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2.1 *At the bottom of the gap. Repertoires and the creation of cultural differences in Dutch mental health care*[1)]

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Introduction

Research in health care for immigrants often suggests that there is a gap, a cultural gap, between immigrants and health professionals. This gap cause many difficulties in interaction and care, which have to be studied in order to bridge it and to provide solutions. It is also believed that under-representation of certain groups of immigrants in for example mental health care is linked to this cultural gap. While perceptions of health care and health seeking behaviour among immigrants have thoroughly changed in the Netherlands, many studies continue to stress the cultural gap, the different explanatory models, the language problems and the life styles of immigrants. Health professionals report similar problems. These ideas have a strong impact on the experience and the daily practices of health professionals and steer research and debates about interculturalisation of health care.

Basically, the discussion about interculturalisation is a discussion about differences and how to deal with them. Elsewhere it is argued that welfare states cannot deal well with differences (COMELLES J.M., this volume). I argue that in welfare states certain differences between immigrants and indigenous persons are used in a particular meaning and with a political-economic purpose. When those differences come into being, one is not able to deal with them.

A recent concept that is used to characterise the European states is multiculturalism. Welfare states are moving from an area of modernisation and development of "better worlds" based on rationality and progress into an era of "multi", in particular of multi-culturalism, an era of "self", in partic-

ular self-responsibility and self-steering (DEVISCH R. 2001). Multi-culturalism emphasises the existence of different cultural traditions in a society and promotes tolerance and understanding (SMAJE S. 1995). Although it is not clear what is meant by multi-culturalism – is it a cultural mosaic in a dominant culture (GUTMAN A. - TAYLOR C. eds. 1994); is it the recognition of different ethnic groups; or is it the recognition of all differences between groups in a society (OKIN E. 1999)? – ideas of multi-culturalism permeate health care and tend to promote ghettoization (KYMLICKA R. 1995). As a result, it happens that research and health care policies are aimed to specific groups of immigrants: the Moroccans, the Turks or the Africans. Country of origin is the most important marker, while categories such as gender differences or social class are often overlooked.

The ideology of multi-culturalism has emerged within the process of globalisation and localisation resulting in "glocalisation" (ROBERTSON R. 1995). Basic in this process is a process of incorporation and selection of external influences, and a process of creolisation, in which meaning systems and expressions are mapped onto structures of social relations. Hannerz (HANNERZ U. 1992) sees in this process a culture of a prestigious centre on the one side, and cultural forms of the periphery on the other. That puts to the fore questions of power, structure and agency. How do people succeed in imposing their definitions of reality on others and how do they attain their goals? Giddens (GIDDENS A. 1994) offers a "radical politics"; what 'used to be fixed is now subject to human decisions' and therefore, humans are engaged in disputes and struggles about how people should live in the world. De Ruijter (DE RUIJTER A. 1998, 2000) applies the metaphor of the arena to multi-cultural societies. In the arena, De Ruijter argues, each group has its own theories about reality that serve as a blueprint for action. The issue is then: which group with its own cultural logic and repertoire has the power to define a situation and will control and exploit the resources? Frameworks such as those of Giddens and De Ruijter show the ambiguity and "practical" use of culture. They show that people create cultural differences as «formative myths that sustain a social organisation of difference» (BARTHES 1994: 30), which will serve as a legitimacy for power and rights. Then, it becomes possible to ask the question: When and why use people culture and cultural differences?

In mental health care in the Netherlands these frameworks are useful, because they challenge the conceptualisation of culture. This concept is central in health care for immigrants and therefore it is necessary to discuss it. Culture, as it is perceived in health care in general, and in mental health care in particular, is a static concept. It is the distinction, the differ-

ence between immigrants and indigenous people, the difference between immigrant groups and the difference between immigrants and health professionals. It is the cause of a gap and the focus of research. The definition of culture in health care is largely influenced by anthropologists, who – in the past – contributed to this static concept by describing 'the patchwork quilt blanket of mutually absolutely distinct cultures' (VAN BINSBERGEN W. 1999). However, anthropology has developed a different conceptualisation of culture. Many argue that cultures do not exist per se but are the outcome of an interaction process, which engenders the position of cultural differences. Cultural diversity is claimed by performative and strategic use of difference.

