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Why Othering should be considered in research on health inequalities: Theoretical perspectives and research needs

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1. Introduction – Othering

There are many terms that 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 group belonging. Depending on which perspective one relies, various terminologies and approaches explain the construction processes of group belonging. Othering is one of such concepts, which has become an internationally accepted term both in public health and in other scientific fields.

We understand Othering as a powerful process that goes beyond concepts of discrimination based on mere categorization processes. The strengths of the Othering concept lie in its analytical capacity to capture knowledge structures, power relations, and categorization processes in their interconnectedness and to identify their effects on different levels. Furthermore, Othering offers the potential to make power relations accessible and visible in their intersectional manifestations. We see a further added value of the concept of Othering in its theoretical compatibility to critical racism theory, which makes Othering interdisciplinary.

This paper discusses why and how Othering should be considered in research on health inequalities. Developing a comprehensive framework of Othering is beyond the scope of the present paper and will be attempted in future work. Instead, we provide conceptual ideas on Othering and its interplay with health.

We first approach Othering from two different research perspectives. The first one concerns the social psychological dimensions of ingroup and outgroup formations. We refer to this perspective because preferred terms from this field, such as prejudice, are often used synonymously with Othering without discussing their theoretical implications when applying the concept of Othering. The second one considers, from a postcolonial perspective, distinctions of group belonging as a result of historically and discursively grown power relations. In this way, we seek to contribute to more theoretical consistency and foundation in using the concept of Othering. Based on our theoretical reflections, we identify relevant features of Othering and critically discuss the concept of Inclusionary Othering as a possible response to Othering. We conclude with considerations about further research needs and interventions to reduce Othering in public health.

2. Terminological ambiguity in the use of the term Othering

In public health literature, the term Othering is predominantly (albeit not exclusively, see Inclusionary Othering in Table 1 below) used interchangeably, or in conjunction with, concepts such as prejudice, (racial) discrimination, racism, marginalization, and stigmatization. Table 1 shows examples of how Othering is interpreted in public health research.

The terminological ambiguity shown in Table 1 indicates that there exists no consensus on the content of Othering. Notably, using stereotyping (Canales, 2000), prejudice (Alpers, 2018), or stigmatization (Canales, 2000) as alternatives or synonyms to Othering contrasts with an understanding of Othering as a conscious construction process in discourses (Grove & Zwi, 2006; Johnson et al., 2004). While concepts based on prejudice and stereotypes assume that Othering arises from misconceptions that need to be *corrected*, discourse-critical ideas suggest that Othering is fed by allegedly objective representations that need to be *deconstructed*.

From this discrepancy, we can posit that these two theoretical views on Othering differ in their initial positions and assumptions about (the causes of) Othering. While the research on group-based attitudes and

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Table 1
Examples of Othering descriptions in public health literature.

