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2.14 Othering, marginalisation and pathways to exclusion in health

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Introduction

An important part of our understanding of social exclusion is that, rather than a dichotomy of included or excluded, there is recognition of long-term processes, grounded in social dynamics and individual experiences. One of these processes is 'othering': marginalisation through being 'the other'. This chapter explores othering and illustrates how it can operate in multiple ways with both positive and negative effects (and indeed affects), acting as an inclusionary process in some circumstances and an exclusionary one in other circumstances. We explore othering in both inter- and intra-personal terms.

We begin by offering a brief overview of the concept of othering, and the related notion of stigma. The process of othering is then explored in a number of different ways. First of all we examine how stigma, secrets and dissociation act as exclusionary othering processes for victims of abuse. We then turn to look at othering and the self in health protective decision-making, exploring how candidacy acts as an inclusionary process in breast screening. The final section explores some more general implications in terms of othering, health, and inclusive health care practices.

Othering and stigma

Othering is the social, linguistic and psychological mechanism that distinguishes 'us' from 'them', the normal from the deviant (Johnson et al. 2004; Grove and Zwi 2006). Othering marks and names the other, providing a definition of their otherness, which in turn creates social distance, and marginalises, dis-empowers and excludes (Weis 1995). Some have argued that othering serves a psychological purpose, where an 'exclusionary urge' (Hubbard 1998: 281) satisfies a need to keep psycho- and socio-spatial proximity 'clean' from deviant, dirty or threatening others, and maintain moral normality. Freud (1930) suggested that othering was an inevitable narcissism; that peaceful groups are made possible only by the presence of others that could be viewed negatively. Ideas of 'in-group' and 'out-group' were illuminated and explored in the models of Social Identity Theory (Tajfel and Turner 1986).
Reflecting the key principles of othering, Social Identity Theory posits that people are aware of, recognise and evaluate others in terms of adherence or belonging to social groups. This is dependent on *naming the other* to form ideas of group membership; *defining otherness* to identify some people as an in-group and others as an out-group; and *marking the other* so that the out-group members are less favoured when compared to the in-group. In-group differences from the out-group are magnified (increasing social distance) whereas differences within the out-group are minimised (marginalising individuals) and this out-group homogeneity is expressed through negative stereotypes of the group members (Brown 2000). In this way, othering leads to ‘in-group identity and out-group antipathy’ (Huddy 2007: 130). However, othering is not necessarily the end of the process.

Othering is a key part of the production of stigma. Stigma, literally meaning ‘mark’, was first described as a social phenomenon in terms of being a ‘deeply discrediting’ attribute (Goffman 1963: 3). Present conceptualisation of stigma tends to focus on the process and socially constructed devaluation of ‘marked’ individuals, and the subsequent exclusion from ‘unmarked’ society. This process is underpinned by othering. Stigma occurs through a categorising label on the basis of an individual attribute (the mark), the marked are separated from the unmarked and the marked label is given meaning by a stereotype, which bears emotional weight and social distance, and excludes the marked through loss of status, and loss or lack of structural power (Link and Phelan 2001b, 2006; Link *et al.* 2004). Stereotypes are collectively understood, through shared cultural knowledge, and can therefore act as ‘cues’ to an individual that identifies with the marked label, threatening to devalue their identity. In this way, cultural knowledge of the stigmatised can act as form of social control (Bourdieu 1977b) and legitimise exclusionary processes: in this way stigma can be ‘highly pragmatic, even tactical’ (Yang *et al.* 2007: 1528). Othering represents one of the ‘generic processes’ of the reproduction of inequality, leading to oppression through identifying ‘difference as deficit’, the exertion of power through moral identities of superiority or success, and the defensive othering by marginalised people as a means to reassert a credible self (Schwalbe *et al.* 2000: 432). Further inequality processes include subordinate adaptation, elitism of cultural capital, violence and threats, scripting emotional responses and conditioning discourse; maintaining or expanding the gap between the powerful, advantaged, in-groups and the marginalised, disadvantaged others (Schwalbe *et al.* 2000).

