While Western mental health professionals are working to provide assistance to displaced populations around the world, it is important to take a step back and consider the unique contexts in which this work is done (Nicolas et al., 2015). The collaboration between mental health professionals, and the refugees frequently faces language barriers, thereby rendering communication difficult during consultations, and increasing the risk of misunderstanding, misdiagnosis and errors in treatment (Gard, 2015; Hecker et al., 2015; IASC, 2015; Karageorge et al., 2016; Maier, 2006; Maier et al., 2010; Maier & Straub, 2011; Rechtman, 2000; Wang, 2012, 2016). In clinical contexts, the use of everyday expressions and proverbs or metaphors to express distress may be misunderstood as “resistance” to direct communication, or even misinterpreted as psychotic symptoms (Hassan et al., 2015). This is especially true in the context of trauma. Often, there are simply no words to describe the horror. For those affected by this trauma, “their problem is not the limits of memory but of language—the inadequacy of ordinary words to express all they have witnessed” (Kirmayer, 1996).

Trauma begets trauma. Exposure to trauma, itself connected to a breakdown in social connection, risks the individual being caught up in a vicious cycle where no addressee may be found, no language exists to form a coherent narrative whereby the event may itself be collectively represented and made sense of. Indeed, many authors highlight that trauma remains simply inaccessible to verbal recollection (Brewin, 2001; Brewin et al., 1996; Brewin et al., 2009), paradoxically the very recollection itself necessary for healing. Returning to the specific context of migration in particular, itself characterized by a rupture in connection to “home” (and all the social, cultural and linguistic connections that this implies)—the physical, social and political isolation so typically experienced by displaced populations serves only to feed monstrous feelings of invisibility and disconnectedness (Bhimji, 2015). In such a state, there is no coherently constituted individual: no memory, no clear defining of the Self and of the world in the safe confines of time—only speaking in embodied signs. Disaffiliation, de-culturation and de-linking both in terms of family and social ties similarly affects the internal capacity to make links between different events and
moments in life. Without the container of home-as-it-was, there is little membrane to hold the symbolic (Goguikian Ratcliff, 2012).

According to Kirmayer (1996):

Traumatic experience is not a story but a cascade of experiences, eruptions, crevasses, a sliding of tectonic plates that undergird the self. These disruptions then give rise to an effort to interpret and so to smooth, stabilize and recalibrate. The effect of these processes is to create a specific narrative landscape. This landscape must fit with (and so is governed by) folk models of memory” (p. 14)

Narratives of trauma, then, may be understood then as cultural constructions of personal and historical memory: What is registered is highly selective and thoroughly transformed by interpretation and semantic encoding at the moment of experience (Kirmayer, 1996). Particularly in cases where trauma has been prolonged, “the survivor may be left with large chunks of endured experience with no meaning, creating disquieting gaps and discontinuities in the experience of one’s life history” (Sucharov et al., 2007).

For displaced populations—particularly asylum seekers and refugees who have arguably been exposed to a plethora of traumatic events both before, during and after migration – what is potentially lost is the ability to draw on meaningful socio-cultural symbolic resources to make sense of these events as well as the ear of a listening Other to whom and with whom the process of sense-making of traumatic experiences may be addressed. In order to illustrate the importance of social recognition as a “powerful element for healing in the aftermath of trauma,” Larrabee and colleagues (2003) refer to the works of Agger (1994) wherein she details her journey through the narratives of forty refugee women. In documenting the healing process among these woman, Agger writes: “in this space they begin to experience the necessary turning point between the wordless nothing dominated by chaotic anxiety and the wordless fellowship given form and expression in the symbol of the circle and its healing ritual” (p. 126). What is interesting to note in her words is the particular value given to “fellowship” as crucial to the healing process of giving “form and expression” to a coherent narrative of trauma.

