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Considerations on the relationship between Othering and Public Health¹

Nurcan Akbulut & Oliver Razum

Abstract

Othering is an unprecise term. It usually refers to various constructed notions of belonging and difference that engender marginality and structural inequality. Social-psychological approaches that conceive Ingroup and Outgroup formations as an interaction between cognitive, emotional, and conative processes are not sufficient to conceptualize Othering. An extension to a postcolonial-intersectional perspective is needed to understand the social and discursive character of Othering and the historically grown formation of Self-Other power relations.

In the context of public health, Othering as an analytical lens provides an essential contribution to understanding the link between minority status and health inequalities. Even though Othering processes exist in health care settings, little is known about how disparities concerning care and access to health services emerge as an effect of Othering. Further research on Othering is required to make the impact of difference visible shaped by Self-Other-constructions, which directly influences the (re-)production of health inequalities.

1. Introduction

In this paper, we discuss how Othering can be considered in research on health inequalities. We first approach Othering from two different research perspectives. The first one is concerned with the social-psychological dimensions of ingroup and outgroup formations. The second one considers, from a postcolonial perspective, distinctions of group belonging as a result of historically and discursively grown power relations. On this basis, we identify relevant features of Othering. We conclude with initial considerations about both the relationship between Othering and health and the relevance of Othering in public health research.

¹ The considerations presented in this paper on the relationship between Othering and public health are pursued within the research project OTHER I (RA 880/9-1) of the Research Unit *Refugee migration to Germany: a magnifying glass for broader public health challenges* (PH-LENS). Further information on the project OTHER I can be obtained on <https://www.uni-bielefeld.de/gesundhw/ag3/projekte/OTHER.html>

2. Othering

On a symbolic level, there are many terms that can describe who belongs and who does not belong to a group. These various social distinctions of belonging depend on constructs of differences. They permit social classifications into which certain groups are categorized, often as binaries or opposing pairs; examples are migrants and non-migrants, or regular refugees and irregular refugees. By using these terms, we construct different narratives of the Other, thereby signifying non-belonging (Reuter, 2002). The underlying processes of the construction of belonging take a socially constituent function (Hall, 2004). Roughly speaking, these constructed concepts of belonging (e.g., constructions of national and ethnic belonging), which lead to the assumption that there are definable, clearly distinguishable, and homogeneous social groups, are essential in understanding relevant mechanisms of Othering. In the following, we will examine this further.

2.1. Social psychological dimensions of ingroup-outgroup formations

Several social psychological theories conceptualize Ingroup and Outgroup formations as an interaction between cognitive, emotional, and conative processes (three component model of attitudes) that define and devalue Outgroups as Other (Rosenberg & Hovland, 1960; Kessler, 2018). According to this conception, stereotypes are considered as a cognitive category, prejudice as an emotional, and discrimination as conative or behavioral aspects of intergroup processes (Zick, 2017a). The formation of Ingroup and Outgroups rests on group differences, which are constructed based on prejudices (Allport, 1954).

From a prejudice research perspective, prejudices thus open the way for the formation of social grouping and set one's own reference group (Ingroup) in contrast to the excluded group (Outgroup) (Allport, 1954; Zick, 2017b). Prejudices can appear in both blatant and subtle forms (Pettigrew & Meertens, 1995). The noted prejudice researcher Gordon W. Allport considers a person's bond to his or her own group and the accompanying development of Ingroup affiliations as an inescapable natural process that occurs in every social group, regardless of whether they are members of a majority or minority group (Allport, 1954).

Thus, this approach is based on the fact that genuine group differences exist since it supposes that society consists of real distinguishable groups. Accordingly, group differences relating to features that define cultures, such as shared origins, language, or religious traditions, are subsumed under the concept of ethnicity (Allport, 1954). Social psychology has often been criticized, not least by social psychologists themselves, for focusing too much on individual- or group-centered patterns when trying to explain how processes of belonging are shaped (Tajfel & Turner, 1972; Wolf, 1979; Terkessidis, 2004).

