ON THE COLLABORATIVE WORK BETWEEN PSYCHIATRY AND SOCIAL WORK IN DEVELOPING TRANSCULTURAL CAPABILITY IN MENTAL HEALTH CARE

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CONTEXT

Settled in France since 1999, Alin (1993, Timisoara) and Ghiocel (1987, Timisoara) were born within two Roma families who emigrated from Romania for economic reasons. The former suffers from heavy psychomotor and cognitive deficiencies; the latter of a deficiency-psychopathology, expressed by delayed psychomotor development with signs of hospitalism (psycho-affective abnormalities due to a prolonged hospitalization at very young age) and, isolated behaviour disorders. Their childhood took place in a forced nomadism due to the regular police evictions their families faced in France. They lived in a shantytown of ruined second-hand caravans, with other Roma families originated from the same village.

Ghiocel's life conditions improved when his family was selected to take part in the Social Integration Project of the SAN of Sénart (2002-2007, France) that involved 32 Roma families. This Project allowed him to gain access to permanent residency, vocational training, medical healthcare and social protection facilities, including a social housing. Nowadays, he still beneficiates of the French government 's economic aid for people with disabilities.

For the Roma excluded of the Project, in November 2003 a group of volunteers of the catholic parish begins to intervene by bringing them clothes and food, but also an accompaniment, in case of request, to the social and healthcare services of the city that were addressed to deprived ill-persons and/or non-authorised migrants. In 2004, backed-up by a volunteer and his mother, Alin started a medical treatment and a psychotherapy to better communicate and gain autonomy. In 2006, his father sent him to Romania with his paternal grandmother.

METHODS: CASE STUDY

Case studies of the psychotherapeutic trajectory of Alin and Ghiocel were reconstructed from the information produced by:

1) a series of conversational interviews with Alin, Ghiocel and their respective parents;
2) focus groups with the therapeutic teams
3) informal interviews to the director of the Social Integration Project and the volunteer who provided a social accompaniment to Alin's family
4) documental analysis of the communication notebooks of the social workers of the Social Integration Project.

Data was triangulated with Atlas.ti software support and analysed by undertaking a socio-genesis of individual and family history and life conditions.

MAIN FINDINGS

Socio-cultural representations of mental handicaps, intrafamilial relationships and personal history are interactive determinants of psychological accompaniment and healthcare provision outcomes.

ALIN

Competing sociocultural representations of his "mental handicap":
Family: As a common phenomenon in paternal lineage (an intergenerational 'family sign'). An irrevocably restraining condition from which to learn fate resignation.
Healthcare team & family accompanying volunteer: a constraining difficulty that can be workable to render existence more autonomous

Intrafamiliar roles:
Father's role: Main family-affairs decision-maker
Mother's role: Power traditionally subordinated to her husband's will and, to her mother-in-law until giving birth to a "normal" son (i.e., family recognition of the "spell breaking")
Alin's status: the elder son, embodying the family spell and whose centrality in the family got displaced with the third pregnancy of his mum which subsequently brought the birth of his "normal" brother.

Personal history:
From an abnormality silently kept to a deficiency requiring special treatment which conveys personal recognition
Learning to get more autonomous entails new exigencies in terms of greater personal investment and responsibilities

GHIOCEL

Differing sociocultural representations of his "mental handicap":
Family: As a personal sign of oddity and outlandishness; Denial of the disabling effects of the condition, which is viewed as revocable with firm hand (including use of violence)
Healthcare team & social workers: a constraining difficulty that can be diminished with medical treatment and social support arrangement to render his existence more autonomous

Intrafamiliar roles:
Father's role: Main family-affairs decision-maker
Mother's role: Power traditionally subordinated to her husband's will
Ghiocel's status: the second son; the one who ended up to economically contribute to the parental household (having his elder brother, married and with a relatively good situation in France, broken contact with the parents)

Personal history:
From a denied abnormality to a deficiency conveying social recognition (specially access to a pension, permanent residency and free healthcare access), as a consequence of the collaborative work of health professionals and Project social workers

Divergences were found in terms of the degree and manner they integrated in their psycho-therapeutics and medical treatment the articulation between diversity, difference and inequality in the family's experience of mental handicap and its care.

ALIN case: medical treatment, psychotherapeutics with the child and his mum & informal family accompaniment

Major issues misconceived by the mental healthcare team in establishing the patient-provider relationship:

The singular views of what is considered as an achievable goal
Parents' perception concerning Alin's capability to get autonomous and father's distrust on the medical treatment utility
Alin's capability to treatment adherence
The particular status that family network attributes to the person with mental handicap: here, a 'special person' as touched by "family fate" and who will necessitate to be under permanent family care
The thread that family counseling may entail for the head of the family head who is yet socially undervalued as being in a deprived and marginalized position.
The real life conditions in France of the household.

In the context of a shanty-town life without social arrangements for community and development , the election for medical care breaking off

Alin was finally sent to Romania to be under his paternal grandmother's informal care. The father argued that: *"Anyway, France can do nothing to cure Alin, his grandmother takes care of him very well; she has raised 6 sons among which one was like him. In Romania there are also doctors and medicines. Alin would not live anymore in a shantytown"*

GHIOCEL case: coordinated medical and social intervention towards the adolescent and all the members of the parental household

Collaboration between his psychiatrist & the Project social workers provided:

Medical and social recognitions of his mental handicap, which allowed him to get aid for people with disabilities in France, residence permit and free healthcare.

Necessary **information on the family life conditions and environment** and the **available opportunities for social and economic development.**

Revailing information on his mental health conditions to **understand** Ghiocel's behaviour and **adapt interventions** on consequence.

Social workers tried to mediate between him and his father (who denies the relational problems liked to his son's pathology), when violent conflicts exploded in the household. High pressure from his parents on Ghiocel to get a regular income.

Social workers helped Ghiocel to obtain a specific vocational training, sheltered employment and social housing for him and his wife

When the Project ended in 2007, Ghiocel, his wife and son went **back to the parental house (also a social housing), loosing part of their autonomy.**

Parents' impressions: "my son son is strange, difficult and very clumsy but not mad" "the social workers wanted to divide the family, they did not achieve it" "We are grateful for the aid France is giving to him"

Ghiocel's arguments: "it is nice to be together. I feel less isolated and I can help my parents with paying one rent". "I do not strictly follow the medication but I respect all the meetings with my doctor"

FOR A TRANSCULTURAL'WORKING ALLIANCE'*

What recommendations can be drawn from both cases for mental health professionals and social workers who collaboratively work with socio-economically deprived and stigmatized foreign beneficiaries ?

Evidence supports the admonition that most professionals need to be more effective in developing concordant relationships and in their communication with ethnic and racialised minority patients and their family caregivers. This means **to build up a medial 'working alliance'*** leading beneficiaries and caregivers to be more connected between them and with professionals and to get involved in setting up the treatment plan. This depends on **professionals' capability to developed socio-culturally sensitive and responsive to beneficiaries' needs psychotherapeutics**, which implies:

1)To overcome communication barriers
2)To go deeper with a sociological diagnosis of the life conditions of the family
3)To understand those cultural lifestyles considered as problematic and acknowledge the conflicting power relations that may harm the connexional dimension of medical care

Transcultural approach is effective when it is integrated to:

✧conventional psychological practices,
✧a collaborative work with the concerned professionals of social work and associative sectors.

* *Fuertes JN, et al., The physician–patient working alliance, Patient Educ Couns (2006), doi:10.1016/j.pec.2006.09.013*