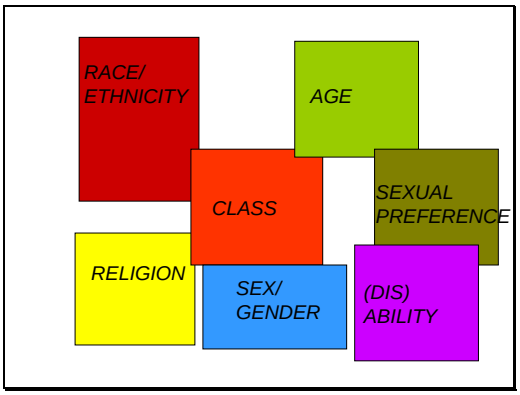
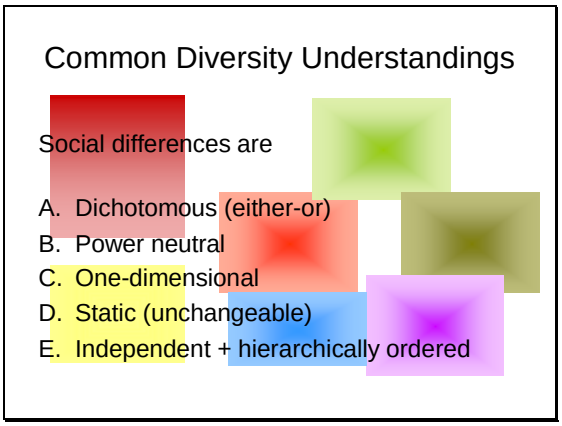
IMPROVEMENT of HEALTH and SOCIAL CARE



with an INTERSECTIONALITY APPROACH to DIVERSITY [1]

Frequently, "diversity" focuses merely on ethnicity. A less narrow, though still limited view also takes gender into account. But, in its broadest sense, diversity includes many possible social categories, such as sexuality, age, dis/ability, class, and, in some cases, philosophy of life or religion[2].

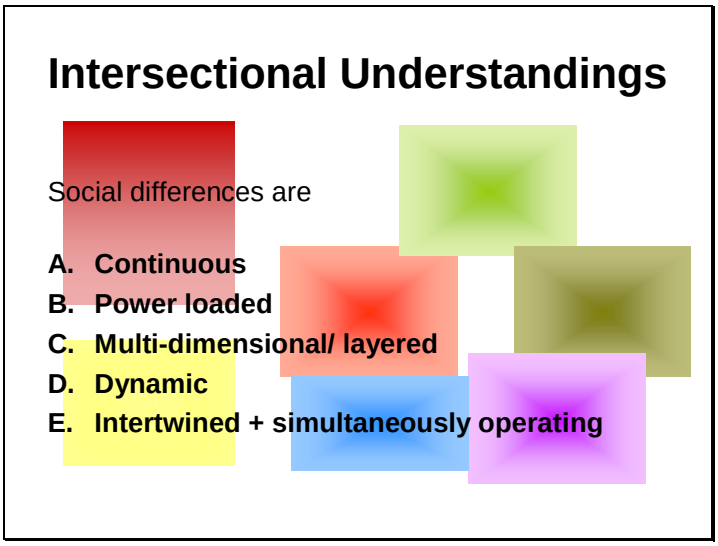
Talking about "Categories of Social Difference" is not simply an academic way of talking about social positions, social groups and social disparities. It is a way to emphasize that social distinctions have been made and that possible similarities were ignored –to divide people into categories on the basis of specific characteristics. So, categories of social difference must be understood as principles of social organization. And the categories of difference just displayed, express the main ways in which we organize our society. But it is important to keep in mind that those differences are constructed at the expense of ignoring similarities.



Usually, we don't spend much time making our understandings of diversity explicit. But today, I will make an exception. On this slide you see an overview of five common, but

[1] In cooperation with professor Lorraine Radtke (University of Calgary)
[2] Nkomo and Cox (1997)

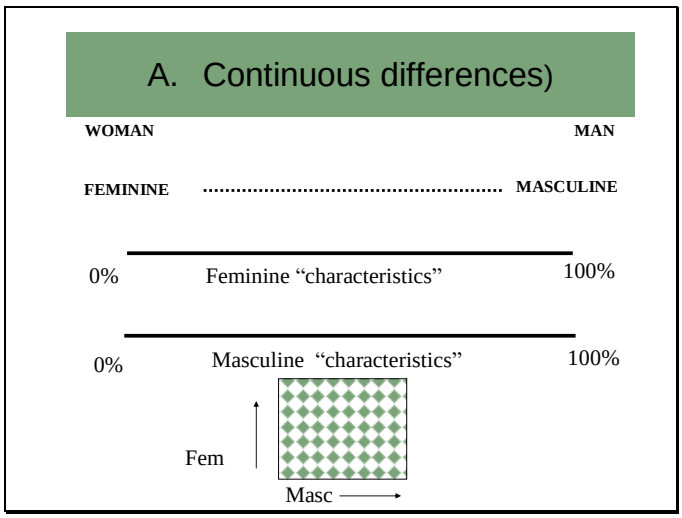
problematic views of social categories. The first four are about the conceptualization of categories as such; the last one is about the conceptualisation of their combination.
Firstly, categorical differences are generally treated as dichotomous. It is a matter of "either-or": man or woman, hetero- or homosexual, and also able bodied or disabled.
Secondly, categorical differences are treated as independent of power relations. That is, as if belonging to one or the other subcategory does not affect a person's social influence or status. Thirdly, each category is defined in uni-dimensional terms, that is as based on either cultural differences or psychological differences or biological differences. Fourthly, the differences are understood to be static and permanent: men will remain men, women women; immigrants cannot become autochtons. Et cetera.
Finally, categories of differences are seen as mutually *in*dependent, but ordered hierarchically: one being more important than the other. Together, these ways of understanding social differences constitute what I have called a "false flat". (This term comes from cycling, and refers to a track that seems flat, but is – instead – treacherous).