Othering, marginalisation, stigma and inequality are inter-related concepts, with a shared component of rewards for being ‘normal’ or like ‘us’; and costs for being different, deviant or like ‘them’. For public health issues, these abstract concepts are seen at work in how people respond to health threats. Othering can be a coping mechanism to manage threats to your wellbeing; keeping secrets and non-disclosure are ways of avoiding health threats and being ‘othered’, as illustrated in the previous chapter around HIV stigma. Conversely, using othering to distinguish yourself from health threats can maintain in-group benefits.
Othering and the self in sexual and domestic violence: how stigma, secrets and dissociation act as exclusionary othering processes for victims of abuse

Secrecy can be a way to avoid being ‘marked’, to avoid othering, labelling and stigma; secrets are kept to protect self-identity and esteem and out of fear of the consequences of revelation (Afifi and Caughlin 2006). However, keeping secrets, particularly those with ‘identity salience’ or attributes that make up essential life roles or status, can have negative consequences in itself. The burden of keeping a secret can lead to emotional distress, worry and a lack of self-authenticity. The weight of this burden is inferred from the sense of relief that can be experienced when the secret is shared, but the quality of the relief is dependent on who the secret is revealed to, their reaction, the potential for consequences of revelation and the social and psychological meaning of the secret (Bouman 2003). In some circumstances, the value of keeping a secret outweighs the burden of keeping it, and secrecy can be a coping mechanism for those in fearful situations, such as the threat or experience of sexual and domestic violence.

Secrecy is concomitant with childhood sexual abuse and children may keep abuse secret in order to protect themselves and others from an abuser that threatens further harm for revealing the abuse; secrecy can be a coping mechanism and a containment of abuse (Lyon 1996). It can also be a containment of the consequences of abuse. Denying domestic violence can be a way of avoiding reprisals from the abuser, avoiding police involvement and loss or incarceration of the partner and/or the children’s parent, avoiding social worker involvement and fear of losing children into the care system, avoiding losing family support, and avoiding the stigma attached to not being believed. An understanding of what would happen to the ‘me’, if I became another me that revealed the abuse, and all of the consequences that ‘other’ me would have to endure can be a strong motivator for secrecy as a coping strategy. Children who have been abused, and do start to reveal that abuse, often tell their secrets gradually, disclosing one aspect of abuse whilst keeping others secret, testing the reaction before further disclosure. In this way, they can bridge the identities of the ‘me’ who kept the secret and the ‘other me’ who ‘told’ (Hershkowitz et al. 2007). ‘Not telling’ can also be a function of psychological secrecy. Enforced secrecy can inhibit memory formation and full cognition of the abuse, removing the words, labels and naming of abuse needed to encode the story of experiences (Fish and Scott 1999). Here secrecy can represent a form of self-othering, where negative experiences or chaotic thoughts are contained within a second (dissociated) self, to protect the everyday self from feeling, thinking about or remembering traumatic events. This suggests a complex relationship between self and identity, and the need to keep secrets from the self as coping mechanisms to keep a functional self intact.

Creating a ‘not-I’ compartmentalises trauma within one fragment of the self, and within the social and psychiatric context of Western bio-medical
models, the ‘experience of “not-I-ness” has become the psychiatric category of Dissociative Identity Disorder’ (Scott 1999: 444). For the individual, the trauma is inscribed on the self twice; as the traumatised identity holding the traumatic events within the self-fragments and as the destabilising experience of not-I-ness with emergent psychiatric disorders (Scott 1999).

Self-othering does not have to be necessarily secretive, nor pathological. Jung (1961) referred to having two selves as part of healthy psychological functioning; personality number one is normal and everyday; personality number two is naturalistic and closer to dreaming. Self-othering also emerges in the grey area where your situation is neither imminently harmful nor coherently healthy. For example, sex workers and strippers who use outward ‘personas’ when working (self othering and keeping part of the self secret from others) and who differentiate themselves from other sex workers (out-group othering) to cope with the realities of their work as well as their stigmatised group identity (Barton 2007). Here, there is secrecy of the self and distance from others, but not secrecy from the self.

