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Ethnopsychological Consultation: a Tool for Strengthening of Partnerships in Multicultural Social Work

Abstract

During international migration immigrants and refugees are exposed to difficulties that can lead to various psychosocial problems. In order to guarantee appropriate support, social workers are required to investigate and comprehend these clients' psychological and socio-anthropological background, especially when they are not socialized into Western culture. In multicultural social work, the international debate on how best to reach this objective has developed several theoretical perspectives. Against such a backdrop, this chapter investigates ethnopsychological consultation as a professional tool that can be used by social workers, educators and health care professionals.

A case study using participant observation in Italy serves as the basis for the discussion on how this technique puts the theoretical principles of multicultural social work into practice, highlighting how it helps professionals establish stronger partnerships with their clients.

Introduction: the multiple dimensions of immigration

People migrate for a myriad of reasons. "Refugees" are forced to flee from their countries of origin due to their fear of being persecuted for their race, religion, nationality, membership to a particular social group or their political affiliations. When these people arrive in a new country they are sometimes unable or unwilling (because of their fear) to avail themselves

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of the protective measures offered by the new country (UNHCR, 1951). “Migrants”, on the other hand:

> choose to move not because of a direct threat of persecution or death, but mainly to improve their lives by finding work, or in some cases for education, family reunion, or other reasons. Unlike refugees who cannot safely return home, migrants face no such impediment to return. If they choose to return home, they will continue to receive the protection of their government (Edwards, 2016).

Legal, psychological, and social implications make it problematic to merge these two groups – the refugees and the migrants – into a single category. However, regardless of the specific reasons motivating each person to move, both groups undergo some extent of trauma, which can be defined as “a deeply distressing or disturbing event or series of events [...] that influences the degree to which new arrivals are able to adjust and integrate into a new society” (Allweiss, Hilado, 2017: 88). Rose Perez-Foster (2005) emphasizes that:

> the risk of experiencing some kind of trauma can occur at multiple points along the journey. The initial events leading to migration (e.g., war or poverty), events that occur during migration (e.g., rape, theft, exploitation, or hunger), issues with obtaining legal status (such as asylum) and associated stress after entering a country, and the struggles of surviving as a new immigrant because of xenophobia, limited employment opportunities, and poor living conditions can all be experienced as traumatic events (Allweiss, Hilado, 2017: 88).

The consequences of traumatic events can lead to long-term health problems that have been well-documented (Cunningham, Cunningham, 1997; Piwowarczyk, 2007). More specifically, recent research shows that immigrants and refugees are more likely than the general population to experience poor mental health symptoms (Porter, Haslam, 2005).

In order to support the adjustment and the integration of these groups into a new society, it is important to take into account that the culture to which they have been socialized plays a fundamental role (George, 2012) both in the process by which the psychosocial difficulties are perceived and in the paths of access to social and mental health services. Hence, practitioners have to develop an integrative framework, which is able to comprehend the “needs of ethnically, culturally, religiously, and linguistically diverse individuals and communities” (Hilado, Lundy, 2017: 136).

After summarizing the main theoretical perspectives (the ecological systems perspective, the strengths perspective, the social justice perspective, the critical perspective, the intersectionality perspective) that characterize multicultural social work and the professional attitudes (cultural humility, critical counsciousness, collaborative accompaniment) that reinforce cultural competence, this chapter will investigate the methodology of ethnopsychological consultation (EC) as a solution that practitioners can use when addressing individuals who have experienced trauma. The aim is

to highlight how this methodology helps better understand the psychosocial difficulties of immigrants and refugees and enable practitioners to build stronger partnerships with them.

The first section of this chapter synthesizes the framework of multicultural social work practice, emphasizing both the main theoretical perspectives and prevailing professional attitudes. The second section describes the methodological foundations of EC. The third section covers the results of the participant observation of ethnopsychological consultations with immigrants and refugees in Italy. Particular attention is given to the processes that facilitate a more effective comprehension of clients and a stronger collaboration with them. The conclusion includes a summary of how EC accomplishes both theoretical principles and professional attitudes towards multicultural social work practices, providing operators with an additional tool to review their traditional methodological references while simultaneously enhancing their cultural skills.

