive form of informal participant-observation. He says about imprégnation : "En vivant il observe, malgré lui en quelque sorte, et ces observations-là sont 'enregistrées' dans son inconscient, son subconscient, sa subjectivité, son ' je', ou ce que vous voudrez. Elles ne se transforment pas en corpus et ne s'inscrivent pas sur le carnet de terrain. Elles n'en jouent pas moins un rôle, indirect mais important, dans cette 'familiarisation' de l'anthropologue avec la culture locale, dans sa capacité à décoder, sans à la fin y prêter même attention, les faits et gestes des autres, dans la façon dont il va quasi machinalement interpréter telle ou telle situation. Nombre des interactions quotidiennes dans lesquelles le chercheur est engagé ne sont pas en liaison avec l'enquête, ne sont pas consignées dans le carnet de terrain, et donc ne sont pas transformées en données. Elles ne sont pas pour autant sans importance"(Olivier de Sardan 1995, 5).

greater understanding of the notion of vulnerability, by situating vulnerability within interventions in a particular context. Throughout my fieldwork, I had many conversations with the usagers, mostly in informal settings. I carefully observed their reactions, their behaviours, their attitudes and emotions during the socio-medical interventions I witnessed and participated in.

Altogether, I conducted about 350 hours of participant observation, during day, evening and night shifts, and I conducted 12 semi-structured interviews with intervenants at both organizations.

At La Maison Frédéric, I initially focused on clinical work with nurses and physicians. I attended more than a hundred consultations where, after having obtained consent, I observed the interaction between the patients and the clinical staff. I focused not only on what was being said but also on how it was being said. I often questioned the clinicians - in between patients, or later during the day or the week - on particular aspects of what I had witnessed and heard. I also followed the social workers and other health workers in their daily tasks. I followed the welcome staff (*personnel accueillant*) throughout many of their routine work, whether it was welcoming a resident to the shelter, being present in the housing facilities, helping to distribute material, doing rounds, etc. On many occasions, I was just there, sitting and observing, while taking written or mental notes. Rarely would these moments be long before somebody came to talk to me, whether it was a resident or an employee. I was present many days a week for the entire summer, including the weekends. I got to see life at La Maison Frédéric in the mornings, afternoons, evenings and nights.

At l'Oasis, I mainly attended staff meetings and followed the team on their maraude, the organized walking rounds of the city to go meet the people on their active file, ie. those who are currently receiving a form of care or attention at l'Oasis, as opposed to those whom the team had not seen nor heard of in the past months. At first, I was mainly interested in how the concept of vulnerability was understood and

integrated into clinical discussions. But as my fieldwork progressed, it became clear to me that I needed to be out there in the streets to better grasp the reality of these professionals working, and of the people living, there. Going around the city, walking for hours with the Oasis clinical staff, allowed me space for informal discussions, in which I could address many concepts with the professionals. The informality of the street, the common emotional engagement we felt toward the situations of the people, and the long periods of waiting gave context, sense and meaning to the more "formal" setting of the staff meetings. During the staff meetings, I took written notes. During the maraude, I either wrote quick notes during breaks or took audio notes. Mostly, I took notes afterwards while sitting at a café, riding the metro or walking home. The streets and the metro of Marseille became inter-zones, serving as both field sites and reflective transition spaces before arriving home.

Finally, the 12 semi-structured interviews with the intervenants addressed larger themes such as the perception of their professional roles, their daily tasks and the difficulties they face. The topic of vulnerability was addressed at times directly ("let's talk about vulnerability") and indirectly ("I've been noticing that you often mention this type of difficulty related to your task"). These interviews resembled more a recorded informal conversation with certain themes (their vision of socio-medical services, their experience of them, the perceived impacts, etc.) decided in advance. Indeed, anthropologist Jean-Pierre Olivier de Sardan (1995) calls for this format of interview, one that is closer to a banal form of interaction.[39] The 12 intervenants were recruited on a voluntary basis, making sure to respect the diversity of professionals and the principle of representation (Atkinson, Coffey, and Delamont 2003; Gobo 2004; Lecompte 2002). The verbatim interviews were coded, and the data I then obtained was

[39] "rapprocher au maximum l'entretien guidé d'une situation d'interaction banale quotidienne, à savoir la conversation, [ce qui] vise justement à réduire au minimum l'artificialité de la situation d'entretien, et l'imposition par l'enquêteur de normes méta-communicationnelles perturbantes" (Olivier de Sardan 1995, 8)

added to my field journal data in order to proceed with a thematic analysis (Fereday and Muir-Cochrane 2006; Patton 2002; Rice and Ezzy 1999).

An iterative process

Throughout this project, I put myself through an iterative process, whether in the field or in the writing process. I constantly did some back and forth between the data and their interpretation. Olivier de Sardan (1995) mentions how this iteration becomes in itself a form of refinement of the data, often conducted in a latent rather than an explicit way:

> Each interview, each observation, each interaction presents another opportunity to find new avenues of research, to tinker with hypotheses and develop new ones. Throughout the entire fieldwork phase, the researcher constantly interprets the observations and interviews, albeit in a latent rather than explicit way. So the data production phase can be interpreted as a continual restructuring of the problem while you are in contact with the data, and as a permanent reorganization of the interpretative framework, as the empirical evidence accumulates.[40] (Olivier de Sardan 1995, 16)

I also confronted my preliminary analysis of the data with two restitution events at each of the organizations the following year. I offered a presentation of this initial analysis to the employees of both organizations followed by a period of questions and exchange in order to see if these results made sense to them (and they did). I also presented these preliminary conclusions at two research symposiums a few months after.

Research and clinician: on position and identity

I entered the field as an anthropologist-in-training, and I wanted to maintain myself in this role throughout the summer of fieldwork. At certain times though, my doctor identity and habitus (Bourdieu

[40] "Chaque entretien, chaque observation, chaque interaction sont autant d'occasions de trouver de nouvelles pistes de recherche, de modifier des hypothèses, d'en élaborer de nouvelles. Pendant toute l'étape de terrain, le chercheur interprète sans cesse, au fil des rencontres, des observations et des entretiens, bien que de façon latente plus que de façon explicite. La phase de production des données peut être ainsi analysée comme une restructuration incessante de la problématique au contact de celles-ci, et comme un réaménagement permanent du cadre interprétatif au fur et à mesure que les éléments empiriques s'accumulent" (Olivier de Sardan 1995, 16)

1980) came back. Whether I wanted it or not, I was not only seen as a researcher and anthropologist, but also as a physician. Quickly, the word spread that there was "a Canadian doctor" around doing some sort of research. Wearing these two hats was not always easy. For Zaman (2008), the clinician status offers a series of advantages in terms of access to the field, to participants and key informants. Physician and anthropologist Aline Sarradon-Eck has written about the various ethical dilemmas physicians face when doing medical anthropology research. She says:

> The encounter with a strong biomedical professional ethics can give rise to power issues as well as common misunderstandings. These problems in mutual understanding arise both from a lack of knowledge regarding what medical anthropology is, and from two different epistemologies.[41] (Sarradon-Eck 2008, 15)

There seems to be no standard for how to address this particular ethical and methodological issue (Sarradon-Eck 2008). Didier Fassin (1992), a physician and medical anthropologist, never hid his medical identity during his research process, for two main reasons: medical (not to refuse to offer health care) and sociological (health care and advice as a counter-gift in a gift economy), while analyzing the epistemological obstacle his medical training and the power differences his double status created during his fieldwork (Fassin 1992, 32). On the other hand, medical anthropologist Sylvie Fainzang kept "total neutrality" in front of other health care providers and patients she encountered. In fact, although she is not a physician, she evolved in so many medical environments where people saw her with time almost as part of the medical team. She constantly refused this medical identity that other members of the health team, as well as patients, wanted to assign to her (Fainzang 2006).

At times, I was known only as a researcher, while in other situations, I introduced myself in both roles. It was a constant back-and-forth ethical process, trying to find a balance among the right of people to

[41] "La rencontre avec une éthique professionnelle (biomédicale) forte peut être source d'enjeux de pouvoir, mais aussi d'incompréhensions réciproques. Celles-ci naissent d'une méconnaissance de la discipline par le corps médical, mais aussi d'une rencontre entre deux épistémologies" (Sarradon-Eck 2008, 15)

consent to research in a fully informed way, making sure my presence did not negatively influence the services offered to participants, and my moral duty to assist people in need of my professional knowledge and skills. At times, I sensed I was oscillating between the two roles in subtle ways. Listening to a resident's story at the shelter alongside the nurse in her office is an example of this. As an anthropologist, I would pay subtle attention to the story, listening for its social or conceptual dimensions, nodding my head while taking a few quick notes. Suddenly, I could switch to the physician role, as when a nurse and resident were trying to remember the name of a particular medication and asked me for suggestions, or when a nurse suddenly asked for my quick opinion while auscultating the lungs of a patient in respiratory distress, putting the stethoscope in my hands. On certain occasions, I definitely "crossed the line" (Zaman 2008) and fully embraced the medical role. A few emergency situations arose during the summer where I was the only trained health professional on site, or when another health professional asked for my formal clinical assessment of patients (a psychotic decompensation, severe chest pains or respiratory troubles, a probable stroke, intoxication, loss of consciousness, etc.). At other moments, my medical knowledge helped to reassure both intervenants and usagers, like once during a maraude in the street when a medical resident turned to me and had questions himself about the details of an upcoming test that was prescribed to a patient when trying to explain this test to the patient, or another time answering questions from a Russian-only-speaking usager of La Maison Frédéric as I was about to leave at the end of the day. The man had not understood the doctor's order that was given to him just minutes before. As the summer went by, I became more and more comfortable integrating the dual identity of researcher and clinician. My methodological approach—and my identity as a researcher—became hybrid, where the power of my observations became strongest in the interstices between these two identities. It gradually became clear to me that denying one or the other of these roles and identities would have been a form of violence, both personal and methodological, concerning who I am as a person, a professional and a researcher. My ethical task

was to constantly set and re-set clear but permeable boundaries on this continuum, one situation at a time, but never to hide either of the two roles. For me then, following work by Bensa (1995) on how to find the right ethnographic distance with your informants,[42] the question became how to conduct ethnographic research without putting aside the professional expertise and insider knowledge of the clinical world that I developed over the years.

Throughout the summer, I constantly questioned the effect of my own presence in the field as a researcher. This presence is, in itself, one of the main tools and expertise of the anthropologist. Olivier de Sardan (1995) mentions how the anthropologist often becomes the "sympathetic stranger" or the "travel companion"[43] (Olivier de Sardan 1995, 5). With this in mind, the anthropologist needs to observe the effects of his or her presence carefully. As Olivier de Sardan (1995) states, "the anthropologist's integration is relative but nonetheless real. Yet, it does not spare him from observing the effects of his own presence, including the effect of this "integration" given to him"[44] (Olivier de Sardan 1995, 5).

I often wrote in my field notes about the effects of my presence. Would a given clinical team meeting have been different, at the same moment, if I had been absent or not in a researcher position? Would a clinical intervention with a nurse and a patient have been different if I had only been a researcher and not an anthropologist-researcher-yet-also-physician-even-if-I-do-not-practice-as-such-in-Marseille? The question remains fundamental, given how this presence is at the core of the ethnographic method. Indeed, I cannot ignore that my observations (and the analysis of them) were obtained by a researcher - present in his fieldwork and in interaction with this fieldwork and its different actors.

[42] "la juste distance méthodologique" (Bensa 1995)

[43] "Utiliser sa propre présence en tant que chercheur comme méthode d'investigation devient alors une des dimensions du savoir-faire de l'anthropologue. L'anthropologue se met peu à peu, et surtout il est mis par le groupe d'accueil, dans une position 'd'étranger sympathisant' ou de 'compagnon de route'" (Olivier de Sardan 1995, 5)

[44] "son 'intégration' est relative mais réelle. Elle ne le dispense pas pourtant d'observer les effets que sa présence induit, y compris la forme 'd'intégration' qui lui est affectée" (Olivier de Sardan 1995, 5)

Somewhere between Montreal and Marseille

I could equally have carried out this fieldwork in Montreal, working at the clinic where I was a resident or with other partner organizations nearby. I could have studied the concept of vulnerability in a familiar clinical setting. But I decided not to. Anthropologist Sylvie Fainzang (1998) explains:

> Another challenge in studying representations of illness in the West arises if one works in a social and cultural milieu similar to one's own. The difficulty arises from the necessity of recreating distance from individuals who are culturally close, just as—we've just seen it—one must recreate distance from objects that are existentially familiar. A fertile intellectual posture is to learn to be astonished at everything and, when studying those near to one, to look at them as if they were culturally distant. (Fainzang 1998, 275)

I decided to distance myself in order to reflect on something happening both "at home" and "away from home" in a context that is "different" yet not "too different."

The choice to conduct this fieldwork away from Montreal is not trivial. In fact, the clinic I work at in Montreal is one of the few specialized clinics in the city working with homeless individuals. It could have been possible to explore vulnerability and homelessness there, as different writings on "anthropology at home" exist (Peirano 1998). Yet, taking some distance appeared to me a better decision, both methodologically and ethically speaking. Within the walls of my clinic in Montreal, my colleagues and patients see me as a medical doctor. I am, first and foremost, a physician in terms of my professional identity and my behaviours, a form of habitus (Bourdieu 1980) that developed itself over time. Doing anthropological research in this context would not have been impossible, but it would have been harder, especially for my first fieldwork.

My fieldwork was conducted abroad, yet I still found myself in somehow similar contexts. For example, I was in a socio-medical system that shares a vision of biomedicine with the way medicine is practiced in

Canada.[45] It is also a system that offers a large array of state-funded socio-medical services. Nonetheless, this geographical distance does not occlude a necessary critical work of reflection. As mentioned by Fainzang, "the difficulty arises from the necessity of recreating distance from individuals who are culturally close, just as […]one must recreate distance from objects that are existentially familiar" (Fainzang 1998, 6). Marseille, therefore, appeared as an appropriate location to allow for enough critical anthropological distance without being too different compared to Montreal. Nonetheless, this phrase often resonated with me throughout my fieldwork, "just as distance is not a guarantee of objectivity, familiarity is not knowledge" (Van Dongen and Fainzang 1998, 247).

Without intending it, it appeared as though I had positioned myself in several ways in an in-betweenness: between clinical and research identities and roles, between Montreal and Marseille, between observation and participation, in between two organizations in the field, in between the city centre and the outskirts, in between the professionals and the usagers, and in between my life in the field and my own life. This in-betweenness appeared as the best conceptual place for me to be. Bolton (1995) appeals to the anthropologically trained physician to write more about medical practice: he says,

[45] Biomedicine refers to a way of practicing medicine that applies biological and physiological processes and concepts to understand a large array of clinical situations involving the body. It often appears as a given unquestioned starting point for many Western medical systems. Regarding this, anthropologist Chrystal Jaye (2004) says, "the formal discourses of Western biomedicine are still perceived as predominantly informed by a philosophical stance of non-reflective positivist empiricism that privileges neutrality and objectivity as epistemological positions. This has led to the charge that biomedicine is primarily concerned with the objectified bodies of patients rather than the embodied patient as an experiencing person, as is manifest in the compartmentalisation of the person into specialty specific components—for example, psychiatry and gynaecology—and a clinical focus that is reductionist in seeking the organic specifics of disease" (Jaye 2004, 41).

The anthropological exploration of Biomedicine questions the assumption of uniformity and equivalency of the human body and its limitations. Anthropologists Margaret Lock and Vinh-Kim Nguyen (2010) refer to this. They look at "a dominant orientation in biomedicine consolidated over the past three centuries that considers the human body, despite its outward differences, as everywhere essentially the same for the purposes of diagnosing and managing disease. This assumption that the human body can everywhere be normalized began to take form when biomedical technologies were used, often on an experimental basis, by the colonial empires of the 19th century on colonized peoples. Today, the global reach of biomedical technologies is undeniable and, together with public health, is the prime means by which governments and developmental agencies aspire to ameliorate disease and disability everywhere. An unexamined assumption about the uniformity of human bodies continues to inform most biomedical practice" (Lock and Nguyen 2010, 1).

"the tiger's experience of tigritude is different from those who hunt tigers and write about tigritude; the more tigers who write about being tigers the better we will understand both tigers and tigritude" (Bolton 1995, 166). It can certainly be the case in various situations, yet both the non-medically trained anthropologist and the anthropologically trained physician face different challenges and may be prone to certain particular biases the other may be less affected by. My insights in this thesis are those that my particular position enabled me to see. The tiger I am felt bewildered and astonished many times throughout this fieldwork, in a constant in-betweenness. This thesis is a written account of that astonishment.

I. ON TEMPORALITY: BEING IN TIME

Vignette: On the highway

> It was the end of the day. We were driving on the highway, on our way to a picnic organized by another association working with homeless individuals in Marseille. I had been invited after having chatted with a few members of their group during a spontaneous protest in front of La Préfecture (the departmental seat) a few days before. During that protest, a wide collection of groups was demanding that homeless individuals and families be given housing in unoccupied buildings. One member of the group, whom I met at the demonstration, invited me to come along to their picnic and then offered me a ride. It was one of those beautiful and warm summer evenings in Marseille. Windows wide open on the highway, the smell of the sea, sunglasses on, music softly playing in the background in competition with the noise of the turbulent wind billowing inside the car.
>
> In front of us, the sun was setting, leaving a powerful but soft orange light on our faces and on the city behind us. The Bonne Mère (the Holy Mother)—Marseille's emblematic cathedral—appeared in the rearview mirror as a distant white-yet-orange building overlooking the city from atop the hill. The golden glimmers of Mother Mary sitting at the very top of the bell tower gave it an even more majestic tone. We were driving on an elevated highway. On our left, the sea appeared calm and infinite. An Algerian ferry had just left the dock.
>
> The elevated highway gave us a rare view of the neighbourhood we were passing through at 110 kilometres per hour. Buildings looked old and decrepit. A few cranes to our right were moving slowly by a hotel. It took me about three or four seconds to realize we were passing right by La

> Maison Frédéric. I caught one specific glimpse during the half-second in which our car was in direct sight of one of the modular dormitory buildings of the shelter. A man stood in the wide-open window, bare-chested, on the second floor of the dormitory building. He was trying to hang his shoes on the windowsill. He must have washed them in the sink in the bathroom of his building. Or maybe in the big sink right by the TV room. For a fraction of a second, I swear I saw him looking me in the eyes. Or at least, I was convinced I had looked at him.
>
> For a moment, at 110 km/h, time stopped. Two individuals going at very different speeds suddenly meeting, for a brief moment. From my position, it was impossible to see time passing by slowly in the courtyard of La Maison Frédéric, impossible to see the waiting line in front of the cafeteria. It was impossible to see the meeting between a social worker and a refugee from the Ivory Coast or to hear him being told there was nothing to do but wait for the decision about his refugee status. I didn't see any of these, but I knew they were happening. Different realities evolving on different temporalities, colliding at times.
>
> "Oh, it's La Maison Frédéric, where I do my research," I told the driver in a loud voice. The noise of the wind was too strong. The kids in the back of the car were laughing at the top of their lungs; their mom had just told them a funny story. The driver did not understand at first and I had to repeat. By the time he finally understood, La Maison Frédéric was already way behind us. We had to hurry, as we were already late for the picnic. People were waiting for us.

Throughout my fieldwork, I became very aware of time. Temporality, as it stood, was more than a plain notion related to my daily schedule. It was more than a simple chronological timeline with constant reference to the present. Heidegger refers to this type of chronological time defined by the present as "vulgar time" (Heidegger 1927), in which "the future is the not-yet-now, the past is the no-longer-now, and the present is the now that flows from future to past at each passing moment" (Critchley 2009).

In my fieldwork, I witnessed a different temporality that involved relationality. Referring to Heidegger, Critchley (2009) says, "time should be grasped in and of itself as the unity of the three dimensions – what Heidegger calls "ecstasy" – of future, past and present. This is what he calls "primordial" or "original" time" (Critchley 2009). Indeed, during my fieldwork, temporality appeared as a form of a relation between past, present, and future. This relationality exemplified a way of being in time, a way of existing within a particular social, economic, and political context. In this manner, temporality was not an

ontological property per se, but "a thoroughly epistemic and social phenomenon," one that "should not be perceived as a given, innate, or intrinsic quality, but as a matter of contingent and contested social practice" (Ringel 2016, 392). Temporality was, therefore, an encompassing social reality that revealed vulnerability.

In the opening vignette of this chapter, when I wrote that I swore I saw the man by the windowsill, I was responding in part to Michael Taussig's book, I Swear I Saw This (2011). In this book, Taussig shows how drawing in field notes can be a powerful anthropological tool. The title of the book, I Swear I Saw This, refers to a moment in which Taussig quickly caught a vision of a woman from the countryside building a temporary shelter in a tunnel in Colombia. He later drew the woman and added the phrase, "I swear I saw this" underneath. At times, Taussig says, visions hit us, in all of their power, a power that words can hardly represent. In Taussig's phrase, "I swear I saw this," the strangeness hit him all in one "glimpse," which was sufficient to capture the numerous hardships and horrors Colombian farmworkers have been facing because of military and paramilitary actions and displacements meant to fight against guerrilla movements. Taussig calls this, "the extraordinariness of the ordinary" and "a dialectic between realism and surrealism" and describes how each of these concepts are bound together in his instantaneous vision of two people in time, at the side of a freeway (Taussig 2011, 72). When I saw the man by the windowsill, an entire world and reality was bound up in that instant. Woven within the ordinariness of his daily movements was the extraordinariness of his life situation. The man had recently arrived in Marseille from northern Africa, most people on his boat having drowned while crossing the Mediterranean. He was now drying his wet shoes on the windowsill of a crowded shelter building located at the side of a highway while awaiting an administrative decision from the state regarding his immigration status that had a high chance of never being normalized—an extraordinary ordinariness, captured in one moment; past, present and future.