In contrast, the intersectionality approach offers a much more complex track to be tamed. Here I show you a brief overview in advance. The categories of social difference are conceptualized as continuous, entailing power relations, multi-dimensional (multi-faceted), and dynamic. Finally, and importantly, they are viewed as intertwined and inseparable.

In the following I will provide a more detailed discussion of each characteristic of social differences. To explain the continuity of social differences, I will deconstruct two categories: sex/gender and ethnicity.
In the last 40 years, the category "sex" has developed from the view that biologically you are either a woman or a man into the view that biological beings can vary in the characteristics associated with *sex*, i.e., chromosomal make-up and hormonal processes, as well as in terms of *gender*, the extent to which they act feminine or masculine. A uni-dimensional view that

placed "pure" masculinity at one end of the continuum, and "pure" femininity at the other end of the continuum was largely replaced by Bem's two-dimensional model in the 1970s, which created independent dimensions, with "androgyny" allowing for the combination of masculinity and femininity.

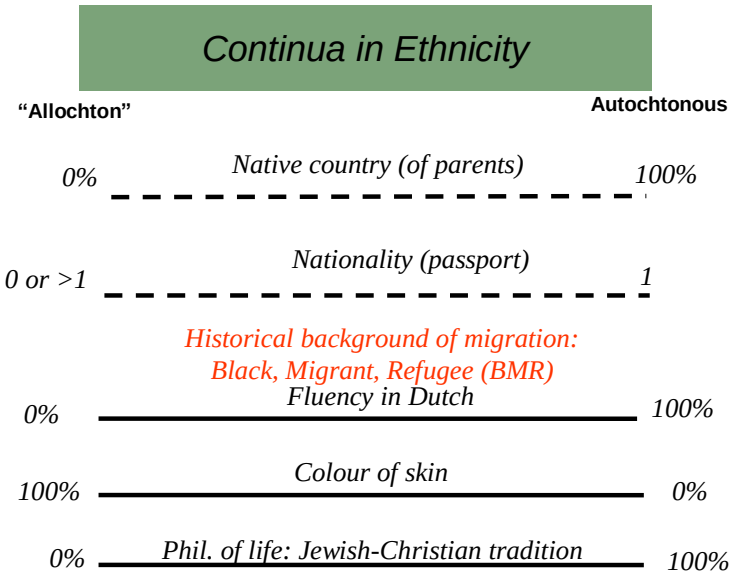


Nowadays, in gender studies, we hold the view that gender is fluid. It is a matter of self-production or self-invention on a checkerboard of femininity and masculinity, on which each person may take several positions during her lifetime. From a taxonomic point of view, this offers space for many forms of hybridity.

Concerning ethnicity, I will speak from my Dutch experience. Until the 1960s, The Netherlands was very white, with a small minority of people from the former Indonesia colony. Then, we invited many migrant workers – firstly from southern Europe, then from Morocco and Turkey, and we expected them to return to their home countries after several years. So, nobody - either the Dutch-speaking population or the migrant workers -, saw the necessity for the migrant workers to learn the Dutch language. All this turned out to be otherwise when, in the 1980s, reunification of migrant families in The Netherlands became the trend. Simultaneously, we received streams of *non*-European refugees, who also did not speak Dutch. Furthermore, the independence of Surinam, in 1975, had already brought many visible minority people who (sometimes) practiced non-western religions, to The Netherlands.

In the 1980s, Dutch policymakers (with the best of intentions!) aimed at organizing assistance for the backlog of immigrants, and began to make a new distinction. They started to distinguish "allochtons", i.e. individuals with at least one parent born outside The Netherlands from "autochtons", individuals with two parents born in The Netherlands. So, suddenly, my family included four allochtons: my husband, my two sons and my daughter. (Their employers welcomed them for improving their statistics on the personnel ladder of diversity.) It took some time before the policymakers refined their criterion to limit those qualifying as "allochtons" to those with ´a parent from a non- western country', hereby

excluding the children of parents born in the former colonies. As a consequence, now my family consists entirely of autochtons. … In the meanwhile, the term "allochton" has shifted from a neutral into a derogatory meaning.



Other criteria employed for making ethnic distinctions in The Netherlands include: Having two nationalities or passports (or none), fluency in Dutch, colour of skin, and type of religion or philosophy of life. And (analogously with the sex/gender continua,) the ethnicity category does not consist of two clear-cut subcategories but of a collection of mixed forms – or "hybrids". F.e. many Dutch people (including my granddaughter and daughter-in-law) have a second passport; Moroccan and Turkish people of the second generation speak fluently Dutch; and visible minority, transnational adoptees grow up in white Dutch families where they learn the norms and practices of white Dutch society.[3] "Allochtons" themselves – in particular the politically conscious ones – like to articulate the reasons for their staying in The Netherlands. Primarily, these entail being transplanted due to the independence of former colonies, economic necessity, or seeking political asylum. This is abbreviated as Black, Migrant or Refugee.

An important lesson to be learned from this is that **"**ethnicity" not only refers to outsiders but also to "autochtons", whiteness, Dutch nationality, and Christian religions. Another lesson is that it is sensible to explain – and to reflect upon - what you mean when saying "ethnicity", because it enc**o**mpasses quite a collection of continua that cannot be reduced to one another in some simple fashion.
So far the first characteristic of social differences. Now we will turn to the second characteristic: power differentials.