In this paper I argue that in Dutch mental health care "culture" is used as a strategic concept, in particular to maintain the status quo of health care. The paper will go to the "bottom of the gap", the reality of everyday mental health care practices for immigrants, to explore how culture and cultural differences are created and used to claim "reality". This is not to argue that mental health care uses culture in an opportunistic way. The issue is more complicated. There are too many interests of different parties in this arena. (Pseudo) traditional identities of people from transnational communities – thus the communities of the immigrants – develop 'cultural mixtures' but at the same time they will confirm traditional identities. Mental health professionals will do the same. Although a form of multi-culturalism is strongly promoted in mental health care, differences are strategically used in a power play, which reinforce the status quo in mental health care by keeping the immigrant in a 'betwixt and between' position. In order to show the 'work with culture' I will discuss the historical development of the debates and discourses on mental health care for immigrants.

The role of anthropology and mental health care in the creation of the concept of culture in mental health care

Anthropology has contributed to a large extent to a static concept of culture, that enables a dynamics of inclusion – exclusion in mental health care. A general and persistent idea in the Dutch public opinion is that migrants have 'exotic and strange' ways of dealing with illness. This idea is reflected in the research reports and publications of policy makers and health professionals (DE JONG J. 1991, MEURS P. - GAILLY A. 1998). 'Culture' is a keyword, which expresses a concern with and persistence of differences

between the mental health and health care of 'autochthonous' and 'allochthonous' patients.

Anthropology has focused on the exotic health practices of the different immigrant groups that entered the Netherlands during the sixties and seventies of the previous century and seems to have become relevant when refugees and asylum seekers entered the country in the nineties and after. However, while in anthropology today culture is differently conceptualised, the static concept of culture is still widely used in mental health care and has remained the same for more than fourty years of research tradition in health care settings that have to deal with migrant groups. How were those differences created, what was the repertoire and what were the effects on care for immigrants? In a contribution to *Health for All* (VULPIANI P. - COMELLES J. -VAN DONGEN E. eds. 2000) Van Dijk and Van Dongen give an overview of the development of perspectives since 1960.

In the 1960s the health problems and health situation of migrants were only discussed when public health was threatened. Large groups from Mediterranean countries came as "guest workers" in the country and were supposed to return "when the job was done". X-ray control and screening for tuberculosis was quite common. That migrants were perceived as a danger to public health, as contagious, becomes clear in the suggestion of Huisken, who insisted that immigrants should be x-rayed three times a year. (HUISKEN D. *et al.* 1966). Residence permits were connected to tuberculosis examination and control during the first years of stay. The repertoire of contagion has persisted over time up until today. Tuberculosis screening is the standard procedure in health care for recent refugees and asylum seekers, while doctors at asylum centres would like to extend screening to other diseases.

Since the 1970s, the time when it became clear that migrants would stay and families would be reunited, the focus of health care and health research shifted from contagion to deficiency and exoticism. Diseases such as rachitis, psychosomatic complaints (ulcers) and exotic diseases such as possession became the focus. Anthropology had to contribute with cultural knowledge about beliefs, practices and models of immigrants. Repertoires in research and health care centred around discussions on the strangeness of behaviour and the expression of complaints. The list of experienced 'problems' is illustrative: expressive presentation of complaints and symptoms, exaggeration of the problem or even simulating, vagueness of symptoms, non-compliance, improper use of medicines, taboos on certain examinations and psycho-social problems. Cultural differences were a core