Temporality in my fieldwork was, therefore, a form of relation that allowed the revealing and circulation of vulnerability, as I will present throughout this chapter. This relationship was dual and simultaneous. It was first a constant relationship between past, present, and future—a relationship that indeed revealed the tenuous connections between history, social structures, agency, inequalities, and possibilities. For the usagers and residents in both l'Oasis and La Maison Frédéric, vulnerability was woven in the way of being in time, carrying as they did the heavy burden of their pasts, its wear and trauma, and facing long periods of waiting in institutions meant to help them, and being stuck with a lack of real future alternatives. For the professionals I met, vulnerability revealed itself in the unceasing adaptation and adjustment required of them due to the constant multiple temporalities in which they were involved. Somewhere between the heavy burden of the institution's past and the oscillations in their present work between constant waiting and a sense of urgency, or the often difficult (or impossible) prospect of finding other jobs - vulnerability was part of the quotidian.

The second form of relationality involving temporality sheds light on different and opposing ways to be in time in socio-medical interventions; that is, on what it involved and meant to be in a socio-medical relationship in this particular context. In fact, the socio-medical interventions that I witnessed throughout the summer often showed a confrontation of visions between how interventions could or should be, both for the usagers and the intervenants. On one side, an intervention based on addressing immediate problems and needs because of the heaviness and the preponderance of the present. On the other, interventions based on a more linear path of recovery, from a difficult past to a present of action towards a future of improvement. The confrontation of these two visions, a form of relationship that exposed the vulnerability of both usagers and intervenants, questioned the actual possibilities of being in time in this entanglement between past, present and future. Throughout the summer, my fieldwork

involved a continuous movement and adjustment among different temporalities, different ways of being in time—the temporality of the intervenants, the usagers, the institution, and the city. Different temporalities with different demands, at times colliding in their contradictions and (im)possibilities, giving rise to situations of tension, uncertainty, and conflict. More than a way of being in time, temporality in my fieldwork revealed instead vulnerable relationships that imposed ways of "being outside of time" (Dalsgaard, Frederiksen, Højlund, and Meinert 2014), outside of a world of real possibilities.

PAST

Vignette: La bagagerie

> I entered la bagagerie (the storage room) on one of those quiet mornings, where only a few residents were still present on site. It was almost the end of my fieldwork, and I had never entered this room until now for some reason I could not explain. It was just a simple, dark storage room, and I had never paid it any attention.
>
> Something felt heavy when I entered. I could not tell whether it was the lack of ventilation and the boiling heat, the musty smell of humidity, or the clutter. I stood there in silence for two minutes, looking at the shelves. Each resident was assigned a number that was associated with a specific spot on a shelf. One suitcase per person was all that was allowed. As I stood there, the heaviness became clearer. I felt intrusive, looking at people's belongings, people's memories and pasts. On these shelves, I saw suitcases suddenly turn into photo albums. Memories of a not-so-distant past that needed to be left aside in order to live in the present here. Residents arrived at La Maison Frédéric with that one suitcase. It was what they carried with them, not being able or allowed to carry or store more. Or simply not having more. They could not leave it in the dorms, for reasons of space but also safety, as there was a great deal of theft in the dormitory rooms. A surveilant once told me, "Des caleçons se font voler ici, vous vous rendez compte, même des caleçons" (Even underwear get stolen here). Eventually, the administration had decided to install security cameras inside and outside the bagagerie. Apparently, it helped to reassure the residents.

The past was omnipresent during my fieldwork. A past that was often confined within a definite boundary and needed to be left at the door, most especially at La Maison Frédéric. This confinement was

about more than leaving a suitcase in a storage room. It was about locking this past inside a dark, musty room, about not addressing this past. Unless you had a severe medical condition in the present, no matter what your story was, no matter what you went through in the journey that delivered you to La Maison Frédéric, the process upon arrival was nearly always the same; a brief recollection of who you were and what had happened to bring you here, your current situation, and your objectives and then you were given shelter for 9 or 30 days, depending on your situation. During this time, you had to wait for the next step.

But what can really be considered the past? How can this past, so present in my fieldwork, be approached and analyzed? In Life and Words, Veena Das (2007) addresses the notion of pastness. Referring to events surrounding the Partition of India in 1947, and the assassination of Prime Minister Indira Gandhi in 1984, she mentions how while these events were certainly "of the past" in her fieldwork, "it did not have a feeling of pastness about it" (Das 2007, 97). She says:

> The survivors in the locality were living not only with memories embodied in the walls of houses, on the charred doors, in the little heaps of ashes in the street, but also with threats embodied in words and gestures as the perpetrators of the violence continued to live in the same neighborhoods as the victims. The blind complexity of the present made it difficult to draw boundaries around the event of Mrs. Gandhi's assassination. When did the event begin and when did it end? (Das 2007, 98)

The pastness I witnessed, heard, read, felt, and sensed in my fieldwork was so vivid, so present. This pastness lived in a constant entanglement with the present and the future. In a way, denying the presence of this past or failing to address its consequences puts people in even more vulnerable situations - residents, usagers and professionals alike. I will now explore this past under the form of trauma.

Trauma

Many times during my fieldwork, I heard stories of heavy, difficult and often traumatic pasts. These stories came in many forms. For the residents of the shelter and the usagers of l'Oasis, it might be the events that led people to call le 115 and ask for shelter or the aggression they faced on the street or the journey through Libya, its unuttered horrors, and the crossing of the Mediterranean, for those who made it alive.

The concept of trauma has been explored extensively in anthropology (Giordano 2016; Kleinman 1997; Lester 2013; Pillen 2016; Scheper-Hughes 2008; Young 1996). Trauma, as an experience, refers to "events that push people to the very edges of their own existence, as well as the various ways they find their way back, often radically transformed" (Lester 2013, 753). This concept of trauma has been heavily medicalized in the past decades, especially with the clinical diagnosis of post-traumatic stress disorder (PTSD), yet the concept itself goes beyond a simple clinical psychiatric diagnosis. It has historically been considered to be social and religious. Referring to medical anthropologists Allan Young (1996) and Arthur Kleinman (1995), Nancy Scheper-Hughes (2008) says this:

> [They] have criticized the 'traumatic vision' of adverse events by noting that for most of human history, people have responded to traumatic events — including floods, epidemics, and wars — as social and religious problems. The 'traumatic vision' of ptsd medicalizes powerful human experiences and assumes a helpless, passive self, 'a mind waiting to be smitten.' (Young, cited in Linenthal 2001, 92) (Scheper-Hughes 2008, 39)

This human experience is powerful, yes, but it's an experience that generates a myriad of negative reactions. The notion of disruption of relations is important in the conceptualization of trauma. It is through this relational aspect that the traumatic stories I heard and witnessed throughout my fieldwork were reported and came to make sense. Regarding this, anthropologist Rebecca Lester (2013) says:

> A traumatic event is traumatic precisely because it sheers us off from our expected connections with others, from our perceived social supports, from our basic sense of safety, however locally construed. Whether this happens in sexual abuse, war, death, torture, natural disasters, spirit attacks, soul loss, or any number of other things, experiences that radically sever regular, everyday modes of basic human connection and relationship bring us face-to-face with the limits

> of our own existence. We glimpse the edge of our very being, and we feel our ontological aloneness. If we think of "trauma" as a relational injury rather than a purely intrapsychic or structural one, we can see even more clearly that, however it is locally defined, it is hardly over once the immediate danger has passed—it simply enters a new phase. (Lester 2013, 754)

Although the professionals I followed during my fieldwork said they knew, as though intuitively, that the current state of the usagers was greatly affected by their often-traumatic pasts, they often considered that they either did not have the time to address this past properly, did not feel equipped to do so, did not consider it their task or were hesitant to do so. They were often debating the wisdom of asking people to open up about possibly traumatic stories in such a rushed way when their mission was fundamentally one of temporariness and transition.

But among the professionals, too, at both of my fieldwork sites, I heard of traumatic pasts, either through conversation, interviews or reports of external evaluation processes. The sense of disconnection I mentioned earlier was frequently reported to me; disconnections from what these employees would have expected in terms of social support. They referred to an institutional past with previous administrations that left scars, individual or collective, in a process that has often been described as "abusive" ("maltraitant"). On top of this, the immensity of the emotional burden they had been carrying around for months and years, helping these men and women in often-impossible situations, combined with the lack of professional support they received, became difficult to live with.

Many times during my fieldwork, some intervenants took me aside or spontaneously told me about their emotional and physically exhaustion, at first telling me "well this will be good for your research" in a more rational way, and gradually opening up more and more emotionally over the summer. Some of them went on sick leaves while others stayed and reduced their workload. All of these professional realities became a negative vector that left the professionals in a situation of vulnerability. The presence

and the weight of the past was a reality that transcended all professional positions. It was more than a simple memory to deal with. It became a paralyzing force that locked people into modes of existence, making moving forward difficult and, at times, almost impossible.

Mission and History

The mission of l'Oasis has remained fairly constant throughout the years, yet the means to accomplish it have evolved over time. Indeed, *l'accompagnement* (social and medical support) and *l'accueil* (welcoming people) had been at the centre of their interventions, yet many questions arose on how to do so, and when. Following a series of violent incidents that took place within their walls (a psychotic crisis involving physical violence, ending in a forced hospitalization involving the police, a service user trying to throw somebody else out of a window, a suicide attempt in the bathroom, etc.), it was decided that l'Oasis would take a different approach to welcome people in their office.

Before, many people could come and spend time at the local (the office) upstairs, whether to meet with the professionals, to grab a coffee, to talk or to simply hang out. Now, the local was not an open space anymore. Your visit upstairs had to bear a purpose and be approved by a team member upon arrival if you just drop-in, or already planned by appointment. It was also a way for the professionals to protect their meeting time, in order not to be constantly interrupted. For some of the professionals, this reorientation was more than necessary. Indeed, their time at work had too often been spent dealing with crises or last-minute urgent requests, rather than intervening in more intentional and concerted ways. For other professionals, though, this new rule completely contradicted their most fundamental mission. If they could not be there to welcome people at the very time it became necessary in the users' own temporalities, then in what way was l'Oasis carrying out the purpose that had made it so distinctive?

While l'Oasis has had steady management capable of carefully weighing changes against a desire for continuity in its mission, the history of La Maison Frédéric is one of successive changes in administration. The shelter opened in 1992, and since then, six different organizations have held responsibility for its management. Over the years, a litany of problems and scandals has painted a sombre picture of the shelter in the Marseille collective imagination, whether in terms of finance, management or infrastructure. The current administration took over from the previous one in November 2016, after problems of "governance, people's safety and confidentiality of medical information" (20 Minutes 2016). In their 2012 annual report, an organization once responsible for the administration of the shelter had raised a red flag about the situation at La Maison Frédéric and reported a very difficult working environment related to catastrophic working conditions, decaying infrastructures, and too great a number of shelter users leading to violence[46] (Leforestier 2013). In a newspaper interview in 2013, Fathi Bouaroua, an important social activist in Marseille responsible for social housing, and then director of an important national charity foundation, claimed that La Maison Frédéric "is the worst in France," in terms of shelters (Leforestier 2013).

Over the years, La Maison Frédéric also had its family history. In fact, one family has been involved in the current and past history of the organization. Their story is heavily influenced by the concept of clientelism, I explained earlier, an often-present reality in the city of Marseille. An employee and member of this family had the reputation of being well connected within the neighbourhood and succeeded in having many members of her own family employed by the shelter over the years. When asking people about this family history, I constantly heard the word "clan," with people often softening

[46] "un grand malaise au travail que l'on peut mettre en lien avec les conditions d'exercice, absolument catastrophiques, les infrastructures très délabrées, la concentration massive d'accueillis avec des phénomènes de violences" (Leforestier 2013)

their voice and checking over their shoulder to see who was around when they said it. In a newspaper interview in 2017, a former employee of La Maison Frédéric who calls himself "a whistleblower" recalls the impact this family on La Maison Frédéric, particularly one person in this family:

> From the moment that the new managers were presented to the 'welcome that was no longer unconditional,' another atmosphere reigned, 'and everything depended on one individual, who was initially presented as a technical advisor but who, as it turned out, managed the staff as she pleased, bringing several members of her family into the UHU, creating division among the teams as a way to better take control. The tension had reached an all-time high (but I wasn't getting on her bandwagon), and the conditions for shelter were becoming increasingly difficult, with a fire that started in the electrical rooms. We had to cut towels in half, save on the amounts of toilet paper we gave to the people we housed... In addition, she wanted to impose a friend or relative as our team's adviser, without holding a competition to fill the position. That's when we blew the whistle.[47] (Guillaume 2017)

According to the vast majority, if not all of the employees I met during the summer, things have changed for the better with the new administration. These changes include a new way of addressing and conceptualizing emergency accommodation, the professionalization of many of the socio-medical intervention sectors, an improvement in resources and living conditions, stricter administrative rules and regulations decided by the new administration, among others. A current *accueillant* who had been there for years under many administrations once told me that he and many of his colleagues were proud to wear the new dark green t-shirt all *accueillants* wore. Under previous administrations, they would rarely even wear the uniform, even less so when going to the nearby flea market, fearing for their safety if they were identified with the previous administration.

[47] "De la présentation des nouveaux responsables à " l'accueil qui n'était plus inconditionnel ", une autre ambiance régnait, " et tout tenait à une personne, au départ présentée comme conseillère technique mais qui s'est avérée diriger comme elle l'entendait les personnels, faisant entrer plusieurs membres de sa famille à l'UHU, divisant les équipes pour mieux régner, les tensions étaient à leur comble (et ma tête ne lui revenait pas) et les conditions d'hébergement devenaient de plus en plus difficiles, avec un départ de feu dans les locaux électriques. On devait dédoubler les serviettes de bain, économiser sur les portions de papier toilette que l'on donne aux hébergés…par ailleurs, elle voulait nous imposer un ami ou proche comme référent dans nos équipes sans appel d'offres pour le poste. C'est là que nous avons alerté." (Guillaume 2017)

Things have changed yet remained difficult for many of the professionals. A few members of the influential family I alluded to were still present, and tensions arose between employees of older generations of La Maison Frédéric and younger ones. Even the newest employees, who had not worked under the previous administration, felt something heavy from that past, a "climat" continuing to affect the functioning of the structure for professionals and residents alike. During an interview, an employee once told me about the continuous toll of the past:

> And you can't fight that. I still can't figure out why it's systematic, and I feel like people are OK with that. It reassures them, or at least [...] I don't know why. Because there have been multiple traumas here, because everyone knows everything here, that's clear. But instead of looking to the future, people stay in the past, and that's good enough for them. They regurgitate it, repeating it, over and over again, and they talk about it systematically, endlessly. And so, as a result, they don't move forward, and anyone who arrives is drawn into this infernal vortex, that brings them down into the mud, that pulls them down [...] you have to pull down. You can't rise up, you have to pull down. And it's quite astonishing. I'm astonished by it.[48]

When one's personal or institutional past is so heavy, how can one exist and live somewhere other than in this past? How can one move forward? For many of the employees I met, it was a very difficult task.

Without referring to notions of temporality or past, Barel (1982) refers to a process of contamination of marginality for the professionals working with individuals in contexts of precarity. He says:

> Managing the marginalized begins to look like a contagious process. It's as if the social workers cannot help but become infected with marginality at the same time as they inevitably distance themselves from the 'marginalized' people they deal with. Either because they get caught up in a network of emotional, ideological and political involvements, or because their proximity to the marginalized makes others recode them as potential marginals themselves, making them 'suspect.'[49] (Barel 1982, 49)

[48] "Et ça, tu peux pas le combattre. […] J'arrive pas à comprendre encore pourquoi c'est systématique, et j'ai l'impression que les gens se satisfont de ça. Ça les rassure, ou en tout cas […] Je sais pas pourquoi. Parce que, il y a eu des traumas multiples ici, parce que tout le monde sait tout ici, ça c'est clair, mais les gens, au lieu de partir sur l'avenir, restent dans le passé et se satisfont de ce passé. [Ils] régurgitent ça, et se le repasse en boucle, et reparlent de ça systématiquement, perpétuellement. Et donc du coup, avancent pas, et ceux qui arrivent, ils les attirent dans ce cercle infernal qui les descend dans la vase, qui les tire au fond […] il faut tirer en bas. On peut pas s'élever, il faut tirer en bas. Et c'est assez étonnant. Je suis étonné de ça."

[49] "L'encadrement des marginalités acquiert la caractéristique d'un processus contagieux. Tout se passe comme si les travailleurs sociaux, en même temps qu'ils prennent inévitablement leurs distances par rapport aux " marginaux " auxquels ils ont affaire, ne pouvaient pas ne pas s'infecter de marginalité, soit qu'ils se prennent eux-mêmes dans un

Working with and living within the margins, therefore, appear to involve an almost obligatory contagious process between all of those who exist around them. The past was contagious in both of my field sites and it was hard—if not impossible—to be rid of. In both places, it appeared as if the past became a mandatory canvas onto which both the present and the future were drawn, too often in sombre tones. It appeared difficult to do otherwise.

PRESENT

I was once having a discussion with two employees of La Maison Frédéric regarding their current working situation. "*Comment trouvez-vous la situation actuelle ici?"* ("How do you find the current situation here?"), I asked them. I could not write fast enough to capture everything they were telling me, including the heavy and overwhelming burden they felt they carry. My field notes present this feeling:

> Horrendous working climate. Trauma to be taken into account, it's going to take time before things change. // There aren't enough nurses on the team for the workload. // Concerning the residents left here during the day; we isolate them, cut them off from other potential resources. If ever they make a scene and are excluded, they lose everything. // If we go beyond that, we turn them into chronic cases. I'm against going beyond that. The user is only a victim. // How can we coordinate the social and medical action to get them out? // Our medical-social coordination is hampered by the work climate. We need leadership to help us deal with educational situations. // lack of time // poorly trained teams // lack of communication // the nursing positions here are just part-time...// The supervisor is overwhelmed; he arrived into a situation that was already difficult. // All kinds of abuse of this population are possible, they'll never complain." [50]

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réseau d'implications affectives, idéologiques, politiques, soit que leur proximité des marginaux les fasse recoder par d'autres comme des marginaux potentiels et les rendent 'suspects.'" (Barel 1982, 49)

[50] "Climat de travail exécrable. Traumatisme à prendre en compte, Ça va prendre du temps à changer.// inadéquation entre charge de travail et équipe infirmerie. // sur les résidents qu'on laisse en journée ici; on les isole, on les coupe de possibles autres ressources. si jamais ils pètent les plombs et sont exclus, ils perdent tout // si on va au delà, on les chronicise. Je suis contre l'aller au delà. L'usager n'est que la victime. // comment coordonner l'action sociale et médicale pour les sortir // La coordination médico-sociale est plombée par le climat de travail. On aurait besoin de direction pour nous aider avec des situations de l'éducation. // manque de temps// équipes mal formées// manque de communication. // les postes infirmiers offerts sont à temps partiel...// Le superviseur est débordé; il arrivé dans un contexte déjà difficile. // Tous les abus de cette population sont possibles, jamais ils vont remonter."

The present in my fieldwork felt like a constant succession of polarities. Both in La Maison Frédéric and in l'Oasis, present events often oscillated within a narrow space of possibilities in-between two main poles; waiting and emergency. Periods of waiting existed alongside an intense series of rapid events that happened with a sense of emergency. The oscillation became part of the ordinary life of both residents and employees. Yet, emergency and waiting were more than simply ordinary events I was witnessing daily. In fact, because they were ordinary events, they revealed something else.

Veena Das' vision of the ordinary became a powerful and helpful concept throughout my fieldwork, for it told me to pay close attention to this narrow space I just described. For Das (2007), "[…]The suspicion of the ordinary seems to me to be rooted in the fact that relationships require a repeated attention to the most ordinary of objects and events, but our theoretical impulse is often to think of agency in terms of escaping the ordinary rather than as a descent into it. […] Thus, just as I think of the event as attached to the everyday, I think of the everyday itself as eventful" (Das 2007, 7-8).

Both in La Maison Frédéric and in l'Oasis, life was lived most often in the extremes, and rarely in the middle. By the extremes, though, I do not intend a vision of strong, powerful and thrilling situations, but rather an extreme that involved acting within extremely small margins of possibilities, a succession of almost-not-possible actions. Sociologist Dahlia Namian (2012) refers to the concept of "*la vie moindre*" (the lesser life) to describe this particular mode of existence, somewhere between nothing and almost nothing. In her exploration of life in a homeless shelter and a palliative care house for people living with HIV/AIDS, she claims that social and biological life is pushed to the margins, which she refers to as des lieux sociaux terminaux (socially terminal places). She questions the real possibilities existing in situations

where not only individual responsibility and capability to act on one's situation is almost impossible, but life itself is almost impossible.[51] (Namian 2012, 7)

As an ethnographer, I allowed myself to be present to the fact that waiting and emergency are oscillating, and that it is precisely this oscillation that is ordinary. By descending into waiting and emergency, it appeared that they precisely constituted the nature of the system, rather than representing states of exception that escape our analysis. Even more so, the tension between waiting and emergency created conditions where a lot seemed to be happening in the daily life of the intervenants and the usagers, yet these temporal modes of being were too often circular, not leading anywhere and almost impossible in nature. Waiting and emergency were, therefore, actual symptoms of an eroding social system supposed to address the needs and hopes of those living in the minute margin of life and society, and the associated powerlessness of those who are supposed to help them.