Telling a story of trauma or reliving it necessarily occurs in a larger dialogical matrix of narrative and social praxis (Kirmayer, 1996). The communicative function of language as a tool, concrete semiotic and symbolic devices provide the connections to an Other and to one’s Self (Daiute & Lucić, 2010). As such, symbolic elements in socio-cultural practices are resources for repairing ruptures in intersubjectivity. Indeed, they are lenses through which experiences may be collectively and individually reflected upon. Within this paradigm, cultural representations are considered in their function not only as shared symbols but also as subjectively appropriated and emotionally invested representations (Sturm et al., 2010). It is therefore through language that one is able to constitute and actualize a coherent sense of Self. Furthermore, this can only take place in the context of ‘interlocution’ or ‘addres- sivity’—towards and with an Other; there is evidently a continual dialogue between the person’s inner world and the socio-cultural context in which internalized configurations or representations of traumatic events are processed (Lemma & Levy, 2004).
The critical issue here is that of the notion of reciprocity (Van Der Kolk, 2015) inherent to social recognition (Marková, 2016). For the transformation of traumatic memories into semiotic forms which connects it through language to its rightful place in time, the elaboration needs to be socially situated and intersubjectively acknowledged (Zittoun, 2014). This is because social resources provide a time orientation, and, consequently, a self-continuity between past and future (Kadianaki & Zittoun, 2014) necessary for the construction of a coherent narrative, and, ultimately, the Self.

The importance of culturally contextualised understanding of trauma when working with refugee populations in particular has been explored, among others, by cultural psychiatrists (Greene et al., 2017; Hassan et al., 2015; Kirmayer, 2001; Rousseau et al., 2014; Silove et al., 2017). In cultural psychiatry, cultural idioms of distress refer to common modes of expressing distress within a culture or community that may be used for a wide variety of problems, conditions, or concerns. Explanatory models refer to the ways that people explain and make sense of their symptoms or illness, in particular how they view causes, course and potential outcomes of their problem, including how their condition affects them and their social environment, and what they believe is appropriate treatment. These cultural psychologists therefore argue that what they refer to as culturally shaped or collective representations of trauma may provide a frame for the construction of narrations which informs the processing of traumatic experiences and the way in which the individual may be able to convey their distress in socially understandable and acceptable ways. This includes, for example, theories about the origins of pain and the possibilities of healing, conceptions of family and social bounds, religious or metaphysical conceptions of the world, ideologies, or positions in a field of political conflicts.

Various linguistically- and culturally-specific examples of different “idioms of distress” and “culture-bound syndromes” in response to trauma have been documented in the literature (Afana et al., 2010; Hinton & Lewis-Fernández, 2010; Jayawickreme et al., 2012; Lewis-Fernández & Kirmayer, 2019; Nicolas et al., 2015; Summerfield, 1996; Ventevogel et al., 2018). Ventevogel and colleagues (2018) for example, highlight the rise the rise of exorcistic healing in Burundi, whereby afflicted persons are assisted to enter into a peaceful and accepting relation with the possessing spirit. Cultural psychiatrists use these examples to show how such distinctive, historically-bound idioms illustrate communal reflections on the meaning behind experiences of violence, forced displacement, social exclusion, and humiliation. Behind all of the various idioms of distress found across the world, they argue, lie the social representations of trauma and ways in which it is defined and processed on a socio-cultural level:

The idioms we have described borrow from everyday language to make sense of the impact of violence in a situation of protracted conflict. They do not represent discrete syndromes or sharply delimited categories. Rather, they are familiar ways of speaking about traumatic events that invoke specific networks of meaning. They serve to communicate to others within the community about the dimensions of suffering through language that references collective experience and that conveys assumptions about the expected bounds of behaviour, the likely course of distress, and outcome of clinical or social intervention. Generally, these cultural idioms of trauma are not diagnostic entities that require treatment but a vocabulary through which distress is expressed and social support mobilized (Afana et al., 2010).
This literature has emphasized the diversity of experiences of interventions for traumatized members of displaced populations across the globe (Goguikian Ratcliff, 2010; Goguikian Ratcliff & Suardi, 2006; Harvey, 2007; Diallo et al., 2009). Droždek and Wilson (2007) offer examples: among Cambodian refugees who had suffered multiple life-threatening trauma during the Khmer Rouge regime, many who suffered from PTSD and depression understood their symptoms in light of their Buddhist beliefs in karma as a station in life, an incarnate level of being and fate where personal suffering is considered from a particular religious-cosmological perspective on the meaning of life. Among the Native American people, illness is thought to result from imbalance, loss of harmony and being dispirited with oneself due to a loss of vital connectedness. A common explanation for the 1988 Yunnan earthquake in China was that a “great dragon” was moving below the earth because he was angry with the people… these are all striking examples of how cultural variations in ways of life and social contexts shape experiences of trauma (Kirmayer & Ramstead, 2016).