Description of Othering	Remarks on the use of Othering
Othering is treated "as a function of structural factors, including **institutional racism**. As such, "**othering**'' contributes to shaping individuals' **ascribed racial/ethnic status** and their **access** (or lack thereof) to **resources** associated with such a status. These, in turn, influence proximate pathways (i.e., stress, medical care, health practices, psychosocial risk factors and resources, and environmental risk factors) to health outcomes. The model also proposes that **''othering'' and discrimination** are experienced by individuals interacting with other people and institutions, and thus it might also be considered a **psychosocial stressor** that impacts health." (Viruell-Fuentes, 2007, p. 1532, bold type added for emphasis)	- Othering is considered as a function of structural factors and is related to health as a psychosocial stressor
"[…] **othering** discourses took three forms: **essentializing** explanations, **culturalist** explanations, and **racializing** explanations. The **alienating** and **marginalizing** effects of these practices were evident in South Asian women's discussions of their health care experiences." (Johnson et al., 2004, p. 260, bold type added for emphasis)	- Othering takes place in discourses and is divided into essentializing, culturalizing and racializing features - Othering is experienced in encounters between patients and physicians - Othering may be manifested in structural features of access to and delivery of health services
"**Othering** is based on **negative preconceptions** where the other person or group is objectified. **Attitudes** such as **stigmatisation, marginalisation and alienation** may be difficult to change, but positive personal experiences may alter one's **preconceived negative ideas** and create understanding and trust. […] Healthcare providers, like other people, may not recognise signs of **prejudice** in their own behaviour, a behaviour that is a **form of othering**." (Alpers, 2018, p. 318, bold type added for emphasis)	- Othering is understood as prejudiced behavior - Othering affects encounters between health care providers and patients
"'**Othering' defines** and secures one's own **identity** by **distancing and stigmatising** an (other). Its purpose is to reinforce notions of our own '**normality**', and to set up the difference of others as a point of **deviance**. The person or group being 'othered' experiences this as **a process of marginalisation, disempowerment and social exclusion**. This effectively creates a **separation between 'us' and 'them'**." (Grove & Zwi, 2006, p. 1933, bold type added for emphasis)	- Othering is understood as an identity formation process which emerges in discourses and creates identity through the construction of Others - Othering is manifested in encounters between patients and physicians - Othering is manifested in structural features of access to and delivery of health services
"**Exclusionary and Inclusionary**. These terms were chosen based on my interpretation of the conceptualizations of **Othering** presented in the literature and my analysis of the Latina faculty participants' perspectives. […] Although both processes exist within the context of power and **power relationships**, what I articulate as **Exclusionary Othering** often uses the power within relationships for **domination and subordination**. The consequences for persons who experience this form of **Othering** are often **alienation, marginalization, decreased opportunities, internalized oppression, and exclusion**. When **Exclusionary Othering** occurs within the context of **health care delivery**, potential **negative consequences exist for human development, maintenance of self-esteem, and health promotion and restoration**. In contrast, I conceptualize **Inclusionary Othering** as a process that attempts to **utilize power** within relationships for transformation and **coalition building**. The potential consequences for persons experiencing this form of **Othering** are **consciousness raising, sense of community, shared power**, and **inclusion**." (Canales, 2000, pp. 19–20, bold type added for emphasis)	- Othering is divided in two ways: Exclusionary and Inclusionary Othering - Exclusionary Othering operates through stereotyping and can have exclusionary effects on health - Inclusionary Othering operates through role-taking and can have inclusionary effects on health - Othering is located in interactional processes

Source: Own table

prejudices roots in social psychological concepts, the power-critical discourse is connected chiefly with postcolonial ideas. We now examine these two perspectives in more detail.

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 & Fritsche, 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). 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).

This approach supposes that society consists of real distinguishable groups, and thus assumes that genuine group differences exist. 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, 1979; 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).

We assume that Othering is not reducible to individual and group-based attitudes. 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 the West and the Rest (Hall, 2004)). However, the question of whether and to what extent the social psychological concept of prejudices is helpful for the empirical investigation of Othering, given the stated theoretical contradictions, is not yet fully answered in this early version of the Othering concept and needs further discussion.

Approaching Othering from the concept of prejudices rooted predominantly in individualistic explanations (Allport, 1954) contradicts discourse-based approaches, which focus on the constructive nature of knowledge (Foucault, 1981). From the latter view, group (non-) belonging is constructed according to power relations. Hence, we consider it necessary to integrate a poststructuralist-oriented discourse approach geared to postcolonial perspectives to reveal overlooked but vital aspects of Othering, such as power relations and intersectionality.

2.2. Postcolonial perspective 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 (post-)colonial 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 (Miles, 1991; Mills, 2007). 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; Akbulut & el-Naggar, 2022). The separation of the Self from the Other is also functionalized to maintain antagonistic collective identities (Miles, 1991).

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 (Dietze, 2019; Rommelspacher, 2002). 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

Categorizing attributions of (non-)belonging – such as the classification of migrants (or people with migration background) – constitute the non-self on a semantic-symbolic level. In other words, the discursive production of a hegemonic idea of (not) belonging arose from the distinction between the Self and the Other (Bauman, 2017; Hall, 2004). This is significant concerning the options for social positioning. The 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).

Groups of migrants who are particularly exposed to Othering are refugee populations. 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 refugees is characterized by stereotypical images that amount to a "demonizing of Others" (Mecheril & Castro Varela, 2016). For example, refugees are being represented as a threat to public health or 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, to public health, and to public safety (ibid.). This 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 (SVR, 2015).