Waiting

> "Nothing happens. Nobody comes, nobody goes. It's awful." [...]
>
> What are we doing here, that is the question. And we are blessed in this, that we happen to know the answer. Yes, in the immense confusion one thing alone is clear. We are waiting for Godot to come."
>
> — Samuel Beckett, Waiting for Godot (1952)

Vignette: Looking for Jules

> Like most Tuesday mornings, the *maraude* (the walking rounds) starts at la Gare Saint-Charles. Arriving early allows us to see more people, according to Thierry. At 7:00am, many of the people who sleep at la Gare are still around. Some are still sleeping when the security guards arrive to evict them. For some, sleeping through the dawn feels safer, since travellers are starting to arrive

[51] "la vie moindre est un régime de vie particulier dont les contraintes à l'oeuvre réduisent jusqu'au moindre l'action possible. Entre rien et presque rien, il y a tout un monde " (Namian 2012, 7)

at the station. It is a form of protection; maybe, if they are attacked, people would intervene. Some of these overnight sleepers are having a quick coffee in the office of a community organization for homeless individuals at la Gare. Others are sitting on the immense and majestic stairs of la Gare. With the sun still low on the horizon and hidden behind the buildings, they can take advantage of the rare hours of shade and breeze that make the heat bearable in July.

People separate themselves by groups into different areas of la Gare. Sub-Saharan Africans are mainly at the back of the station. Eastern Europeans at the front. The Maghrébins somewhere in between. Inside the station, travellers are in a rush while the heavily armed soldiers of the Plan Vigipirate counter-terrorism unit patrol in groups of four with their machine guns in search of anything suspicious. Looking at some of these soldiers, I wonder what the minimum age is to join the army in France.

Taking the long escalator to get out of the metro station inside the Gare Saint-Charles feels like a long surfacing every time. How is this *maraude* going to unfold today? How will the heat be? Will we run into the people we are supposed to? I take a deep breath. Even at 7:00am, just outside the station, you can feel the brisk morning air being slowly pushed away by another July heatwave day in Marseille.

After 45 minutes of walking and not having met anybody we were looking for, we arrive at l'ADJ Centaure, one of the *Acceuil de Jour*, a network of day shelters for homeless individuals around the city. The "115" phone service organizes a shuttle every day to take people from night shelters to these different day centres, back and forth at specific times and locations. For some residents of La Maison Frédéric, this shuttle is the chance to go to town to deal with administrative issues. For others, it is just a way to get to move around. Except for those with special authorization because of their health status, les hébergés need to leave La Maison Frédéric by 9:00am every morning. They can only come back at 4:00 pm in the afternoon (3:00 pm during Ramadan). For many of them, the question then becomes, 'what to do during the day?' For those not working or not going to a CCAS or la Préfecture, what is there to do, really? Faire la manche (begging)? Or wait somewhere for something to happen before going back to La Maison Frédéric?

The entrance of l'ADJ Centaure is nestled in a series of buildings spread through the roundabout of Place Marceau in the quartier Saint-Charles, close to la Porte d'Aix. The nearby patisserie and the Halal boucherie a few doors away make it hard for those not familiar with the area to know that there is a service centre for homeless people around. A few hundred meters away from l'ADJ, cranes are scattered all around empty fields. Next to one of these cranes, an immaculate white building stands there, alone. The Tokyo Inn: a new, 7-floor, 3-star hotel built by a Japanese group, marking Marseille as their starting point for a conquest of the European market.

In front of l'ADJ, many people, mostly men, are hanging around. We are looking for a man called Jules. Born in Haiti, nobody really knows how long he has been in Marseille. People have an

image of him, though. He is always seen around town wearing a big jacket with many layers of clothing underneath, no matter what the temperature is. He often carries his heavy bag around, talking to himself, sometimes getting angry. The team at ADJ had somehow succeeded at creating a relationship with him over the past few days while disinfecting some wounds on his face. During a recent heavy and agitated conversation with himself in the street, he spat on an unknown girl's face a few days ago. " Oh, but he's usually so gentle and friendly", said one of the workers. This girl at the time apparently called some of her male friends who quickly arrived to take on Jules, pour "lui faire sa fête."

The Oasis team was called to try to make contact with him and evaluate his situation. "Come on Tuesday morning around 8:00; that's usually when he stops by." But he never showed up that morning.

As I enter inside the courtyard of l'ADJ with Thierry, I recognize a few familiar faces from La Maison Frédéric. Some ignore me. A few of them greet me, having recognized me; "Oh hello Doctor, you are also here?" Others look at me with doubt, wondering where they know me from.

Inside the main room of l'ADJ, about 25 men and women are sitting on assorted plastic chairs placed against the wall all around the non-air-conditioned room. I know some of these people. I cannot stop thinking about how the day before, I had met one of them during a medical consultation. I heard this man's migration story, trying to make it to Greece after weeks of walking. Here, he is just another person sitting there, waiting below an old, discoloured poster of the Eiffel Tower on the wall.

I ask one of the intervenants what type of services they provide here since so many people are sitting here, waiting. A few are here for the showers. At times, there are a few "*interventions d'accompagnement*." There is a nurse on duty certain days. There are no meals. Most of them are just there, just waiting. "What are they waiting for?" I ask. "Not much," he replies.

As we leave l'ADJ to continue our maraude, three men are trying to climb onto an adjacent roof to feed a cat, while a loud argument between two people living in one of these suffocating apartments resonates through the inner courtyard. This cat will be there during each of my visits to l'ADJ during the summer.

During the maraude with l'Oasis, we spent a lot of time walking and waiting. Waiting for something to happen, waiting to meet somebody, waiting to see if a person would show up around a specific spot as he or she usually does on a given day. I often experienced feelings of boredom, and sometimes frustration, when we would fail to meet anybody in the street. For Chantale, an *éducatrice* at l'Oasis,

waiting is part of a greater general mission of being present. She once told me during a very quiet and uneventful *maraude* how she considered she was not paid to do nothing, but rather she was paid to wait. Chantale conceived her professional role as necessarily involving periods of waiting.

> Well, I can already say that I really learned this notion of time at l'Oasis. I really did. I learned it from people in the street. From the users. It's really from them, from their approach, their way of asking, when we go talk to them, "Ah… you don't want to discuss it today, OK, OK, we'll come back, we'll come back next week, no problem. OK you don't want an ID card, OK, we won't talk about it now... OK." You see, it's whenever you want, take your time. That's enough, you've said enough, OK? But you want to see us again next week. OK, we'll come back and do everything. You'd like to see us on such-and-such a day, at such-and-such a time? OK. We'll do everything we can to [make it work].[52]

At La Maison Frédéric, throughout the summer, there were many kinds of waiting: waiting for an administrative reply from the state, waiting in line for the next meal, or waiting in front of the shelter gate that opens at 4:00 pm. The various professionals I followed and observed, on the other hand, constantly told me they were busy, always in movement. At times, they were even busy waiting.

The theme of temporality is explored throughout Kelly Ray Knight's (2015) addicted.pregnant.poor. In this ethnography, the author followed the daily life of 19 pregnant and addicted women in daily rent hotels in San Francisco. The author goes beyond a simple focus on behaviour and looks at the structural constraints these women face. She shows how addicted, pregnant and poor women operate on various "time zones" every day, caught in "unrelenting and often conflicting temporal demands" (Ray Knight 2015, 8). She says:

> Within this complex social fabric, an addicted, pregnant woman operated in multiple 'time zones' every day. She was on 'addict time,' repeatedly searching for and satiating her addiction to crack and heroin. 'Pregnancy time' reminded her that her expanding womb was a ticking time bomb.

[52] "Ben moi je dirais déjà que cette notion de temporalité moi je l'ai vraiment appris à L'OASIS. Vraiment. Je l'ai appris par les gens de la rue. Par les usagers. C vraiment eux, dans leur façon de les aborder, dans leur façon de demander, quand on va discuter avec eux, "ah tu veux pas discuter aujourd'hui ok ok on revient, on revient la semaine prochaine c pas grave. Ok tu veux pas de carte d'identité, ok on n'en parle pas encore.. ok" tu vois c quand tu veux, prends ton temps. Ça suffit tu nous as assez parlé ok. Par contre tu veux encore nous voir encore la semaine prochaine ok on repassera on fera tout. Tu voudrais bien nous voir tel jour à telle heure ok on va tout faire pour."

> On ‘hotel time’ the rent was always due. ‘Treatment time’ demanded she answer: When was she going back? Was it too late? Could the baby be born ‘clean’ if she stopped today? These are questions she asked herself and that were being asked of her. ‘Epidemiological time’ converted her previous experiences with trauma, violence, and risk into public health statistics. ‘Jail time’ reflected her repetitive relationship to carceral regimes. ‘Life time’ reminded her of her own history of childhood trauma and a life of addiction, homelessness, and institutional involvement. Studying addicted, pregnant women in the daily-rent hotels required recognizing how they were emotionally, physically, and structurally bound in a limbo state betwixt and between these temporal demands. (Ray Knight 2016, 166)

The clashing of “time zones” was frequent in my fieldwork. Numerous employees at La Maison Frédéric told me how the time of les usagers and the time of the administration were not the same. One of them commented that, for a resident at La Maison Frédéric, there was a sense of action within the first few days of arrival, as they were put into administrative démarches, but then they are doomed to wait.“ You can clearly deteriorate if you wait too long here,” an intervenant once told me while he was on the phone, on hold. He was trying to solve a situation regarding a spot that had been reserved at the shelter by the 115, a situation that, he would later learn, had already been dealt with by a colleague a few days prior. “You see, I just lost 50 minutes,” he said, visibly frustrated—only to catch himself, saying nothing was lost in terms of time since it was part of his job to wait.

There were many such instances of time zones colliding. During one maraude with l’Oasis, the team tried to discern the objectives of a man they encountered, what he wanted to do in the coming weeks, and how they could help him. His answer was unequivocal, “I’m waiting for death as a relief,” he said. Somebody then asked him politely whether he had any life plan in the meantime. The silence resonated strongly in that moment.

Another example took place at La Maison Frédéric. That day, during a long, important coordination meeting between nurses in the nursing office, residents kept knocking at the door, at times even entering uninvited. This was a frequent situation throughout the summer. That day, the nursing

appointments were supposed to have started 15 minutes before, and the residents were becoming impatient outside, at times loudly arguing about who had been first in line. A man entered the office to complain, without knocking, visibly irritated. One of the nurses, who was usually a model of calm and composure for her colleagues, raised her voice at that time, visibly frustrated and exasperated, “It’s hard for you to accept that we are not always available, right?”

So much was happening, yet so little changed in the lives of the people we followed during the summer. For the residents of La Maison Frédéric that I spoke with, a sense of immobility was omnipresent, boredom was part of the quotidian. In The Space of Boredom, Bruce O’Neill (2017) presents homelessness in Bucharest, Romania, through the lens of boredom. O’Neil sees this boredom as a direct result of globalization, in which time is slowed down “in the margins of Europe” (ix) because of the impossibility of participating in the post-communist consumer society. Boredom is represented as an affective and embodied reaction to a “deepening immiseration” and downward mobility (x). O’Neil (2017) sees boredom as “a window into the cultural politics of exclusion in a moment of troubled global consumerism” (xiii). In this setting, boredom is not only about the passage of time; it emerges as “the affective expression of one’s condemnation to a slow death” (O’Neil 2017, 183). For one of the l’Oasis usagers we followed in the street, a previous attempt to get him housing had failed. His life became too centred around his apartment, and he reported feeling trapped inside. The rumour went around that he had apparently developed calluses on his elbows from constantly supporting his head on the table, feeling completely bored. He ended up abandoning his apartment.

In the opening vignette of this section, I asked the l’ADJ *intervenant* what people sitting in the waiting room were waiting for. Similarly, I often asked myself during my fieldwork what people were actually

waiting for at l'Oasis and La Maison Frédéric. What was it that was waited for by so many of the residents and the professionals? It was never fully clear to me.

In French, the word "waiting" and the word "expectation" are the same: *attente*. The Latin root of the word is of interest and revealing:

> 'Attente' must be defined etymologically, not only as a relationship between a subject and a reality, but, at an even more basic level, as a movement of tension carrying the subject toward the object, toward what the subject 'tends' toward, in an expectant situation corresponding to the object of his attention ("adtentio"). This indicates the extent to which, based on its etymology, 'attente' is defined as a focussing, that mobilizes and directs a subject's observations toward a reality that captures his attention.[53] (Tourrel 2007, 19)

It appears then that attente reveals a tension between the present and a desire for something else, the expectation of something, and waiting for it to come. This tension was palpable at La Maison Frédéric. Every new resident had to go through a few quick meetings with different professionals on their first day. During these meetings, the common rules were explained by les *accueillants*; they had a brief tour of the premises, a stop by la *bagagerie*, a meeting with the nurse and one with the social worker. People had to wait in line in front of the office of the social workers, sitting on a bench.

It was now the turn of a 24-year-old man from Côte d'Ivoire. He had been in Marseille for a week, and tonight was his first night at La Maison Frédéric. "*Quelles sont vos attentes envers nous*?" ("What are you expecting from us?"), the social worker asks him. He remained silent for a few seconds, with his eyes wide open, not knowing what to answer, what to expect, or what to desire, really. After a few questions, it was time to finish the meeting. The social worker said: "Ok, so you have an appointment at the

[53] "l'attente doit être définie étymologiquement, non seulement comme une relation entre un sujet et une réalité mais, plus fondamentalement encore, comme un mouvement de tension portant le sujet vers l'objet, ce vers quoi "tend" le sujet en situation expectative correspondant à l'objet de son attention ("adtentio"). C'est dire combien, d'après l'étymologie du mot, l'attente se trouve définie comme une focalisation qui mobilise et dirige l'observation du sujet vers une réalité qui attire son attention" (Tourrel 2007, 19)

government office in three weeks regarding your asylum claim. Until then you can sleep here but it's this other organization for refugees that will help you with all the other questions and paperwork." The man left the office, still silent, this time looking at me. Once the man was outside, the social worker turned to me, "you see, this is an asylum-seeker. We cannot do anything for him. It's awful." The social worker and I finished our short conversation as we arrived outside the office to greet the next person. But they all had left. *"Souvent c'est comme ça, ça se vide, les gens sont tannés d'attendre"* ("It's often like this, she said. People leave because they are fed up with waiting"). Waiting, therefore, appeared inevitable, but was also strongly revealing of a lack of alternatives. It was impossible not to wait; yet, waiting could also come to feel impossible.

In her ethnography, Carolina Kobelinsky (2010) presents the reality of the asylum seekers living in a *Centre d'accueil de demandeurs d'asile* (CADA), a temporary shelter for asylum seekers in the region of Paris. The theme of waiting, *l'attente,* is central to her work. She mentions three main sequences related to the waiting process that each follow one another. They are: "1. the imposed halt of the initial arrival at the shelter and the beginning of the waiting period, 2. the boredom and the need to fill in time, 3. the bypassing of the wait period" (Kobelinsky 2014, 1).[54] As in my fieldwork, the refugees' waiting, as described by Kobelinsky, is more a general stagnation, a symptom of an eroding system that is meant to tend to the vulnerability of those in precarious situations, but that often further reinforces and maintains this vulnerability through a profound affective reaction.

This link between vulnerability, temporality and affect is therefore important to consider here. Regarding this, philosopher Miri Rozmarin (2017) says:

[54] "1.la halte qu'impose le début de l'attente et l'arrivée au foyer, 2.l'ennui qui s'installe et le temps qu'il faut remplir, 3.le contournement de l'attente" (Kobelinsky 2014, 1)

> As a subjective experience today, vulnerability does not only designate the actual risk people think they are in, nor does it signify a distinct event that breaks into the stability of everyday life. Vulnerability is an affective relation people hold with their world and with their lives. Vulnerability becomes a permanent feature of how people imagine their stand in life. As such, it influences their notion of relations with other people, with the state, and other aspects of their social and private lives. Vulnerability shapes and is shaped by people's expectations, ideals, worldviews, and imagined identities. (Rozmarin 2017, 1)

Throughout my fieldwork, I witnessed this vulnerability that manifested itself through affective reactions and processes. The constant waiting periods, coupled with feelings of insecurity and boredom, exemplified the temporal quality of vulnerability. Rozmarin (2017) also mentions the notion of "fractured temporality" to reflect on affect and vulnerability in which "the past, the present, and the future [were] not connected in any way and [how] actions lost their roles as anchors to define who [people] are and what they were striving for" (Rozmarin 2017, 3). This lack of connection revealed itself during periods of waiting, yet it was also present in times of emergency, as I am about to show.

Emergency

During any given week or day, the residents of La Maison Frédéric, who were confined in positions of waiting, were also often confronted with emergencies. For example, the constant nine-day renewal policy through the 115 was a major source of stress and tension that always had to be dealt with in an emergency mode. As I already mentioned, most individuals with no severe medical conditions coming to La Maison Frédéric for the first time are initially offered a 30-day stay. After this, they have to renew their stay every nine days. Starting at 8:00 am sharp on the last day of their 30-day (or nine-day) stay, and not before, the person wanting a nine-day renewal had to wait on the phone (at times for up to two hours), hoping to secure a spot for that same night. Not being fast enough on the phone often meant not securing a spot in a shelter that night. Things were more complicated if you did not have a phone, or if you did not speak French.

The workers at La Maison Frédéric were often in a position of constant emergency, having to deal with the numerous emergency requests of residents trying to extend their stays at the shelter. The structure of the work schedule allowed little time for planning and organization, requiring constant action. The email communication with the 115 was a constant source of frustration for the workers. They could rarely get a simple confirmation of reception, let alone a reply - unless the matter discussed was one of great urgency, and even then, sometimes, there was still no reply. Similarly, the numerous patient files in the office were rarely organized, making it difficult to find information in a timely manner when an emergency arose. Once a nurse flipped through the pile looking for a specific file, visibly frustrated, swearing. She said, "It's so chaotic here, there are so many dead patient files lying around." Staff reported finding precious few moments in which to organize themselves as a team. During an interview, an employee once told me, "there is a constant sense of emergency here, but there is no coherence in all of this. You know, having to do so much here necessarily makes us all scattered." A constant sense of urgency dictated the professionals' rhythm of work, mirroring the urgency of the situations the residents constantly faced.

The situation was similar at l'Oasis. Emergencies happened alongside intense periods of what appeared as waiting, or non-action. In one case, a Greek man was still waiting for the state's reply regarding his immigration status, as the deadline to get his migration status regularized was approaching. One of the employees then called to inquire about the situation, only to realize that the Prefecture had never received the file (or was it lost?). It then became an administrative emergency for the entire team, who were desperately trying to find a way to get his status regularized. Could they find him a job? Or could he possibly get married to a French citizen?

It frequently happened that people were in crisis, requiring the Oasis team to act quickly. One day, there was an intense debate about whether a particular person needed to be hospitalized against his will. A woman living in this person's neighbourhood, and who was familiar with the Oasis team, had contacted them to report that the man had been behaving more aggressively in the past few days and that people in the area were, in turn, starting to act aggressively towards him. "We need to act urgently here. He's too psychotic right now and he'll get attacked,"[55] one of the intervenants said, pushing for hospitalization by force. There was a sense of urgency to get him help, that was shared by all - but the decision to impose a forced constraint was not a unanimous one among the team. In fact, far from it. "It is not the time anymore to discuss and reflect on the ethics of whether or not we should address this with him. We need to act. We have to see him and if needed, we have to force a hospitalization if we think he is dangerous after our evaluation,"[56] one of the intervenants repeated again. It was very often during an emergency that actions were taken, as though it were difficult - even impossible - to act in another temporal mode.

Therefore, for the workers of both l'Oasis and La Maison Frédéric, the job was often a perpetual wait for the next emergency to arise. But what actually becomes an emergency? Anthropologist Michael Taussig, referring to Walter Benjamin, reflects on when emergencies become not "an exception but the rule" (Benjamin 1968, 257). Taussig (1989) says:

> Terror is what keeps these extremes in apposition, just as that apposition maintains the irregular rhythm of numbing and shock that constitutes the apparent normality of the abnormal created by the state of emergency. Between the order of that state and the arbitrariness of its emergency, what then of the center - and what of its talk? (Taussig 1989, 4)

I often asked myself whether this oscillation between waiting and emergency was inevitable in these two organizations that face and address vulnerability. It is as though this movement back and forth between

[55] "Là il y a urgence d'intervenir. Il va se faire péter la gueule, car il est trop envahi en ce moment"
[56] "L'éthique de dire ou pas dire ce n'est plus ça en ce moment; c'est le temps d'agir. Il faut le voir et l'évaluer et s'il le faut, on forcera une hospit car il se met en danger"

waiting and crisis is itself the natural consequence of a state and social system that forbids larger reflections on the contexts of intervention— operating within a temporality of exclusion, that both produces and maintains vulnerability as it swings its subjects back and forth between these extreme poles. To ask why these people are so vulnerable might slow the swinging down, but this question is precisely what appears to be forbidden or ignored.