[3] Wekker a.o. (2007)

B. Power-differentials within social categories

- One end is higher valued than the other and functions as standard.
- The dominant pole is invisible
- There are privileged and minoritised positions within each category

In our western, democratic societies, we like to think that people's ascribed status, or the identities they take up themselves, do not matter in relation to their influence or social value. But reality is different. Even if we treat categories as consisting of descriptive continua, we cannot deny that one end is valued more highly than the other, and thus sets the societal standard for the other positions on the continuum, pathologising those who depart from that norm. The privileged positions in western societies include: Men (over women), heterosexuality over gay/lesbian/bisexual/ transgender, and adult age (between 25 and 45) over either young or old age.
Being privileged means: Having social, cultural, economic or ethical capital, or some combination of advantages. Besides, the advantages for privileged people are mostly taken for granted, and not consciously noticed. They are almost invisible, so to speak, which makes it difficult to identify the contents of the knapsack. As a rule, insight into one's own privileges is not readily evident. One may listen to "outsiders within": people who participate in the privileged group but are - or have been - also part of the minoritised group (upstairs-downstairs, is an example).
In 1988, Peggy McIntosh constructed the *knapsack analysis of white privilege*. I cite just a few examples from her 50 statements:

1. I can if I wish arrange to be in the company of people of my race most of the time.
6. I can turn on the television or open to the front page of the paper and see people of my race widely represented. (And positively represented, I would add).
8. I can be sure that my children will be given curricular materials that testify to the existence of their race.
15. I do not have to educate my children to be aware of systemic racism for their own daily physical protection.
17. I can talk with my mouth full and not have people put this down to my color.
21. I am never asked to speak for all the people of my racial group.
41. I can be sure that if I need legal or medical help, my race will not work against

me.

As a result of this invisible privilege, the term "diversity" frequently is used to refer only to the group with the minority status, instead of enc**o**mpassing every power position. In the intersectionality approach, however, diversity means more than women; people of colour; gay/lesbian/bisexual/transgender people; disabled people, the elderly and so on. This approach claims that people are minoritised or privileged – not by inherent properties – but by all kind of socio-historical and political processes pushing them towards a disadvantaged or advantaged position.

Additionally, the intersectionality approach recognizes the possibility of combinations of privilege and minoritisation[4]. For example, some members of so-called disadvantaged groups also hold privileged identities: e.g. middle- or higher class Blacks, White women, and able-bodied elderly. Such contradictory mixing also exists for privileged groups, as in the case of men who are Black, gay or unemployed; White people with disabilities, women professors, and so on. Such combinations may cause unease, because they disturb easy stereotyping. On the other hand, by focusing on power relations, we notice unexpected similarities that may be relevant for health and social care. We may come to understand health and social issues in a new light and see correspondences that previously were not apparent. For example, the psychological sense of "being under siege"(p. 212) on multiple fronts associated with the lives of Black middle-class men[5] may - in terms of mental health outcomes - bear some similarity to the psychological consequences for working- class White men -- of feeling that economic restructuring, changes in gender roles, ~and increased immigration have eroded privileges they previously held with respect to their status as earners, their gender, and their race.

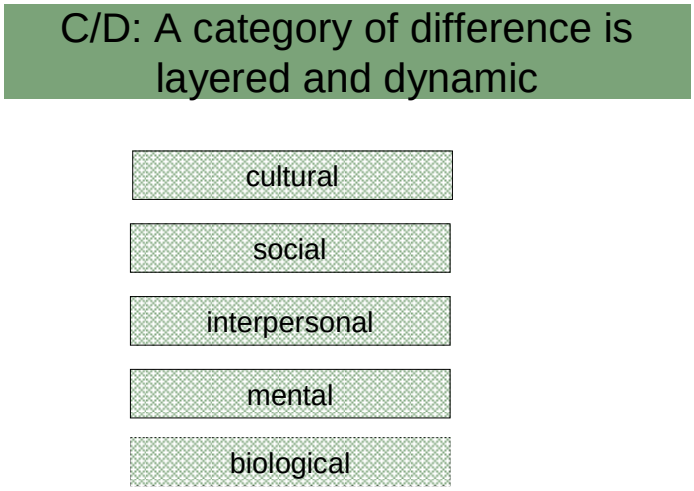
However, I would like to emphasize that power is not negative in itself. In my view, -- and in this respect I follow Foucault ---, power can be positive in that, for example, it is also associated with having the strength to demand access (to services, for example), to normalize certain practices, to enable, to inspire and to create order.

The third and fourth conventional views were that a category of difference would be one-dimensional and static. Instead, intersectionality theory claims multi-dimensionality - or layeredness - and dynamic processes associated with each category. Usually, at least 3 dimensions are distinguished: biological, personal and symbolic. But the number of

[4] …. highlight that groups and communities do not occupy the position of minority by virtue of some inherent property (of their culture or religion, for example) but acquire that position as the outcome of a socio-historical process' (p. 59). Commensurate with intersectionality, as a concept, minoritization is said `to encourage a reading that indicates areas of continuity as well as differences of position between women from different minoritized groups – so spanning the black/white divide that usually structures the discussion' (Burman 2004, p. 60, footnote 2).

[5] Weis, Proweller, & Centrie (1997) in Cole (2009)

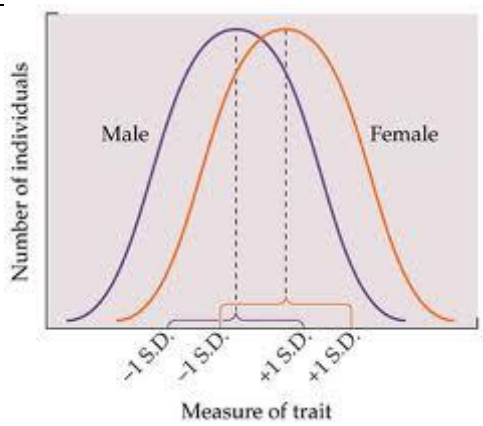
dimensions can be adapted to the relevant problems and context. For health and social care, I prefer at least 5 layers: biological, mental or psychic, interpersonal, social and cultural.