The practice of multicultural social work

Multicultural social work practice is defined by Derald Sue, Mikal Rasheed, and Janice Rasheed (2016: 79):

> as both a helping role and a process that uses modalities and defines goals consistent with life experiences and cultural values of clients; recognized client identities as including individual, group, and universal dimensions of existence; advocates the use of universal and culture-specific strategies and roles in the healing process; and balances individualism and collectivism in the assessment, diagnosis, and treatment of – and problem solving with – clients and clients systems.

Multicultural social work is guided by different key-concepts, which refer to a wide range of theoretical perspectives: the ecological, the strengths, the social justice, the critical and the intersectional.

The ecological perspective focuses on the adaptive (or maladaptive) transactions that individuals and families have within the biological, psychological, social and cultural environment. Individual and family problems are not considered to be pathological, but as a response to a lack of resources or as a result of interrupted growth due to the lack of resources. Interventions work through the mutual support that can be developed within the natural systems (family, community, cultural networks) of the clients' ecological space (ibidem: 32).

The strengths perspective emphasizes the shift of focus from the pathology of the individuals seeking help to the way they use their resources and assets. Attention is given to the clients' basic dignity and resilience, thereby relativizing the negative stereotypes that label them as

weak, needy or incapable. Through the use of the strengths perspective, a more empowering counternarrative of cultural and personal aspects arises, as well as how people are able to make use of group competencies (ibidem: 35).

The social justice perspective is closely related to the ethical mandate of the social work profession, which requires practitioners to "meet basic human needs and other forms of social injustice - especially directed toward those who are vulnerable and oppressed" (ibidem: 35). This perspective is important, as it requires social workers to recognize and strive to end various forms of discrimination and social injustice often embedded in social interventions.

The critical perspective includes a wide array of theoretical concepts, which mostly refer to postmodern theory, social constructionism, narrative theory, critical social science, conflict theory, critical race theory, antiracist and anti-oppressive theory. Social constructionism shows how the meaning of social problems is a social construct, which has developed through processes profoundly influenced by dominant ideologies. These ideologies act as organizing principles for a particular social order (ibidem: 37). Thus, the clients' experiences, social relationships and problems are shaped by social, economic and political systems. The challenge is to dismantle the main power asymmetries, such as white supremacy, patriarchy and class elitism so that a dialogical relationship can be built where clients' specific psychological and sociocultural resources are understood.

The intersectionality perspective emphasizes the complex lived experiences of human beings (ibidem: 43). Individuals belong to many social worlds and affiliate with multiple groups of social reference (based on culture, ethnicity, gender, disability, sexual orientation, religion, etc.). Some group identities can lead to situations of oppression, marginalization, alienation, as well as privilege and power. Hence, carrying out their interventions, social workers have to recognize the fluidity of clients' social identities, taking into account both the weaknesses and their access to resources in their daily lives.

Beyond their specific objectives, every theory cited above maintains culture – that of the social worker, the client and the social setting in which EC is carried out – as one of the key variables in building an effective and comprehensive aide relationship. Developing *cultural competence* is, therefore, a central goal for any professional who works with diverse populations. The strategy used in reaching this aim has changed over the last few years. In fact, it is not a matter of merely accumulating information about the specificities of clients' societies, but of developing an open-minded attitude willing to constantly learn and review the practitioner's own conceptual systems of reference (Johnson, Munch, 2009).

Writing from this point of view, many authors emphasize the importance of three professional attitudes. The first is *cultural humility* (Horevitz et al., 2013), that Lundy and Hilado (2017: 495) define as:

> an approach to practice wherein the professional comes from a place of unknowing and curiosity about culture. There are no preconceived judgments but instead a collaborative process with the client (individual, family, community) as a teacher in understanding the meaning of culture in her/his life and how to integrate that into meaningful work that will bring a person to her/his full potential. Cultural humility does not mean there is no knowledge or understanding of culture. Instead, it is recognizing that culture manifests and influences in varied ways and learning those unique facets of a person at each encounter.

The second attitude, closely correlated with the first, is that of *critical consciousness*. This attitude can be defined as the capacity for deep self-reflection and in-depth understanding of the various obstacles that prevent the full understanding of clients' needs. These obstacles can be external (related to social values, stereotypes, asymmetries of power, violations of human and/or civil rights) or internal (based on personal beliefs, biases and attitudes, which are adopted during the communicative processes of daily life). As Marta Lundy and Aimee Hilado point out (2017: 503), critical consciousness requires not only becoming more aware of these obstacles but also accomplishing concrete actions that can change the clients' situations. "It will allow professionals to critically challenge power dynamics in the provider-user relationship" and "to look at ways of creating systematic change that can impact larger swaths of society" (ibidem: 503).