In the specific context of migration in particular, itself characterized by disruptions in connection to “home” (and all the social, cultural and linguistic connections that this implies)—the physical, social and political isolation so typically experienced by asylum seekers upon arrival to host countries and often imposed by the state through legal requirements, serves only to feed monstrous feelings of invisibility and disconnectedness (Bhimji, 2015). In such a state, disaffiliation, de-culturalization and de-linking both in terms of family and social ties similarly affects the internal capacity to make links between different events and moments in life through the use of words. Without the container of home-as-it-was, with no interlocutor to whom to address the distress (Womersley & Kloetzer, 2018), there is little membrane to hold the symbolic (Goguikian Ratcliff, 2012). In this context, the role of cultural interpretation and mediation, defined as a “negotiation process” (Wang, 2016, p. 141), is necessary in the healing process.

As the number of refugee mental health programs has increased in recent years, so has the use of cultural mediators, without whom clinical services for refugees could not be provided (Miller et al., 2005). Here, the term “cultural mediator” is purposefully used instead of “interpreter” in order to reflect the dynamic and complex nature of their work which often extends far beyond that of simple translation; they are often the mediators between the world of the health professional and that of the refugee. Wang (2012, 2016) points out the complex “subjectivity” of the cultural mediator: “he or she has to be interested in both the content and the form of the discussion, and gives attention to interpersonal relationships” (Wang, 2016, p.141). As noted by Resera and colleagues (2015), this comes with challenges surrounding the need to be precise, emotionally detached, firm, to know how to behave in relation to a specific culture, and being neutral and impartial.

This is particularly true in the context of mental health were words are the tools of the professional. Indeed, the literature highlights mental health as being the most demanding context for cultural mediators compared to their work with other professionals. Here, cultural mediators have been shown to have to negotiate multiple positions including that of a cultural broker, community organizer and even a directly implicated co-therapist (Goguikian Ratcliff et al., 2017; Miller et al., 2005; Mitschke
et al., 2017; Pestre & Benslama, 2011; Resera et al., 2015; Wang, 2012, 2016). Miller and colleagues (2005) go even further in arguing that not only is mental health a unique context for cultural mediation among refugee populations, but that this is particularly true for victims of torture and other political refugees. They identify two factors: (1) the prevalence of exposure to extreme violence and deprivation and the subsequent development of severe and persistent psychological trauma and (2) the experience of multiple losses—of social networks, personal possessions, valued social roles, and environmental mastery. In these traumatic contexts in particular, the challenge of translation goes beyond a literal transcription from one language to another (Pestre & Benslama, 2011). As stated by Maqueda (2005):

> the presence of an interpreter enables to calm fantasies of infringement and involvement of one culture by another. The interpreter is a transitional space both to the migrant and the caregiver. He or she symbolizes the comparable and different to both of them. He or she occupies the position of cultural mediator clarifying the understatements, implicit information in any culture. He or she uses singular words, embodying the particular story of the individual in a background group. The interpreter symbolizes the possible development between both contexts: cultural but also temporal, between a before and an after. He or she represents the cultural weaving, thereby enabling to adapt oneself without quite being another (p. 3)

So how are the different representations and understandings of trauma managed in this space? How are they negotiated among the various actors (refugees, psychologists, cultural mediators) in the complex context of psychotherapy in humanitarian settings? To explore this question, I present the case study of cultural mediators working in a centre for refugee victims of torture in Athens, Greece.

**Case Study: Cultural Mediation Among Victims of Torture in Athens**

Since the height of the migration reception crisis that shook the continent in 2015–2016, Greece remains one of first sanctuary ports in Europe. In a country exposed to a serious financial crisis, fewer resources are available to ensure quality mental health services to refugees (Gkionakis, 2016). Several refugees who enter Greece through the Aegean Sea remain blocked on Greek islands, far from the adequate medical care they could receive in Athens. Others continue their way illegally through the Balkan route and find themselves trapped in limbo, unable to make their asylum application. The asylum system is often long and opaque, and the numerous obstacles to the access of basic services in Athens, and throughout the country add to the day-to-day difficulties (Kotsioni, 2016).

