

Strengths and opportunities of a universalist approach

The inclusive psychiatric clinic: dealing with asylum seekers

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Summary

In Switzerland, migration and asylum policy have changed dramatically since the end of the Cold War. It has become more restrictive and seeks to categorise people according to the logic of the nation state and its ideas of belonging and not belonging. This contrasts sharply with a psychiatric clinic's general inclusive logic reflecting a universalist perspective based on the Universal Declaration of Human Rights. This article seeks to analyse the contrast and the structuration mechanisms of the two "logics" and how the two are intertwined. By looking more closely at the Psychiatric Clinic of Basel-Land (Clinic), it also seeks to analyse the structure and implementation of the current transcultural approach used by the Clinic since 2008 when transcultural psychiatry was given priority.

Key words: transcultural; psychiatry; refugees; asylum seekers; universalism; Switzerland; liberal paradox



Caught in the liberal paradox

Switzerland, like other European states, is faced with a situation characterised by increasingly greater transnational openness in economic matters and increasingly growing pressure for closure in security matters. This contradictory state of affairs, which has emerged in the context of globalisation, is referred to by Hollifield as the liberal paradox [1].

One of the consequences of globalised markets is migration. Migration happens when there is movement of goods and capital, a significant demand for labour, and a discrepancy of wealth and security between the global south and north. Migration can happen for a variety of reasons, for example when the UK forced criminals out of its over-populated cities and shipped them to Australia, or when people were seeking religious freedom and colonised North America, or – what can be observed now – simply when people cannot live safely in their home country [16].

Migrations patterns often follow prior existing links between countries of origin and destination immigration countries. After World War II, the Swiss state played an important role in actively helping employers to recruit labour from countries such as Italy, Spain and the former Yugoslavia. The already existing infor-

mal networks amongst people from ex-Yugoslavia (enthusiastically recruited until 1989) also provided support structures for many of the refugees into Switzerland in the 1990s.

Even though Switzerland actively recruited the so-called guest-workers in great numbers in order to remain competitive economically, as early as the 1970s it faced political pressure to limit these economic work migrants owing to security concerns. Interestingly, most of the measures that improved the living conditions of the "foreign labourers" or "guest-workers" came not from within Switzerland but from outside: the original work permits granted a 9-month stay without the option of a family reunion. As a result of pressure from Italy (arising from its trade unions) and later the Organisation for Economic Co-operation and Development, guest workers were granted a settlement permit and the right to family reunions after a 5-year stay, i.e., children and spouses would be allowed to live in Switzerland. This change was highly appreciated by employers' organizations as it allowed them to compete with other European countries to attract immigrant workers. It is noteworthy that it was outside forces and not Swiss entities, particularly the Swiss employer organisations, which induced such a change. The xenophobic and security-related concerns present in the Swiss state outweighed other interests aligned with a more open policy [2].

As a liberal democracy, Switzerland is bound by international agreements and legal standards when designing immigration rules and managing its migration regime. An important step was the March 2002 national referendum to join the United Nations and ratify various international conventions that affect migration policies (in particular the Geneva Convention with regards to asylum legislation). Additionally, in 2002 the Agreement on the Free Movement of Persons (AFMP) between the European Union (EU) and Switzerland came into force¹, and in 2005 Switzerland became part of the Schengen Area after the signing of the Schengen Treaty in 2004. As a member of the Schengen Area, Switzerland has to adhere to EU law applicable to Schengen and Dublin, including free movement within the Schengen Area and strict border

1 The AFMP and its additional protocol lift restrictions on EU citizens wishing to live or work in Switzerland. The right of free movement is complemented by the mutual recognition of professional qualifications, by the right to buy property, and by the coordination of social insurance systems. The same rules also apply to citizens of EFTA member states. Due to an initiative launched by the right-wing People's Party that was approved by national referendum in February 2014 the AFMP is now under scrutiny.

control for non-EU citizens, as well as cooperation in asylum regulations.