The theoretical guidelines and the professional attitudes described here translate then into the third attitude of *collaborative accompaniment*. Collaboration is one of the pillars of social work skills not only among practitioners themselves but in their relationships with clients. Their "accompaniment" can be defined as "a healing partnership that emerges through the mutual recognition of the inherent human dignity between a helping person and those who suffer" (Lundy, Hilado, 2017: 506). This attitude aims to "establish a purposeful, empathic, egalitarian, and respectful relationship" which aims to support the adjustment and adaptation of clients' in the host environment (ibidem: 506).

The ethnopsychological consultation (EC)

Against the backdrop of these theoretical perspectives and professional attitudes, the ethnopsychological consultation can be considered a methodological tool able to enrich the multicultural social work methodology for immigrants and refugees.

EC is a particular type of psychological consultation (Kirmayer et al., 2015) aiming to support the problem presented by a person of non-Western culture adopting a complementary method that requires reference to both psychoanalysis and socio-anthropology (Devereux, 1970); the former to understand the emotional processes of the individual and the latter to decode the symbolic and normative references that emerge from the discourse with the client (Moro et al., 2004: 14). Tobie Nathan (1986) translated this principle into innovative strategies of therapeutic intervention, deepening how cultural representations of sickness, which he named "traditional etiologies", were elaborated by people in their personal life, combining a plurality of social references on the basis of highly individualized logics. The aim was not only to help clients to explain suffering but to activate the construction of positive change, mobilizing social and symbolic resources linked to their cultural background (Sturm et al., 2011: 207). As the debate on participatory social work stresses, this approach provides an important basis for collaboration between clients and welfare organizations because practitioners are not seen as the only experts who are able to define goals and tools of the helping relationship. On the contrary, practitioners actively involve clients in co-defining the problem or the need, understanding the situation and deciding the plan of action to be taken (Levin, Weiss-Gal, 2009; Warren, 2007: 6).

This method follows different operating rules. As Moro and Real (Moro et al., 2004: 109) observe, the relationship with immigrants and refugees is sometimes ineffective when it is established according to the communicative rules typical of western institutions: a conversational exchange, where not only the methodology of conducting the interview, but also the setting (the desk separating the speakers, for example) or the clothing of the operators (for example, the uniforms in health institutions) emphasize even from a formal point-of-view the distance and asymmetry of the status role among those who seek assistance and those instead who have the competence and instruments to help. In many non-western societies, these relationships necessitate: the mediation of a third-party: a therapeutic group, the community, members of the family, the neighborhood. The presence of the third party is a guarantor of the relationship between patient and therapist: the latter is often, in fact, conceived of as a powerful figure; that can heal or manipulate others at will. Therefore, going to a consultation accompanied by a close relative is commonplace as the presence of a family member is reassuring. This methodological choice not only helps practitioners build a more egalitarian and reciprocal relationship, but promotes a more effective involvement of carers' network in the psychosocial interventions (Adams, 2008: 29).

Care given in a group setting is also consistent with many etiological theories of discomfort and sickness. In many cultures, the whole community is involved in the problem of the individual since it is presupposed that the

affected person is not the real target: it is held, in other terms, that the agent of the evil, sometimes conceived of as a metaphysical entity, can attack the weakest members under other aims. Collective research is considered necessary, therefore, in order to get a better sense of what is really happening to the individual. Moreover, it is important to keep in mind that the identity for many societies is inextricably linked to the group to which a person belongs. An individual's problem disrupts the entirety of the group, as it no longer can be thought of as a whole if a dysfunction befalls one of its members. An individual problem is, therefore, a collective problem and the involvement of primary networks is at the same time a prerequisite and an instrument of intervention.

Shifting the focus on professionals, EC is carried out by many co-therapists of different languages, cultures and education levels. The team may also include other figures with medical, socio-educational, and social welfare knowledge, such as social workers, who are available to put into practice a collaborative professional approach (Quinney, 2006). A common characteristic of the co-therapists is that all have studied socio-anthropology.