Regarding this, Myriam Ticktin wrote about the politics of humanitarianism in France in Casualties of Care: Immigration and the Politics of Humanitarianism in France (2011). Talking about emergencies and the various problems associated with them, she says, "The second problem is that humanitarianism addresses only the present: we have humanitarian "crises" or "emergencies," which require immediate action. With this temporal perspective, there is no way to understand events in a larger historical context, no time to think of the past or plan for the future: humanitarianism frames events as sudden and unpredictable" (Ticktin 2016, 262).

> A focus on the emergency requires us to be surprised over and over again; shocked, as if this were the first tragedy, the first horror we had been confronted with. It is unsustainable—not simply in the face of history—as recent articles have reminded us, comparing the American desire to shut out all Syrian refugees to the closed doors Jews encountered in the 1930s and '40s (Neier 2015; Tharoor 2015; Walter 2015)—but in terms of the emotional toll it takes to feel horror each time, as if it were the first time. Ultimately, one ceases to feel. (Ticktin 2016, 264)

Sometimes, during my fieldwork, I found waiting and emergency existing side-by-side; at other times, they were in sharp opposition. In waiting, so much could be happening; and often through emergencies, nothing seemed to happen at all. Neither was sustainable—neither a perpetual state of emergency, nor interminable waiting without any clear options or sense of future.

One of the *intervenantes* I met told me how this duality between urgency and waiting mirrored the duality between reflection and action and was actually extremely beneficial for her as a professional.

Waiting allowed her to reflect on her clinical positions in order to prepare for action in the next emergency. But for most of the people I encountered, waiting and emergency - mostly in the opposition Taussig refers to - represented a social erosion, the dehiscence of a socio-medical system that was supposed to deal with the vulnerability of others, but that instead maintained and created vulnerability for all. In fact, the professionals were undeniably affected by the temporalities within which the residents existed - which were, in turn, imposed upon them by the socio-medical structures and regulations in place to deal with homelessness. Waiting and emergency became inevitable forms of violence for all—violence related to the lack of options or alternatives, and the lack of possibilities for both the intervenants and the usagers.

FUTURE

I encountered two faces of the future during my fieldwork. On one side, the future was a projection space for dealing with the difficulty of the present, and on the other side it was an idea of change. Although different, both of these sides were united by a common reality: a sense of impossibility. At l'Oasis and La Maison Frédéric, the future often served as a dumping ground. During clinical meetings at l'Oasis, a phrase was often said during the numerous meetings, "let's deal with this later" *("on fera le suivi plus tard"*). It was certainly a way to adapt to the temporal reality of the people they followed in the street, but it also served as a pressure valve to deal with the hardship and the impossibility of the present. Projecting oneself into the future appeared as a very difficult task for the workers and the residents alike. Difficult, if not impossible at times. In both field sites, many of the professionals and residents I followed were often stuck in webs of events that were woven through a "landscape of violence and generations of suffering" (Ray Knight 2015, 224), which resulted in people having difficulty changing their personal and professional situations, so it seemed nothing was really happening. At La Maison Frédéric, the real possibilities for the men being sheltered there were slim. For those coming

from outside of the European Union with irregular immigration status, as I already have discussed, chances of regularizing this status and gaining access to a series of socio-medical protections in France were tenuous. For those coming from France or other EU countries, possibilities were different; yet the short-sighted vision of temporariness in assistance combined with the associated experience of being caught in the constant state of tension between emergency and waiting, made it difficult for people to escape or make effective changes their personal situations. Oscillating constantly between emergency and waiting made people look busy, as though going in some direction. Yet the real possibilities of something else emerging and happening in a near or distant future were, in fact, usually very limited. Similar to anthropologist Anne Line Dalsgård's (2014) work on temporality and the experience of "empty time" in violent neighbourhoods in a Brazilian town, the question becomes how to "conceive a future and distance [oneself] from an immediate current situation and a social environment that devours hopes and dreams" (Panagiotopoulos 2019, 3).

In one planning meeting at La Maison Frédéric, the cases of residents were being discussed. Different situations were presented, each unique; and yet so similar in the administrative (im)possibilities and the feeling of exhaustion generated in the end. My field notes of this meeting express this, through both verbatim quotations and my observations:

> It's just awful that he's sleeping at the station, but he's beginning a process that leads toward no status at all. If he wants to stay in France without a residence permit, he can't rely on the UHU [La Maison Frédéric] // Doing that is not helping them, it just turns them into chronic cases. // Our role is to maintain a dynamic that is transitory...We're not the ones who're going to solve his problems here. ... He has to be part of a project dynamic, not an assistance dynamic. // At the end of the meeting, I'm exhausted. Paul and Emma come down the stairs in silence, and they look exhausted and tired... It's tough; I don't even know where to stand. [57]

[57] "Ça c'est horrible qu'il dorme à la gare, mais ce mec entame un processus de sans statut. S'il veut rester en France sans titre de séjour, il peut pas s'appuyer sur l'UHU [La Maison Frédéric] // c'est pas les aider de faire ça, ça les chronicise. // Notre rôle à nous, est de maintenir une dynamique que c'est transitoire…c'est pas nous qui allons régler ses problèmes ici. ... il doit être dans une dynamique de projet, pas d'assistanat. // Fin de la rencontre, je suis épuisé, Sébastien et Emma descendent l'escalier en silence, on l'air épuisés et tannés... c'est lourd; moi même je ne sais pas où me placer."

Being in any mode other than that of immediacy appeared almost impossible. Becoming something other than a person in a homelessness situation living in an emergency shelter, or being a worker dealing with so many difficulties at La Maison Frédéric - both appeared difficult for the residents and the workers alike, because of the socio-political contexts and the temporal modes of being in which they were all stuck.

The concept of becoming is helpful in thinking about this world of (im)possibilities. In Unfinished: The Anthropology of Becoming (2017), João Biehl and Peter Locke present "unfinished views of people […] in the process of becoming through things, relations, stories, survival, destruction, and reinvention in the borrowed time of an invisible present," saying how "ethnographic creations are about the plasticity and unfinishedness of human subjects and lifeworlds" (Biehl and Locke 2017, x). The authors present the notion of the plasticity of "people, worlds, and thought," as the "the power of specifically growing out of one's self, of making the past and the strange one body with the near and present" (Biehl and Locke 2017, x).

In my fieldwork, I often wondered how much of this "plasticity" the people I encountered, usagers and intervenants alike, truly had to grow out of their situation; how much real possibilities there were in front of them. Regarding this, Biehl and Locke insist on the difficulty of becoming in today's world. They say:

> Indeed, the realities in which we are all entangled today, and in which the becomings of our characters unfold, are on the edge: of financial collapse, infrastructural breakdown, and environmental calamity; racial violence, right-wing populism, and alarming new regimes of security and surveillance; and chronic warfare, mass migration, and deadly health disparities. In the meantime, people may find ways to endure the intolerable and struggle to repair and heal, untangle themselves from the known and establish new relations (or not), negotiate threatening detours and the newly uncertain, and make use of these very realities to craft viable forms of life

> and project themselves into a future—or simply remain in suspension amid the collapse of messianic structures. Yet amid today's alarming global political shifts, it is also obvious that people's plasticity— shaped as much by fear and resentment as by hope and desire— carries destructive and violent potentials. (Biehl and Locke 2017, 3)

The context of life and intervention in my fieldwork rendered this "becoming something else" difficult most of the time. Clearly not impossible for all, but certainly challenging for most of them. Similar to the concept of *la vie moindre* (Namian 2012) I described earlier, Biehl and Locke (2017) pay attention to "worlds on the edge" (18) and question the possibility of plasticity and transformation in these contexts. Referring to Biehl and Locke's book, Costa (2018) says that reflecting on this topic involves looking at people "engaging with and working on the tangle of lifeworlds' (re)actions and hopes at a granular level" (Costa 2018, 391). I often wondered during my fieldwork if dealing with such limited possibilities at this "granular level" was not profoundly—and inevitably—an expression and a consequence of vulnerability.

TRI-TEMPORALITY: A CONSTANT VULNERABILITY IN MULTIPLICITY

Vignette: Michel and the staff meeting

> That day, Michel rang the doorbell as usual. It was in the middle of a staff meeting. His very distinctive voice resonated through the intercom, and everybody around the table recognized him. He was asking for help with his monthly allowance, and for a coffee. For some reason, the bank had apparently decided to close his account, and he turned to l'Oasis, thinking—or convinced? — that they had his money.
>
> Over the intercom, Michel sounded agitated, as was often the case. There was really no need for an intercom since the Oasis office is located only one floor above street level, with windows wide open onto the street. The heat these days made it impossible to close them.
>
> We could distinctively hear—and see, by standing on the windowsill—Michel shouting at the intercom, more angrily this time. People walking on the sidewalk looked uncomfortable, crossing to the other side of the street. One woman sitting outside the nearby hair salon said, "The man is crazy." Inside, the discussion with the team went on: "Should we let him in? He's causing trouble on the street." Because of various reasons, including previous violent events and the need to

secure time between professionals, your visit to l'Oasis had to bear a purpose and could not be a drop-by visit anymore.

Although Michel clearly wanted to come upstairs right now and was not interested in being attended to in the street directly ("*reçu à la rue*"), in the end, two *intervenantes* decided to go downstairs to talk with him on the sidewalk. They said, as they were going downstairs, that simply showing up at the Oasis office like this, for no reason and with no clinical setting was not helpful nor therapeutic for him anymore. They brought coffee and a few cigarettes with them. As Michel continued to shout on the street, with les *intervenantes* trying to calm him down, the discussion carried on upstairs, around the table, with the other members of the team.

> Thierry: "We should have let him in. Sorry, but it would have been much less complicated. These types of situations are so demanding in the end."

Thierry tells everyone that Michel was able to respect a 30 min time limit he had himself agreed to last time he came upstairs. Apparently, he stayed for 30 min, had a coffee, cleaned the floor as he usually did and left, satisfied.

> Ali: "We should have let him in."

Thibault, who was the first one to convey the decision to Michel over the intercom, says:

> "it's better if he goes ballistic here compared to in the street"

When the two *intervenantes* come back upstairs, they look exhausted.

> "It's literally like trying to have a conversation with somebody in a manic episode. He needs lithium."

Another team member said:

> "No, what he needs right now is to get hospitalized."

The meeting then continued for a while, until suddenly, loud noises resonated through the staircase. Everybody looked at each other, anxious. Some thought at first that Michel had gotten inside the building, but soon we realized it was actually the upstairs neighbour coming down with his three children.

A long, animated discussion followed. What is it that Michel needs? What is it that they can offer him, and when?

> Thierry: "We would need to be able to respond to his requests on the spot. We are the one not being flexible enough."
>
> Dominique: "Sure, welcoming him unconditionally like this calms him down in the moment, but it is not really a form of care."
>
> Sophie: "Yes, it is. He knows we are here for him, in his own temporality."

Dominique: “Ok, but what about in the long run? It is really useful?”
Sophie: “Yes, I do believe that welcoming him is a form of care.”
Juliette: “Ok, sure, but I think at this point he needs to be hospitalized.”
Thierry: “We have to consider his recovery, but in his own temporality again.”
Sophie: “Sure, but he is vulnerable right now… “
Thierry: “Ok, it’s been a month now that we keep saying let’s reevaluate this…Either we go along in his own temporality, or we hospitalize him against his will.”
Juliette: “Ok, I say we force the hospitalization.”

A tense silence resonates around the table.

Ali: “Yeah, but Michel goes himself to the hospital when he feels he needs it.”
Sophie: “Yes, but it’s always in a voluntary way. He leaves after 2-3 days. It’s too short.”
Juliette: “Now that we don’t let him come upstairs anymore, it’s destabilizing for him.”
Ali: “Well, in our own reality, he is not well I agree, but in his, he’s not that bad. And again, why is it that we don’t let him in anymore?”

Another silence.

Juliette: “We let him in at times, but not all the time.”
Thierry: “Well, it’s quite exceptional now that we let him in.”
Halima: “Maybe it was to give him a chance to organize himself a bit better, without us. He just told me downstairs: You’re now like Catholics or Muslims, you don’t welcome me anymore. All you do is bring me a coffee in the street.”
Thierry: “Maybe it would be better if we would tell him, ok, come here once a week instead of every day for a coffee. Maybe it would be better this way to prepare an eventual hospitalization? I don’t know.”

The staff meeting is once again paused. People are sighing. Smokers leave the room to go outside on the back patio. The coffee in the broken coffee pot sitting in the middle of the table is now cold. The handle is still crooked and wobbly even with the extra layer of duct tape that was added last week. No consensus emerged on what to do for Michel, on how to be available for him. Or when.

Michel’s demand to come upstairs immediately that day, and the decision by the team not to let him in, exemplified how the past, present and future were intertwined and formed multiple wholes in my

fieldwork. Indeed, the multiplicity was obvious. The history of l'Oasis, the recent decision to allow only certain people upstairs, Michel's previous aggressive reactions, the sense of urgency his request bore, the need for the team to work in conditions where they were not constantly interrupted, and the concerns about preserving the therapeutic relationship (lien thérapeutique) with Michel; all these were part of a situation that represented the constant tri-temporal reality within which the intervenants must labour. These conflicting "paradoxical" temporalities (Lévy-Vroelant, Joubert, and Reinprecht 2015) and their respective demands cannot be ignored by professionals and need to be taken into consideration when reflecting, making decisions and taking actions.

The multiplicity of time was present throughout my fieldwork. Referring to Desjarlais (2003), Veena Das sees this multiplicity "as experience and not simply as different ways of bending or deforming Newtonian time" (Das 2007, 98). She exposes how past and present are intertwined, and she "invites reflections on the modalities in which the past becomes present in our lives" (Das 2007, 99). Critchley (2009), referring to Heidegger's Being and Time (2010), says, "For Heidegger, we are time. Temporality is a process with three dimensions which form a unity" (Critchley 2009). On a similar note, referring to the process of becoming, Biehl and Locke (2017) also explore this interwoven temporal multiplicity. They say:

> Lived time is not reducible to clock time, and people inhabit multiple temporalities at once. Becoming occupies its own kind of temporality that unfolds in the present: a dynamic interpenetration of past and future, actual and virtual. […] [B]ecoming is characterized by the indeterminacies that keep history open, and it allows us to see what happens in the meantimes of human struggle and daily life. (Biehl and Locke 2017, 6)

Throughout the summer, I paid attention to these "meantimes," suspended in time and in possibilities. Time was, therefore, multiple. Yet, as Das (2007) and Biehl and Locke (2017) have presented how multiple temporalities appear to be part of life itself, something inherent to the experience of living; I have also shown how the multiplicity of temporalities in my fieldwork imposed a sense of vulnerability. In fact, the constant interaction between past, present and future—between trauma, waiting,

emergency and impossibility to become something else—allowed vulnerability to express itself fully. I often came to wonder during my fieldwork if these two notions - multiplicity and vulnerability - were contradicting each other. Or, could life in this context involve both temporal multiplicity and vulnerability? I believe so.

Life is in itself vulnerability. Yet, it is a vulnerability that is firmly anchored in multiple temporalities - whether individual, social, cultural or historical (Lévy-Vroelant, Joubert, and Reinprecht 2015) - different temporalities that need to be taken as a mandatory whole. Referring to Dalsgaard, Frederiksen, Højlund, and Meinert's (2014) work on the social aspect of temporality, Panagiotopoulos (2019), says:

> Their approach to an anthropological objectification of time is multi-faceted, and includes an examination of how time and temporality frames social life, how actors reflect on discordant temporalities, and the different ways they cope with their (dis)ability to act on time – indeed, indeterminacy and uncertainty are core themes. […] 'Boredom, waiting, inactivity, subjunctivity and inertia' […] are central to an anthropological consideration of time, since during these moments the regularity of time flows is fragmented. (Panagiotopoulos 2019, 4)

Anthropologist Lisa Stevenson (2014) explores the condensation of temporalities in her ethnography exploring suicide among Inuit populations in Northern Canada. She says:

> If in this modern way of reckoning time one must always have a future in order to vouchsafe the present, then to be without a bright future is also to be denied a present. In an age that is obsessed with controlling the future as a way of having the present, Inuit suicide may be seen as a response to a future devoid of surprise, a response that instead pays attention to the poverty and pain of the "now." The pain, of course, is the shadow of this chapter, a constitutive absence. It is the pain of living in the future's wreckage. Whatever else it may be, suicide is also a leap into another way of being in time, one that questions whether there is always a brighter future around the corner. I want to say that suicide answers in one temporality a question that cannot be posed in another: what if the future cannot redeem the present? (Stevenson 2014, 147)

Similarly, Angela Garcia (2010) explores the daily lives of Hispanic individuals addicted to heroin, living in a community of New Mexico with the highest rate of heroin addiction in the United States. In this community, chronicity is presented as the main mode of existence regarding addiction, where the

person is doomed to live in a lack of possibility and a lack of alternatives to addiction. She refers to this existence as “a mourning without end,” as a form of suffering “sin termina” (“without end”) (Garcia 2010, 91). So often during my fieldwork, I came to wonder what sort of future was lying ahead of the usagers and intervenants I met. And how much of it was truly bright, or even possible. Still, today, I am not sure of the answer.

Addressing vulnerability in its multiple temporalities involves looking at an intense social life that often happens in an in-betweenness, at times discreet and even hidden. Regarding this, Biehl and Locke (2017) mention that “these meantimes and interstitial spaces are not stagnant vacuums: they overflow with shifting aggregates of desire and power, the emerging sociopolitical fields and intersubjective entanglements produced as people imagine and attempt to make real what they need and long for” (Biehl and Locke 2017, 6). Like Michel and the intervenants of l’Oasis in the opening vignette of this section, the waiting after the doorbell rings is multiple, and left all of them in an in-betweenness. The hesitance to buzz him in exemplifies and sheds light on a saturated system of assistance where the intervenants are caught between different logics and visions of care. These differences are related to conflicting administrative rules on what their mission should be, how many resources should be allocated to this, which approach is to be taken in this type of socio-medical intervention, and how much energy and care these intervenants have themselves, in order to do these things. The waiting also demonstrates for Michel the difficult in-betweenness he exists in; between his own history, what he desires in terms of life and goals, in the present and in the future, and the actual possibility that these things can be achieved, given the social reality within which he exists.

Life happened in a temporal in-betweenness in my fieldwork. In order to seize the reality of the experience of the intervenants and usagers I met, I needed to dive into the multiplicity of time, all at

once, to better capture what was at play. Over the summer, I constantly witnessed these different temporal and social modes of being interwoven within the same moments. Existence took place within a constant entanglement of the past, the present, and the future, whether people wanted this entanglement or not, or tried to do things differently. This, Stevenson (2004) says, is "about being caught in one time but aware of the truths of another. [Y]ou are responsible (in the sense of mortally affected by) the truths of both temporalities" (146). Life was a constant tri-temporality, in which the intervenants and the usagers alike lived. The present was always firmly anchored in a frequently haunting past, of which the future, lying ahead, loomed ominously, foreclosing itself before itself as a doomed repetition of the past. Existing in this constant tri-temporal reality was a precarious experience marked by vulnerability.

II. VULNERABILITY IN RELATION

Vignette: On seagulls and human nature

> When I left Emma's office, the heat was still suffocating outside. It was the end of the day; the sun was slightly lower on the horizon, but still, the heat radiated from the concrete pavement up onto my face. The last people who had not yet eaten were still in line in front of the cafeteria. I recognized many of them as they shook my hand and touched their heart afterwards. "Hello doctor, how are you?"
>
> I passed by a *surveillant* who looked frustrated. He had just finished a pretty animated conservation with an *hébergé*, from what I could see from far away. He sighed, nodding his head. "What the hell, they're all so drunk tonight. It's so hard. They don't realize that I am not the one making the rules here. I cannot start making exceptions because everybody will know about it."
>
> I ran into a man that I had seen every day I had been at La Maison Frédéric. This time, his face was severely bruised. He had been beaten in the streets of the city yesterday. I did not ask what had happened. He told me he had spent the entire day today running around: to the post office, the doctor's office in town, the police station where he had to wait two hours. He could not really tell me why. He had to make it all the way to l'Estaque (a nearby town) to submit a certificate of some sort, but it had not been the right one and he was turned away. As he smiled, we both laughed, me more nervously. "Better laugh at it," he told me with his strong alcohol

breath and his few missing teeth. “I usually know my own limits. I had been sober for the past week, but this was too much for me today.”

Leaving the man there, I headed toward the side door of the main dormitory building, next to the staircase. People usually sat there to relax or to smoke, often quietly. Even with the rumbling sound of the cars on the elevated highway, there is a certain tranquillity there. As I arrived, I tried to find a non-occupied spot on the concrete doorstep. Instead, there was only one spot on the blue metal bench next to it. My field notes from that moment are clear: I felt uncomfortable being there, not knowing where to put myself.