Let me give the example of sex/gender. Thanks to cultural anthropology, sociology, social psychology, developmental psychology and biology, it is possible to do this much more systematically, based on a number of theories, models and research findings. Today, I will limit myself to a quick overview, just to sensitize you to the topics.

For a long time the biological layer of sex/gender has been taken to be the genital organs. Gradually, this was extended to hormones, and genes. Nowadays, much emphasis is put on the operation of test**o**sterone, **e**strogen and oxyt**o**cin. It has been argued that testosterone explains the risk-taking behaviour of men (but estrogen too), whereas oxytocin is held responsible for women's inclination toward caring for others (,albeit only within their *own* group). Anyhow, experiments have reported that men became more empathic after receiving oxytocin, f.i. Since the neurological sciences are booming, research reports on sex differences in the brains are also readily available. However, we should never forget scholars, who some time ago, already pointed out that all such sex differences are statistical constructions, founded on the creation of two groups that supposedly differ in some absolute way when in fact relative differences are at stake.[6] Actually, the same procedure is applied physically in the case of hermaphroditism or intersexuality: In the Western world this phenomenon has been almost eliminated by surgery. Subsequently, its existence in non-western cultures has been pathologised.[7] he only certainty seems to be that there are more women than men with an **i**nclination toward caring; and the probability that a woman will engage in caring for others in ways other than financial is higher than that for a man.

[6] Anne Fausto-Sterling (2000)
[7] Lena Eckert – dissertation(2010).

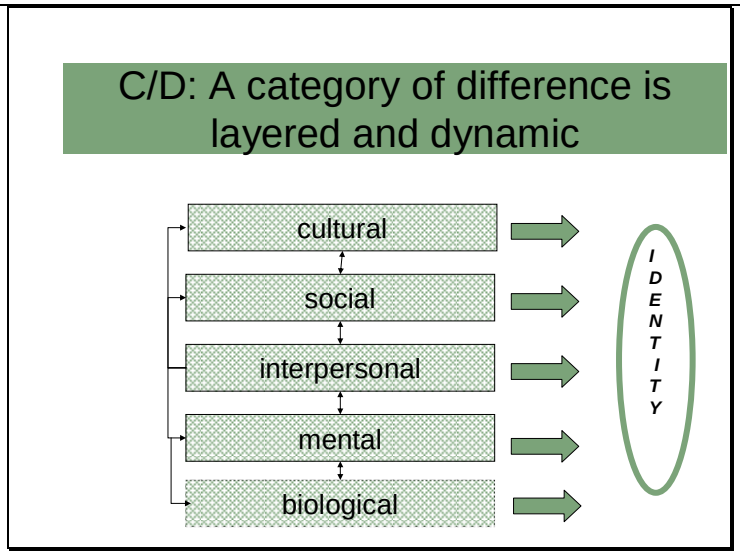


You may know this famous drawing of the two normal distributions: although significant differences can be proved, we should not forget that the majority of men and women are situated in the same realm. So much for the biological layer.

The mental layer focuses on cognitions, emotions, behaviours, coping styles etcetera. It has been argued that spatial ability and empathy are differently distributed among men and women. Also, in the last 10 years, some research evidence supports the conclusion that the so-called universal coping options of fight or flight (and possibly freezing) are more common among men and that women more frequently have a coping style of tending and befriending[8]. (Thirty years ago, there was much debate about that claim that women have weaker ego boundaries than men, but this –psychoanalytic - type of knowledge is now simply ignored.)

The interpersonal layer highlights which direct contacts men and women have: at work, in their family, during leisure time. And which rules of interaction apply to them; which language games? According to available research, women are cooperative and men competitive in their interactions. But this cooperative interaction between women is not confirmed for private situations. In the context of medical consultations, there is an extended body of knowledge available about this topic. There is evidence for gender differences in style of problem presentation. So, care professionals should anticipate more problem-solving by men clients; and more contextualisation (thus more words) from women clients. This interpersonal layer is also the layer of daily discrimination, alongside the encouragement and support that women and men may receive. Returning to the context of professional consultations: many women-clients complain about their complaints and treatment desires not-being-taken-seriously. And, unfortunately, men-seeking-help are confronted with (sometimes hidden) disdain even from professionals: it is not sturdy to need help.

[8] Shelly Taylor a.o., (1999)



The social layer refers to the positions and roles men and women occupy; the type of networks they are participating in; as well as their access to, and influence within institutions. Although men no longer *exclusively* participate in the labour market and in politics, and women no longer exclusively care for children and do the housework, horizontal and vertical segregation between men and women remains –which means that women are (more frequently than men) employed in the caring and educational professions, and in the lower status, lower paying jobs + and still take more responsibility at home.
Our insights in what's going on in the social layer of gender differences may be sharpened by theoretical approaches of stratification and globalisation. Economic capital in the sense of money and transportation is important just as cultural and ethical capital in the sense of preferred language and religion. Combined, they help us to understand the influence of both genders.[9]

The cultural layer contains the gender discourses, with stories about ideal men and women; stories that translate behavioural standards for each sex into rights and duties (formal and informal). Thus, discourses bring about social exclusion and stratification. Traditionally, those gender discourses associated men with production and women with reproduction, and depicted fatherhood and motherhood correspondingly. They also glorified males' rationality, autonomy and strength while they denigrated female intelligence, dependence and the female body. Unmistakably, these discourses created a heterosexual matrix, with gender as the foundation of intimate relationships between women and men where men had the sexually active role and women the passive one. In general, the rights for men were well formulated while their duties were less well circumscribed. For women it used to be the other way around: their duties were sharply defined but their rights were not so well established.
Forty years ago, the discourses about the unjustified disparities between men and women

[9] M.M.Ferree in Frankfurt conference

emerged (of course, there had been feminist waves before), accompanied by stories about the bored housewife and women's social isolation in the home[10]. Subsequently, emancipatory discourses of female freedom and gender equality gained ground[11]. More recently, postmodernity appeared on the scene with more subtle and complex accounts of fluid, gender-inflected discourses. We touched upon this in discussing the sex/gender continua, and could see that such discourses may diminish the probability of exclusion and stratification.