EC is conducted by the primary therapist: he or she has a psychoanalytical background and coordinates the interventions with the aim of enabling everyone to express themselves. The objective of the leader is to ensure that various contributions can help the individual to co-construct his or her own experiences. EC begins with every person speaking according to a predetermined order. After the introduction of all of the participants, space is given to the narration of the client. Subsequently, it is the group to be invited to propose its thoughts on the situation. Sometimes traditional etiologies are immediately advanced: "my daughter is haunted", "they cast a spell on me and I could not have children". The primary therapist tries to find out what the family thinks or what the family back in the country of origin would think of the disorder in question. This allows for the evaluation of existing family ties with the country of origin and the understanding of the symptoms as they are encoded and referenced within the original culture.

Another methodological junction concerns the therapist's attention to the etiological theories related to the context of origin. In line with ethnopsychiatry (Devereux, 1970), they assume the function of a "therapeutic lever": they facilitate the conversational exchange in order to help the people to reconstruct their stories and suffering, according to the symbolic references coherent to the cultural universe to which they belong (Moro et al., 2004: 60).

The relevance of the group dimension should finally be thematized, not only for the client but also for the team of therapists leading the consultation. Nathan cited the need to implement a reflection on the cultural counter-transference or the reactions that every therapist manifests towards cultural

differences (Devereux, 1970). The “otherness” of who comes from another culture can indeed lead to different processes – denial of differences, fascination of the exotic, etc. – induced by a variety of psychological or sociocultural factors (Giordano, 2011; Masocha, 2015). The plurality of viewpoints allows team members to reflect on their approach, so as to implement interventions better oriented to the specific circumstances of the client (Moro, 2008: 192).

EC in practice

Based on participant observation of the consultations performed by the Italian NGO, Metis Africa (2018), an organization active in the city of Verona, the main methodological features of EC will now be broadened in their application with the aim of highlighting how this tool contributes to building more effective partnerships with non-Western clients.

In understanding how EC works, it is important to first consider its setting. EC takes place at a location (for Metis Africa, this is their headquarters in Verona) that does not belong to the local public system of social and health services. This choice reflects the attempt to create a welcoming environment that, through its furniture and care for details, transmits an openness and demonstrates respect for different cultures; sessions are not held in public offices that often seem sterile and impersonal.

A second important element of EC concerns the rules for communication. As aforementioned, the consultation is carried out in a group setting. For a person socialized in Western culture, respect for privacy is key in building the relationship between the client and aide. Therefore, communication with the doctor or any other social or health care practitioners requires a dual exchange relationship. On the contrary, for a non-Western person often what facilitates intimacy is the presence of plural listeners, a wider listening group. This comes from the idea that the community is involved in the addressing and healing of various issues. So being alone while searching for assistance is uncomfortable, or even unacceptable, for some clients. Emblematic is the case of V., a refugee from Nigeria: before narrating her situation, she thanked all the people of the listening group for their availability to participate in the consultation because their presence made her feel “at home” as if she were “in a family”. As reported by the practitioners of the centre where she was being hosted, the presence of the group helped V. to share certain aspects of her story that she had never told before. The group allowed her to overcome her feelings of isolation, thereby permitting her to be more open to new, more effective opportunities for further psycho-relational support.

The third fundamental aspect of EC is the space it gives to the involvement of the group to which a particular client belongs (the family, the ethnic community, the primary networks…), during the communicative exchange. EC is conducted by the primary therapist: he or she has a psychoanalytical background and coordinates the interventions with the aim of enabling everyone to express him or herself. The objective of the primary therapist is to ensure that various attempts at aid can help the individual co-construct his or her own experiences. EC begins with each person speaking according to a predetermined order. After the introduction of all of the participants, space is given to client's narrative. Subsequently, his or her primary group (the family, neighbours, etc.) is invited to give their thoughts on the situation. At this point, the co-therapists can also contribute to the conversation. Hence, during EC, practitioners aim to create a collaborative process in which the client is seen as the true expert of his or her own problem and the entire group has the function of supporting the construction of a complete narrative. Particularly valuable moments occur when the group does not fully understand the significance of the consultant's story. Sometimes this is due to a linguistic problem; sometimes it is because it is difficult to understand the symbolic meaning of the words used; while in other cases, the general sense of the story itself may be unclear. In these situations, a creative process arises through which the group discusses and collaborates with the client to effectively reach a shared view of the problem.