cause of misinterpretations and ineffective care and became «an excuse for failing health care» (VAN DIJK R. 1998[1989]). The recipe was cultural knowledge ("Give us the tools, we do the job!"), to be delivered by anthropologists and experts of religion. A board for medical care for migrant workers was established in 1972. This board advised the minister and centres for interpretation. In 1977, an information service for foreigners was established. Additional services such as the Refugee Health care Centre (former Central Medical team of the Ministry of Health and Environment Hygiene) and the Social Psychiatric Service for Refugees (1978) focused on specific groups with 'high health risks'. Numerous studies focused on cultural explanations of illness behaviour and migrants' illness behaviours were reduced to 'traditional cultures'. Migrants were "exoticised" and stereotyped. Cultural knowledge has not helped therapists, but according to Van Dijk the cultural difference of the migrants was helpful in concealing inadequate mental health care:

> «The care provider cannot get a hold on the symptoms; he cannot interpret them and bring about a cure or alleviation of a problem. He does not succeed in passing on his view on the nature of the symptom. His feelings of impotence and frustration are softened and camouflaged by the cultural label. One could call this 'tertiary illness profit', but the profit does not fall to the patient.» (VAN DIJK R. 1998: 246)

Since the 1970s 'culture' is the focus of research. Conferences with suggestive names such as "Cultures within the walls of psychiatry" or "The cultural factor in medical care for migrants" attract dozens of mental health professionals, who experience constraints and problems with foreign patients.

During the 1980s Dutch policy changed from a facilitation of migrant groups (then called minorities) in the 1980s towards an integration of allochthonous individuals (change of terms for migrants!) in the 1990s. The Minority Bill of 1983 stressed that health care should be accessible for migrants, but no special services for migrants were needed. Exceptions were made for 'new problem groups' such as Vietnamese refugees. This did not mean, however, that in mental health care no problems were signalled. Somatization and communication problems – already widely discussed in the 1970s – remained topics of interest in both research and psychiatric practice. Differences between autochthonous and allochthonous persons were re-created with an important change: Migrants not only *explain* their afflictions in different frames; they also *experience* their afflictions differently. The main repertoire of exoticism and strangeness was transformed into a repertoire of inadequacy on the side of professionals. Similarities between migrant

and indigenous clients came into being, because studies stressed that the latter reported similar complaints and behaved in a similar way as the migrant clients. A general trend in mental health care was to improve knowledge and especially know how of professionals, so that they could 'decode' the messages sent by migrant clients. In other words, professionals had to become "culture (or culturally sensitive)-sensitive".

While the spotlight shifted from the migrants to the health professionals, old repertoires persisted. "Culture" and "cultural relativism", technical, anthropological concepts, which served – according to Van Binsbergen (VAN BINSBERGEN W. 1999) – as concepts that could sustain concurrence among anthropologists (every anthropologist his or her own village or "culture") and that have made fieldwork as a unique inter-subjective and uncontrollable experience, had become the most used and obvious terms to describe the world, its differences and conflicts (VAN BINSBERGEN W. 1999). Within mental health care (trans-cultural psychiatry) the debate on universalism and relativism and culture-bound syndromes continued to rage and finally resulted in the creation of the Cultural Formulation of Diagnosis in the Diagnostic and Statistical Manual, which infused mental health with the creation of cultural differences at the individual level, which in my opinion is more difficult to capture . The use of the Cultural Formulation of Diagnosis will probably strengthen the trend within Dutch mental health care to focus on case studies without relating these cases to other, similar cases, so that structural thresholds and constraints in the lives of migrants will not become visible. Anthropologists have contributed to the debate about the Cultural Formulation of Diseases.

In the meantime, the anthropological debate about culture changed into a debate about human rights, poverty, oppression, violence and the effects on mental well-being. These scholars plead for a collection of case studies "at the margin", which would clarify the relationship between mental health and the social-political-economic situation. Issues of discrimination and racism were put on the European agenda.