Common approaches on intergroup relations such as the realistic group-based conflict theory (RCT) (Sherif & Sherif, 1969) or the concept of group-focused enmity (Heitmeyer, 2002) point to the importance of group-based attitudes, -prejudices and -conflicts as generators of intergroup differentiation processes and devaluation of Outgroup members. Although

prejudiced knowledge is essential in explaining certain mechanisms of Othering, it is too simplistic to reduce Othering to prejudices or attitudes caused by the existence of different opposing groups (Terkessidis, 2004).² Rather, Othering calls into question the implicit presupposition of social groups and the process of their making. In order to be able to describe and analyze Othering more comprehensively, it is important to include the social and historical imprint of Othering and the resulting power relations between Ingroups and Outgroups. Because without these connections, it is not possible to explain, for example, why certain prejudices in producing and reproducing the Other always prevail. Most social psychological approaches are group-centered and do not include power asymmetries in their analyses to explain how Ingroup and Outgroup affiliations are formed and maintained even beyond group-based structures (e.g., the construction of West and Rest (Hall, 2004)).

Therefore, we consider it necessary to expand the social psychological perspective to include other approaches such as a postcolonial-intersectional perspective.

2.2. Postcolonial view of Othering

Conceptually, Othering emerged in the context of Postcolonial Theory (Ashcroft, Griffiths & Tiffin, 2007). Spivak (1985) and Said (1978), in particular, succeeded in establishing Othering as a critical concept in their famous works.

Postcolonial theorists criticize current relations of dominance derived from long-established power structures (Hall, 2004; Said, 1978; Spivak, 1985). Distinctions of belonging can be described as manifestations of power relations which are produced by practices of boundary-drawing (Powell, 2012). These distinction practices can be functionalized for creating privileged positions in society, e.g., in the form of privileged access to resources (ibid.). Due to their relevance for securing privileges, distinctions of belonging are constitutive in several ways for the discursive construction of the Others (Mills, 2007; Miles, 1991). Othering takes place in iterative processes of comparison, differentiation, and classification. In comparison with one's Ingroup, the Other is produced and an expression of the mutual relationship between Other and non-Other (Bauman, 2017). This comparative and at the same time distinctive juxtaposition between Self and Other creates an asymmetric dichotomy (ibid.). Othering produces a dependent, and at the same time, a power-constituting asymmetrical structure. Within the process of constructing the Other, a normative understanding of an Us simultaneously becomes apparent (ibid.). Constructions of the Other simplify identities and categorize them in a way that makes them seem incompatible, such as the distinction between Muslims and Germans (Akbulut, 2016). The separation of the Self from the Other is also functionalized to maintain antagonistic collective identities (Miles, 1991).

² We assume that Othering is not reducible to individual and group-based attitudes.

Depending on which categories of belonging are used, even dominance relationships between different marginalized groups can become relevant. From an intersectional perspective (Crenshaw, 1989), dynamic power relations between marginalized Whites (such as East Germans or White women) and othered or racialized groups (such as refugees and migrants) can be revealed that are not visible from a one-dimensional perspective (Rommelspacher, 2002; Dietze, 2019). This example indicates that intersectionality is an essential factor that needs to be considered when analyzing Othering. Thus, constructions of the Other can be understood as a social phenomenon since they are both identity-forming and serving specific power interests.

3. The emergence of Othering in migration societies

In Germany, categorizing attributions of belonging – such as the classification of migrants (or people with migration background) – constitute the non-self on a symbolic level. In other words, the discursive production of a consensual idea of (not) belonging arose from the distinction between the Self and the Other (Hall, 2004; Bauman, 2017). This has a far-reaching significance concerning the options for social positioning. The high discursive connectivity of the distinction between migrants and non-migrants, for instance, represents a generally available source of power that can be used by individuals, but also by institutions, because it has a high degree of plausibility (Mecheril, Castro Varela, Dirim, Kalpaka & Melter, 2010).