An example of this can be found in the consultation with J., a refugee from Nigeria, who was hosted in a centre for refugees, including other individuals from sub-Saharan Africa. J. is an albino and left his country because he was afraid that he would be used as a human sacrifice, which is not an uncommon end for albinos in that area. At the centre J. displayed an understandable spectrum of emotions: sometimes he cried; sometimes he was very aggressive and sometimes he couldn't control his reactions to various stimuli. During the consultation, J. described a dream in which he was bitten by a dog. Initially, the primary therapist hypothesized that the dog symbolized the most instinctive and aggressive part of J.'s own identity, which suddenly reared up, overwhelming him and hurting him. Other co-therapists, however, did not share this explanation and wondered if there might be other reasons behind this type of dream. In fact, in some cultures, the symbol of the dog is viewed differently: in some places it is just a part of the food chain, in others it is revered. The co-therapists asked J. what the meaning of the dog was in his native culture. J. recounted that the dog was the totemic animal for his family. Following his revelation, significant changes were noted during the second part of his consultation: the tone of his voice was stronger; he assumed better posture and even displayed more bravado in the retelling of the story. He elaborated that the

dog represented protective functions and that certain taboos regarding the animal exist. This case demonstrates how team members collaborated in a creative process that gave various possible interpretations of a cultural symbol through which J. himself could then link the symbolic reference to his native culture and give meaning to his experience. The consultation ended with his commitment to further develop the meaning and practicing of the rituals that celebrate dogs as a totemic animal within his family.

A fourth element of EC serves to help understand the approach to the familial and community – based explanations of a client's illness. This element concerns etiological theories that sometimes come out during group discussions. Examples of this include statements such as: "my daughter is haunted" or "they cast a spell on me and I could not have children". In these traditional etiologies, many explanations refer to the relationship of the individual and the entire group with invisible and metaphysical presences on which many non-Western religions are based. The inclusion of these explanations within the discussion has a crucial function, as they address the problems by introducing a meta-individual symbolic space that raises clients from their condition of loneliness, responsibility, shame and guilt and enables the building of intersubjective solutions that are more consistent with the psycho-social background of all the co-protagonists of the consultation.

A case that exemplifies some of the concepts described in this chapter is that of M., a refugee from Nigeria, who came to Italy by crossing Libya and then the Mediterranean Sea. He had no connection with his family of origin: his mother died, his sister disappeared during her journey to Europe a few years ago and since his father got remarried he has not maintained any relationship with him. M. was very unstable emotionally. At times he was euphoric, while at times he was depressed and unable to concentrate. He did not eat and became thin. He came to the consultation describing his deep sadness and said that if he was not able to find a job he would commit suicide. At an early stage, the consultation reconstructed the map of his family ties and tried to give emotional support. The exchange, however, did not seem to yield significant results. Subsequently, a member of the team asked M. how his community of origin would cure a person who had the same problem. A new phase of the consultation opened in which M. found new energy and motivation and participated more willingly. He described the rites that his village periodically performs to receive the power of the ancestors. The consultation ended in a second appointment where M. shared youtube videos of these rituals while explaining their meaning, "at least for the part that is not secret and can be told to people outside the community", he noted. Therefore, the reference both to the relational ties and the traditional rituals of the community of his origin allowed the group to open a new avenue of expression through which M.'s emotional discomfort

could be addressed using elements from his native context, rendering his experience more comprehensible to his aides. This meant that new possibilities for action and care were finally feasible. Furthermore, EC methodology proves to treat the non-Western individual more respectfully and more appropriately than with previous methods (Parin, 1967; Sow, 1978) based on the interaction with others through two main axes: horizontal (family ties, cohorts, etc.) and vertical (ancestors).

The fifth aspect of EC to highlight is the participatory assessment of the client. In fact, when immigrants and refugees come from non-Western societies, it is necessary to change the traditional evaluation criteria and adopt references more consistent with their cultural background. Through the intersubjective exchange of EC, this change becomes possible.