Two forces have to be considered in order to understand the liberal paradox trap as it applies to Switzerland and, particularly, to understand the context in which an inclusive psychiatric clinic has to operate. Economic forces and international conventions push the individual nation state towards more openness, while security concerns and political strains based on the idea of the enclosed national community push towards closure. As long as the nation state exists with its institutions such as national health programmes, social security systems, and overall protection duties for its citizens, the nation state is unable to fully accommodate a universal right to health provisions, education and protection for everyone regardless of origin.

As circumstances present themselves today, the liberal paradox trap holds specific risks for migrants, and for refugees in particular. For individuals granted a temporary permit to live in Switzerland, ongoing insecurity affecting all aspects of life persists. They may at any time be ordered to leave the country.

This backdrop of insecurity revisits some of the types of concerns that prompted individuals to consider migration and flight. It prolongs and aggravates the anxieties and fears that persuaded individuals to become refugees in the first place. To make matters worse, temporary status does not allow any family unification in Switzerland nor does it facilitate visiting family members abroad. Temporary permit holders are not allowed to leave the country. A person living in this ongoing state of insecurity and with ongoing worries may be subjected to increased health risks.

The inclusive clinic reflecting the liberal democratic tension

Like other public health institutions in Switzerland, a psychiatric clinic is based on the principle of equality. Persons receive treatment irrespective of skin colour, sex or gender, age, religion, linguistic knowledge or impairment. As a functional system, the psychiatric clinic has always been inclusive and at the same time also exclusive: because of its *raison d'être*, mentally and psychologically healthy people would be excluded from it as patients. In this sense it is exclusive, but in all other respects it is inclusive because of its nature as a health institution that admits all persons who require care.

Switzerland grants a general right to medical care without discrimination as part of the basic right of security of existence [3]. Article 41 lit b of the Swiss

Federal Constitution states that Federal as well as Cantonal institutions must ensure that everyone has the right to the care necessary for the person's well-being. All hospitals as well as all medical professionals are obliged to assist in the case of need. This implies that everyone who resides in Switzerland, irrespective of his or her legal status, is obliged to have health insurance. It also implies that people who do not have the necessary means to cover the costs for their health insurance must be subsidised by the Canton where they reside [4].

People are granted access to psychiatric clinics whether they are citizens, residents or individuals without a permit. When looking at the inclusive logic of the psychiatric clinic in our present discussion it follows that the Clinic does not react functionally to the origin of a patient or his/her permit, yet is functionally organised according to the medical and social needs of the patient. Hence, it has developed its own formal procedures and modes of documentation, as well as rational routines like division of labour that allows the system to work properly as a psychiatric clinic. In the systemic logic of its own organisational management, the national or ethnic origins of the patients are irrelevant.

Origin may matter when communication between staff and patient becomes impossible because of linguistic obstacles. In this case, inclusion is context specific: upon their employment all staff are asked about their language competence. Speaking several languages is considered an asset in the Clinic. Over time, a pool of 22 different languages has become available for cases or situations where there is not enough time to organise a professional interpreter. Working with professional interpreters is part of the standard operating procedure, even though it is not always easy to get funding for the interpreter's vital contribution in the clinical setting that enables the psychiatric staff to do their own work professionally. Professional interpreters have to be alerted in advance, which is not always possible in a Clinic that also deals with emergencies and unforeseeable events.