In order to explore this diversity of perspectives on trauma, I present the analyses of 12 months of fieldwork in an NGO-run centre for refugee victims of torture in Athens, Greece. Ten refugee victims of torture (9 men and 1 woman) treated in the clinic were identified by the medical staff to participate in this research. Participation was entirely voluntary. Exclusion criteria included psychosis, serious dissociative symptoms, and acute suicidality. The over-representation of male participants reflects to some extent
the demography of the beneficiaries of the centre, of whom 80% are men. I carried out five in-depth qualitative interviews with each of them throughout this one-year period. Interviews with refugees were focused on symptoms of PTSD, subjective experiences and explanatory models of trauma, and the integration process within Greece. Interviews were conducted in English or French without a translator.

To further a sociocultural understanding of trauma within this particular context, I conducted 36 interviews with health professionals working with refugees victims of torture in various humanitarian organizations across Athens, as well as with seven cultural mediators, speaking French, Arab and Farsi, and working with patients diagnosed with the PTSD. These seven cultural mediators were all full-time employees of the project who had been recruited on the basis of their language skills, and work experience with NGOs. They consisted of 3 French-speaking women, and 4 Arab/Farsi men respectively, aged 22 to 65. Like several other humanitarian actors, the centre officially uses the term “cultural mediator” instead of “translator”—in order to highlight the importance of their work as mediating between cultural norms—a job which goes far beyond a simple translation verbatim. The other two French-speaking mediators were retired Greeks locals, and the third was a young Congolese of 23 years living in Athens for three years on a student visa. One of the Arab mediators was an Egyptian migrant of 40 years living in Greece for four years, while the three others were themselves refugees recently arrived in the country. No mediator had a translation or cultural mediation certificate or diploma.

Qualitative in-depth interviews were also carried out with 21 community representatives and leaders of various refugee associations around Athens in order better to understand the perspectives, and explanatory models that exist in their respective communities at a sociocultural level. Furthermore, I engaged in three-months of participant observation, which included attending daily staff meetings as well as facilitating sessions and workshops with beneficiaries of the project.

In this case study, I particularly focus on the accounts of cultural mediators, by taking into account their work as revealing existing tensions between representations of trauma among health professionals and those of their patients. The analysis will focus on three themes: (1) the negotiation of the cultural mediators’ complex roles, (2) alliances with health professionals, and (3) working with “culturally inexperienced” health professionals.

Through analyzing cultural mediation in this context, I explore the role of culture in the care of refugees diagnosed as having mental disorders, and the implications of these diagnoses for treatment, issues that pose significant challenges to health professionals regarding the relationship between trauma, culture, and subjectivity (Rechtman, 2000).

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1We are using the term “cultural mediator” and “community interpreter” in order to respect the official title used in this project.
Cultural Mediators as Negotiating Different Interpretations of Trauma

Interviews with cultural mediators highlight three main themes: (a) the difficulty of positioning their translation between verbatim accuracy and interpretation; (b) the complexity of the alliance process between emotional proximity with refugees, and allegiance to a professional mental health approach; (c) the challenge of working with “culturally incompetent” health professionals.

Translation: Accuracy Versus Interpretation

In regards to experiences with the PTSD diagnosis in particular, none of the cultural mediators referred spontaneously to the diagnosis of trauma. At the request of the researcher, all seven expressed doubts in regard to (i) the exact meaning of the diagnosis, as well as (ii) the usefulness of this diagnosis to the refugee population. For instance, one cultural mediator explains:

KI28: they don’t have such stress because they were used to the joy of living. We can have it but they don’t. They knew how to hustle on a daily basis. These are habits and traditions. You cannot find this kind of depression there.

It should be noted that the individual life history of each cultural mediator has a substantial impact on their position. This particular cultural mediator is Greek—as alluded to in her distinction between “we” (culturally the same, we can experience with the PTSD), and “them” (others, culturally different, they cannot). The fact that no cultural mediator had previous training in the fields of medicine or psychology may explain, to an extent, their doubts regarding the use and exact meaning of the PTSD Many of them seem to prefer referring questions of PTSD to the medical doctor or psychologist, even during our interviews with them.