In the 1990s a remarkable change in repertoire took place. This change may be captured by the term "inter-culturalisation". It was believed that having a toolbox filled with cultural knowledge was no longer an option, since so many persons with different cultural backgrounds had entered the Netherlands. It is important to note that 'culture' is still an important trigger in the health process of migrants. The 1990-focus was on management of cultural diversity. Instead of 'fitting' migrants into the health system, the health system had to adapt itself to the needs of people (*inpassen* versus *aanpassen*). The Council of Public Health and Care published a report on

inter-culturalisation (2000). The repertoire in this report is characterised by "lacks": the Council concluded that there were numerous shortcomings: lack of a shared vision (perspectives of professionals are too diverse), lack of structure, lack of connectivity between demand and need of care, lack of cultural competence, lack of cultural sensitive education and training, lack of proper registration, lack of epidemiological research, lack of participation of migrants in patient organisation, lack of information about care facilities, etc.

Within health policy it was believed that attuning organisational structures, procedures, personnel and care to the multi-cultural society would lead to cultural change in health care. Flexibility, openness to innovation and dynamics, training and education and diversification became core concepts in multi-cultural mental health care. Migrants were no longer a "constraint" or a "problem"; they became a *challenge* for management and professionals.

The arrival of large groups of asylum seekers and refugees from many parts in the world was followed by the establishment of new, special services that focused on enhancement of skills and knowledge of professionals (training and education). The ideal of the inter-culturalisation was involvement of and collaboration with migrants in a learning process. However, it is not clear what is meant by involvement and collaboration. Is it participation of professionals with a migrant background in treatment? Is it participation of migrant organisations in the process of attuning health care? Or is it the individual migrant who will have to take a role in the health arena? In any case, a repertoire of *zorg op maat* (care cut down to the patients' needs) suggests that individual migrants will have to 'stand for their rights'. The arena-metaphor glooms....

While the official ideology seems democratic, another exclusion mechanism came into being; The *Koppelingswet* in 1996. This law connects the right to almost all provisions, thus also to health care, to a permanent residence permit. All governmental files are connected to those of the aliens department/police, so that the Dutch government can control foreigners. The result is that all migrants without such a permit and all persons who are in the procedure, or being tolerated or 'un-deportable', are excluded from the right to provisions. Thus, health care may have become an instrument of aliens policy. Professionals had to determine whether a mental problem was acute or not.

The minister of Health (Volksgezondheid, Welzijn en Sport, Vws) presented her vision on the future of health care. In a memorandum the minister

presented the answer to the problem of increasing diversification: rationalisation, standarisation and expansion. From mental health care the critique was that migrants were no longer a focus group. Particular stressors such as uncertainty about a residence permit, acculturation, disruption and uprootedness disappear behind evidence-based protocols for treatment (cf. KORTMANN F. 2003). It is striking that racism, discrimination and subordination were not discussed in the minister's memorandum. In a manifesto, Van Dijk and others (VAN DIJK R. *et al.* 2000) protested against the memorandum and presented a new orientation based on equality of migrants and professionals. A main argument for this new orientation was that migrants wrestle with future problems of the autochtonous Dutch population, such as increasing mobility, changes in life world, cultural fragmentation, disorientation or detachment. Instead of exotic others or persons with special needs, migrants now become "pioneers" for what possibly will happen with others in the Netherlands. They will have to carry the responsibility of representing an alienating, fragmented, disrupting and 'sick' society.

Kortmann (KORTMANN F. 2002) commented on the manifesto and presented the idea of "inter-culturalisation cut down to the patients' needs" and insisted on relative equality. Kortmann creates new differences based on an old dichotomy (universalism-relativism), because the nature of the affliction determines the relevance of cultural differences between professional and clients. Kortmann states that in cases with afflictions with known organic substrates, a dialogue about cultural differences or equality is not needed.

Both advocates and opponents of inter-culturalisation based on equality stress that mental health care will have to become more active in signalling health risks, preventive intervention, outreaching and exchange of knowledge with others such as primary health care and migrant organisations. Keywords are: reflection, dialogue, experiment and critical reconsideration of professional practice.