> July 6th
> I'm uncomfortable, observing. I don't know where to stand or what to say.
> "It's much quieter here, isn’t it?" I say it out loud as if to break the ice.
> No one answers. They just look at me in silence.
> There's a man on the stairs looking at me. He has piercing blue eyes. He's drinking some multivitamin juice. He has a shaved head and scars on his face.
> A man tells me that his cellphone has been stolen; he wants me to report it to the guards. He writes his name in my notebook so that I’ll remember.
> In the meantime, the man who got beaten up yesterday arrives. He smiles at me. He only has two teeth left, and stitches above both eyebrows.[58]

In front of us, the employees' cars are parked next to the big garbage bins. A shelter resident left the cafeteria, walking toward the bins, carrying used aluminium cooking sheets: the unserved food from the cafeteria I assumed. Two cats then appeared from somewhere following the man. With his severely curved back and his prominent belly, the man carefully put the trays on the pavement, not without difficulty, next to the bins. I would often see this man doing this throughout the summer, always around this time of the day. Most of the time, the man would stay there in silence, smiling, looking at the cats eating. The cats were always there on time. I often wondered how they always ended up coming back at the same moment. I imagined them going around the neighbourhood all day long and then coming back for a well-timed evening snack. Or maybe they would not go anywhere else during the day but stayed around the shelter. I did not know much about cats and their habits.

---

[58] “6 juillet
Je me sens mal à l'aise avec l'observation. Je ne sais pas où me mettre ni quoi dire.
“C'est beaucoup plus calme ici, ein?” je dis alors à voix haute, comme façon de briser la glace.
Personne ne me répond. On fait juste me regarder. Silence.
Un homme dans les marches me regarde. Yeux bleus perçants. Il boit son jus multivitamine. Il a le crâne rasé, des cicatrices au visage.
Un homme me dit que son cellulaire a été volé; il veut que je le rapporte aux surveillants. Il écrit son nom dans mon cahier de notes pour que je me souvienne.
L'homme qui s'est fait battre hier arrive dans l'entre fait. Il me sourit. Il n'a plus que deux dents et des points de suture au-dessus des deux sourcils.”

> That day, all of us were watching the cats from afar, sitting on the blue metal bench and the doorstep of the side door of the main dormitory building. That day, the curved man did not stay to watch the cats eat. As he was walking away from the bin, a seagull landed right next to it. It charged the two cats and pushed them away from the trays. After a few seconds of hesitation, the two cats finally laid down at a distance, licking their fur and watching the seagull finish what should have been their meal. I do not know much about cats, but there was something that looked like abdication in their eyes. The man who had been beaten yesterday looked at me. "This is human nature, you know," he said, pointing at the seagull. I did not know what to reply so I stared in silence like everyone else.

Something felt heavy throughout my fieldwork, a heaviness that resonated on and through both the intervenants and the usagers. Many events that felt beautiful and meaningful, even somehow necessary, also felt heavy, and additionally, still. The numerous conversations I had with the different professionals and usagers, as well as the many hours I spent in participant-observation, made me think of whether—and how—things could be different for both of them; if there was a way to care and live in this context without feeling exhausted, frustrated, or resigned.

Quite a few times, when reading over my field notes regarding difficult situations that happened over the summer, I had to stop reading and go back a few pages to remind myself whether I was describing and referring to the professionals or to the usagers. As I explained earlier, I decided to focus my analysis on the interactions between the usagers and the professionals. The focus of my interest came to be precisely this relationship between individuals: individuals inhabiting different stories and carrying different roles, yes, but sharing a common sort of experience in the form of vulnerability.

Through the summer, I became an observer of relationships; between individuals, between bodies, and between individuals and social systems. No matter what position people were in, though, there seemed something in common between them: something was moving around, as though vulnerability itself was

circulating and moving between them, no matter what position they were in. The consequences of this vulnerability were different depending on whom it struck, yet in a shared experience of its circulation, a sense of commonality emerged.

Before continuing, I simply want to reinforce a notion I have already mentioned in the introduction. I am pointing at the commonality of the experience of vulnerability in this thesis, while saying the consequences were different depending on who was affected by it. I am reporting a shared difficulty in these socio-medical relationships between the usagers and the intervenants, yet I do not intend to say nor pretend that these difficulties are similar in terms of their scope and their consequences. The intervenants go home at night, with a roof over their heads, and an income. I am trying to be explicit about how vulnerability operates in relation, without ignoring notions of class, privilege, or socio-economic status. Ultimately, I want to show that professional titles and responsibilities do not prevent the experience of vulnerability. If vulnerability operates in relation, then everyone in this relationship is affected by it - though in different forms, and with different consequences, and with different protective measures.

The bodies of the intervenants and the usagers also carried sense and meaning. Throughout my fieldwork, I witnessed exhausted bodies, bodies going through experiences of violence, bodies struggling to navigate and make sense of a crumbled social system that created the conditions for the circulation and the maintenance of vulnerability. A body in such an experience became a carrier of this crumbling and this vulnerability.

I will now explore these two concepts: the circulation of vulnerability through relationships, and the body carrying this vulnerability.

A CIRCULATING VULNERABILITY

Vulnerability as relational and circulatory

Vignette: Food donation

Every now and then, people living or working in the neighbourhood would stop by to offer food donations to the residents of La Maison Frédéric. Once in a while, a car would stop in front of the shelter, and the driver would either get out of the car quickly to hand some boxes to the few men hanging outside of the gate or pass some bags through the windows of the car. It could be anyone from a local family stopping by with their kids to hand out homemade cookies, to the local baker stopping by around 10pm on his way home to donate all his unsold products from the day. During Ramadan, a team of volunteers would come every night to distribute full meals right after sunset. The men at La Maison Frédéric were fed two meals each day, breakfast and dinner. Especially during Ramadan, the late arrival of the cafeteria shelter employee in the morning would mean that a few of these men would have to go with empty stomachs to their work sites.

For lunch, the men not authorized to stay during the day have to figure things out for themselves. Either they turn to a soup kitchen or buy themselves a lunch with their saved money or wait until dinnertime when they are back at La Maison Frédéric. Sometimes, for those who had jobs, lunch would be provided with their work. For those working in restaurants, lunch was often good. For others, working on construction sites for example, it is a different story. One of the main employers in construction close to La Maison Frédéric paid each employee 20 euros a day for about 10-12 h of work, undeclared, with a sandwich jambon-beurre (a ham and butter sandwich) for lunch. A “form of modern slavery,” an intervenant once told me.

Initially, donors at La Maison Frédéric used to ring the bell of the gate to give their food to employees, which would ensure the distribution of that food. With time though, it became complicated and time-consuming for these employees, something beyond their task and job definition. They did not handle this anymore while I was there. The administration had installed a few picnic tables outside the gate for the residents to be able to sit down, mainly in the evening, to interact with one another, or to simply sit down to eat the food donations, when necessary.

I am sitting with a few residents outside of the gate this afternoon. There is no medical consult today; the doctor had to cancel last minute. It’s about 5:30. Workers in the city are slowly starting to go back home. The highway on top of us generates loud noise from a never-ending procession of cars eagerly going back home.

Even with the rumbling noise of the highway, there were moments when messages would go around La Maison Frédéric quickly. Like an even deeper tone vibrating through the structure of the place. This was the case for fights, but also for food donation.

Three women had just arrived to distribute food: little individual bags, each with a sandwich and a piece of fruit. I got closer to the distribution area, sitting there, watching and listening as I wrote in my notebook.

> August 17th, 2017. 17:25
> People are flocking into the donations table. I'm told that these women come here often. “It's good what they do.”
> I'm sitting on the bench, a little stunned. I'm listening to the women talking to each other.
> “Ah, you see, they're impressive.” “They're like animals.” “You see, they eat with their hands.”
>
> At that moment, another vehicle arrives. Two men have arrived with some couscous. A big brown wooden bowl of couscous. Slices of hard-boiled eggs and pieces of meat.
> The women say: “You bring them spoons and look, but look, they eat with their hands.”
>
> The women barricade themselves behind their car, parked near the big fence. They use small movable metal fences to create an enclosed area between their car and the big fence. One shouts out to another, “Quick, close it, we're going to be attacked.”
>
> I approach them. One of them says to me in a dry tone, “Have you eaten?” “No.” “You look like an intellectual,” I tell them that I work here. “Ah, okay, I thought, well, there's an intellectual in the group.” The lady continues, “You see, there's a lot of misery here. They're so selfish (pointing to a kid who's keeping for himself the big bottle of cola that they brought).” I don't answer. I ask them if they've been coming here for a while. “Since 2009. But we stopped because of a death in the family.” Since then, they come just a few Fridays each year, during their celebrations to mark the death of their sister and brother.
>
> An elderly medicalized man approaches the women. (He’s the man who always greets me with ‘Hello Doctor’ and shakes my hand while asking how I’m doing). “No, go away, you've already eaten. Go away.” He speaks Arabic. “No, I don't understand your language” (impatiently).
>
> The women tell me it's better when they hand things out like this, from behind a fence (showing me the fences). “It’s always this way, the first group that comes in, they're nice. And then they come in like this” (her hands make a gesture indicating an explosion).
>
> I'm so uncomfortable here. And at the same time, I want to stay. I'm a bit taken aback.
>
> The Tunisian man with his khaki fisherman's jacket walks in front of me. I greet him. He says hello, holds out his hand to me with couscous on it. Rather, he extends his wrist.

> “Just missing a camera, eh?” Does he mean that I should be filming all this? Or that he thinks I'm a voyeur? I’m unable to stay. I feel hot.
>
> I go behind the fence. The guards ask the residents for their tickets again, to prove that they're allowed to be here for the night. One guard says to me, “It's unbelievable, eh? They eat all the time, sometimes four times a day like this. Yet they have everything here. And on top of it, they eat all the meat from the couscous and leave the rest.”
>
> I take refuge in the staff room on the second floor to write. I need some peace and quiet. There's some yelling downstairs, at the door to the cafeteria. It’s probably someone who tried to cut into the line, right? I receive a BBC alert on my phone: there’s been a terrorist attack in Barcelona. Soon I'll be leaving for the day. I'm thinking about my interview earlier in the day with Emma. "Making sense of it.” Yeah, right. How do you make sense of actions, when there doesn't seem to be much sense to anything?
>
> As I leave, I look out the window. I realize that the second floor of the building has a better view. You can see over the famous stone wall. You can see water in the distance and buildings in the port. There is the highway. Cranes in the distance. Train tracks, with an abandoned train. There are lots of tags and graffiti; broken windows.
>
> That famous stone wall obscures the whole view to below. The only people with a different view are the few ones who sleep on the second floor of the only two-storey dormitory, although that view is only from the two rooms looking out between the two administration buildings.
>
> It's hard to see the horizon here. To elevate yourself.

Vulnerability is relational, “La vulnérabilité est relation” (Lévy-Vroelant, Joubert, and Reinprecht 2015, 17). This is an important concept that is pivotal to this thesis and to the vision of vulnerability in socio-medical interventions. For the authors, vulnerability is, therefore, much more than status, a condition, or even a socio-medical category. It is a far-reaching relation. It encompasses and involves individuals, structures, and social policies. In fact:

> Once we consider social vulnerabilities as the result of a combination of factors—resources (disposition and ability to act), areas of fragility (the potential for one’s balance and/or integrity to be affected or injured) and an environment marked by broad-based precariousness and fewer

> protections—we understand that the context in which they take place plays a decisive role.[59] (Lévy-Vroelant, Joubert, and Reinprecht 2015, 17)

It, therefore, appears that in order to address vulnerability, one needs to address the relation between capacities, fragilities, and the environment - both individual and collective.

When thinking about the dozens of socio-medical consults I attended, I remember the precise relations between the usagers and the professionals. By this, I mean the human interaction happening between these two individuals, not so much in the professional sense of a nurse welcoming a patient, but rather two human beings in different roles and realities, yes, but in a relationship, nonetheless.

For Lévy-Vroelant, Joubert, and Reinprecht (2015), vulnerability presents itself precisely in an interaction, therefore circulating between individuals. The concept of the circulatory nature of vulnerabilities (*la nature circulatoire des vulnérabilités)* is helpful here (Lévy-Vroelant, Joubert, and Reinprecht 2015). For the authors, the circulation of vulnerabilities combines a difficulty on the part of the usagers to act upon their own lives, combined with a difficulty on the part of professionals to actually to intervene in these people's lives. In order for vulnerability to circulate, the authors insist on the double nature of vulnerability: vulnerability as it is exposed by the vulnerable person, but also as it is acknowledged and shared by the professional.

> Therefore, in addition to vulnerability/injury, meaning what it means to be exposed, we must necessarily add vulnerability/openness, meaning that you accept to be affected or bothered by others: being aware of having a shared condition of interdependence. The first concerns fragility, and the second, resources. (Lévy-Vroelant, Joubert, and Reinprecht 2015, 313)[60]

[59] "Le fait de considérer les vulnérabilités sociales comme la résultante de la conjonction entre des ressources (dispositions et capacités à agir), des fragilités (possibilité d'être affecté ou blesse dans son équilibre et/ou son intégrité) et un environnement marqué par la précarisation de masse et le recul des protections, assigne un rôle déterminant au contexte dans lequel s'opèrent ces articulations." (Lévy-Vroelant, Joubert, and Reinprecht 2015, 17)

[60] "Dès lors, à la vulnérabilité–blessures, signifié par ce qu'être exposée veux dire, il faut ajouter indissociablement la vulnérabilité–ouverture, signifié par le fait d'accepter d'être affecté, dérangé par autrui: conscience d'une condition commune d'interdépendance. La première s'inscrit sur le versant des fragilités, la seconde sur celui des ressources." (Lévy-Vroelant, Joubert, and Reinprecht 2015, 313).

Therefore, in order to circulate and have meaning, vulnerability needs the co-existence of a revealer and a receiver in interaction. In this vision, vulnerability exists because two individuals are present (and exposed) within a given relationship from which emerges vulnerability, and not because two vulnerable individuals are in relation. It exists because a patient living under almost impossible conditions is welcomed in a medical consultation by a nurse, and from this interaction, vulnerability emerges and circulates. It exists because a woman distributing food behind a barrier somehow feels threatened by men living in a shelter that has a rough reputation in the city, whereas material scarcity reflects the impossible and unequal conditions that the men's irregular immigration status gives them.

Le lien

Throughout my fieldwork, the relationship—*le lien* (the connection)—between the intervenants and the usagers appeared fundamental and served as the starting point of many socio-medical actions. One of the nurses at La Maison Frédéric once said, in a meeting regarding the professional attitude, that it was the *lien* that reassured people here, not the white coat.[61] A fundamental relationship based on trust, yet at the same time, one with another side that is impossible to dissociate. This relationship is a necessary aspect of their work, but it is also through that relation which vulnerability circulates placing both sides, intervenants and usagers, in situations of vulnerability. It appeared as something inherent to the work of these professionals.

So many examples of this *lien* come to my mind. So many examples where an intervenant developed a fine, deep understanding of an usager through the initial creation and ongoing maintenance of this *lien.* During a maraude at l'Oasis, two intervenants once told me about a man they had worked with. It took

[61] "c'est le lien qui est rassurant ici, pas la blouse blanche"

them about a year and a half of quick hellos and chats to establish a relationship ("*pour créer le lien*") before the man accepted anything from them (the first thing was a bottle of water during a heatwave). Another story is of a man, always standing by the same street corner in front of a cathedral, whom the team got to know through the numerous coffees we drank with him on a nearby terrace. The interventions they made daily in their work were important, but at times what seemed even more important were all the little things they did to cultivate this lien in-between.

Le lien between the intervenants themselves was also fundamental. The presence of colleagues with whom to go through the daily routine, to share lighter moments or to debrief, especially during difficult situations, was fundamental. Conversely, the fragility or the rupture of this precise relationship was also a reality, whether it had already happened or was feared to happen. Conflicts between colleagues sometimes arose. Many times I was told stories of a certain colleague who had done this thing or that thing, a kind of horizontal denunciation. There was also a fear of breaking this supportive link between colleagues and then finding oneself isolated. One example, in particular, comes to my mind. At l'Oasis, important decision-making happened as a group. Team meetings were moments to discuss sensitive topics or issues with one's colleagues in order to get their input and benefit from their clinical distance from the situation.

One day, during one of these team meetings, it was somehow mentioned that one of the intervenants had decided by himself, without talking to the team, to offer some money (*un secours*) to an usager to buy prescribed drugs. In fact, the team had at their disposal a discretionary budget specified for just such situations, but the team had to decide whether or not to give this money collectively, based on certain criteria. The discussion that followed was tense. The head *intervenant* was criticizing the decision of the *intervenant* because it put him at risk of being manipulated by the usager, and thus being isolated from the team.

Another similar situation reflected the heavy weight individual decisions could have on the whole team. Once again, financial support (*secours*) had been offered to a usager by an intervenant without consulting the team. This time, the conversation was much more animated, probably the tensest that I witnessed throughout the summer:

> "But it's clear that, with this, we will end up with institutional violence. But we need to protect ourselves, too. If need be, if the guy loses his patience when he's refused money the next time, well, there's always the police."[62]

A social worker tried to ease the atmosphere at the end of the conversation:

> "Yeah, but as far as that's concerned, we could also ask for financial help at the end of the month, given our shitty salary, right? A massage for Juliette, a new cellphone for Stéphane, who just lost his…"[63]

At the end of this conversation, everyone laughed tensely.

If vulnerability then circulates in relation, and the other end of the relation are the intervenants, they are then themselves caught in webs of vulnerability. The vulnerability of the intervenants was a reality I witnessed throughout the entire summer. It appeared as an all-encompassing relationship, a relationship that has consequences, yet a relationship that is also revealing of something deeper. Observing this vulnerability circulate made me wonder how to address it, the vulnerability of those who are supposed to deal with and care for the vulnerability of others. How did this vulnerability express itself? And mostly, what did it reveal in terms of the social system of care in place?

[62] "Mais c'est clair qu'avec ça on va finir par se prendre de la violence institutionnelle, mais faut qu'on se protège aussi. Au besoin, si le gars pète les plombs quand on lui refusera l'argent la prochaine fois, ben y'aura le droit commun, la police"

[63] "Ouais mais à ce compte-là, on pourrait demander nous aussi des secours pour les fins de mois au salaire de merde qu'on fait. Thalasso pour Juliette, Stéphane qui a perdu son portable…"

One of the ways the vulnerability of the intervenants expressed itself was through a feeling of fatigue. I witnessed a lot of fatigue - even exhaustion at times - at both of my field sites. I saw a few of the intervenants go on sick leaves. There were certainly individual characteristics that allowed some intervenants to face the hardships of their job better than others, yet there was a very common experience of weariness amongst the staff as a whole. When in the position of bearing witness to the constant difficulties and almost impossible situations of the usagers, while also being caught yourself within the constant tension/precariousness of tri-temporality, and while also facing your own problems associated with your job - discouragement can easily be around the corner. The intervenants often mentioned a lack of support from supervisors and administration, combined with the difficulty of finding moments to communicate and let off steam, as real problems:

> "The problem here is that no-one listens to you. Emma, she's alright. At least she listens to you. Besides, they're under-staffed here. It's under-staffed. They're exhausted."
>
> "You see, people need to talk. It makes us feel good. It's a difficult environment" [64]

The feeling of powerlessness was also another major factor in the way vulnerability was distributed among so many of the intervenants. This feeling was not only related to the difficulty of intervening in such complex situations, but also to their own professional identity. The same was found by Lévy-Vroelant, Joubert, and Reinprecht (2015). In fact, they say:

> "The circulatory nature of vulnerabilities therefore refers to the feeling of powerlessness felt by some professionals, or even to a feeling of unease that affects their professional identity and their relationships with people; it makes them doubt the relevance of their presence or their interventions, and adds to the feeling that they are vulnerable."[65](Lévy-Vroelant, Joubert, and Reinprecht 2015, 200)

[64] "Ici le problème c'est que personne ne t'écoute. Emma elle est bien. Au moins elle t'écoute. En plus il manque de personnel ici. Il manque de monde. On s'épuise". "Tu vois, les gens ont besoin d'échanger. Ça nous fait du bien ça. C'est difficile comme environnement."

[65] "Le caractère circulatoire des vulnérabilités renvoie donc au sentiment d'impuissance ressenti par un certain nombre de professionnels, voire au sentiment de malaise qui affecte leur identité professionnelle et leurs relations aux personnes ; elle vient interroger la pertinence de leur présence ou de leurs interventions, et redoubler le sentiment de leur propre vulnérabilité."(Lévy-Vroelant, Joubert, and Reinprecht 2015, 200).

This powerlessness was also associated with the conflicting temporalities the intervenants were caught within, as I have already presented. Again, Lévy-Vroelant, Joubert, and Reinprecht (2015) mention this aspect in their own research with front-line workers working with homeless individuals. “In this context, the powerlessness comes from gaps between the temporality of individuals, front-line actors and institutions.”[66] (Lévy-Vroelant, Joubert, and Reinprecht 2015, 200). It therefore appears as though the conditions of work and life within such contexts were in themselves inherently *vulnerabilizing* and expressed through particular affects such as powerlessness.

The level of training and remuneration was also an important factor in the vulnerability of the intervenants I met. The professionalization of the intervenants through formal training and diplomas serves not only as a way to increase one’s income, but also as a way to gain the professional tools required to face the realities of one’s job in an empathetic but critical and professional way. The reality of the field of socio-medical intervention that I witnessed in Marseille was very often associated with financial precarity for many of the employees. Salaries are low, as is the case for many other professional fields in the city, making it difficult to recruit highly trained or experienced employees. Despite the competence and experience acquired in time through their work, these employees often felt unsupported by their organizations in developing their skills, and the administration struggled to hire new staff with comparable experience. “Working in these conditions is pretty much like going for slaughter,” an employee once told me. A supervisor of one of the organizations also spoke clearly about this situation:

> How did we ever expect to put people with so little education, so little training… to be able to manage what is... not more complicated, but still very complicated, which is highly precarious... You need people with experience [...] and professionals. Otherwise, you get caught up in something. [...] And at the same time, it doesn't work all that badly, in some ways. But, indeed, people are... the employees are at least as damaged as the people living there. Don’t you see?