Several cultural mediators are confronted to the following dilemma: on the one hand, they are asked simply to provide a literal translation of what is said, and in the other hand, they have to play the role of a more implicated and nuanced mediator. As one participant states:

KI4: My role consist of just translating words or images, the message they want to transmit to the psychologist in regard to their trauma, uh, in the past. I try to do my best to use the interpretation and not words.

Despite his initial affirmation that his role is “just to translate words,” it is clear that he sees the need to broaden this function by offering something more complex than a simple translation (“interpretation and not only words”). This ambiguity is also reflected in the opinion of another cultural mediator:

KI39: You try to transmit the same messages as the psychologist [...] but at the same time, you also do the mediation of terms.
Most often, discussions in this area focus on accuracy (where cultural mediators who are considered to be the most professional are those who can translate the words with technical precision) versus mediation (where cultural mediators who are considered to be more professionals are those who manage better to grasp the cultural nuances). To be understood by both parties, the cultural mediator is supposed to adapt his position and translation to a situation with flexibility, and in a dynamic way. As one participant states, “we are facilitating an appointment, you switch your role in a continuous way to adapt yourself to millions of cultural barriers.” As another one underscored, “I cannot behave like a machine, a Google translation.” Indeed, a complex system of interpersonal dynamics seems to play out in the triad between psychologist, cultural mediator and refugee where the cultural mediators are tasked with taking on an active role—that of a co-therapist:

KI5: It’s not easy, translating for psychology because the person have many mental problems, many psychological problems. First, I want that he feels safe with me, the interpreter, not with the psychologist. Because he has to trust me. When I feel that he doesn’t trust me, I can’t work. I can’t make an appointment with the person. Because for me, especially if he shares, he wants to talk with the person, he’s not scared to talk. First of all, with this way I create the, the, trust between the interpreter and the patient to not feel uncomfortable.

This active role of co-therapist similarly involved an emotional investment in the well-being of the refugee beneficiaries:

KI26: I’m touched, I really like it because I think that I’m offering something to these people. I think I’m helping them in this way to externalize their feelings, to be able to express themselves, and mostly what they have in themselves And obviously, I’m touched, and I get attached. I don’t show it, but during the consultation I want to know what happened in their life, about their experiences

What is noteworthy in the above statement is the clear active voice, and use of the first person “I.” There is no mention of the role of the therapist themselves, it is the cultural mediator who sees herself as being the one to facilitate the psychotherapeutic process. Indeed, all of the cultural mediators interviewed referred to the idea that they felt closer to the refugee beneficiaries than the health professionals:

KI4: Always, the interpreter is the person who he is understanding more deeply the patient who has any kind of problem because the interpreter is the person that he is native of this language and maybe he’s more closer because he’s closest with, ah, things that happened to the country. Ah, but, ummm, I try even to explain even when we finish the session to explain why, why we say that, just to have message. Because the patient has in his mind always the message that ‘you don’t understand me, the doctor don’t understand what’s going on’

KI5: You have to see every person in the room, the psychologist, the interpreter and the person. Many times, the person will not see the psychologist, many times. Because they all see me, talk with me. Every time they say, ‘I don’t see, I want to see you, the interpreter.’ They never want to see the psychologist. You’ll ask something and he’ll say this one, « you understand what happened ». You see, you ask about something that happened, they say, « N [cultural mediator], N, I have this problem. »

KI39: I will see [the sessions in] exactly the same way as a psychologist.

For some cultural mediators, this active role was not of their own choosing but which they felt was imposed upon by refugee beneficiaries seeking assistance who
turned to the cultural mediators, rather than the health professionals, as their primary source of aid:

KI29: A lot of people from our country, when they come here, when I’m the cultural mediator, the interpreter, they think I am the best one who decide about everything. A lot of people, they are thinking, I am the first one, I am the manager, I am the psychologist, I am the doctor, and I am everyone here.

To defend against being placed in this often unwanted position of being an active co-therapist and, furthermore, even having to assume the role of “everyone here” with the responsibility for “everything,” many explained the need to clarify their roles and keep within the limits of their job descriptions:

KI29: We have to explain them, « this is not my decision to give you ». Because I am cultural mediator, [I cannot] give her money, pharmacy, medicine, accommodation, everything. We must be clear for the first time […] they are thinking that ‘R [himself, the cultural mediator] is here, and he will decide about everything.