In many European countries, there is a distorted perception of the number and situation of refugees due to discursive effects. For example, the UK population overestimated the number of refugees in the country by more than eleven times (Galabuzi, 2016); this phenomenon of distorted perception applies similarly to Germany (Hemmelmann & Wegner, 2016). The public representation of the refugees is characterized by stereotypical images that amount to a “demonizing of Others” (Mecheril & Castro Varela, 2016). In this context, refugees are predominantly presented as a general threat to public health and as an unmanageable burden (Grove & Zwi, 2006) by anticipating increased demands on state institutions through the excessive use of social and health services. It turns people at risk into people who pose a risk, e.g., to society, public health, and public safety (ibid.). This general perception of refugees, shaped by Othering, has a powerful impact on evaluating this group both on a social and individual level particularly on their health situation and care needs (see section on “Othering and its impact on health”). Othering processes influence not only the social positioning of groups (ibid.) but also chances and opportunities of direct and indirect social participation (Sachverständigenrat deutscher Stiftungen für Integration und Migration, 2015).

In a nutshell: Othering produces and forces inequality relations between social collectives or categories, accompanied by the attribution of the characteristics real or imagined. In this case, not the categories are regarded as the cause of the power relation but the mechanisms of evaluation and hierarchization involved. This could lead to legitimizations of disadvantageous institutional structures and social practices. Othering furthermore, causes a controlled opening of the Own to the Other to keep the Other’s irritation as low as possible (Reuter, 2002). Othering is structural, embedded in discourses of power and representation. The migration

discourse unfolds a powerful perspective on migrants and refugees through which they become Others – they are made into visible Others allegedly linked to integration and cultural problems (Akbulut, 2016). For instance, through constant reference to cultural differences, the discourse on migration health in public health research plays a major role in constructing an antagonistic culture. In psychotherapy, for example, migrants are often made into othered patients by referring to cultural differences (Oberzaucher-Tölke, 2014). Even if this happens unconsciously and in a well-intentioned sense, it nevertheless promotes mechanisms of Othering such as homogenization and essentialization. Cultural Othering forms the implicit basis of daily practices and usually remains unreflected as it is perceived as normality. Against this background, Othering occurs as a discursive practice among health providers and all members of society.

In response, we hold the following three premises for the investigation of relevant mechanisms of Othering, using refugee health as a particularly illustrative example for similar processes in the population:

- 1) Othering processes are particularly powerful in referring to migrant minorities because of their high discursive visibility (visible minorities). It is assumed that Othering develops a significant impact, especially concerning refugees. This is because the migration discourse has many different connections to topics such as integration, threat, security, Islam. Each may produce powerful narratives/contexts that are present and operative in all areas of society.
- 2) Othering works by referring to discursive connections. For example, the dominant discourse on refugees produces a group of statements, often conceived as knowledge (Mills, 2007). To understand Othering, it is necessary to analyze the dominant discourse, in this case, on refugees and migration.
- 3) Othering feeds premises, ascriptions, expectations, and notions of normality in the research and care of minorities that are difficult to identify due to their implicitness. Due to Othering's contextual flexibility, its seemingly rational forms, and its seemingly plausible but subtle effect, a comprehensive conceptualization of Othering for its empirical analysis is required.

4. Othering and its impact on health

International studies show that minority status correlates with unfavourable health status (Galabuzi, 2016). To further understand the relationship between minority (or in other ways othered) status and adverse health outcomes, we draw on the approach of Othering. We distinguish two different but mutually dependent levels on which Othering takes place. Distinctions of belonging and Non-belonging (Otherness) are produced by discursive force in a dichotomous manner on a symbolic-semantic level and create hierarchies of belonging (e.g., migrant vs. non-migrant). Thus, we understand Othering not only as a semantic differentiation between Us and Them. In addition to a symbolic hierarchy, constructions of (non-)belonging constitute also a material hierarchy within a dominant order of belonging.

On this basis, Othering can have a benevolent effect (benevolent Othering (Grey, 2016)) by treating Others as a particularly vulnerable group and offering support (e.g., health care) to them. On the other hand, Othering can create social exclusion and reinforce disparity in excluded or othered groups' material resources. Correspondingly, symbolic exclusions of the Other, which predominantly operate within public discourses, can affect access to social and material resources such as housing, education opportunities, and particularly health by legitimizing restrictions³ and access barriers in health care. Social exclusion, therefore, is identified as one of the most important social determinants of health (Wilkinson & Marmot, 2003; Galabuzi, 2016).

In the context of health care, Othering can thus lead both to overprovision of health care services through the construction of an essentialized vulnerability and to underprovision of health care services through exclusionary or restrictive structures³.