[66] “Dans ce contexte, les écarts entre la temporalité des personnes, celle des acteurs de première ligne et celle des institutions, se trouvent à la source de l’impuissance ressentie.” (Lévy-Vroelant, Joubert, and Reinprecht 2015, 200)

> It's... it's a bit of a paradox. We give precarious people, some of them, or at least damaged people, the task of managing precarious and damaged people [...] [And all this] for €1,200 per month. See what I mean? Here, €1,200 is a pittance. [67]

There was also a deep ambiguity about the roles of these intervenants - the perceived role, the required role and everything in-between. In one interview, an intervenant told me about his uneasiness regarding what could really be accomplished at La Maison Frédéric, an organization that is supposed to deal mainly with emergencies: "We don't have a duty to support them. It isn't our emergency mission. We need to welcome them, evaluate them, reorient them, but that's all... Can we give them a bit more support temporarily as a way to motivate them? Perhaps."[68]

The roles of each of the intervenants with partner organizations were also, at times, a source of tension. In difficult situations, issues of communication and coordination arose, and the relationships between partners were tested. It then became blurry whose responsibility it was, to take care of an usager in a given situation, and what to take care of precisely. A meeting I observed between a shelter team and a partner psychiatric clinical team offering specialized on-site consults every two-to-three weeks was particularly revealing. There had been confusion about the date of an appointment with one of the usagers, and about who was supposed to remind him of the appointment. The 20-minute discussion between the psychiatrist, the nurse and the coordinator was filled with tensions, frustrations, accusations, and defensiveness:

> Psychiatrist: "But it's your responsibility."
> Coordinator: "No, it isn't our responsibility to follow up with outsiders. He was supposed to have been seen today, by you."

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[67] "Comment est-ce qu'on espérait un moment en mettant des gens peu éduqués, peu formés, pouvoir gérer ce qui a… pas de plus compliqué, mais quand même de très compliqué, qui a une grande précarité. Il faut des gens aguerris […] et professionnels, sinon tu te fais embarquer dans un truc. [...] Et en même temps, ça marche pas si mal à certains endroits. Mais, effectivement, les gens sont… les salariés sont au moins aussi abimés que les hébergés. Tu vois? C'est… c'est un peu paradoxal, on donne à des personnes précaires, pour certaines d'entre elles, ou en tout cas, abimées, la gestion de personnes précaires et abimées [...]. [Et le tout] à 1200 euros par mois. Tu vois? 1 200 euros ici, c'est un salaire de misère."

[68] "Les accompagner, ce n'est pas notre fonction. Ce n'est pas notre mission d'urgence. Il faut les accueillir, les évaluer, les réorienter, mais c'est tout… Bon est-ce qu'on peut les accompagner comme levier? Peut-être."

Psychiatrist (in a very firm tone): "Oh no, I won't see him."[69]

By the end of the conversation, the tone had changed. "You know it's good to argue. It puts things in perspective", said the psychiatrist. Trying to reassure the nurse about the constant tension employees must feel here, the psychiatrist pointed outside of the window and said, "at the same time, look outside, the place in itself calls for this…," as if it was almost impossible in such a place to be in any mental disposition other than crisis, tension and confusion, and not to be caught in a web of vulnerability.

When the psychiatrist finally left the office, the nurse started to cry. "We're not credible. I've always been credible," she said. Talking with the intervenant, they both mentioned constant problems of communication, coordination, and organization. Visibly affected, the coordinator quickly tried to put the blame on "*le système*" and not on "*le personnel*," mentioning how "everyone is trying to pass the buck."[70] He then looks at me. He tells me how the week before, they had to call the police for a man who had physically threatened him and the nurse. "We cannot constantly exist in such a context of urgency. And we simply cannot talk with partner organizations like we just did. It's too tense." Referring to an assistant coordinator who had just been hired to work with him, and who was about to begin work, the coordinator said, "I've been exhausted for the past six months. This new assistant and I, we really need to be working together as a strong team, otherwise, there's no way I'll be able to stay." As it was the case so many times during my fieldwork, vulnerability expressed itself through bodies, at times tired and exhausted bodies, bodies under great pressure and facing frequent nonsense and violence. I will now explore these conditions and consequences on the body.

[69] Psychiatre: "Ah mais c'est votre responsabilité."
Coordonnateur: "Non, ce n'est pas notre responsabilité de faire le suivi des personnes extérieures. Il devait être vu aujourd'hui par vous."
Psychiatre (sur un ton très ferme): "Ah mais non, je ne le verrai pas."
[70] "tout le monde a envie de se lancer la balle"

VULNERABILITY-BEARING BODIES

The body as proof: categories and extensions

Categories of individuals were important during my fieldwork at La Maison Frédéric. There were categories of people, which were at the same time categories of bodies, that altered the types of services one would receive and with what moral vision. These different categories also became ways to manage and deal with the perceived non-sense that professionals often faced. Two such categories were particularly salient, with people being referred to directly as such: *les médicalisés* (the medicalized individuals), and *les Grands Marginaux* (*les GM)* (the highly marginalized individuals).

Les médicalisés represented a category of individuals with important medical conditions that were offered specialized services. The category of *les médicalisés* has been of great importance in terms of political recognition and financing in Marseille. A major research project on homelessness in Marseille, conducted by a well-respected university-based research group from Lyon in 2011, found that there were major obstacles related to access and continuity of health care for people living in situations of precarity and homelessness. One of the more significant obstacles they named was related to access to healthcare for homeless people with major health needs, and the associated coordination of health care providers. The offer and coordination of "medicalized spots" (*lits médicalisés*) that I saw in La Maison Frédéric were part of the official response to this need.

La Maison Frédéric kept a number of beds especially for these *médicalisés*. As previously discussed, their stay at the shelter comprised a series of 30-day renewable periods, pursuant to the evolution of their condition. Contrary to the "regular," non-medicalized *hébergés*, the renewal process for the *médicalisés* was dealt with directly by the intervenants of the shelter, instead of by the residents themselves. Every

few weeks, a clinical meeting took place, during which the professionals involved in health care decided who would be granted the status, who would be renewed with this medicalized status, and who would be returned to the simple status of "*hébergé."*

Les Grands marginaux, les GM, was the other specialized category of individuals at the shelter. It was comprised of a few individuals whose overall condition—physical, social and mental—granted them a special status that came with different types of services. The chronicity and severity of their conditions and the fragility of their bodies could earn them this status. In the opening vignette of the thesis, the man walking slowly with his walker, who was taken to the ground by a gust of wind, was a GM. Once a person was designated a GM, they were allowed to stay at La Maison Frédéric for a long time, for years at times, not needing to "officially" renew their stay. Procedures were undertaken in order to eventually find them a more appropriate place to live or discussions occurred regarding their clinical orientations, but these procedures unfolded over the long term. Most professionals saw these men as living in a chronic form of vulnerability. In fact, les GM were referred to as *les résidents* in the informal language of La Maison Frédéric, inhabiting the space, unlike les *hébergés*, referring to the hundreds of other men (and almost anonymous bodies) coming to get a place to sleep every day. Les GM, like selected *médicalisés*, were also allowed to stay on the premises of the shelter during the day and come in and out as they wanted, unlike the other *hébergés*, who were asked to leave every morning by 9:00 am and not return until 4:00 pm. The GM also ate earlier at the cafeteria, at a time reserved only for them.

Through the bodies of these individuals, both *les médicalisés* and les GM, a different status could be granted, a different form of assistance and care. Some of these men and some intervenants even described 'privileges' that your disabled and fragile body allowed you to have. An intervenant once told me during an evening round at the shelter that there should be two different entrance doors, one for

those “who are really in trouble” and one for the others. I asked him to explain to me who were those that could really benefit from this special entrance: “the sick ones, the elders and those who are really vulnerable”, he told me, stating that the vast majority of people at the shelter did not fit in that category.

Throughout the summer, there was one man whom I would usually find outside the gates at 7:30 pm, waiting. Starting at 8:00 pm, employees of the shelter could call le 115 to see if there were any remaining spots available in the system to offer to people on the phone waiting list or waiting at the gate. Waiting directly at the premises was not supposed to be tolerated since the implementation of the 115. Any would-be *hébergés* now needed to call ahead. But this man rarely, if ever, called the 115 himself. The intervenants most often adopted a moral position of exception and assistance to the man’s sickness and “vulnerability,” a state of exception they would adopt towards those in especially vulnerable situations. The man was a former elite athlete in his home country. He had fled to France because of sexual and physical violence he suffered after denouncing corruption within the sports federation of his home country. Most, if not all, of the intervenants, were clear regarding how an exception needed to be made to offer this man a spot. “You can’t turn this man away. He has mental health issues and he’s harmless. You can’t refuse him. And doesn’t even speak French.”

Various authors have written about ways the body can grant social advantages, whether it is health care, citizenship, or social protection. Marcel Mauss introduced the concept of techniques of the body (1934) from which Pierre Bourdieu developed his theory of habitus (1977). This relationship between biology and forms of citizenship is addressed in specific contexts by different writers. João Biehl wrote about “biomedical citizenship” (2004) and “patient citizenship” (2007) referring to the situation of AIDS in Brazil, while Adriana Petryna refers to “biological citizenship” (2002) and Nancy Scheper-Hughes mentions the concept of “medical citizenship” (2006). Vinh Kim Nguyen (2005) uses the term “therapeutic citizenship,” to refer to “claims made on global social order on the basis of a therapeutic

predicament" (126). Anthropologist Sandrine Musso (2016) explores the notion of *l'étranger malade* (the sick foreigner) referring to the social movement at the beginning of the 1990s in France to grant foreigners recently diagnosed and living with AIDS special medical treatment, and especially a right not to be expelled from the country. In her book exploring the world of immigration politics in France, Miriam Ticktin (2015) refers to the "morally legitimate suffering body" (3) as the basis of recognition by the state. She points out how the recognition of this suffering injured body is heavily influenced by various contexts (social, political, cultural, economic and historical). Things have to be shown and proven on the body, "[s]ick bodies are given recognition by the state over labouring bodies, but only as long as they remain sick; this gives immigrants rights, not as equal citizens, but only insofar as they are—and remain—disabled" (Ticktin 2015, 3).

In my fieldwork, official statuses were important for the classification of individuals, but the process of obtaining such a status sometimes seemed arbitrary and very subjective. So often during the summer, I received the same answer when I asked what these categories were, most especially with the GM. Similar to the notion of vulnerability I already presented in the literature review, whereby medical professionals may intuitively understand what vulnerability is without being able to pin it down precisely in words (Appleton 1999), everybody among the intervenants could point me to a man they considered to be a GM, but had a hard time explaining to me what made him a GM, or why certain individuals who had once been considered a GM, then had not had that status renewed. These existing categories were at times questioned and discussed in clinical meetings in an attempt to operationalize them.

The process for giving and re-evaluating the *statut médicalisé* was undergoing transformation during the summer of my fieldwork. Initially, it was based solely on *le bon vouloir* (the good will) of each and every individual doctor coming to practice at the clinic. It was up to the doctor to decide whether somebody

had to be medicalized. Then, a few weeks later, the head nurse decided she would oversee the attribution of the *statut médicalisé* instead. This was done in order to bring more coherence and uniformity into the process, and also to liberate the doctors from this responsibility so that they could see more patients. Then, after a few weeks, there was a move to make this decision a clinical team effort and to discuss the matter in meetings.

I once attended such a meeting between all the socio-medical intervenants of La Maison Frédéric to decide what objective criteria should be used to determine who gets assigned to the category of GM or *les médicalisés*, going through individual cases. At the end of the long meeting, when everyone appeared exhausted, I asked a few intervenants what their understanding of the criteria was, because my field notes appeared confused. They could not really tell me either. These excerpts from my field notes present this constant ambiguity and confusion during that one single meeting about what criteria to use:

> Just because someone is sick doesn't mean that they're medicalized. (All together, and loud) Ah but it's clear, they're all sick. // We really have to evaluate people, because until now we just medicalize sick people. // (Speaking about the young man with a broken pelvis) He's in emergency until July 25; we won't medicalize him, because he never comes in for treatment; yeah, we never see him...// The depressed patient, if he comes back to see us, we'll talk to him again about his status. Otherwise, we stop here. // (82-year-old man with behavioural problems): "Everybody's great friend" (everyone gives an exasperated sigh). // The only reason we're keeping him here is because he has no resources. The problem with taking responsibility for everyone is that we lose the essence of our work. Because we're putting ourselves in a situation where we're making up for what isn't being done outside. // The medicalized status is not permanent, it's a "T" moment // (urgent need to take a position about whether they have to hand over a patient with hepatitis C as medicalized) "Well, he loses his place in 2 days...we have to decide... OK, let's keep him." // (22-year-old man with severe wound) "OK, it's clear that with him, with a wound like that, there's no problem." // (Hesitation concerning a man who lied about whether or not he had money; some hesitate to re-medicalize him because he lies.) // Karine is crying as we talk about the man with prostate cancer who's going to die... // (A young man with kidney failure): "(sigh) Well okay, he's in kidney failure, but just a little bit, it's no big deal..." // (Another man, who has been in Europe for close to five years; he'll finally be able to ask for social welfare at the end of this five-year period, "another reason to keep him medicalized, if he wants to obtain his status." // (A man who told Fatiha that she's the one who needs a psychiatrist) "I'm sorry, but he's more of a GM than someone who is medicalized." // (A man who is described as manipulative) "Oh yeah, him. I think that one or two nights at the train station will do him some good... I really don't like him." // (A man with latent tuberculosis) "He's being kept medicalized to avoid a gap in his treatment because there's a risk of multi-resistance to the treatment." // (A

caregiver, proud that she's the one who has a special bond with this GM. She is the only one able to get him to take a shower.)[71]

Something was going around the table that day during that meeting, something circulating between all these intervenants. A sense of confusion, not knowing how to manage and react to the complexity of such difficult life situations. While trying to answer the initial question of the meeting that day (what criteria they should use to grant the status of GM or médicalisés?), their interactions revealed the circulating vulnerability that they are caught in, oscillating between subjectivity, objectivity, and contradictory affect.

These categories were more than simple administrative ways of dealing with the population. I often wondered if they were not a way to manage and organize difficulty to help the institution and the intervenants face the regular impossibility I have been describing so far—a way to deal with vulnerability. In The Republic of Therapy, Vinh Kim Nguyen (2010) discusses the practice of triage in the way antiretrovirals were distributed, attributed, and to whom, in the context of the AIDS epidemic in

[71] "C'est pas parce que quelqu'un est malade qu'ils sont tous médicalisés. (Tous en choeur et fort) Ah mais c'est clair, ils sont tous malades. // Là il faut vraiment évaluer les gens parce que là on fait juste médicaliser des gens malades. // (parlent du jeune avec une fracture du bassin) lui il est en urgence jusqu'au 25 juillet; on le passera pas médicalisé car il ne vient jamais chercher ses traitements; ouais on le voit jamais...// Patient déprimé, s'il revient nous voir, on reparlera de son statut. Sinon on arrête là. // (Homme de 82 ans avec des problèmes de comportement): " Notre grand ami à tous " (soupir exaspéré de tous) // si on le garde ici lui, c'est parce qu'il n'a aucune aucune ressource. Le problème si on prend la responsabilité de tous, c'est qu'on on perd l'essence de notre travail. Parce que là on se met en situation de palier à ce qui ne se fait pas à l'extérieur // Le statut médicalisé n'est pas permanent, c'est un moment T // (urgence de se positionner s'ils doivent remettre un patient avec hépatite C comme médicalisé) " bon, sa place finit dans 2 jours...il faut statuer… ok remettons le " // (Homme de 22 ans. avec plaie sévère) " Ok lui c'est clair avec une telle plaie, y'a pas de souci "; // (Hésitation sur un homme qui aurait menti sur s'il avait de de l'argent ou pas; certains hésitent à le remédicaliser à cause du mensonge) // Christine qui pleure pendant qu'on parle du Monsieur avec le cancer de la prostate qui va mourir... // (Un jeune en insuffisance rénale): "Soupir, ben ok, il est en insuffisance rénale, mais juste un peu, c'est pas grand chose..." // (Un autre homme. Presque 5 ans qu'il est Europe; pourra demander le RSA, "raison de plus de la garder médicalisé s'il veut obtenir son statut " // (Un Monsieur qui avait dit à Rachida que c'est elle qui avait besoin d'un psy) "Je m'excuse mais il est plus GM que médicalisé lui" // (Un homme décrit comme manipulateur) Ah oui, lui je pense qu'une ou deux nuits à la gare ça va lui faire du bien... Lui je l'aime vraiment pas. // Une homme avec une tuberculose latente) Lui on le garde médicalisé pour éviter une rupture de traitement car la multirésistance au traitement est possible. // (Une intervenante toute fière que c'est elle qui a un lien spécial avec ce GM, seulement elle qui réussit à l'ammener à la douche."

West Africa in the mid-1990s. He writes that triage "linked procedures for selecting people, the ways in which people seek to transform themselves, practices of 'telling' the truth about the self, and the paradoxical affirmation of citizenship" (Nguyen 2010, 109). He seeks to "explore and expose the obscene inequality and insidious logic" that underlies the notion of triage, a logic "valu[ing] lives differently" (4). In this situation, he presents the "forms of politics," in which "the only way to survive is by having a fatal illness" (6).

During my fieldwork, I witnessed the intervenants doing a form of triage, trying to apply the rules of selection of *les médicalisés* and les GM based on a seemingly arbitrary criterion of biological vulnerability. It would be fair to say that, with very few exceptions, all the men crossing the threshold of the shelter needed a form of assistance. The intervenants bore the burden of a saturated system of help with limited resources. A feeling of helplessness and being overwhelmed often emerged in the attempt to attribute these limited *places médicalisées*. I wondered if creating categories and criteria, in all their arbitrariness, was not an attempt to organize and give a certain sense to these impossible situations—a form of response to the intervenants' own vulnerability as much as the residents'. These intervenants were asked to perform triage in a system that was already saturated and punctuated throughout with nonsense. With more 'vulnerable' men than the shelter could reasonably admit, with few exceptions, it was unclear how the system of triage served the *hébergés.* It seemed clearer how it served the professionals, helping them to relieve somewhat the moral pressure they suffered as they managed an almost impossible task, one that they could never face without enduring personal moral consequences.

I often wondered in this situation: what happens when it's not enough to be sick? When categories are not enough anymore to face this constant ambiguity? When professional roles, identities, and definitions are not sufficient to face the struggles and the pain of others, the intervenants are then confronted with

their own limits and vulnerability. “We are healthcare providers, yet frankly, we are asked to be triage agents of a saturated system. It’s very difficult,” a nurse once told me. It is precisely this difficulty and vulnerability that I sensed throughout my fieldwork.

THE BODY AND ITS EXTENSIONS: AVEZ VOUS DES DROITS?

The bodies of the usagers we followed throughout the summer were far from being sharply delimited. Bodies were blurred within a social insurance system and a regulatory system that allowed—or did not allow—health care to be provided to these people. *Les droits* in France represent the social and medical coverage system to which citizens can have access. The people at La Maison Frédéric varied in their state of classification under these systems. *Les droits* became defining characteristics of the body, almost like extensions, that decided whether or not you could be medically attended to.

The French health and social systems are complex and multiple. During my first few weeks of fieldwork, I carried a piece of paper in my field notes with a list of acronyms and diagrams referring to this system. Social workers, nurses, doctors, and educators constantly used these acronyms with the different people we met, and I needed this paper to follow the discussion. So many letters, conditions, programs, requirements and exceptions made it difficult for me to fully understand how one could obtain health care in France. Many times, these acronyms seemed difficult to understand for the residents or usagers I met as well, and even for certain professionals I followed.

The French national social security system (*la Sécurité sociale* or *la Sécu*) was established in France in 1945. Health care coverage in France involves a combination of different financial sources, including

state funding through income taxes (*l'Assurance Maladie, la Sécu*) but also financing coming from employers and employees (*Complémentaires santé, les Mutuelles*) or private insurance. For people with low income, a number of different measures and programs have been established over the years. These are called la *Protection universelle maladie (la PUMA),* formerly l*a Couverture maladie universelle (la CMU), la CMU complémentaire (la CMUc), l'Aide au paiement d'une complémentaire santé (l'ACS)*, and *l'Aide médicale d'État (l'AME)*.[72]

For asylum-seekers and refugees, social security technically includes a form of housing, although the demand for places in the homes set aside for refugees can take months to obtain, and therefore many asylum-seekers and refugees turn to emergency shelters like La Maison Frédéric. A monthly monetary allocation is also offered, as well as medical coverage. From the time of the submission of their application at la *Préfecture*, until the reception of the final decision, asylum-seekers are covered by la PUMA (and la CMU-C if they ask for it). This is the regular legal procedure for asylum-seekers who follow the regular legal path.

[72] La PUMA allows any individuals working or residing in France for more than 3 months (under strict conditions) to have their health care needs covered through l'Assurance Maladie. La CMU-C allows certain individuals covered by la PUMA but with low income or no job to have a full coverage of their health needs.