KI39: The major thing for me is to keep neutrality. My primary role is just to facilitate appointments I’m not a psychologist. I am not a medical doctor or a physiotherapist to put things in my own way.

The strategy of maintaining neutrality and clarifying the limitations of their role implies deferring to the expert position of the health professional. Straddled between two worlds, that of the health professional and that of the refugee beneficiary, many drew on a “us” versus “them” discourse—whereby as cultural mediators, they were positioned as a member of the health professional team, in other words in alliance with the health professionals and not the refugee beneficiary.

**A Game of Alliances Between Refugees and Health Professionals**

Alliances done in the triadic interaction are complex. Cultural mediators are by definition in both “camps”—at times, they themselves are often from the same migrant population, as well as being members of the professional team. These alliances can influence the quality of the collaboration. As cultural mediators adapt intelligently to the context, the quality of their interventions are often most visible in field of mental health (Goguikian Ratcliff et al., 2017).

Working as an intermediary between health professionals (especially mental health professionals), refugees who may have never met a psychologist has its challenges. Sometimes, being identified as “agents of the medical system” (Leanza, 2011), cultural mediators are often employed to serve as “defenders” of mental health services, explaining for instance, the role of the psychologist, and the advantages that the refugee may have from psychotherapeutic sessions:

KI25: Furthermore, they explain to them that the work of the psychologist is to discuss with someone who is in danger. And someone who is going through tough moments, they advise
him of her to talk with the psychologist. When you talk to the psychologist, he or she listens to you, he or she liberates you, and you tell your story and what hurts you. When you are talking, it is just as if you are narrating a normal story. It won’t hurt you anymore. It is a story that won’t affect your health anymore.

One cultural mediator, for example, describes being proud of assisting the psychologist in convincing refugee beneficiaries to attend psychotherapeutic sessions. This was because, according to her,

KI26: With sessions, [...] the psychologist succeeds in achieving what she or he wants

Her words imply that the therapeutic sessions are what the psychologist wanted and is searching to obtain. It is their goal, not necessarily that of the refugee beneficiary. She further continued to give a specific case as an example:

KI28: We succeeded to convince her to see a psychologist. She didn’t want because she was ashamed. You can quite understand because the mentality is different. This is a lady who is not educated. She grew in a very strict and closed society. On one hand, her only worry was not to remain pregnant and to keep to herself. Finally, we succeeded because she started to see a psychologist in the evening, and she had a four-month baby with her. It was really successful [...]. When we convinced her to go and see a psychologist, it was really a party for us.

In this example, the words “it was really a party for us” allude to the fact that managing to convince a refugee to see the psychologist was a cause for celebration, a party for the whole team including the cultural mediator herself. As such, it is part of the role of the cultural mediators to convince the refugee population about the “truth” of western psychiatric knowledge and the benefits of seeing a psychologist, as similarly reflected in the words of one cultural mediator who gave another example of such a case:

KI4 I understand the guy, that he was not having knowledge before and when he get understanding and the peadopsychiatrist explained his problem or his story or his trauma with another way, of explaining, by drawing, by feelings, then he understand that, ‘yeah,this is the truth.’

There is an implicit acceptance of the “truth” in what says the psychologist, and through an explanatory process, the professionals manage to convince the refugee of this truth as well. It is also noteworthy that, despite the apparent alliance with health professionals regarding the “truth” of western psychiatric knowledge, the words below also underscore the complexity of the position: the sentence “I understand the guy” may indicate the fact that cultural mediators are seeing both the perspective of the refugee and that of the medical doctor. Such an understanding of these different perspectives is not without challenges, and is often a source of responsibility for cultural mediators who, according to Wang (2016), defines their work as a “negotiation process, eased by a third party not exercising the power of decision, whose purpose is to allow the parties concerned to solve a conflict situation or a relationship” (p. 141).
Working with Health Professionals Perceived as “Culturally Inexperienced”

In negotiating the variety of complex roles, including that of an active co-therapist in alliance with the health professionals, many cultural mediators also alluded to the challenges of working with health professionals who they perceived as lacking a certain cultural proficiency. This was a specific challenge manifesting within the therapeutic triad between refugee beneficiary, health professionals and the cultural mediators who found themselves between the two.