Because of a lack of theoretical frames, mental health care is characterised by intuitive practices as far as care for migrants is concerned. Research is biomedical and less based in a narrative approach. In personal interaction between professionals and migrants dialogue is the main way of interaction. At institutional and professional levels a struggle for paradigm change exist. At this level the arena metaphor is most applicable. Traditionally oriented professional have interests in maintaining the status quo; pioneers in intercultural mental health (involuntarily) contribute to feelings of inadequacy of their colleagues; allochthonous professionals may avoid a discussion with their Dutch colleagues for different reasons or may think

that they have the correct perspective and reference frame, because they are allochthonous. In short, in mental health care a struggle over the power of definition and situation exists. It is this arena that De Ruijter has written about (DE RUIJTER A. 1998).

A general conclusion may be that repertoires have changed and migrants are approached differently. However, a recent research inquiry among Cape Verdean migrants in mental health care (BEIJERS H. 2003) suggests that repertoires may have changed but perspectives and difficulties in mental health care have not. Cape Verdean migrants and "learning communities" (composed of representatives of migrant communities, professionals and scientists) reported familiar and traditional bottlenecks and thresholds in mental health care that can be summarised as follows: cultural background of the migrants, lack of knowledge about health care facilities, experiences of being discriminated, reluctance to use mental health care facilities, language problems, lack of cultural knowledge of professionals. The results of this study were confirmed by studies in other European countries, such as Italy, Spain, Sweden and Belgium. They reported the same bottlenecks.

But it was also found that Cape Verdean migrants, like Chinese or Philippine migrants, belong to the so-called "silent migrants"; invisible, self-reliant, under-using mental health care. Why did they become of interest to mental health care? Was it because mental health care took the advice of the "inter-culturalisation movement" at heart and adopted a more active attitude towards migrants? Or was it because the Cape Verdean community itself – or a part of it – wanted to participate in the arena of mental health care?

Another recent issue, which is related to 'inter-culturalisation', must be discussed: cultural competence. This concept stems from an Anglo-Saxon background. Cultural competence aims at improving the performance and competency of health professionals thereby enhancing the capacity of a health system to respond to cultural diversity. It means that health professionals will have to be 'sensitive' to all aspects of differences and will have to develop reflective, self-critical and respectful attitudes. Del Vecchio Good (DEL VECCHIO GOOD M. 1995) made a typology of competence: she distinguished three repertoires that can also be found in recent debates in Dutch mental health care. The first is the intra-professional repertoire. In this repertoire, professionals are able to talk about inadequacies of mental health care and their colleagues. The second is the repertoire of professionals to the public. This repertoire is meant to affect public actions such as liability, legislative and financing reforms. The third form is reflective repertoire, meant to reflect on good and less good practices. Thus, cultural compe-

tence is an instrument for health professionals. Immigrant clients are the passive recipients.

In short, two aspects of inter-culturalisation deserve critical attention. One concerns the term culture. What is meant by culture? What is meant by cultural sensitivity? The other concerns the "inter" part of the term. What is meant by "inter" and why has it a special relation to health care for migrants? In order to address these questions, I suggest an alternative approach, which draws on the concepts of anomaly and liminality (cf. BARRETT R. 1998) in order to focus on how the category "migrant" is socially constructed.

The migrant as anomaly

There are two main ways in which mental health care uses the term "migrant" (equivalent "allochtonen"). First, it refers to a specific category of patients/clients and a spectrum of afflictions that are thought to be specific for this category. In this way, the word describes characteristic symptoms of the "condition migrante" such as rootlessness, alienation or cultural fragmentation. Second, the term is used to qualify a type of person rather than his or her condition. We can have "migrant clients" and "non-migrant clients" (cf. TER HAAR W. 2000). Clients are portrayed as individuals who have something quintessentially migrant-ish about them. It is as if their being-migrant infiltrates their illness with no alternative explanation. The problem (affliction) becomes the person. Such usage of the term "migrant" enables mental health care to lump diverse people together into a single group.