L'AME (Aide médicale d'État) is a form of insurance allowing foreigners in irregular status in the country to benefit from medical coverage, since immigration irregularity excludes an individual from la PUMA. The person needs to have been present on French territory for a minimum of three months before applying to l'AME and it needs to be renewed yearly. Once obtained, the coverage is one thing, using it is another. In fact, the card you get allows you to have access to services, yet each time you show your AME card it is like showing you have an irregular and/or illegal status in the country. Often in my fieldwork, I heard individuals under l'AME not wanting to show the card, and therefore not being able to access health care, for this precise reason.

The process to obtain l'AME requires an application form and first and foremost a fixed address, une domiciliation. In France, la domiciliation is extremely important in terms of access to the majority of social and health services. Emergency health services that could threaten one's life is an exception to this rule; no matter what status you have in the country—regular or irregular—or whether you have a residence or not, emergency health services are covered. For other services, you need an address. In my fieldwork, in order to obtain services and coverage, the initial step for homeless individuals arriving at the shelter and planning to stay in France for a longer period was to set an address in a state centre offering la domiciliation (for example in a Centre communal d'action sociale (CCAS). Shelters like La Maison Frédéric do not offer domiciliation.

In practice, things were different in my field sites, most especially in the emergency shelter. A significant proportion of people coming to the shelter were either completely *sans-papier* (not yet having or not intending to ask for refugee status), or "Dublin." The Dublin status refers to the Dublin III Regulation of the European Union (EU) that states that the country of the EU, where somebody initially asks for refugee status, is responsible for the evaluation of this request. Only one EU state, therefore, becomes responsible for it. In practical terms, this means the following, as it was so often the case during my summer.

Suppose, for instance, a man coming from northern Africa is now in Marseille at la Maison Frédéric. Yet, Marseille is rarely the initial entry point to the EU. During my field word, most people who arrived in Marseille had initially arrived in the EU in Italy (after crossing the Mediterranean, like the man in our example), or in Greece or Bulgaria (by land or sea crossing). France carries a reputation for having lots of social services and health coverage and it was a destination often praised by many of the usagers I met. Once the man arrives in Italy, let's say, he asks for refugee status there. Perhaps he does so without even knowing that he has, since he signs documents and gives fingerprints often not knowing why, after being strongly (at times almost forcefully) advised to do so by authorities. In both conditions, Italy then becomes responsible for the evaluation of his refugee demand. Because France was the final destination he had in mind, he will stay a few weeks in Italy and then somehow make his way out of the country. Once he arrives in Marseille by land after weeks and months of train ride, hitchhiking and walking, the situation becomes more complicated. If he goes to the Prefecture and asks for official refugee status in France, the Dublin III agreements come into effect. France will see Italy as responsible for his demand. He will temporarily be offered la CMU for medical coverage until this evaluation procedure in Italy takes place, but he will also be given regular appointments at the Prefecture so to follow him until the French government receives an answer. Once Italy gives the answer, if positive, France issues an order for this

man to leave the French territory (*OQTF – Ordre de quitter le territoire français*). If he does not show up at a meeting at la Prefecture, or if he does not leave the French territory once ordered, his status becomes illegal, and the CMU coverage ceases as well as all other services.

Many of these individuals, therefore, decide not to ask for official status in France, as was the case for nearly the majority of men at La Maison Frédéric. In this situation, they can only ask for l'AME after three months of residing in France. In the meantime, many of them remain at the emergency shelter and are simply not covered for any medical services for the initial three months (except for emergency medical services). It was mostly these men that ended up in the nursing and medical offices at La Maison Frédéric.

Health coverage in France is complex and filled with acronyms and criteria. The notion of what to do when you fit nowhere was of great importance during my fieldwork. How do you obtain healthcare when you have been in France for less than 3 months, and you did not ask for official refugee status? What happens in terms of medical coverage when you initially asked for asylum in Italy and you are not planning to ask for any official status in France? What do you do when you are a French citizen who has been living in France, and therefore have been attributed a social and medical insurance number (la Sécu), but you lost all of your papers? The professionals and the residents or usagers alike found themselves caught in this in-betweenness at both field sites I spent time in.

At La Maison Frédéric, I witnessed an important renovation of the health and social structure during my fieldwork, under the leadership of a nurse who was hired to put in order the medical services. The question of who could access health care at La Maison Frédéric was often debated. Initially, at the beginning of the summer, La Maison Frédéric offered a form of medical attendance based on a first-

come-first-served principle, where a nurse (or an assistant nurse) would triage the men and decide if and when they should see the doctor. All residents had access to this system. Depending on the availability of the physicians (on average, there would be one or two clinicians during a given week), the patient could be seen either the following week or even during the same week or the same day, if needed. At times, if there was no real need to see the doctor, the demand could be taken care of by the nurse herself. The lines to see the nurse were often long, the demands endless and the working hours at times extended, according to the nurses and doctors I followed throughout the summer. On a given day, not everybody could be attended to and many people had to be turned away.

With the objective of changing the way things were done, a new form of triage was implemented over the summer. Only those without medical coverage from the state—*les droits*—would be attended to at La Maison Frédéric's medical clinic. Everyone with a form of medical coverage would have to go to into town to seek treatments and prescriptions in any other clinic. This was done to reserve time for those with no other alternatives for receiving health care.

The situation appeared logical, yet the Quartiers Nord (13e-14e-15e arrondissement) is an area referred to as a medical desert (Tanguy 2015), with an underrepresentation of both generalist and specialist physicians (Plan local de santé publique 2013).[73] People residing or sleeping at La Maison Frédéric could obviously go to other parts of town to seek a doctor, but the distance was often a limiting factor. The complexities of the refugee health insurance system caused stress for the shelter staff as well.

[73] "Selon les acteurs locaux des 13ème et 14ème arrondissements, l'accès aux consultations des médecins généralistes s'inscrit dans une triple contrainte. La combinaison : densité médicale moindre / recours au généraliste supérieur / allongement des consultations pour des raisons psycho sociales, met les médecins dans une situation de " flux tendu " permanent. Les consultations se font dans la plupart des cas sans rendez vous ; en théorie, elles présentent un intérêt certain pour les patients: leur accessibilité. Mais dans les faits, les cabinets sont " débordés ", les files d'attentes sont très longues, les médecins faisant face à de multiples problématiques (psychologiques, sociales…) avec des consultations plus longues" (Plan local de santé publique 2013, 7)

Sometimes nurses in private practice (*infirmières libérales*), but paid by the public system (*la Sécu*), were hired by La Maison Frédéric for particular kinds of supplementary nursing care (wound care, help with the shower), in order to relieve some of the burden on the staff nurses of La Maison Frédéric. In these situations, people without *droits* were not eligible, since they had no insurance coverage through *la Sécu*. This meant that the nurses of La Maison Frédéric needed to attend to these patients. The health staff of the shelter, therefore, had to spend a large proportion of their time with the most underserved population, increasing the difficulty of their work.

Over the course of the summer, I therefore witnessed changes in the introductory questions asked by health professionals in their consultations with patients, most especially regarding their *droits* in the country. After brief introductory comments or questions, the first "real" question was often related to their health insurance administrative status in France. One of the nurses was systematic; after a very brief introduction, "Hello, my name is X, I'm a nurse here,", the first question was: "Do you have health insurance?" ("*Avez vous des droits*"?)

Before attending to the body, before even getting into a form of triage based on need, there was first and foremost an administrative triage. Les droits and les papiers created an extended administrative body, attached to the physical body, that required its own kinds of attention, diagnosis and prescription. Medical staff had to attend to administrative status, diagnose whether the patient is admissible for care in this facility, and prescribe a course of action; either you stay here, or leave the premises to seek care. It was a form of administrative peri-care, which was certainly time-consuming. Nurses and physicians often spent a great amount of time figuring out and understating the type of coverage an individual had, at times through language barriers, in order to decide whether they could offer them a form of health care. Sometimes the patient's health demands were complex, yet other times the patient was just asking

for two Tylenol tablets. In these situations, being sick was not enough. The body was not enough. Both the resident and the professional needed to navigate a reality of negation; no health care because of your status, until proven otherwise.

The intervenants were therefore caught in "different logics of care," to borrow Miriam Ticktin's words (2016), with different expectations - both administrative and moral. The institution asked *les soignants* to attend to people based on specific criteria, while often *les soignants* were challenged in complying because they sensed that medical attention needed to be provided no matter what the administrative situation, and sometimes even where the diagnosis and treatment would take less time than figuring out the proper health coverage for the individual. Extending the body with *les droits* extended the frontiers of care and created zones of uncertainty about whose responsibility it was to attend to this body.

This uncertainty created zones of tension that put people in positions of vulnerability, both the patients and the intervenants. One afternoon, one of the doctors was seeing patients. The new rule regarding asking for *les droits* had recently been put in place. One of the patients was a man in his mid-fifties who had lost more than 10 kg in the past four months. He also had abdominal pain and significant changes in his stool habits. The condition required important medical attention, including a set of tests to exclude more serious pathologies like gastro-intestinal cancer. The head nurse then entered the office in the meantime and realized that this precise patient had *des droits*. As soon as the patient left the office, she turned to the doctor, visibly frustrated, "ok, this needs to stop. You will go in the waiting room and first ask if these people have *des droits*." The doctor, usually with a calm demeanour, responded in a frank, irritated way, "yeah sure, I could ask about their droits Emma, but nobody speaks French in the waiting room," to which the nurse angrily replied "yeah, it's difficult here," leaving the room swiftly.

Another day, the same nurse was doing the consultations. Mr. Najar, a man with incurable cancer presented in the first opening vignette of the thesis, came in again, asking when his appointment with the specialist would be. The man came to France from Algeria with a tourist visa, hoping he would get quicker access to medical care and be cured of his prostate cancer. Health care is not covered in France for people entering the country with tourist visas like his, including oncology and palliative care:

> "Sir, but you don't have *des droits*."
> "I know Madame, but I am very sick."
> "I know Sir, I understand, but we cannot do anything."

After that man left the office, the nurse looks at me. "This does not make any sense. The man looks at you, with the look of death in his eyes, asking for an appointment with a specialist. He's lost so much weight and now he has jaundice. Of course he is going to die soon. He does not belong here; he should be in a palliative care centre with his family, not here."[74]

It was the same nurse in both situations. A nurse who is appreciated by her colleagues and recognized as extremely competent and compassionate. A nurse stuck in a vulnerable in-betweenness; caught between the demands of a saturated institution trying to respond to the needs of the usagers and the demands of these same usagers; between her own vision and ethics of what care should be and what she actually can offer; between situations she saw as not making sense and the need to pursue her work; between roles that put her in fragile positions. In addicted.pregnant.poor, Kelly Ray Knight (2015) addresses the "ontological shift" that was asked of mothers navigating between their different roles. She says, "as addicted, pregnant women were displaced between these multiple locations, they experienced ontological shifts that shaped how they were visible as mothers and as addicts, as victims and as perpetrators in an interwoven system of care and coercion" (225). In my fieldwork, this in-betweenness

[74] "Tu vois, ça n'a pas de bon sens. Il te regarde avec ses yeux de mourant qui disent "Prenez moi un rendez-vous chez le spécialiste" Il a tellement maigri, il est ictérique. Il va mourir bientôt. Sa place est dans une unité de soins palliatifs avec sa famille, pas ici."

of roles (care provider, representative of a given social and political system) and their associated (im)possibilities appeared difficult to avoid, as if this constant "ontological shift" was part of the social fabric of life and work in these contexts.

Anthropologist Carolina Kobelinsky works on migration policies and asylum seekers at the frontiers of Europe. She followed immigration workers having to decide on the regulatory status of these individuals, as well as social workers. She mentions the moral dilemma many of these social workers face, torn between loyalty to their work and to their professional role, and loyalty to their moral principles. She says:

> The fragments of interviews presented above underscore the dilemma that most social workers face when they are carrying out a policy that they consider to be far removed from the basic principles of their work. It is a real dilemma, in the sense that they have to choose between two contradictory and equally unsatisfactory alternatives: "getting them out," which implies taking the role of agents in a logic that they disagree with, and refusing to do their job, and refusing to expel them, arguing, for example, that the rejected family in question has a baby, or that they cannot find a hotel for them. This would call into question their ability to do their work, and they would risk losing their job.[75] (Kobelinsky 2012b, 34)

These contradictions were even more powerful, given the very limited possibilities actually available to these individuals. "No matter what happens anyway, there's only expulsion on the horizon for them"[76] (Kobelinsky 2012b, 35).

At La Maison Frédéric, could it make sense to attend to every single individual asking for healthcare without regard to resources, time and priorities? Could it make sense to ignore situations of imminent

[75] "Les fragments d'entretiens présentés plus haut rendent compte du dilemme que constitue pour la plupart des travailleurs sociaux rencontrés le fait d'être vecteurs d'une politique qu'ils considèrent éloignée des principes de leur travail. Il s'agit d'un véritable dilemme dans le sens où ils doivent choisir entre les deux termes contradictoires et également insatisfaisants d'une alternative : les "faire sortir" implique de s'assumer comme un agent dans une logique qu'ils contestent ; se refuser à accomplir leur travail, c'est-à-dire refuser de les expulser, en arguant par exemple que la famille déboutée en question a un bébé ou qu'ils n'arrivent pas à leur trouver un hôtel, mettrait en cause leur aptitude à faire leur travail et ils risqueraient leur emploi." (Kobelinsky 2012b, 34)

[76] "Quoi qu'ils fassent, comme l'observait un intervenant, il n'y a que l'expulsion à l'horizon" (Kobelinsky 2012b, 35)

physical and mental deterioration without intervening? Could it make sense to ask vulnerable professionals to take care of highly vulnerable individuals? The answers were far from clear to me. Lévy-Vroelant, Joubert, and Reinprecht (2015) followed social and community workers at the heart of front-line interventions with so-called vulnerable populations. They saw many intervenants engaged in "almost impossible missions" given the scarce resources they often have available to them[77] (Lévy-Vroelant, Joubert, and Reinprecht 2015, 40), and many intervenants who "are forced to be pragmatic" (41) because of the constant interaction these intervenants have with the same factors of vulnerability that the usagers themselves face (42).

Throughout the summer, I witnessed this constant pragmatism that the intervenants had to use in order to navigate the various demands of their job - in part just to get the job done, and in part to reach for some sense of meaning in their actions and in their roles overall. It is, therefore, as if this vulnerability were a reality that served as a common background, and that transcended positions and roles, because of the nature of the work and the precise social structures in place to address vulnerability. It was a vulnerability that circulated among (every) body.

Nonsense and violence

Vignette: Blind at night

> The new air conditioning in the medical office was still not functioning. At least there was the old noisy one still to blow a tiny bit of fresh air, but mostly toward the other side of the consultation room. Today, Emma, the new supervisor, was filling in for the nurse who had to go to another clinic. For Emma, these days of clinical work were a way to keep a foot in the clinical world, away from the administrative tasks and pressures. She truly enjoyed these days, most especially when she was alone in another small shelter for women only, doing things by herself, with no phone

[77] "des intervenants engagés dans des missions parfois littéralement impossibles au regard des moyens alloués." (Lévy-Vroelant, Joubert, and Reinprecht 2015, 40)

ringing, nobody to constantly stop her or to ask her questions. It was just her and the patient, one-on-one.

With the new rule at La Maison Frédéric of only attending to those without any "droit", a major reason of nursing and medical consultation was now to obtain one of the "*lits médicalisés*" (medicalized beds) for particular medical care. For those in need of more structured health care, there were a few spots reserved at the shelter. Each and every man passing through the office seeking one of these spots would present their argument for why they needed such a place. Sometimes they would show lab results—recent ones, or at times an almost-torn-apart sheet of paper showing results of blood tests conducted in Algeria many years ago. Sometimes also, they would show a doctor's memo from a clinic in town stating how they would either benefit or absolutely need a *place médicalisée* for various reasons, ranging from fatigue to foot pain, to severe heart problems, to terminal cancer or fractured legs. Sometimes though, the motive was not clear. A lot of people tried and failed to obtain a spot.

It was just a brutal reality. Every man passing through the nurse's office thought he deserved a place, yet there were a limited number of places that could be attributed by the supervisor. The nurse would fill out the request and tell the resident to come back in a few days; she would transmit it to the supervisor for analysis. This new procedure had been decided by Emma a few weeks prior, in order to have a more unified and coherent message about who gets accepted or not and also to relieve the nurses and the assistant from having to take these decisions. Today, Emma, the nursing-trained supervisor, was filling in for the regular nurse, so the decision could be made right away.

The man entering the office now is a healthy-looking man in his mid-twenties. As he enters, he seems to be walking normally. He has no cast, no crutches. He does not carry any documents with him. He does not speak a word of French, only English. He is asking Emma for a *place médicalisée*. After a few back-and-forths and a few questions, Emma finally understands his story and the reason for his request. The man arrived from Nigeria. He suffers from a degenerative eye condition that leaves him almost blind at night. As soon as dusk falls, all he can see are blurry shapes and shadows. As his initial 30-day sheltering period is coming to an end today, he is asking Emma for a *place médicalisée* because he is afraid not to get an immediate renewal through the 115, which would mean having to spend a night (or two, or three) outside. Even if the summer nights are hot in Marseille in the month of July, he feels his eye condition would mark him as a moving target for aggression and robbery in the street, and especially around the train station at night, where a lot of people end up by default.

I was sitting right by Emma when she was telling him her decision that he could not get a place médicalisée. I could not see her face, but the man was facing me almost directly. The silence felt so long to me. The humming sound of the air conditioning filled the room. During these two seconds of silence, I saw the man's eyes changing rapidly, from a form of hope to one of self-resignation, I sensed. It is as if this silence followed by Emma's brief hesitation when addressing

his request, were in themselves a response. There were too many demands, not enough spots. His condition was certainly difficult and serious, yet other people who are sicker than he is needed these spots more than him.

“Where will I sleep then?” asked the man.
“…Well…I don’t know… at la Gare Saint-Charles… [the central train station]?” she replied.

It was difficult for me to look at the man’s eyes. I did not turn to see Emma’s, yet I could almost hear them cringe from inside. For a moment, I wondered if she could have given him a *place médicalisée*—made an exception, found another bed, taken one out of the storage. The man left, politely saying, “ok, thank you.”

Emma’s eyes seemed heavy when she looked at me. She did not say anything, nor did I ask anything. The man had not closed the door behind him, and already two other men were arguing loudly in front of the office about whose turn it was and who was there first.

The following day, I interviewed Emma. She herself brought up the topic of this man. I remember her furious eyes in that conversation, talking about an inhuman system that made no sense to her.

> Emma : “It was horrible yesterday, that guy getting turned away [...] It's so arbitrary, it's inhuman.”
>
> Researcher: “Inhuman? Why?”
>
> Emma : “Well, because it's hard, you know, to tell someone… For example, the young guy yesterday who can't see at night. You know, to kick him out, knowing full well that he’s going to sleep outside. There isn’t enough space. So you know… well, that's inhuman, because this guy… In fact, it’s the system that’s inhuman. I mean, everyone should have a bed to sleep in, you know.
> Afterwards, we have to do something about this... we must not be satisfied with this, it must not end this way. These accommodations must be, you know, a step in a process. People need to want to get out of here, because otherwise, it’s like you’ll find yourself, like in a hospital, with chronic cases who are institutionalized in the… You know, there, and here too, some people don’t have a problem with that, you know, but that’s what we need to try and avoid. It's hard, you know, to find a balance between not stressing people, in an inhumane way, calling... I ask them to call a service that can’t be reached, which will give them nine nights. It's outrageous. How do you want to be able to build yourself up somewhere, how do you want to work on this issue of vagrancy, you know, if the system itself generates vagrancy? And you realize that when you keep people for three months, well, it's not… It doesn't necessarily do them any favours. It's a bit complicated, you see. But these are questions with no holistic answers. There are

> piecemeal answers, involving teams and people, and that's it. And for that, we need to be together, we need to think, we need to be informed, trained, you see? That's it."[78]

Over the next few days, I walked around la Gare Saint-Charles a bit more than usual, looking for this man. Whether early in the morning, on my way to La Maison Frédéric, or in the evening on my way home, I never saw him.

NON-SENSE

I stopped counting the number of times the different professionals in both field sites said something about how certain things made no sense; a certain policy, a situation, or a consequence. My fieldwork revolved considerably around a world of perceived non-senses. In themselves, these non-senses were part of the reality of those professionals and employees. Yet in the critical eyes of some of these intervenants and in my own anthropological eyes, they were more than that. They were a reflection of how the social and medical protection system failed to secure the needs and safety of those with greater needs. To me, this pervasive experience of non-sense was a reaction to perceived unfair, unethical, and violent realities that different bodies were going through, both intervenants and usagers alike.