In some cases, the cultural mediators took on a more “experienced” role as a “cultural passeur” (Leanza, 2011) in relation to the health professional, who needed to be “taught” by the cultural mediator, in a manner of speaking, of the cultural norms relating to specific refugee populations:

KI4: For me, as an experience, the psychologist, okay especially the psychologist, I see that they have difficulties to, in communication between the patients. This is, I think, especially for somebody who doesn’t know about the cultural, where does this guy from, what his culture, how he think, how he look at you, how he look at things, of course this is not like as we look, as we think, so, I try to a little bit to give some tips to colleagues that you can use it or you can try some things that will, where he comes from, some words or some things, okay try, that helps the person to feel comfortable and that this guy, he knows about me and my culture and I can trust him, I can be comfortable.

KI23: For the psychologist this is a little bit hard, because this culture doesn’t understand psychology.

KI29: I saw in my experience life, many psychologists who are not experienced. And she says, she asks the patient, it was too directly, it was too directly. And he was afraid to say correct. But this is my job, this is my job like interpreter. I cannot say other words. For example, you are psychologist and you ask her if she had in her country sexual violence, yeah? You cannot ask her like directly. But you find a way.

As such, the cultural misunderstandings were perceived as emanating not only from the side of the refugee beneficiary, possibly unused to seeing a psychologist, but also from the health professionals, possibly unused to working with refugee populations:

KI39: Sometimes there are cultural barriers - not only from the client’s side but also from the professional side.

This discrepancy in cultural knowledge and savoir-faire seemed to inverse an expected hierarchy within the power dynamics. It is often the cultural mediators, not the health professionals, who position themselves in the role of the expert:

KI39: If a psychologist is trying to help them to understand their problems then […] some of them culturally is not appropriate to the patients and some of their suggestions. Even describing things in a particular way that is not appropriate. If I just come with this message exactly as it is to the patient then it harms the trust in the therapeutic relationship that wasn’t there with. It would decrease the efficiency and quality of the session.

Therefore, there appears to be a significant sense of responsibility felt by the cultural mediators to assume the role of “expert” in relation to cultural knowledge of
refugee populations. This lead them to assume an active role in facilitating sessions, in mediating between the health professional and the refugee beneficiary, when they felt it was necessary to do so. Thus, mediating between refugees and western medical professionals, psychologist and traumatized patient, it is clear that the role of cultural mediators extend far beyond that of a simple translation. It is a complex task requiring a myriad of subtle negotiations of power. A professional dilemma exists between the fact of wanting more responsibilities in sessions with professionals who are often culturally inexperienced, and on the contrary, refusing this responsibility which is not supposed to be theirs. This research work reveals the complex challenges and tensions surrounding the diagnosis and the implementation of mental health interventions.

Conclusion

Many refugees have lived through horrors beyond description, indeed beyond words in any language. In this context, humanitarian organisations are engaging in the important work of implementing mental health interventions for communities whose lives have been devastated by a multitude of traumas. Here, the role of cultural mediators is an essential one. Indeed, as stated by Summerfield (2006), the challenges they face are “not…of translation between languages but of translation between worlds” (p. 255). Within this context, they are active co-therapists, advocates of mental health and experts assisting health professionals to explore the culturally-informed psychic worlds of traumatized refugees.

What further characterizes the position of the cultural mediator is the emotional investment in the relationship on the part of refugees. Working in a neutral and impartial way in this context necessitates taking a detached professional and inter-professional position (in their work in and of itself as well as in the collaboration between health professionals and cultural mediators) which takes into account the substantial emotional impact of the work, rather than denying it. The construction of this position a significant, collective and ongoing task. To ignore these factors runs the risk of ignoring (or worse, denigrating) local support systems, pathologizing and stigmatizing individuals, and usurping resources from social and structural interventions (Nicolas et al., 2015). In the face of extreme adversity, people often turn to collective cultural systems of knowledge, values and coping strategies to make meaning in the face of adversity. In this context, providing culturally safe environments, including competent cultural mediators and culturally adapted tools for respectful dialogue and collaborative work, is essential to assist displaced populations in constructing meaning from suffering and finding adaptive strategies to cope with their situation (Hassan et al., 2015).
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