It must be said, that nowadays this qualification is refined, either geographically, in reason of migration or in time. Migrants have become "Ethiopian migrants", "Turkish migrants"; they have become migrants, refugees or asylum seekers, or first, second and third generation migrants. Yet, they remain "migrants". By using this qualifier mental health conveys the implication that all "migrants" have the potential to exhibit mental health problems ("risk groups"). Recognition that "migrant" refers to a category of person as much as to certain types of mental illnesses draws attention to institutional practices and their cultural traditions. It explores the extent to which the mental health institutions are embedded within a web of other, related institutions – universities, pharmaceutical industries, patient groups, insurance companies and governments – and how this web influences the production of knowledge of migrants' mental health problems.

Sue Estroff (ESTROFF S. 1993) has published an important study of these issues. Although not focused on a "migrant population", Estroff seeks to

call into question the authority of psychiatry and examines the structural problems inherent in mental health care. Starting with the question: Who does not get well and why, Estroff presents a political economy of mental health problems (i.e. chronic schizophrenia). She shows how a person who experiences an event of psychiatric treatment develops into a category of negatively valued and dysfunctional person. In our case, this is the "migrant" who by being-a-migrant is "at risk" and who is sometimes burdened with a label (such as schizophrenia) that is in itself negative and disabling. Estroff argues that social welfare and health policies codify cultural ideas about identity, illness and productive activity. In our case, this is expressed in memorandums and reports of inter-culturalisation that stress cultural differences and call for 'respect' and mutual definitions of the health situation of migrants. Estroff mentions several factors that contribute to the construction of this category: «the growing numbers of and demand for jobs by mental health professionals; ardent public and political advocacy and espousal of medical models of mental illness among family members; and income maintenance resources that are illness-tested» (ESTROFF S. 1993: 251). She observes a significant increase in the number of mental health professionals, their level of professionalisation and their unionisation, while «an odd coalition between employees who wish to protect jobs and relatives of persons with mental illnesses» is formed. For very different reasons professionals protect their personal and economic interests by affirming the severity of the illness. I am not aware of the existence of any statistical data on increasing number of Dutch professionals who work with migrant clients in mental health care, but some studies suggest that in the past decades mental health institutes are 'flooded' with migrants, while only a couple of professional 'hobbyists' arrange care for migrant clients. Institutions pay little attention to professionalisation in this field and they do not cooperate with each other, so that it becomes possible that different agencies are engaged in the assistance of one family (KORTMANN F. 2003: 46). Migrant organisations that cooperate with mental health care or "migrant professionals" often affirm the status quo.

Institutions and policies position the category "migrant". This category is located at the margin, quintessentially because "culture" is the main threshold in mental health care for migrant patients. "Migrant", however, is not just a marginal category; it is an anomaly in the sense that it refers to an irregularity. It does not fit into the Dutch system of classification (cf. DOUGLAS M. 1966). However, because a migrant is an anomaly, he or she can simultaneously be regarded as being-similar and being-dissimilar. This anomalous position is reflected in recent position taking in mental health