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 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.

4. Othering and its impact on health

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 ways in which Othering takes place. The first way relates to the semantic part as a core interacting element of Othering processes: Othering operates as a discursive practice. This means that distinctions of belonging and non-belonging (Otherness) are formed and presented as mutually exclusive through discourse in a dichotomous manner and create hierarchies of belonging, e.g., migrant vs. non-migrant. Discursive speech refers to a particular mode of representation evident in political, media, scientific, and everyday discourse. It is a powerful representation insofar as it is institutionalized (Foucault, 1981; Jäger & Jäger, 2007; van Dijk, 1993). Constructed hegemonic collective identities of belonging and simultaneously not belonging create a specific meaning within special contexts as they occur as discursive knowledge – which in turn means it is possessed by all members of society and can be used by them at any time. Hence, the emergence of Others is based on a comprehensive system of convictions that are discursively structured and maintained through power relations (Mills, 2007).

Othering influences social reality and has material consequences which can be traced in the construction of symbolic boundaries between supposedly mutually incompatible identities, such as between Occident and Orient (Said, 1978), the West and the Rest (Hall, 2004), Men and Women (de Beauvoir, 2012). Thus and second, we understand Othering not only as a semantic/categorical differentiation between Us and Them. In addition to a *symbolic hierarchy*, constructions of (non-)belonging constitute also a *material hierarchy* manifested in (under-)privileged access to power and material resources.

In this way, Othering can have benevolent intentions (benevolent Othering (Grey, 2016)) by treating Others as a particularly vulnerable group and offering support (e.g., specifically targeted health care) to them. In most instances, however, Othering creates social exclusion and reinforces disparity in distributing material resources to excluded or othered groups. 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 restrictions and access barriers in health care.

In the context of health care, Othering can thus lead both to overutilization/-provision (e.g., high use of emergency departments (Sauzet et al., 2021)) and underutilization/-provision of certain health care services (e.g., low use of rehabilitative health care (Brzoska & Razum, 2015)). This inadequacy may be due to maintaining an institutionalized homogeneous view of the Self, which not only produces Others who deviate from this Self-image but also leads to inappropriate health care.

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., group-based discrimination and racism, which have various consequences on health and healthcare outcomes. The associated potential health consequences can manifest on three levels:

1) Othering can affect othered persons on an individual level. It influences both mental and physical health outcomes. In this context, Schunck et al. demonstrated that migrants' self-reported mental health is negatively affected by perceived discrimination (Schunck et al., 2014). Shorter life expectancy, higher infant mortality, and hypertension are additional health consequences associated with Othering and discrimination (Akhavan & Tillgren, 2015).
2) Othering can manifest itself at the institutional level of health care 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). The term 'context' refers to the social embedment of language use – so one can describe discourse as social practices and structures (van Dijk, 2009). Social categories related to culture or ethnicity often have a homogenizing and stereotyping effect. Cultural differences serve as an essentialized explanation, for example, then when institutional homogenous 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 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 'Morbus Bosporus' have become institutionalized in medical settings in Germany based on the widely held assumption that migrants tend to somatize or exaggerate when they describe their pain (Castañeda, 2012). Moreover, Johnson et al. (2004) showed in a qualitative-ethnographic study a connection between Othering and health inequality using the example of health care for South Asian women in the Canadian health system. They identified three different forms in which Othering is realized: essentializing, culturalizing, and racializing patterns of interpretation. Health professionals often referred to essentialized categories such as *culture*, *origin*, *religion*, or *race* to explain failures and barriers in care for South Asian women (e.g., low use of health services, lack of compliance). Inherent barriers within the health system are not recognized by displacing them onto essentialized characteristics of the Others.