The case of R., another immigrant from Nigeria, is particularly interesting. During a periodic review of the relationship with her daughter, who was separated from her by the juvenile court, social workers observed how the mother gave attention only to some concrete, physical aspects of the daughter. She noted the dryness of her child's skin and her unkempt hair. At the beginning this behaviour was considered by social workers as an indicator of the inability of the mother to grasp the basic psycho-affective needs of her daughter. The subsequent EC, however, showed that in the culture of the client's origin these practices were rich in symbolic significance and constituted a fundamental communicative medium through which the parental affection, as well as a more complex construction of gender identity would be transmitted. Without the intercultural approach and the space for the communicative expression allowed for with the use of EC, these interpretative elements would not have surfaced and the assessment might have produced outcomes inconsistent with the actual situational dynamics.

A second emblematic case is that of C., an immigrant from the Ivory Coast, who had been undergoing treatment from mental health services. One night she decided to take off her clothes and go out in the rain. Her neighbours called the police, who in turn reported the event to health and social services. During the following EC, her social and cultural references were explored, obtaining useful information to interpret her behaviour not as a psychological imbalance warranting psychiatric or even pharmacological treatment (Abraham, 2010; Barker, 2012), but as a ritual of purification and regeneration enacted during a particularly difficult existential phase in the woman's life, a healing method consistent with a religious and ritualistic practice carried out in her culture for generations. Thus, the complementary approach of EC, which integrated the analysis of her psycho-emotional disturbances, actually unrelated to a mental pathology, with her socio-cultural background allowed for a more comprehensive reconstruction of her situation, mobilizing new existential resources to help her. What appeared to be a malfunction was thus redefined in terms of resilience and

the intervention that followed was no longer provided on an exclusively medical basis but through the emotional and relational support of the informal networks of the woman's everyday life.

Another aspect that is evidenced in both cases reported above is that when practictioners are able to become sensitive to the psychosocial perspective of their clients, the relationship can be much more effective. Conflicting dynamics cease and mutual trust arises. The path to support and better care for the individual is, therefore, secured.

A sixth aspect of EC focuses on the collaborative processes that occur within the team of practitioners. This collaboration takes place first during the mutual exchange of ideas, interpretations and proposals that arise during the consultation and then at the second phase of the process when the client leaves the room and the team reflects on the previous communication exchange. The cross-examination of each contribution allows for inter-subjective supervision that highlights the professionals' psychological projections or other methodological errors that may hinder the full effectiveness of the EC.

This happened, for example, after an EC with A. (a Kurd). A. was an asylum seeker and was hosted at a reception centre near Verona. A. no longer adhered to the initiatives organized by the staff supporting clients, did not sleep at night and became thin. During the consultation, he recounted his thoughts and shared his hopelessness. He longed for his sick mother, whom he left in Mosul during the bombing there. He lamented of the impossibility of reaching Germany, where a friend had guaranteed him a job. A. said that at certain moments he felt like dying. Initially, co-therapists sought only to understand the reasons for his lack of appetite. Then, A. told of his studies in Mosul and his beloved literature and philosophy books that he had needed to sell along the Balkan route for cash. He cited several authors, some well-known in Europe, others known only in the East. At that point, the group changed its attitude. "Fascinated" by the possibility of communicating with a highly educated person, the practitioners began to focus on stimulating his cultural interests as a way to cure his malaise. The group suggested that he visit local libraries, but A. replied that he couldn't because he no longer had the strength in his legs necessary to do so, that he would need someone to accompany him. After the consultation, the team reflected on this moment, stating that the excitement of some staff members to speak with a highly educated person might have completely diverted the consultation in a direction inconsistent with the client's primary needs, risking the psychological and relational support he really required. It must, therefore, be reiterated that although it may be costly, constant intersubjective monitoring allows staff co-therapists to develop a greater awareness of their attitudes towards the clients, the clients' well-being and the methodology with which the psycho-relational support is actually provided.

Conclusion

During their journey, both immigrants and refugees face deeply distressing events that influence their adaptation to a new society, especially when it is characterized by symbolic and cultural references that are very different from their context of origin. In these types of cases, EC reveals itself as particularly useful because it is able to comprehend the client's discomfort in light of his or her social and cultural background (Fernando, 2010; Nathan, 1986).