Othering can affect health in different ways as it occurs in multiple dimensions and forms that vary according to marginalized groups and institutional as well as social contexts (contextual flexibility). In the literature on which this paper is based, Othering is often equated with different forms of discrimination, e.g., racial discrimination and racism, which have many various consequences on health and healthcare outcomes:

1. Othering affects othered persons on an individual level. It influences both mental and physical health outcomes. In this context, Schunck et al. demonstrated that migrants' health is negatively affected by perceived discrimination (Schunck, Reiss & Razum, 2014). Shorter life expectancy, higher infant mortality, and hypertension are described as further significant health consequences associated with Othering and discrimination (Akhavan & Tillgren, 2015).
2. Othering manifests itself at the institutional level of health institutions. Difference-based categories of belonging structure social practices and form social interactions, e.g., by making ethnic or cultural attributions embedded in discursive contexts (Grove & Zwi, 2006). Such categories often have a homogenizing and stereotyping effect. These tend to be functionalized, for example, then when institutional structures become ineffective in dealing with migration-related diversity. Under these circumstances, Othering has direct effects on health care, and thereby implicitly on health outcomes, for example, in the nursing context (Roberts & Schiavenato, 2017). In line with this, nurses and other healthcare practitioners tend to depersonalize their patients through a discriminatory use of language and put their patients in the role of the Other (Peternelj-Taylor, 2004). Devaluing expressions such as "Mediterranean syndrome" (Mittelmeer-Syndrom) and

³ According to the "Asylbewerberleistungsgesetz" (§ 4 AsylbLG), asylum seekers are entitled to health care, which in the first 15 months of their stay is in many German states (except Hamburg and Bremen) limited to acute and pain treatment as well as pregnancy care and vaccinations.

“Morbus Bosphorus” have become institutionalized in clinical settings in Germany based on the widely held assumption that migrants tend to somatize or exaggerate when they describe their pain (Castañeda, 2012). A further study demonstrated that midwives used Othering to decide who accessed services or how care was delivered (Bradley et al., 2019). Thus, for instance, Johnson et al. (2004) were also able to show in a qualitative-ethnographic study a connection between Othering and health inequality using the example of health care for South Asian women by the Canadian health system. They identified three different forms in which Othering is realized: essentializing, culturalizing, and racializing patterns of interpretation. The surveyed subjects (health professionals) often referred to categories such as *culture, origin, religion, race* to explain failures and barriers in care of South Asian women (e.g., low use of health services, lack of success in care). In Germany, there are also significant disparities in access to and quality of rehabilitative care and general health among societal groups (Brzoska & Razum, 2015; Brzoska et al., 2016). In sum, Othering has a profound impact on patient-healthcare provider relationships and the quality and access to healthcare. It results in non-individualized care that does not take the patients’ needs into account (Peternelj-Taylor, 2004). Different studies on medical rehabilitation in Germany (Schott & Razum, 2013; Brzoska & Razum, 2015; Brzoska & Razum, 2017) show that health care structures and services are not sufficiently adapted to the needs and expectations of the increasingly heterogeneous groups of care users, among them Turkish migrants and ethnic German resettlers (Spätaussiedler and Aussiedler). This leads to access barriers and, subsequently, health disadvantages. Barriers to access (e.g., language barriers, information deficits, legal entitlement barriers) have intersectional effects (resulting from the interaction of various difference categories) and affect different social groups to different degrees. Besides barriers restricting access to health services, there are also differentials in health outcomes (ibid.). Refugees not only face access barriers but are subject to legal restrictions of their entitlement to health care (Razum & Bozorgmehr, 2016). Entitlement restrictions reinforce their already difficult access to health services and other support systems. Also, like other migrants, refugees are confronted with discrimination even after the lifting of restrictions on entitlement because health care services are not adequately prepared for the diversity of their clientele (Brzoska & Razum, 2017; Razum, Wenner & Bozorgmehr, 2017). The health care system is therefore faced with the challenge of dealing with the consequences of Othering and developing new anti-discrimination and anti-racism programming that can be realized under the conditions of diversity and difference.