Keeping part of the self secret from the self (e.g. dissociation), self-othering (e.g. sex worker personas) and secrecy (e.g. non-disclosure) represent a range of reactions and coping strategies that may be employed to manage the experience, knowledge and repercussions from sexual abuse, invasion and violence. These processes lead to a marginalisation of the self, marginalised from the self and from others. However, there is a further, malevolent dimension to marginalisation in sexual and domestic violence – that of the intentional marginalisation perpetrated by the abuser. Isolation from peers and family that often occurs with the escalation of domestic violence is marginalising, eroding the victim’s connections with their in-group and othering the victim from ‘safe’ society. Humiliation, a common feature of power and control abuses, is closely related to stigma by making the victim feel ‘marked’ and discredited (Karlsson 2007). Othering processes that are imposed from without (by the abuser) combined with coping self-othering from within (by the victim), can help to illuminate the complex, threatened and excluded identities of victims of sexual and domestic violence and those victims accessing health and help services, disclosing or keeping secret their experiences.

Othering and the self in health protective decision-making: how candidacy acts as an inclusionary process in breast screening

Candidacy is the notion of who is a good or likely candidate for a disease, and reflects an informal or lay nosology of diseases, health and who is at risk (Taket and Barter-Godfrey 2005). This can be an anthropomorphic characterisation of a disease – he is a heart attack waiting to happen – as an articulation of risk factors and aetiology (Emslie et al. 2001).

Conceptualising candidacy as an othering process, we can see that the mark or label is the disease; the stereotype is the lay understanding of causes and occurrences of that disease; and the distance between others is how
individually we separate or align ourselves with candidacy. In short, candidacy is othering on the basis of whether that disease happens to 'people like me' and whether my health identity is 'marked' or threatened by that particular disease. Understanding our own candidacy expresses our perceptions of risk burdens and our vulnerability to diseases (Pfeffer 2004).

From an othering perspective, role models are aspirational others, a champion or leader for a desirable in-group. In public health, role modelling is used in health promotion campaigns, with role models acting as the 'face' or 'ambassador', through celebrity or athlete endorsements. Similarly, 'success stories' in weight loss programs use role modelling to encourage identification with the 'common man': if I can do it, so can you. These approaches to health education draw on principles of candidacy by embodying health issues and principles of othering by 'marking' or labelling a person, defining and defined by a culturally understood attribute. Health, diseases and health behaviours become written on the identity of the role model. In response to this positive other, people can identify with and aspire to healthy decisions and behaviours. This continues into health educational materials – can the reader identify with the case studies and illustrations used in information and pamphlets? For breast screening it has been noted that diagrams used to explain self-exam and mammography procedures are unrealistic, with small, perky breasts that bear little resemblance to the post-menopausal bodies of breast screening service-users. The materials, which are supposed to inform and assist women to prepare for mammography, do not identify with the lived experiences of the readers, and create social distance between the service-users and representation of who the service is for. Aspirational role models, when these are unrealistic, can increase social distance, as observed in the phenomenon of beauty magazines that make you feel ugly. The inclusionary quality of role models is in part dependent on the inclusiveness of the role model herself. Simply, health education materials need to represent a realistic image of the people 'like us' who use services, and minimise social distance between the health service materials and the users in order to draw on the inclusionary potential of role models and candidates.