care. One the one hand, it is argued by some that "migrants" have (very) similar problems as autochthonous persons; on the other hand many insist that migrants can be distinguished from autotochthonous clients by their specific problems and particular ways of presenting complaints and explanations. Migrants encounter avoidance and are associated with public danger, especially after the murder on the politician Fortuyn and September 11. If danger is fixed in people's (minds)imagination, it would play its part in mental health care. Several studies suggest a higher incidence of psychotic and schizophrenic disorders in migrant groups (DE JONG J. 1996, SCHRIER *et al.* 2001, STRONKS K. - RAVELLI A. - REIJNEVELD S. 2001). Although it is not clear which factors contribute to this higher incidence, others have suggested that the different cultural background of migrants is an important contribution to differences in diagnosis (cf. LITTLEWOOD R. 1992). In mental health care, culture is still a static concept: homogenous, demarcated and used to characterise the Other: the migrants. This idea is expressed in repertoires such as those on "cultural distance", cultural gap" or "living between cultures". "Inter" as prefix of interculturalisation seems to express a horrifying and uncertain descend into the gap; who will be the first to make the step, the professional or the client? Bartels (BARTELS E. 2002, 2003) argues that transcultural psychiatry will have to actively act upon cultural differences in such a way that both, professionals and migrants have equal power over definitions. I argue that the immigrant's position – a position 'at the bottom of the gap' – only becomes possible because the category "migrant" is constituted from the onset as an anomaly, while it is simultaneously argued that migrants are 'equal' to the 'natives'. The hallmark is ambiguity and gives rise to a double interpretation. Are the migrants' mental health problems defence of defiance? Are migrants actors or are they victims? Is there a "cultural problem" for mental health care or an organisational problem? Many more of such questions can be raised. Estroff (ESTROFF S. 1993) would arrange this question in the 'can't versus won't controversy' in mental health care and society at large (can't we care or won't we care for 'migrants'?). Thus, "inter" as part of the term of interculturalisation can be seen as expression of this ambiguity.

Migrants as *liminal personae*

Placing too much emphasis on classificatory schemes such as DSM, stable cultural categories ("the migrant") and on a society as a fixed structure denies the dynamics and the agency of immigrants. One should empha-

sise the dynamic social processes that generate and sustain such anomalous categories such as "migrants". Trans-cultural psychiatry is a suitable domain to inquire into these processes because it remains, despite changes in repertoire that guide actions, the principal site where clients are diagnosed, receive treatment and will undergo radical changes in their personal identity.

I want to focus on the inter-structural situation (TURNER V. 1967: 93) of liminality, because it leads beyond the static concept of anomaly. A number of authors have used the concept of liminality to describe and analyse illnesses such as chronic illness, disability or schizophrenia. Moore and Meyerhoff (MOORE S. - MEYERHOFF B. 1977) have addressed this issue in *Secular Ritual*. They examine the distinctive nature of ritual in contexts of heterogeneity, fragmentation and change. Participants are often strangers to each other and the sacred (i.e. the unquestionable) reaches beyond the domain of religion. The authors refer to de-secularisation of 'modern' societies. I must add that – although the Dutch society seems to be a de-secularised society and religion does not play its part in psychiatry – religious aspects re-enter the mental health care stage through the backdoor: "Culture" as main part of the repertoire in trans-cultural psychiatry is limited to ways of life of Islamic migrants and refugees. Culture is used as synonym of religion and language and remains static.

If illness itself can be characterised as a period of anomie, alienation and angst, migrants will have to deal with a double pair of alpha sisters, because they are ill and are "migrants" who possess "culture". The strong call for a "dynamic concept of culture" (VAN DIJK R. 1998) and for interculturalisation of mental health care may shift the focus to the performative dimension of care. Knowing HOW to do prevails in this repertoire over knowing WHAT. Words as "dialogue" (VORSTENBOSCH J. 2003), "active work with cultural differences" (BARTELS E. 2002, 2003) stress the performative and expressive dimensions of the work with migrant clients. Mental health care is increasingly conceptualised as a market. The much used concepts *zorg op maat* and *vraaggestuurde zorgverlening* (care steered by demand and need) suggest that migrants will have to become a party at this market in order to receive proper health care, limited by the conditions set by insurance companies and law. One thinks that migrants cannot take this role of self-confident consumer, which results in new templates such as empowerment and participation. Again the position of liminal personae is freezed, because they are defined as persons in transition. They are in a permanent state of decomposition and growth, a permanent limbo.