In principle, comparable pictures – with all five layers - can be made for ethnicity, and for the other categories of social difference. For that reason, I will hereafter alternately take examples from the other categories of difference.

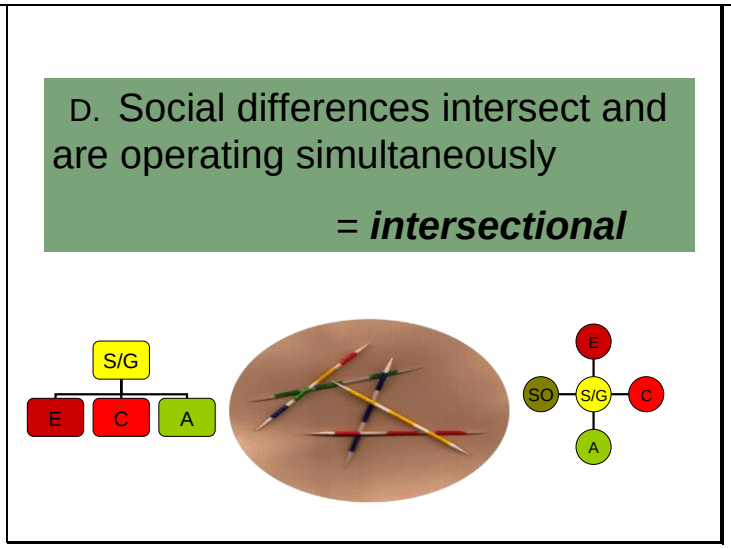
The fourth consideration is that *within* each layer there are dynamic processes at play, although the tempo may be slow. Especially with regard to the biological and cultural layers, these dynamics are easily overlooked (except in relation to ageing).
The discovery of neuroplasticity (that is, the ability of the human brain to change as a result of one's experience – and especially the experience of violence) is rather new, for instance.[12] Also, care professionals - being focused on the micro-level - sometimes have difficulty appreciating the process-character of *culture*: for example, not seeing the shifts in images of `real' men, `real' lesbians or `real' Muslims, and also missing the new tensions and conflicts that may arise in light of those shifts, such as: between being sturdy and soft as a man; gay and lesbian couples desire for marriage; or adopting external signs of religion (such as head scarves or djellabas) that may create complications in finding a job or social integration (and recently have been forbidden in several European countries).
Dynamic processes are also present *between* the layers. The interactions going on there, are described with words such as acculturation, social representation, social positioning, socialisation, identification, internalisation and imitation. Together, I call them "spirals of difference".
The result of such processes of becoming are displayed always and everywhere. Generally, we call it identity, of a group but also of an individual. To emphasize the agency of a person or group, we also speak of "doing gender", "doing ethnicity", or "doing sexuality". Thus, it becomes possible to recognize someone choosing to identify with a specific group, and to represent that in her or his behaviour, clothing etcetera. But the extent-of-identification and the intensity- with-which-this `identity-game' is played, is highly variable.[13] Actually, we are talking about multiple identities: a gender identity, a sexual identity, an ethnic identity, an age identity. Taken together - and in interaction - they constitute someone's overall identity at- a -certain- moment. So, this insight may imply an important warning for care

[10] Everingham (2007)
[11] Mc Robbie
[12] Environmental changes can alter behaviour and cognition by modifying connections between existing neurons and via neurogenesis in the hippocampus and other parts of the brain
[13] Maybe, a handy distinction to begin with, is normative, emotional and functional idenitification.

professionals: it is not enough to be informed about a client's biological sex and cultural background.
However, we should not overestimate the freedom people have in their identity construction. Their degrees of freedom depend at least on the visibility of specific indications of difference. For instance, without "coming out", sexuality identity will remain hidden. Furthermore, class can be "betrayed" as we say in Dutch, by which is meant that one's social class is unintentionally revealed, f.e. by speaking, clothing or dinner habits. Some disabilities can be concealed; others simulated. Age can be manipulated as we all know, with hair dying, face lifts, botox or whatever. But language, colour of skin and - most of the time - sex is easily perceptible from the outside. This implies that each individual is already ascribed a position in the societal order, such that identity construction also entails coping with processes of allocation. An individual cannot independently define her position in a category of difference. In other words, an individual's preferred identity can be confirmed or undermined by others, and by institutional practices. Overall, in their day-to-day interactions, people are constructing differences as well as similarities between themselves and others.

In effect, we are talking about doubly dynamic processes. Your identity of last year does not need to be the same as today. In particular, historic events or life transitions can produce big changes in one's identity. I would like to provide two examples. Firstly, many women who claimed to have no experience with sex discrimination and consequently did not identify with a woman feminist profile, made a shift in that direction after having given birth: because in their new position as mothers they suddenly experienced sex differences and sex discrimination. Secondly, after the murder of Theo van Gogh (a Dutch film director, film producer and columnist) by a Dutch-Moroccan Muslim, many care professionals who used to identify themselves as white (although they had some visible "allochton" characteristics), started to identify themselves as non-white - because they met much more discrimination in their daily life. In this way social categorizing and societal ordering create spirals of difference in individual lives that are on-going and variable. However, the creation of such spirals can also be disrupted through processes of acculturation, socialisation, and internalisation.