By aligning yourself as distant from a health threat (one that 'doesn't happen to people like me'), an individual can protect their healthy identity, out-group othering the disease and avoiding 'unnecessary' concern. Non-candidacy, or othering the disease, can make health advice personally irrelevant and self-exclude from uncomfortable health guidance (e.g. smoking cessation) and prevention programs (e.g. attending breast screening). Conversely individuals affirming candidacy, particularly where an individual feels fatalism, are more likely to identify and take action on relevant health threats and participate in prevention or detection programs. Fatalism manifests as perceptions of genetic inheritance, or that a disease is 'in the family'; or as a faith-fatalism perception that destinies are in the hands of gods and that human agency is not plausible; indeed to look for cancer was to invite it. If you feel marked, like breast cancer is written on you, because family members have been
diagnosed, or because you identify with the 'sorts of women' who develop breast cancer, you are more likely to attend and consistently attend breast screening appointments. In this way, identifying with the health threat and assessing yourself as a potential candidate for breast cancer is an inclusive process, and connects individuals to appropriate health services. Importantly in the case of breast screening, the label (the mark or the disease) is not stigmatised and therefore the othering processes can encourage healthy, inclusive and age-appropriate behaviours. Where the label, or the disease, does have a stigma attached aligning with candidacy may have costs for the healthy identity of the candidate. As commented earlier, the shared cultural knowledge of a stigmatised disease (for example 'avoidable' diseases where the sick become blamed for their own sickness) acts as a cue to the individual, who in turn may resist the disease candidacy and self-exclude from health programs. Disease stigma can also promote secrecy, where the candidate avoids social repercussions of their health threats, by concealing their vulnerability, an example of which is non-compliance with partner contacting schemes in sexual health clinics.

Candidacy does not have to be fearful; awareness of potential candidacy can motivate health protective decision-making and behaviours, such as attending screening, that lead to reassurance and informed management of health risks (Taket and Barter-Godfrey 2005). Identifying with women who can benefit from breast screening becomes inclusionary, increasing attendance and providing the anticipated benefits, either as reassurance or as early detection. Women also identify that noticing changes in their body (not just 'lumps' in the breasts) motivated them to attend breast screening; physical changes remind us that we change as we age, and re-align our candidacy with those requiring breast screening, again including women as service-users who may benefit from the screening service (Taket and Barter-Godfrey 2007).

In this way, those who engage in candidacy, in non-stigmatised and non-fearful ways, and who accept reasonable health threats in perspective of their own vulnerability and capabilities to protect their health, become more included within health services and prevention systems. To an extent, reasonable othering towards yourself that identifies with the need to take precautions can encourage adherence to public health guidelines and promote the inclusion and uptake of services by those who need them most.

**Othering, health and inclusive health care practices**

By decreasing the social distance between service users and service providers, there can be a greater identification with health advice leading to greater uptake of health benefits of services and behaviours and more inclusive service coverage. However, social distance is moderated by the 'in-group' powerful others and so it is incumbent on the service providers to narrow social distance. Pathways to narrowing the gap include revising practices, campaigns, imagery and representations that are inaccessible to the communities they serve.
Idealised representations need to be balanced against being unattainable or over-aspirational, appealing to the identities of target groups but also offering coherence with their self-perceived capacities for consumption, change and lifestyle choices. In increasingly multi-cultural areas there may be a shift away from photography and literal representations of the target audience to more schematic diagrams as more identifiable and inclusive for a range of ethnicities and cultures. Alternatively, the natural diversity of a community may be reflected in a variety of health promotional materials and services, with tailored messages and programs for under-served groups. In this way, pathways to inclusiveness can be parallel to pathways to equitable health provision. The experiences of health care, as well as how services represent themselves, needs to be culturally competent, to support inclusion and equity. Culturally competent care requires recognition of othering as a power issue for health providers to manage, and respond to by engaging with the othered, connecting with and facilitating reciprocity with out-groups, the stigmatised and under-served communities, challenging othering, stereotypes and stigma, and integrating cultures and diversity of identities in community care (Canales 2000; Canales and Bowers 2001).

At an individual level, competent care needs to recognise similar processes, that people bring complex and sometimes fractured identities particularly in services that see a high proportion of violence and psychological trauma. The value of personal information should not be underestimated; the labelling processes involved in revealing aspects of private lives to health professionals can challenge, reinforce and change self-perceptions and identities. The consequences of revealing or concealing information have ramifications outside the health provision sphere, and professionals need to understand these in able to be able to offer appropriate care. This includes providing ways for people to reveal threatened identities and secrets in a safe and private way that supports transitions of identity and does not marginalise the individual. In particular, health professionals need to respect and value the role that privacy and information control has in the coping strategies of threatened or abused people, whilst encouraging expression of the hurt, abused or violated parts of their life stories. Individually competent care needs to recognise othering, challenge stereotypes and stigma and support the integration and diversity of the clients to provide socially and identity inclusive care.