The Clinic's general inclusive character reflects a universalist perspective based on the Universal Declaration of Human Rights. The concept of universal human rights is built on the recognition of the inherent human dignity and of the equal and inalienable rights of each human being. This universalist perspective and the above described inclusive logic contrasts sharply with the logic of the nation state and its migration regime. It lies in the nature of the nation state that the differentiation between those individuals that belong and those that do not belong is made

according to national citizenship. Switzerland as a nonimmigrant country is a typical example of a solidarity group bound by strong inside ties. Membership in the insider group is defined by birth or naturalisation and considered a privilege. Switzerland's migration policy applied a rather liberal handling of mobile people until World War I. But by the end of the Cold War, a comprehensive control system to regulate migration was put in place. People migrating into Switzerland then turned into what Wimmer and Glick Schiller called "natural enemies of the nation" [5]. With the AFMP between the EU and Switzerland the boundaries between nation states within Europe became outdated, but for persons from outside Europe the fortress walls became higher and the controlling regime stricter. One decisive characteristic of the controlling regime is the categorisation of types of migrants. Categories are the base on which the systemic logic of managing the conditions of mobility is built. They define rules of entry, residence, economic and social rights.

Migration research has shown that little "(...) can be more important for the eventual status of immigrants than the legal circumstances of their first entry ... Immigration laws, observed or violated, necessarily precede and often constrain the migrant's interaction with market, welfare, and cultural regulations" [6]. The initial categorisation invariably facilitates or impedes later movement between categories. Liza Mügge and Marleen van der Haar [7] argued that the organisation of immigration and integration policies is tied to the "labelling" of immigrants. As a result, differences between immigrants are introduced and social opportunities, and hence realities, are shaped. The category into which an immigrant falls defines his or her rights, whether he or she is wanted or not, and if there is a requirement for integration measures or not. The set of categories form an organisational principle of inclusion and exclusion based on the logic of national provenance and on national imaginations of cultural proximity and distance. With regards to refugees, the country of origin determines the process of entry and whether the claim for asylum is granted or not.

Implications of categories on asylum policy for a psychiatric clinic

It was shown that the organizing principle of migration rules is based on completely different features than the functional organisation of the Clinic. Sardadvar [8] argued that the healthy migrant effect that can be observed by many migrants at the point of

their initial time of arrival is changed by the conditionality of the legal status. He showed that over time health conditions change because migrants are subjected to physiological and psychological stress related to work. For instance, more often than not qualifications acquired in their country of origin are not recognised and hence they must seek out jobs for which they are overqualified.

Furthermore, health provisions and information are generally communicated in the local language; therefore, to be informed is always connected to an additional obstacle. When a migrant seeks healthcare, normal and basic communication to health staff is often difficult as a result of language barriers.

Asylum seekers and refugees are most affected by ongoing life-determining aspects of uncertainty and insecurity, and uncertainty has the greatest effect on health conditions. The European Network for Rehabilitation Centers for Survivors of Torture draws attention to the fact that, regardless of how well a country of arrival attempts to cater to the needs of asylum seekers and refugees, there remain continuing aspects of anxiety related to physical insecurity (racist or unfriendly attitudes or acts due to physical appearance), psychosocial and legal insecurity (long and complicated legal procedures cause an awareness that security is not guaranteed upon arrival) and material insecurity (limited access to resources and opportunities). Typically these forms of insecurity are interconnected and constitute a health-affecting frame of reference [9].

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The structuring effect of the Swiss asylum system on new arrivals and its effect on the daily lives of those arrivals are significant. Using 2015 as an example, we find the following: the refugee protection quota was 34%; and there were 39523 new asylum requests, of which 6377 people were granted asylum at first instance (B status) and 7050 received F status for temporary protection. After 5 years temporary protection status the case can be re-opened. Average quotas for these cases are difficult to obtain because there are different regulations in each Canton. Persons who did not fulfil the B or F requirements were told to leave Switzerland or were sent back to the country of their first entry into the Schengen Area (Dublin Regulation). During the whole asylum procedure the person carries an ID card with the letter N, which is valid for 6 months and can be renewed. The formal procedures

and routines in order to reach a decision can last up to 500 days, and the average time span between first entry and, in the case of asylum denial, departure from Switzerland is four years [10].