The reference to the foundations of current multicultural social work (Sue, Rasheed, Rasheed, 2016) enables us to observe how EC puts into practice many theoretical principles and methodological strategies of this approach. Consistent with the ecological perspective, the relational and sociocultural context plays a key role in analyzing the client's psychological problems and in finding an appropriate solution. In line with the strengths perspective, EC relies on the symbolic and relational wealth of such a context. On the basis of the critical perspective and of the social justice perspective, EC also aims to relativize the stereotypes and representations of the culturally diverse people that do not correspond with their true identities, reducing different forms of discrimination. In addition, as the intersectional perspective points out, EC aims to take into account the wider array of factors that affect each situation. However, unlike other approaches, EC is also characterized by operational criteria that translate these theoretical principles into communicative practices typical of non-Western cultures. Furthermore, when using EC, the three professional attitudes that reinforce practitioners' cultural competence, discussed in the first section, come to the fore.

Referring to the first attitude of *cultural humility*, the goal of putting the client at the centre of the group support session requires practitioners to be empathetic. However, empathy needs to be coupled with the willingness to learn new psychological, social and cultural references, even when they diverge from Western habits. If this epistemological shift is not accomplished, the risk of oppressive and discriminatory practices may occur (Dominelli, 2012) despite practitioners' best intentions for doing good work.

As for the second attitude of *critical consciousness*, it is important to stress that when practitioners are able to consider the socio-cultural background and the psychological condition of their non-Western clients, the asymmetries of power and discrimination become more apparent, helping the team to pursue the best possible solutions for their clients, even when it becomes necessary to revise the assessment and evaluation criteria of their own organizations.

Finally, focusing on the third attitude of *collaborative accompaniment*, EC demonstrates that when the basis for a sympathetic relationship is actually guaranteed, conflicting dynamics diminish. This change leads to interventions more consistent with immigrants' and refugees' prerogatives and enables social services to carry out more participatory procedures.

Even if EC can not be properly considered a methodological tool of social work, the inclusion of social workers in the team as co-therapists thus proves to be a useful resource through which meaningful partnerships with non-Western clients can be established, reinforcing the bases for effective and appropriate social services. The aim of activating clients through the recognition of their sociocultural background and their particular expertise, ideas and experience encourages practitioners to avoid paternalistic attitudes that restrict immigrants and refugees in a dependent and passive role. The group setting, moreover, not only helps the team review its own analysis and intervention criteria, but facilitates the implementation of shared assessments and the construction of intersubjective solutions, consistent with the basic principles of participatory approach in social and health services.

Between the recognition of the different knowledges, skills and experiences expressed by non-Western people and the deconstruction of culturally conditioned professional approaches, the EC can therefore be considered a useful tool able to break down the symbolic and communicative barriers that separate social work practitioners and clients and to create new collaborative paths based on mutual trust and effective partnership.

References

Abraham J. (2010), *Pharmaceuticalization of Society in Context: Theoretical, Empirical and Health Dimensions*, "Sociology", vol. 44, no. 4, pp. 603–622.

Adams R. (2008), *Empowerment, participation and social work*, Palgrave Macmillan, Basingstoke.

Allweiss S., Hilado A. (2017), *The context of migration: pre-arrival, migration, and resettlement Experiences*, chapter 2, [in:] A. Hilado, M. Lundy (eds.), *Models for Practice With Immigrants and Refugees: Collaboration, Cultural Awareness, and Integrative Theory*, Sage, London.

Barker K. (2012), *Pharmaceuticalisation: What is (and is not) medicalisation?,* "Salute e Società", vol. XI, no. 2, pp. 161–165.

Cunningham M., Cunningham J.D. (1997), *Patterns of symptomatology and patterns of torture and trauma experiences in resettled refugees*, "Australia New Zealand Journal of Psychiatry", vol. 31, pp. 555–565.

Devereux G. (1970), *Essais d'ethnopsychiatrie générale*, Gallimard, Paris.

Dominelli L. (2012), *Anti oppressive practice*, [in:] M. Gray, J. Midgley, S. Webb (eds.), *The Sage Handbook of Social Work*, Sage, London, pp. 329–340.

Edwards A. (2016), *UNHCR viewpoint: "Refugee" or "migrant": Which is right?*, available at: http://www.unhcr.org/en-us/news/latest/2016/7/55df0e556/unhcr-viewpoint-refugee-migrant-right.html (accessed: 23.02.2018).