3. Othering has far-reaching effects on a contextual level – an often-neglected dimension. It leads to spatial exclusion (Powell, 2012) by providing a legitimacy basis for spatial segregation practices. For example, isolated refugee camps are being used to “reinsert irregular migration back into the productive logics of society by making out of irregular mobility, either controllable populations or illegalised people” (Papadopoulos & Tsianos, 2013). This phenomenon can be observed both in the mass housing of refugees isolated from society and in the closely linked segregation of migrant children in under-endowed schools (Sachverständigenrat deutscher Stiftungen für Integration und Migration, 2013) combined with substandard housing conditions, which in turn have adverse health effects.

The ideas presented in this section provide a first attempt at understanding the complex relationship between Othering and health. Whether and in what way Othering processes impact the three levels mentioned remains to be investigated.

5. Othering and its relevance to public health research

Othering, as an alienating process, evokes various forms of marginalization and exclusion. This association can also be demonstrated for the health care context in international studies – mainly from English-speaking countries (Grove & Zwi, 2006; Roberts & Schiavenato, 2017; Johnson et al., 2004; Kirkham, 2003). Some authors see the potential for an inclusionary Othering (Canales, 2000; Roberts & Schiavenato, 2017) in Othering processes. Inclusionary Othering is supposed to unfold an integrating force by using the existing asymmetry. It involves a reflexive reference-taking of the Self to the Other. In turn, this should lead to a questioning of one's perspective on the Other and the associated evaluations and finally to an increased awareness of excluding Othering processes. "Role-taking and world-travelling" (Roberts & Schiavenato, 2017) are described as inclusion-promoting projects. It is doubtful whether Othering has any inclusive potential since the idea of an inclusionary Othering is inherently contradictory. Othering causes exclusion already on a semantic and symbolic level. The notion of inclusionary Othering is not theoretically sound enough to be convincing and cannot be derived from primary literature on Othering (Said, 1978; Spivak, 1985).

There are hardly any studies in Germany that deal with the construction of the Other in and through the health system. Coors and Neitzke (2018) suspect that Othering is effective in the already asymmetrical communication relationships – for example, in the doctor-patient relationship – and see it as an increasing factor of inequalities. Although Coors and Neitzke agree upon Othering as unavoidable for the constitution of the Self as well as for the shaping of the relationship between the Self and the Other, they plead for an ethically responsible approach to Othering. They also refer to inclusive strategies of Othering and demand critical self-reflection as a fundamental ethical competence for health professions. It remains questionable whether an awareness-raising for excluding tendencies of Othering is sufficient to change or overcome socially prevailing inequalities. On the one hand, the structural and social impact of Othering is ignored. On the other hand, the discursive power of Othering within the development of including structures and concepts is wholly disregarded.

We postulate that concepts of diversity as social opening processes, and in particular the opening of health care institutions, can only succeed in the long term if theoretical and empirical insights concerning the effects of Othering are taken into the design of opening processes and are implemented in appropriate (preventive) structures. For diversity processes to be successful, it is necessary to point out historical structures of exclusion and dismantle their continuing causes.

Despite the evidence that Othering exists in healthcare settings, little is known about how disparities concerning care and access to health services emerge as an effect of Othering practices. Therefore, further research on Othering is required to make the impact of difference

and the invisibility of unequal treatment visible shaped by self-other-constructions on a material level, which – that is the assumption – has a direct influence on the (re-)production of health inequalities.

Health inequalities are primarily considered through social determinants (e.g., poverty, social background) and contextual determinants (environmental factors such as housing conditions, noise pollution). However, the social impact of discursively relevant difference categories (e.g., migration, culture, ethnicity, religion) in their structural functionality and intersectional encounter for the health care system and health care is not fully understood. Othering, offers a productive research perspective for a difference-related analysis of disparities in public health.

So far, Othering is not considered in explanatory models on health inequalities; one reason for this is that the Othering approach for this field of research has not yet been sufficiently investigated theoretically or empirically. Also, there is no systematic concept that provides theoretically founded knowledge of the characteristics and mechanisms of Othering concerning the health system, nor are there validated instruments for measuring Othering processes in health care. This gap points to a considerable need for research on a comprehensive theory-based conceptualization of Othering in the context of public health for further empirical research.

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