With regards to the life determining structurization power of the various categories, the above-mentioned psycho-social and legal insecurity, as well as the material insecurity factors, must be underlined. The categories are decisive when it comes to security of residence, access to the labour market, family reunification, social security rights and welfare benefits, civil, and political rights. In addition, there is the time factor. The longer the whole procedure takes the more frequent are psychological disorders and health problems in general, and most importantly, refugees exposed to violence before and during their flight suffer from post-traumatic stress disorders (PTSD), chronic pain or other somatic symptoms (cf. [11]), and must have quick access to a specialised treatment for trauma patients.

In addition, there are crucial factors, subtle and “hidden”, that reflect the logic of the asylum regime and how much it contrasts with the logic of a psychiatric clinic, and yet how much the two are intertwined. Based on research from a multi-sited ethnographic study on Kurdish refugees from Turkey coming to Switzerland, Salis-Gros [12] argued that refugees are “pushed” into identifying with the presently predominant trauma discourses in order to become what she called “good refugees” and receive a legal permit to stay in Switzerland, to get access to the labour market and to be united with their families. In short, to lead a normal life and leave the past behind. Before the past can be left behind, however, the refugee must again and again make certain that the authorities “see” the psychological and/or physical damage that was done earlier by adopting the “trauma discourse”. Certain medical diagnoses can be accepted by the Swiss asylum authorities as sufficient reason to grant (temporary) asylum on humanitarian grounds for persons who would otherwise not be accepted. If medical proof can be put forward that the person in question suffers from a physical or psychological condition that does not allow the person to be sent away, he or she is accepted either temporarily or indefinitely for medical reasons.

Salis-Gros stressed the fact that “... medicine plays a decisive role in the daily routine of Switzerland’s refugee politics and in the lives of asylum seekers coming to Switzerland” [12]. Even though PTSD was included for the first time as an official diagnosis in third edition of the Diagnostic and Statistical Manual of Mental Disorders in 1980 [13], it was only in 1999 that the

Swiss government introduced the category “violence refugee” [13]. By the example of a 36-year-old man, in the text called Ekrem, the complex intricacies of law, medical diagnosis, doctors and patients can be shown. Ekrem had suffered from torture in prison, but when telling his story later while in the prolonged asylum procedure he reflected his own adoption of the trauma discourse. He realised how bad it was for him that he constantly has to talk about the past and the time in prison and said: *“The torture was bad, okay, but I had my companions in prison and we supported each other, so I could handle it. My situation here is much worse. I cannot take care of my family, I just sit around ... I am not even able ... to continue my political work without the possibility to move to other countries legally ... I am a broken man. The doctor tells me to talk about all this stuff, and that it would help. But instead it makes me sick even more, if I recall my desperate situation twice a week.”* [13]

We will never know if Ekrem’s reaction was part of a PTSD. Or, if indeed, the best treatment for him would have been to “just” leave the past behind because he belonged to the approximate 60% of all refugees who need the opportunity to build on their own resilience, and through that process pull through the difficulties on their own.

In a white paper concerning the present refugee situation in Europe the president of the dtppp (Dachverband der Transkulturellen Psychiatrie, Psychotherapie und Psychosomatik im deutschsprachigen Raum, i.e., The German-Speaking Society for Transcultural Psychiatry, Psychotherapy and Psychosomatics) states the importance of not depriving refugees of the chance to enhance, independently, their resilience. In order to do this they urgently need security and peace. This need for security and peace is contrary to the ongoing pressure to “enact” oneself as a victim of violence and at the same time be deprived of family reunion and the freedom to travel. Moreover, medical professionals like therapists, psychiatrists and psychologists involuntarily become accomplices of the asylum regime because of the “indecency of the law” (Maier 2015²).