Until now, I have mainly talked about the conceptualization of social categories.
Now, we will focus on their combination.

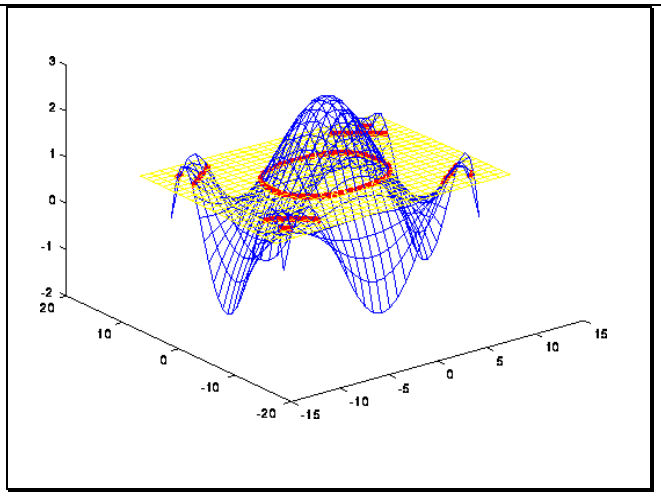


These two images depict conventional theorizing. In both cases, a central role is allotted to sex/gender. In the left image sex/gender has a one-sided impact downwards on the meaning and operation of ethnicity, class and age. In the right image the influence between sex/gender and the other categories of difference is reciprocal, but without any connections between the other categories of difference.

The intersectional conceptualisation of diversity allows for more complexity in the possible permutations of categories of difference. It assumes that the intersections of social difference continua operate simultaneously. To put it differently: The meaning of gender varies with ethnicity, and the meaning of ethnicity varies with gender. More concretely: The sexual interest imputed to men varies with the colour of their skin. (Black men are stereotyped as more sexually active). Also, the emancipatory behaviour and assertiveness expected from women varies with skin colour. White women are stereotyped as less assertive. But these constellations also vary with class, age and sexual preference! Black men are more frequently associated with a lower status: The Black doctor is assumed to be a male nurse, or sometimes a cleaner; elderly men and women are not assumed to have any sexual interest, and certainly not to depart from heterosexual interest.

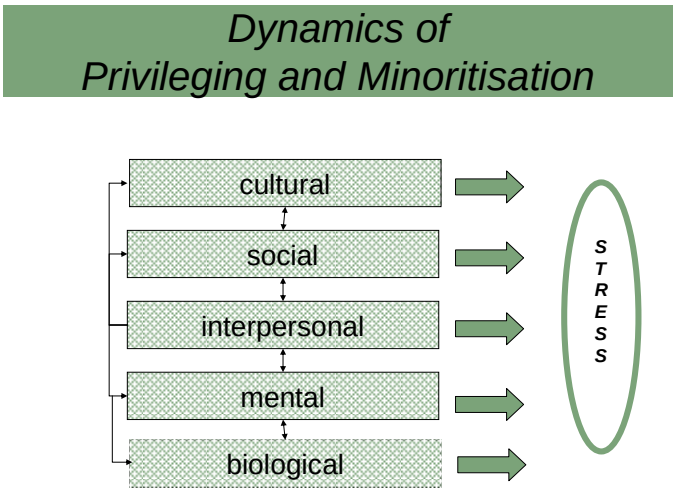
All of these images and expectations operate simultaneously: in daily interactions, during professional interventions, and in policy development. And, what is taken for granted, and what is considered to be problematic, can shift within a society. Remember what happened after the war on terrorism was proclaimed; and how the commotion about sexual abuse in religious institutions has worked out, for instance.

The image of simultaneity is sometimes expressed as a Mikado-game: Even if the continua of difference (also called “axes”) are the same, their combinations or configurations can be different. An intersectional approach characterizes differences as entwined but also involving dynamic processes. Therefore, another metaphor is the Kaleidoscope.



Just to stimulate your imagination: Here, you see another intersection, between two two-dimensional figures. You could see it as symbolizing four categories (2 blue ones, two yellow ones) with the red lines representing the simultaneous crossing. This figure is produced by a computer simulation. You can imagine the dynamics yourself, I hope. If the categories change, the red lines will change too, of course.

With this multidimensional and dynamic model, I want to go back to the power relations. It will help us to be more precise about power mechanisms and especially about some unique social stressors, namely, stress associated with being in a minority position, and stress associated with being in a privileged position. In my opinion, this is especially relevant for health and social care professionals. (Of course, there is also stress due to violence, but for today I will set this aside.)



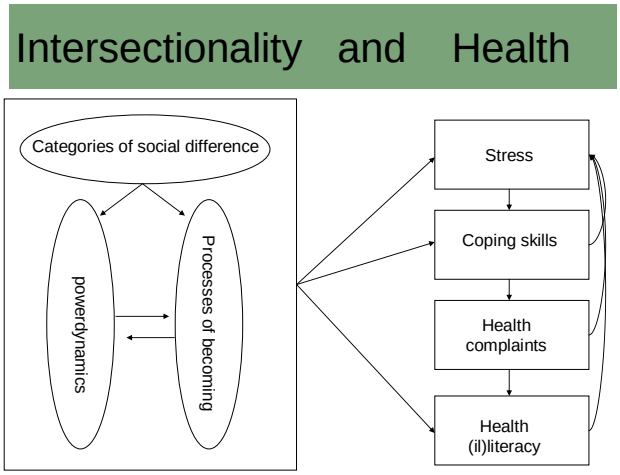
Minority stress[14] stems from one's ascribed inferior status. In fact, it is a chronic condition in which socialisation and internalisation processes mean that the individual frequently confronts unfavourable self-images. No wonder that a sense of powerlessness may be internalized, and may result in a lack of confidence – even shame; in anxiety that one may not be fully accepted; in feelings of helplessness and hopelessness and in the inclination to withdraw, with a permanent *fear* of being labeled and stigmatized[15]. In addition, a minority position may result in survival strategies, such as keeping silent, concealing, telling lies, avoidance behaviour, indirect responding, and appeasing, that contribute to continuation or worsening of the situation.[16] Imagine *(self-)concealment* in the case of being a lesbian. This could easily foster stressful consequences such as constant monitoring of emotional responses, hiding affection for one's partner, and superficial behaviour towards others in order to prevent being exposed. It may also result in anger, sadness, and isolation. In contrast[17], self-disclosure of personally distressing information has positive effects on physical and psychological well-being. But this is only true, of course, if the legal and formal conditions don't permit discrimination.