Fernando S. (2010), *Mental Health, Race and Culture*, Palgrave, England.
George M. (2012), *Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice*, "Clinical Social Work Journal", vol. 40, no. 4, pp. 429–437.
Giordano C. (2011), *Translating Fanon in the Italian context: rethinking the ethics of treatment in Psychiatry*, "Transcultural Psychiatry", vol. 48, no. 3, pp. 228–256.
Hilado A., Lundy M. (eds.), (2017a), *Models for Practice With Immigrants and Refugees: Collaboration, Cultural Awareness, and Integrative Theory*, Sage, London.
Hilado A., Lundy M. (2017b), *Transnational practice as the clients process: Reorienting Practice With an Integrative Theoretical Approach to Practice With Immigrants and Refugees*, chapter 4, [in:] A. Hilado, M. Lundy (eds.), *Models for Practice With Immigrants and Refugees: Collaboration, Cultural Awareness, and Integrative Theory*, Sage, London.
Horevitz E., Lawson J., Chow J.C.C. (2013), *Examining cultural competence in health care: implications for social workers*, "Health & Social Work", vol. 38, no. 3, pp. 135–145.
Johnson Y.M., Munch S. (2009), *Fundamental Contradictions in Cultural Competence*, "Social Work", vol. 54, no. 3, pp. 220–231.
Kirmayer L.J., Gudzer J., Rousseau C. (eds,), (2015), *Cultural Consultation*, Springer, NY.
Levin L., Weiss-Gal I. (2009), *Are social workers required to engage in participatory practices? An analysis of job descriptions*, "Health and Social Care in the Community", vol. 17, no. 2, pp. 194–201.
Lundy M., Hilado A. (2017), *Maintaining Critical Consciousness, Collaborative Accompaniment, and Cultural Humility: The Common Denominators of Transnational Practice*, chapter 17, [in:] A. Hilado, M. Lundy (eds.), *Models for Practice With Immigrants and Refugees: Collaboration, Cultural Awareness, and Integrative Theory*, Sage, London.
Masocha S. (2015), *Construction of the 'other' in social workers' discourses of asylum seekers*, "Journal of Social Work", vol. 15, no. 6, pp. 569–585.
Metis Africa (2018), available at: www.metisafrica.org (accessed: 23.02.2018).
Moro M.R. (2008), *Aimer ses enfants ici et ailleurs*, Odile Jacob, Paris.
Moro M.R., De La Noe Q., Mouchenik Y., Baubet T. (eds.), (2004), *Manuel de psichiatrie transculturelle. Travail clinique, travail social*, La Pensée sauvage, Grenoble.
Nathan T. (1986), *La folie des autres. Traite´ d'ethnopsychiatrie Clinique*, Dunod, Paris.
Parin P. (1967), *Considérations psychanalytiques sur le Moi de groupe*, "Psychopathologie africaine", vol. 3, pp. 195–206.
Piwowarczyk L. (2007), *Asylum seekers seeking mental health services in the United States: Clinical and legal implications*, "Journal of Nervous Mental Disorders", vol. 195, no. 9, pp. 715–722.
Perez-Foster R.M. (2005), *Psychosocial stressors, psychiatric diagnoses, and utilization of mental health services among undocumented immigrant Latinos*, "Journal of Immigrant and refugee Services", vol. 3, pp. 107–107.
Porte M., Haslam N. (2005), *Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis*, "The Journal of the American Medical Association", vol. 294, no. 5, pp. 602–602.
Quinney A. (2006), *Collaborative Social Work Practice*, Learning Matters, Exeter.
Sow I. (1978), *Les Structures anthropologiques de la folie en Afrique noire*, Payot, Paris.
Sturm G., Nadig M., Moro M.R. (2011), *Current developments in French ethnopsychoanalysis*, "Transcultural Psychiatry", vol. 48, no. 3, pp. 205–227.
Sue D., Rasheed M., Rasheed J. (2016), *Multicultural Social Work Practice: A Competency-Based Approach to Diversity and Social Justice*, Wiley & Sons, New Jersey.
UNHCR (1951), *The 1951 Refugee Convention,* available at: http://www.unhcr.org/en-us/1951-refugee-convention.html (accessed: 23.02.2018).
Warren J. (2007), *Service user and carer participation in social work*, Learning Matters, Exeter.