"Culture" as part of inter-culturalisation is in this view something that has to be produced, but cannot be produced, because it is argued that developments in health care and migrants' culture hinder this process. Professionals complain that working (in a cultural sensitive way or inter-culturally?) is a "Sisyphus job" (BAARS J. - KAL D. 1995), because social contexts are neglected and "modern societies" are "risk societies". The few studies that have explored migrants' experiences and actions in mental health care (BEIJERS H. 2003, VAN DIJK R. *et al.* 2002) show that people in the first place need a "human", "understanding" and "respectful" approach of professionals. This cry for humane treatment in medicine is nowadays very common in public discourse, but it also is the *point d'orgue* in medical anthropological research, philosophy and (yes) psychiatry. What does this mean? Does it mean that with "humanness" problems such as those mentioned here could be solved? Is it a counter movement of medicalisation processes within mental health care? I believe we have to be critical in accepting the idea that a "human approach" is a solution. Seeing migrants as "humans" with rights to "human treatment" might be an excuse just as culture might be an excuse for failing therapy. 'Being nothing as human' might be the greatest danger because it depoliticises, dehistoricises and displaces the fundamental inequalities and injustices between people matters in place and people matters out of place (AHRENDT H. 1973).

Immigrants seem to reaffirm and reinforce the social definitions and values to which they do not conform. Entrusting people with symbolising society, its structural elements, paradoxes, contradictions and definition of personhood is not uncommon. Although such a view may have the advantage of providing a way of understanding experiences and persons that are strange and disturbing, it also has limitations. It may reconfirm and reinforce the symbolism of liminality instead of the dilemma of those who are typecast as *liminal personae*. An alternative strategy might be to identify metaphors that migrants use to "make sense of their experience". The category "migrant" is alienating and distancing, because it denies the creativity of the person. Understanding "migrants-with and migrants-as-problems" may better be pursued by studying how they force a connection with the cultural mainstream. I argue that they often do a better job than professionals.

Conclusions

Perhaps I replace repertoires by other repertoires without making substantial progress. However, I have showed that "migrants" in (mental) health

care run the danger of being defined as "migrant", an anomalic category; the social avoidance (also in mental health care) they experience, and a subtler notion of contagious effect attributed to them (the cause of all problems mental health care experiences). Ambiguity and contradiction are features of the category, which is often described in terms of oppositions and contrasts (autochthonous versus allochthonous).

Can such concepts as anomaly and liminality as analytic tools be used to understand the way migrants experience their illness?

It may be important to explore with migrants the extent to which the notion of "migrant" (or refugee or asylum seeker) influences their self-concept and actions. That implies a totally different approach, in which the focus is not on health per se but on "ways of being-in-the-world". If the idea of anomaly and liminality pervades thinking about being a migrant, it may be fruitful for them to consider other ways of thinking about themselves. By exploring this with migrants it may be possible to understand better what it means to be a migrant with a mental distress. This, in turn, may give rise to specific strategies to deal with the ambiguous limbo of migrants. But I am also sceptical about this enterprise. This mechanism explains the power of the unchanged concept of culture as it is used in mental health care, especially in trans-cultural psychiatry. This does not mean that culture is static; it means that culture is used to engender differences without questioning or investigating the answers the Dutch population have to their health problems. This needs research of concrete interactions and idioms used to talk about mental health problems. Underneath 'culture' there is a more serious problem. I agree with Singer and Baer, when they write: «Much of the tension in the [clinical] encounter does not derive from the existence of diverse health subcultures nor is it due to a failure in medical education to instil an appreciation of folk models of health and illness, but rather is a reproduction of larger class, racial, and gender conflicts in the broader society» (SINGER M. - BAER H. 1995). Remarkably, class, gender, ethnic or racial "clashes" are not a part of the mainstream debate of interculturalisation in Dutch mental health care. In the Netherlands, the debate on intercultural health care is not about racism, sexism or class differences; the debate is about "culture". This implies that mental health is not linked to broader structures «as a configuration of power alignments»(SINGER M. - BAER H. 1995: 376). Thus, before discussing inter-culturalisation, we will have to have a debate on taboos in the Dutch society on gender, racism and discrimination; topics that are very sensitive in a society, which sees itself as "tolerant" and "open-minded".

Note

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