A chronic stress condition may be exacerbated by discriminatory events (sometimes legal injustice, other times physical or psychical violence). Such events are stressful in three ways: because of the experience itself; because of the fear that this could happen, and because of the possible self-devaluation that is the result. Other types of stress that are relevant in relation to social divisions are gender role stress and acculturation stress. Both refer to situations in which one does not fit into the available social categories in terms of drives, feelings, and behaviour.

Contrary to what you might expect, privileged positions also imply some specific sources of stress. Here, we find the fear of loss (because most privileges are not guaranteed forever). And the desire to be liberated from feelings of guilt about the privileges (that are perhaps undeserved indeed?). Remember the imposter's syndrome - originally ascribed to women[18] but nowadays also observed among men.

Another stressor is the alienation from what seems to be one's other part: Men rejecting or resisting anything considered to be feminine; autochthons who deny any commonality with "strangers"; heterosexuals who repress any "homosexual" feelings; career stars who disown their humble origins. Hence, the knapsack is filled with stressors and coping skills too (and this content is partly historically defined). However, remember that the intersectional lens also showed us that people don't necessarily live in a completely minoritis ed position; and that not all women, immigrants and elderly belong to a vulnerable group. They may be privileged in other respects: education or money, for example.

[14] Katarzyna Banas, B.A. & John B.F. de Wit (2006) Minority stress, Self-Esteem and Health of Homosexuals.
[15] Meyer (1995), Gail Pheterson (1986)
[16] Pheterson (1982).
[17] See also Cole, Kemeny, Taylor & Visscher (1996a, 1996b), Cole, Kemeny & Taylor (1997).
[18] Clance en Imes (1978)



Now we arrive at the key question of today: How may clients and professionals in health and social care profit from the intersectionality approach?

Here you see a scheme in which I have tried to capture the main points. On the left the intersectionality view on social differences is summarized as multiple categories of social difference that entail power relations and processes of identity formation in mutual interaction. On the right I have depicted (very briefly) the most relevant health aspects from the clients' perspective, namely health threats and health behaviour – also valid for *social* care, I assume. Health threats in the sense of stress (that is, not only caused by life events, work load or violence but also by acculturation, shifts in the meaning of gender and minority or privileged position).

Coping skills and health literacy are also influenced by one's social positioning – now and in the past. (By `health literacy' I mean the ability to read, filter and understand health information in order to form sound judgements, and to know where you can find the help you need.)

My scheme shows rather roughly how social disparities may affect individual clients, or groups of clients – possibly resulting in various physical and psychological symptoms.

Next I will consider the possible contribution of an intersectionality approach to quality improvement.

Conventional health care presumes that its concepts and methods are universally applicable – with some exceptions made based on age, class and sex/gender. In contrast, the intersectionality approach claims that such universality does not exist. Taking social differences as a point of departure, the intersectionality lens makes visible groups and people who were hitherto hidden within or between categories, or were misunderstood because they were too easily stereotyped. So, the quality of health and social care, and especially preventive care, may increase by less exclusion, by policy-makers as well as direct providers. This can be achieved in five ways.

QUALITY IMPROVEMENT

Less exclusion (neglect) b.o. alertness for:
- Variety *within* social categories
- Recognition of hybrids
- Similarities in addition to differences

Comprehensive understanding b.o.
- Identity as a *sociopsychobiological* process influenced by *social inequalities*
- Variety in the meaning of life transitions

Firstly, social categories must be acknowledged (and treated by researchers) to be specific mechanisms - with potentially harmful and potentially advantageous consequences for health and well-being – instead of as simple, unequivocal demographic variables. Knowing more about variety within a category may help doctors and psychologists envision new ways of creating treatment-interventions-and social-change to benefit all members of the category.
Secondly, not overlooking so-called hybrids. For a long time, heterosexual women with AIDS were such a group as were (suicidal Hindu girls in The Netherlands,) and trafficked women from outside Europe. Furthermore, intersexuals were "normalized" by surgery a.s.a.p , shaping them in the form of *one* sex. Also, there has been little attention paid to the identity adventures (and troubles) of children having one white and one black parent. (If you want to have an impression, read Rebecca Walker's "*Black, White and Jewish*").
Thirdly, by recognizing the main similarities, social differences don't necessarily result into analogue social divisions within health or social care anymore. This entails:
not immediately defining problems like domestic-violence-and-female-circumcision as a private matter based in `culturally specific' practices. Consequently, the victims or survivors would be referred to regular services specialized in violence against women, instead of to services in their own cultural `communities'.[19] So, similarities – for example in one or more layers or power positions – may open possibilities for connection and also offer similar services across other layers of difference. Besides, the intersectionality lens may simply improve health and social care through its more comprehensive understanding of clients.
Fourthly, recognizing identity development as encompassing socio-cultural and biological layers (in addition to the psychological one), and as dynamic and historically situated invites a more systematic exploration that - likely - will make clients feel acknowledged for who they are. (I admit, there is a problem with time pressure, but such an approach at the start may enhance effectiveness and efficiency later on.)
And the last point: professionals may become more sensitive to specific transitions in a

[19] Example from Burman (2004)

client's life path (such as, for example, being married off, becoming a mother**,** `coming out', migration, going into retirement, or – for chronically ill people - receiving `the' diagnosis) through awareness of their distinct social positions. On the other hand, the intersectionality approach heightens our awareness that the meaning of such transitions is not fixed: Being married off is not likely the same for him as for her; motherhood may differ with age, class and ethnicity; coming out with class and religion; and migration with class and colour of skin.