Creating an environment where refugees can develop resilience cannot, however, be assigned to medical professionals alone. It is the responsibility of the society at large. Once individuals decide to flee their country of origin, they must embark on a difficult journey that requires their physical and emotional resources. When at the moment of arrival the exhausting insecurity continues and aggravates as described above people often break down. What they need in order to reactivate their faculty to positively regain levels of func-

2 Thomas J. Maier
paper read at the dtppp
conference in Münster-
lingen 2015.

tioning and develop their stress coping capabilities are protective factors that nurture their (proven) strengths. Next to the internal factors that promote resilience (self-efficacy, perseverance, internal locus of control, coping and adaptation skills) there are external factors that can be provided by society, namely social support networks (cf. [14]). The relationships promoted by these networks can be with professional people, but also with nonprofessionals of the neighbourhood, various religious institutions, in community centres, etc.

Critical appraisal with regard to the inclusive pragmatic nature of the clinic

The universalist perspective that typifies an inclusive clinic prevails at the Basel-Land Clinic. It is apparent in all accessible documents relating to the philosophy or guidelines of the Clinic. However, there are pragmatic arrangements that have over time given room to difference-sensitive, context-specific inclusion formats. I would suggest summarising these as the clinic's strengths with regards to refugees and asylum seekers. One such instance of context-specific inclusion characterised by difference-sensitivity was mentioned earlier with reference to multilingualism. Working with interpreters has long been standard practice. The appreciation and use of several languages has an important organisational function, but it is also an important symbolic gesture. Another instance is how the clinic deals with the different religious backgrounds of its patients and/or their family members. The worship room originally designed in a Christian style has for some time been called the "Hall of Silence" (Raum der Stille), where anyone who wishes to withdraw is welcome to do so, and where the Thora, Bible and Koran are available for those who wish to read the scriptures. All religious holidays are also observed.

These are two examples of how context-specific inclusion of linguistic as well as religious pluralism is done in a very pragmatic way. Another example is the meals offered to cater to religious-, lifestyle- or health-related diverse needs. Other strengths are specific trauma-oriented therapies that are available in the clinic. Since trauma-related symptoms occur not only in refugees and asylum seekers, the therapies are open for all patients, and trauma specialists are available to care for them. Migrants are further encouraged to take part in all nonverbal therapies if this is medically indicated. Additional aspects that reflect the inclusive (universalist) character of the Clinic, and are beneficial for all migrants, are the interdisciplinary and diverse teams

that treat patients, and the knowledge and experience the social work department has developed in legal issues facing asylum seekers and refugees.

These practices of the Clinic are arguably its strengths and lead to further opportunities. With regards to multilingualism, general information for patients is available online in several languages or in those most often needed. However, the multilingual information is not available on paper and may constitute a barrier to some. Multilingual documentation on disease or illness patterns is available on the intranet, but use of the intranet is not yet routine. Further training programmes in transcultural approaches for staff are available, although not compulsory, and supervision routines will be expanded by transcultural supervision. The measures taken at the Clinic at times operate only at the margins and are not fully incorporated. For example, the treatment teams are interdisciplinary and may be comprised of people with different backgrounds; nonetheless there are no standards to ensure that working groups are made up of co-therapists from different ethnic/national backgrounds and with migration histories of their own.

The above examples show that dealing with "difference" and diversity has not yet been incorporated in all of the Clinic's formal operating procedures; however, the process of decentering Western normality [15] is increasingly at the heart of the Clinic's functional organisation and standard practice. The ongoing further training programme that is offered for all staff on diversity competence supports the tendency. The training programme incorporates a difference- and minority-sensitive approach, through which a patient's culture is "read" in the given context and is not nationalised or essentialised. This approach pays tribute to the intersections of discrimination and constantly requests staff to reflect on their own ideas of "the immigrant patient". It also shows ways to interact with patients with a more collectivistic value orientation than the individualistic one that forms the foundation of many Western-based therapeutic approaches. The Clinic has taken important steps to react to the overall political and societal liberal paradox described above. Its ongoing efforts have integrated some of the particular needs and interests of asylum seekers and refugees in its universalist approach, which have allowed the universalist approach and the Clinic to evolve.

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