[78] Emma :"Hier c'était horrible de virer le mec […] Donc c'est arbitraire, c'est inhumain. [..]"
Chercheur: Inhumain, pourquoi?
Emma : "Bien parce que c'est difficile, tu vois, de dire à quelqu'un, par exemple, le jeune, hier, qui voit pas la nuit, tu vois, de le foutre dehors en sachant très bien que le mec il va dormir dehors. Il y a pas assez de place. Donc si tu veux, tu, eh bien ça c'est inhumain, parce que ce mec, en fait ce qui est inhumain c'est le système. C'est-à-dire que tous les gens ils devraient avoir un lit où dormir tu vois.
Après, il faut dynamiser cette... il faut pas s'en contenter, il faut pas que ce soit une fin. Il faut que ces dispositifs d'hébergement ils soient quand même, tu vois, une étape dans un processus quoi, il faut que les gens, ils aient envie d'en sortir parce que sinon tu te retrouves comme à l'hôpital avec des personnes chroniques qui sont institutionnalisées dans le tu vois, voilà et ici aussi y'en a qui se contentent de ça tu vois et ça il faut essayer d'éviter. C'est dur, tu vois, de trouver un juste milieu entre ne pas stresser de manière inhumaine les gens, appeler... moi je leur demande d'appeler un service qui est injoignable qui va leur donner neuf nuitées, c'est scandaleux. Comment tu veux te construire quelque part, comment tu veux travailler cette question de l'errance, tu vois, si le système en lui-même génère de l'errance? Et tu t'aperçois quand tu gardes les gens trois mois, bien c'est pas, ça leur rend pas forcément service. C'est compliqué un peu, voilà. Mais, c'est des questions où il n'y a pas de réponses globales, il y a des réponses individuelles avec des équipes et des gens, voilà. Et pour ça il faut qu'on soit ensemble, qu'on réfléchisse, qu'on soit nourri, formé, tu vois, voilà."

This field of 'non-sense' is not an absence of sense but the presence of injustice and inequalities that make themselves known through a particular affect. This affect emerges out of the experience of watching the system fail to deliver what appears to be morally obvious to everyone present. In the previous vignette, even though the person in one role (the supervisor/nurse) has the power to say 'yes' or 'no' to a request for a medicalized spot, and the person in the other position (the usager) must accept the decision - both of them are caught in this field where they are prevented from living out a reality together that matches the human empathy they share. By being caught in such a position, they are both exposed to and made dependent upon, this system that takes away their agency to do what they see is right.

These non-senses, through the complexity and impossibility they uncovered, therefore exposed and maintained a common vulnerability. It appears important at this point to return to the notion of vulnerability I wrote about earlier:

> Becquet (2012) is therefore critical of the notion of separation between the "us vs them" (Soulet 2008) when reflecting on vulnerability, especially when trying to differentiate the protected population from the excluded one ("la population protégée de celle des exclus") (Castel, 1995). She therefore calls for an analytical posture that focuses on the porosity of situations and how vulnerability circulates between them ("s'intéresser à la porosité des situations et à la circulation [de la vulnérabilité] entre elles"). (Becquet 2012, 53)

Therefore, when exploring vulnerability, the focus of analysis lies somewhere between the individual and the socio-political context, and in-between the human beings in relation with one another.

Vulnerability is, therefore, a multifaceted construct that exposes the commonality and relationality of life. It becomes a form of integration of the various social processes that take place in social relations. As I said earlier, "vulnerability can be situated in an in-betweenness, somewhere amongst poverty, exclusion, precarity, and risk."

Through this in-betweenness, vulnerability becomes a way to conceptualize the social relations happening in a world of inequalities in which poverty, exclusion, precarity and risk are part of the social fabric. The various perceived non-senses I witnessed and heard from the intervenants throughout the summer were mostly a deep reaction to their standing in this in-betweenness. It is a reaction somewhere between the rational and the emotional, showing the heaviness, the almost impossibility, of combining poverty, exclusion, needs, precarity, risk, social inequalities, and scarcity of resources with the morally obvious. The nurse thought and felt that the man who is left blind at night should not have slept at the train station but did not have any other real possibilities. It did not make sense.

VIOLENCE

The concept of violence in anthropology is large and multifaceted, and its presence could be felt throughout my fieldwork. Many authors have written on violence as a multifaceted concept (Bourdieu and Wacquant 2003; Farmer 2004; Feldman 1991; Ferguson 2009; Scheper-Hughes 1993; Scheper-Hughes and Bourgois 2004). Various forms of violence are, therefore, to be considered - as stated by anthropologist Alisse Waterston:

> [A]nthropologists and other social scientists have developed labels that differentiate forms of violence, categories that include the spectacular violence of war, genocide, and massacre; the structural violence of unequal social and economic relationships—the violence of racism, sexism, and class inequality; and interpersonal violence—all forms that are understood to be intertwined, interconnected phenomena. (Waterston 2013)

In Life and Words, Veena Das (2007) explores the concept of violence and its presence in the most "ordinary" events. She says about the violence imposed on bodies:

> It is not only violence experienced on one's body in these cases but also the sense that one's access to context is lost that constitutes a sense of being violated. The fragility of the social becomes embedded in a temporality of anticipation since one ceases to trust that context is in place. The affect produced on the registers of the virtual and the potential, of fear that is real but not necessarily actualized in events, comes to constitute the ecology of fear in everyday life.

> Potentiality here does not have the sense of something that is waiting at the door of reality to make an appearance as it were, but rather as that which is already present. (Das 2007, 9)

Violence in its physical and psychological forms were part of the everyday fabric of life for professionals in both field sites, no matter how they tried to avoid or alter it, no matter what strict policies were in place. I witnessed a lot of these events and heard reports about others. I heard verbal intimidation between residents and towards employees, I heard of people carrying knives around the shelter, I saw a resident entering the medical office, angrily looking for a nurse he was unsatisfied with and said "where is she, I'll smash her face." There was also often tension in the waiting room, requiring the intervention of the surveillants. There were people destroying walls and water pipes at l'Oasis when in crisis. Staff were afraid of being fully exposed to possible aggression in the street when trying to approach a man who was visibly in crisis. An accueillant once told me a story about a man who had been expelled from La Maison Frédéric a few years before. Frequently, he would wait outside the gate, just around the street corner, and threaten the more elderly residents with an axe, trying to get the money from their pensions, "you see, these little 8-euro axes?" he told me, showing me the small size of it with his hands. The police would come to arrest him, but then they always ended up dropping him off again a few blocks down the street, so the man kept coming back to that same street corner. The police apparently just stopped coming to investigate anymore after a few weeks. "Here, violence hits everybody," I was once told by a social worker at La Maison Frédéric.

The violence was more than physical and psychological in my fieldwork; it was also systemic and relational. In the recent vignette, I remember distinctly not wanting or being unable to speak at the end of the encounter with the man with the degenerative eye condition. It appeared as if neither the man nor the nurse could speak at the end of the encounter, and so did I. I felt silenced and paralyzed, and yet something felt so ordinary. Something felt violent, but not only for this man who was denied the spot he

was asking for. I wondered a lot about the nurse too, how this situation made no sense to her, how she described being asked to serve as a intermediary agent (*couroi intermédiaire*) of a system she sees as inhuman. Or perhaps, should we say, as violent? And in a way, she was also hit by common violence- like this man - and they both remained silent, with very few alternatives to silence, if any. Veena Das' words (2007) are useful in this situation. She says, referring to violence:

> […]A possible vicissitude of such fatal moments is that one could become voiceless—not in the sense that one does not have words—but that these words become frozen, numb, without life. Thus there were men and women who spoke, and if asked, they told stories about the violence they had seen or endured on their bodies. My thought was that perhaps they had speech but not voice. Sometimes these were words imbued with a spectral quality, or they might have been uttered by a person with whom I was in a face-to-face encounter, and yet I felt they were animated by some other voice. Contrarily, I describe those who chose to be mute, who withdrew their voice to protect it. (Das 2007, 8)

This diffusion and commonality of the violence made me reflect on who is vulnerable in these situations, and when? Lévy-Vroelant, Joubert, and Reinprecht (2015) argue that existing within contexts of vulnerability means existing in a world full of contradictions - both for the individuals and for the professionals. Many of these perceived contradictions and this non-sense appeared throughout the summer. One such contradiction had to do with the neoliberal discourse of individual responsibility and the disengagement of public powers (Lévy-Vroelant, Joubert, and Reinprecht 2015). Other forms were related to administrative rules that seemed to the professionals to contradict one another, causing the professionals significant emotional distress. They usually endured this stress for a time in silence, at first. The level of professionalization and training among the different employees varied considerably. Because of their professional training, some described feeling a bit more prepared and equipped to deal with such difficult situations but were nonetheless affected by the constant complexity and the chronicity of it. On the other end, some were easily caught in deeply affective reactions when facing such dilemmas. No matter the level of training, though, there were always situations that confronted these

professionals with violence, at times overwhelming, and made them vulnerable to situations that outstripped their capacities to cope.

AN ONTOLOGY OF IN-BETWEENNESS

This common vulnerability is central to this thesis and reveals various aspects that need to be considered concurrently. During their everyday tasks, when confronted with constant emergencies, periods of waiting, impossibility, violence, non-sense and inaction, it appeared difficult for the intervenants to pause and reflect on what was really happening to the usagers and to themselves (and their body) in this life context. The socio-economic and political aspects of their situation - while often eluded to - constituted a fundamental aspect of it. Yet, it was as if the political decisions of the last few years - in the way irregular immigration and homelessness were handled in France - did not register in how the intervenants individually felt. It is as if the delivery of socio-medical care in this country - which largely determines who can access it or not (and for what reason) - was not in itself a political act.

Consequently, self-blame was often the initial reaction of many intervenants when trying to understand why things were not working the way they wanted them to work, or why they felt so exhausted and powerless. Yet, during interviews with these same professionals, when we paused for a moment, the systemic aspect was more often mentioned. One of the intervenants once told me, regarding the refusal of some usagers to accept services:

> You see, with a refusal, well, you can choose to refuse. We see a lot more refusals from marginalized people. First of all, because of priorities. A lot of them are in survival mode. Then, they are dependent on the structures for everything. Different structures, each one with different rules. But all these structures are overwhelmed so we end up with mechanisms implemented to exclude and refuse you. That's what the 115 is; it excludes and keeps the desperates away from your gate. You have to call; you have to wait 45 minutes to an hour. But it isn't just to get some candy; it's to get a roof over your head. [...] By not questioning the word 'refusal,' we aren't asking ourselves any questions, and therefore about yourself, your practice

> and society. Here we're talking about overworked caregivers who are at the end of their ropes. It's less work to say that the patient has refused. And the guys… in order to deal with a system like that, well, they have to drink. [...] so with the word 'refusal,' you also have to talk about the person, but also about an exclusionary society and an exclusionary health care system. [79]

In fact, this reflection on individual refusal - as hiding a larger systemic exclusion within a reality of shared difficulties between the intervenants and the usagers in relation to one another - was revealing.

This difficulty—and at times inability—of the intervenants to see the broader socio-political dimensions/contexts of their work is a result of a neoliberal ontological position in which the characteristics of life and self are framed as/rooted in the individual. Indeed, deeper than politics or society per se, this individualistic ontology of the self is specifically tied to and reinforces certain approaches and reactions people have towards this same politics and society. Similar to the above discussion on refusal, we not only endure the consequences of this individual neoliberal discourse, but our interpretations of these consequences are also affected by it.

I am instead arguing in this thesis for a different ontology of the self—a relational ontology—in which everything happens in-between; in-between individuals (whether intervenants or usagers) in relation to one another, and in-between individuals in constant relationship with socio-political characteristics, decisions and history. This fieldwork revealed that we are all always suspended in complex webs of

[79] "Tu vois, avec le refus, ben on peut choisir le refus. On voit beaucoup plus de refus chez les personnes marginalisées. D'abord pour une question de priorités. Beaucoup sont en logique de survie. Ensuite, ils dépendent des structures pour tout faire. Des structures différentes qui ont tous des réglèments différents. Mais toutes ces structures sont débordées. Donc on finit par mettre en place des dispositifs pour t'exclure et te refuser. Le 115 c'est ça; exclure et empêcher d'avoir la misère devant ta grille. Il faut que tu appelles, que tu attendes 45 min, 1heure. Mais ce n'est pas pour obtenir un bonbon à la menthe, c'est pour obtenir un toit. [...] En ne questionnant pas le mot refus, on ne se remet pas en cause, et donc de te poser des questions sur toi, ta pratique, la société. Tu fais face à des soignants débordés, à bout de souffle. C'est moins de travail de dire que le patient refuse. Et les mecs, pour affronter un système comme ça, ben ils doivent picoler. [...] Donc avec le mot refus, il faut aussi faire face à la personne mais aussi à une société excluante et un système de santé excluant."

relationships comprising our individual characteristics and the total characteristics of the system. As I have already presented, vulnerability is fundamentally relational. It is not an individual's fault, nor is it an individual characteristic; it circulates in a system of vulnerability. This relational ontology makes it impossible to dissociate this vulnerability from the actors it involves and from the system they exist within. Vulnerability, therefore, exists in relationships and cannot be looked at individually. These relationships exist in constant in-betweenness. For Butler (2004), this common vulnerability "is always articulated differently [and] cannot be properly thought of outside a differentiated field of power and, specifically, the differential operation of norms of recognition" (44).

Something deeper about life also resonates within vulnerability. So often in my fieldwork, I caught myself wondering was what really happening there, what was at play, and what it was revealing of life itself, in general, but most particularly for those living on the margins. In Precarious Life (2004), Judith Butler looks at vulnerability in a more commonunal and broader sense, as a "fundamental openness toward the world and others," a vulnerability that is recognized as an inherent "part of bodily life itself" (29). For her, this vulnerability associated with life cannot be denied, and it needs to be attended to. In fact, she says, "We cannot, however, will away this vulnerability. We must attend to it, even abide by it, as we begin to think about what politics might be implied by staying with the thought of corporeal vulnerability itself, a situation in which we can be vanquished or lose others" (Butler 2004, 29). Similarly, Käll (2016) wrote about the commonality of the experience of vulnerability between individuals and their bodies. In fact, she takes "bodies in [a] doubleness as both bounded from and bound to each other as its focus," insisting on "this double boundedness as the locus of a fundamental vulnerability intrinsic to embodiment" (Kall 2016, 1). Becquet (2012) refers to the fragile in-betweenness of vulnerability regarding human existence. She says:

> This broader use refers, on the one hand, to the very nature of human existence - vulnerability as an underlying dimension of individuals' subjectivity - and, on the other hand, it refers to a

> structural and structuring dimension of modern societies - vulnerability as a 'pathology of a global world in crisis.' This makes the line between integration and exclusion less clear-cut, and transforms the area between into a shared area, defining a "universe of vulnerability."[80] (Roy, 2008 as cited in Becquet 2012, 53)

It, therefore, appears that life itself carries an inevitable vulnerability, yet it is one that does not stand alone.

Claiming that "something deeper" (or inherent) exists regarding the vulnerability of human life does not serve as an alternative to looking at the political and social components of vulnerability. The intrinsic vulnerability of life itself is an important aspect of the socio-medical consults I attended during my fieldwork - for both nurses and patients. Nonetheless, this 'something deeper' is not a replacement analysis standing in for an analysis of the socio-political nature of the problem in the vignette involving the man who was almost blind at night. This 'something deeper' about life itself can at times resonate so strongly that it can become difficult to see the socio-political nature of the problem. Similarly, asking what allows vulnerability to circulate so freely between the intervenants and the usagers goes beyond the erosion of a social system that is supposed to take care of the vulnerability of others. Simply blaming the state is not the answer to why these systemic aspects are often occulted in the everyday reflections of the intervenants. One needs to critique not only the state but also the neoliberal state-endorsed ontology of the self that makes these socio-political webs persistently difficult for the intervenants to see. The ontological argument needs to deepen the socio-political one, not serve as an alternative.

[80] "Cet usage élargi fait référence, d'un côté, à la nature même de l'existence humaine – la vulnérabilité serait une dimension constitutive de la subjectivité des individus –, et, de l'autre, à une dimension structurelle et structurante des sociétés contemporaines – la vulnérabilité serait une " pathologie d'un monde global en crise " (Thomas, 2010). La frontière entre intégration et exclusion serait ainsi moins prégnante, transformant la zone intermédiaire en zone commune et définissant un " univers de vulnérabilité." (Roy, 2008 as cited in Becquet 2012, 53)

CONCLUSION: WHAT IS REALLY HAPPENING HERE?

Many times during the writing of this thesis, I returned to the final paragraph of the opening vignette, the one with the man who was taken down by the wind:

> The wind keeps blowing hard as I sit back at the picnic table. It will be like this for the rest of the day and the next few days. I get my field notes and I start writing. I wonder, where do this man, the other residents, and the nurse actually belong? What is actually happening here?

This last question has accompanied me throughout my fieldwork and the writing process. What is really happening here? What was it that I saw and felt in so many of these socio-medical encounters between homeless men and women and the professionals? What was it that throughout time appeared central in the experience of so many of these people? It was vulnerability as a form of existence that questions the real possibilities of life in these contexts.

In addicted.pregnant.poor, Kelly Ray Knight (2015) beckons us to think about the pregnant women she followed, asking, "what forms of life are possible here? And for whom?" (2015, 6). In *La vie moindre,* Dahlia Namian (2012) explores homelessness in a shelter and calls such places "terminal zones" *("des lieux terminaux").* The possibilities for life in a zone like this are close to nil. The possibility for life she sees there, she calls la *vie moindre* (the lesser life)—the space between nothing and almost nothing. Yet this space, she implores us to see, is still space. "This 'moindre,' this 'less,' is not to be understood as nothing, emptiness, non-existence - for however small the action, the action is still possible […]"[81] (Namian 2012, 180). In between nothing and almost nothing, there's an entire world, she says.

[81] "[C]e moindre ne doit pas s'entendre comme le rien, le vide, l'inexistence, dans la mesure où, aussi infime que soit l'action, elle est toujours possible […] (Namian 2012, 180)

Through all of my fieldwork, my eyes begged me to think about the real forms of possible life there, to see how little space for life is left in these places, and also all of the life that is nevertheless lived in-between the myriad of personal, professional, social, and political constraints.

Among these various constraints, I came to reflect on resistance. How could one resist these constraints that make life almost impossible? How could one bypass certain rules or limitations that reinforce this common vulnerability? What were the ways in which people tried actively to make sense of the constant perceived non-senses? And what did it mean to defy a certain policy at one moment, and then comply with it at another? These questions are a limitation of this thesis. As I write above, I did observe certain forms of resistance during my fieldwork (mostly from professionals) but given the short duration of my study, and the fact that I interacted with the *intervenants* and the *usagers* almost entirely in a professional setting, I wonder what other forms of defiance I might have witnessed if, say, I had spent more time in Marseille or had more interactions outside of La Maison Frédéric and l'Oasis. Sherry Ortner (1995) says of resistance that

> one can only appreciate the ways in which resistance can be more than opposition, can be truly creative and transformative, if one appreciates the multiplicity of projects in which social beings are always engaged, and the multiplicity of ways in which those projects feed on [as] well as collide with one another. (Ortner 1995, 191)

The different projects that are necessary in order to live, work, survive, and resist in my fieldwork — projects that exist in relation to one another — are indeed multiple.

Life happens in a constant in-betweenness in my fieldwork, in a constant vulnerability. In between the trauma, the emergencies, the waiting and the difficulty of becoming something different, vulnerability revealed itself and affected everybody. In-between the different professional responsibilities, in-between socio-political structures, in-between the administrative statuses, and mostly in-between individual bodies in relationships—no matter what roles they were in, vulnerability was a form of existence. Vulnerability was not just a neoliberal property of any one individual or their life

circumstances or their characteristics, neither was it an existential condition. Vulnerability also involves a body in relation to an environment of vulnerability. Butler (2014) says:

> I have suggested that we rethink the relationship between the human body and infrastructure so that we might call into question the body as discrete, singular and self-sufficient and I have proposed instead to understand embodiment as both performative and relational; relationality includes dependency on infrastructural conditions and legacies of discourse and institutional power that precede and condition our existence. (Butler 2014, 11)

This ethnography seeks to reveal vulnerability not as a category of individual vulnerable bodies and vulnerable populations existing in contexts of vulnerability, but as a relational ontological form of existence inherently shared by all of those living/working/intervening/existing in the margins of society, in the margins of life itself. This vulnerability certainly takes different forms and has different direct and indirect consequences, depending on which bodies it hits, and when, and how. But its commonality, its circulation, and its ordinariness and ever-present-ness persist through every change in intensity and direction. Inevitably, vulnerability is life in such contexts.

During one of the consultations with the nurse, a man was telling us his migration story, about leaving his native Guinea, hitchhiking and walking to Libya, crossing the Mediterranean, waiting a few months in Italy in a camp, and now being at La Maison Frédéric. His words still resonate through me, “I endured a lot, but now I have hope.” I often wondered, how can these professionals carry this hope, while acknowledging its fragility and almost impossibility, while the ordinariness of life in this place is, in itself, vulnerability?

Maybe such impossibilities can come to make sense. In the last paragraph of Life Beside Itself, Lisa Stevenson (2014) makes us consider how suicide can make sense. She says, “Recognizing that suicide is not always a failure of imagination does not lead us to nihilism or to stop caring for those who are suffering profoundly. It allows us to listen differently to the lives and imaginations of the people who

matter to us" (Stevenson 2014, 174). Maybe this implies we need to listen to and think differently about what it means to experience life.

What if we take seriously that vulnerability is in-between us all? And we take seriously that it is the life we are living in? Could these "politics of acknowledgment" (Giordano 2014) open a new way of caring for one another? What if everyone involved in this fieldwork could recognize that they were all embedded together in vulnerability? I came to wonder what the act of paying attention would do to each other, of listening to one another, as I tried to do in this ethnography? What new possibilities might open if we could see one another's humanities and (im)possibilities?

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