Further translation into convenient procedures of practice and research is necessary, however. I will attempt this with seven tips.

1. Always check the self-identification of patients and clients.
2. Apply this intersectional or holistic view during the entire caring process: In diagnosis- treatment- and aftercare. On the content, instruments and relationships.
3. Apply knapsack analysis. I mean: Never forget to analyse the processes of minoritisation and privileging that precede the health complaints, and are involved in the cure and care processes. Try to identify the "spirals of difference" and their possible influence on well-being, and the effectiveness of treatments.
4. Pay attention to patients' strengths (knowing about the interplay between the person and their social locations). Doing so may help to overcome vulnerabilities and also to start a process of empowerment[20].
5. Put the "other question" to yourself, to control your own interpretations.
6. Utilize the opportunities for coalitions that the intersectionality approach makes visible. I mean, common structural experiences that offer possibilities of political organizing across conventional categories. F.e. autochton and migrant women may both profit from consciousness raising on the `caring for others' standard.[21] Aged people and people with disabilities will share interests regarding the accessibility of public transportation and buildings, the standard pace of life and health insurance conditions. (Women on welfare targeted by marriage incentive policies may form alliances with gay men and lesbians if their sexuality and intimate partnerships are also stigmatized and proscribed".[22]) So, there are grounds for joint mobilization to lobby for prevention and treatment resources.
7. Finally, analyse your own situatedness, in the sense of your social locations, privileges and perhaps disadvantages. Sensitivity of care providers to their own situatedness may increase empathy and modesty in judging clients.

[20] Robinson (1993)
[21] Mens-Verhulst & Bavel (2004, 2006)).
[22] Cohen (1997). See community activism in Schulzer & Mullings (2005)

The last question for today is how intersectionality can be incorporated into research. In other words, how to include this multi-dimensional and power-conscious lens on social categories.

Many researchers fear that it is necessary to develop complex designs involving prohibitively large heterogeneous samples, or to enlist the cooperation of an interdisciplinary team to triangulate the problem. Others simplify the intersectional approach to the inclusion of variables assessing race, gender etcetera and their interaction in statistical models – being multiplying or subtractive effects. Additionally, others see the adoption of qualitative research methods as "the" solution because only ethnographic methods and depth interviews could guarantee primacy to interaction effects of the categories (but simultaneously risking a one-dimensional view[23]. Probably, such radical strategies are not essential, even though an intersectionality framework does ask researchers to examine categories of identity, difference, and disadvantage with a new lens.

Elisabeth Cole has made this lens concrete with 3 questions that must sound almost familiar now:

1. Did you attend to diversity within social categories? (Who is included; who is not?) To answer that last question, you may consult experts, but also members of the investigated group in advance.
2. What is the role of inequality? So, did you conceptualize the social categories as con**no**ting hierarchies of privilege and power-structuring-social-and-material-life, and more or less shaping someone's identity (through acculturation, socialisation, internalization etc.).
3. Where are there similarities? In other words, did you look for commonalities across categories commonly viewed as deeply different.

However, these seemingly simple questions must be answered at each stage of the research

[23] according to McCall (2005)

process: the generation of hypotheses, sampling, operationalization, analysis and interpretation. In effect, it requires revision of the justification for the methodological choices we make.

I highly recommend Elisabeth Cole's article in the American Psychologist 2009. And I also like to add some reassurance, namely: Don't be too hard on yourself when starting intersectional research. In this realm too, it is not a matter of "all" or nothing. Gradually, we may evolve from research ignoring diversity into research acknowledging it more and more, better and better.

Finally, you may wonder if there are no critical remarks to make. Yes, there are indeed. And I will give you a short impression: To begin with, the suggestion that all categories of social difference are similar must be nuanced. There are at least two important *dis*similarities. First, they are ontologically different. Qua origin they stem from different layers: class from a socio-economic layer; sex/ gender from biological and cultural layers, and ethnicity from a cultural layer (sense of adherence and belonging to cultural practices), for instance. Second, as I mentioned before, the categories differ in their visibility. F.e. age and sexuality are easier to conceal than sex/gender or colour of skin.
Additionally, the intersectional approach cannot be easily translated into policy-making and management solutions. Herewith, I refer to another branch of intersectionality studies, in addition to the identity branch I was talking about.
Unfortunately, we are lacking time to elaborate on this. But shortly summarized, it is clear that (1) mainstreaming in accordance with intersectional ideas will require very complicated organizational structures - or a revolutionary turn; that (2) health care informed by an intersectional approach may be seen as a threat to services organized to meet the needs of specific categories; and (3) clinical guidelines need far-reaching revision – as they are mainly tailored to a – non-existing - standard human citizen.
Finally: A willingness to always orient to the specificities of the immediate context is required because the simultaneous impact of all categories on an individual's or group's life is not something that is measurable and stable. Instead, the potential interaction (interference) between social categories is assumed without there necessarily being a "full" intersection of all possible categories. In other words, on every occasion the permutations of the intersections must be reconsidered, and simultaneous intersection must be made plausible through some analytic process.
However, this does not change the multidimensionality and power focus of the intersectionality lens, the validity of the tips for professionals, or the potential of the intersectionality approach to improve quality.

Thank you for your attention