In Germany, there are significant disparities in access to and quality of rehabilitative care, and in health status, between societal groups with and without migration status/background (Brzoska et al., 2016; Brzoska & Razum, 2015). 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 (Brzoska & Razum, 2015, 2017; Schott & Razum, 2013) 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 refugees. This leads to access barriers and, subsequently, health disadvantages. The cumulation of access barriers (e.g., language barriers, information deficits, legal entitlement barriers resulting from the interaction of various difference categories) affect social groups to different degrees. Such multiple access barriers are associated with differentials in health outcomes (ibid.). According to Germany's Asylum Seekers' Benefit Act ("Asylbewerberleistungsgesetz"), asylum seekers face entitlement restrictions to health care in the first 18 months of their stay, limited to acute and pain treatment as well as pregnancy care and vaccinations (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 (Razum, Wenner & Bozorgmehr, 2017; Brzoska & Razum, 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 programs that successfully address the complex nature of Othering processes.

3) Othering can have far-reaching effects on a contextual level – an often-neglected dimension. It can lead to spatial exclusion (Powell, 2012) by providing a legitimacy basis for spatial segregation practices. For example, decentralized isolated refugee camps are being used to make unwanted migrants' mobility controllable by dividing it into legalized and illegalized mobility (Pieper, 2008). This phenomenon can be observed both in the mass housing of refugees isolated from society (Penning & Razum, 2021; Razum et al., 2022) and in the closely linked segregation of migrant children in under-endowed schools (SVR, 2013) combined with substandard housing conditions, which in turn have adverse health effects.

Othering is relevant to public health as an analytical lens that helps to understand the link between minority status and health inequalities. This association can be demonstrated on the institutional level – even though the studies referred to lack broader theoretical frameworks to draw on to distinguish Othering from other concepts such as discrimination and racism. Group-based discrimination revealed in mere categorization processes can potentially be experienced by everyone. Othering refers to people represented as the opposite of the We, whose exclusion enables the We to construct its identity. Discrimination based on Othering processes is part of mainstream (scientific) and everyday practice and occurs on several levels, notably on a semantic-symbolic level representing a normality. The conceptualizing of Othering often remains vague. A comprehensive theoretical understanding of Othering is needed to benefit from the analytical capacity of this concept. In comparison to scientific evidence on the institutional effects of Othering, such evidence on health-related consequences of Othering at the individual and contextual levels is scarce.

The ideas presented in this section provide a first attempt to understand the complex relationship between Othering and health. The potential impact of Othering on health is first and foremost driven by the findings derived from the public health literature that used Othering in empirical work. However, the theoretical foundations of Othering have to be worked out more thoroughly and comprehensively to clarify the difference between Othering and discrimination as well as racism, and to develop better conceptual and empirical tools to assess and analyze the pathways through which Othering processes impact health.

5. Inclusionary Othering as response to Othering?

In public health research, some authors see the potential of inclusionary processes of Othering (Canales, 2000; Roberts & Schiavenato, 2017; Tallarek et al., 2020).

The concept of Inclusionary Othering (IO) was coined by Canales (2000). She postulates that "different meanings of Othering exist" (p. 18) and focuses primarily on approaches of Symbolic Interactionism. She uses the concept of role-taking, which goes back to George Herbert Mead and builds the basis of her understanding of IO. Canales criticizes that the prevailing discourse conceptualizes Othering as something exclusively negative and perceives this as limiting. She argues that current understandings of Othering ignore its dynamic complexity. To address this complexity, she divides Othering into two possible processes: (1) Exclusionary and (2) Inclusionary Othering (p. 18). Both processes depend on power relations. The power in Exclusionary Othering is used to exclude and oppress Others. In contrast, IO is described: " […] as a process that attempts to utilize the power within relationships for transformation and coalition building." (p. 19). Accordingly, Othering can have a positive, inclusive effect when power is used to build alliances and expand consciousness.

We argue that two aspects of the concept of IO are problematic:

(1) The strategies of coalition building, role-taking, consciousness-raising, etc., which Canales presents are supposed to be positive effects of Othering. None of these strategies, however, would be necessary if there were no Othering. Instead, they can be considered as examples of different responses to Othering, rather than a causal effect of it. If those strategies were an effect of Othering, there would be no need to initiate them, as they would inevitably occur. IO is more concerned with the consequences of or how to deal with Othering and less concerned with the main characteristics of the Othering process. In other words, the intervention against Othering is characterized as Othering. This assumption leads to a profound misunderstanding concerning what Othering comprises and tends to downplay Othering.

It is doubtful whether Othering has any inclusive potential since the idea of an IO is inherently contradictory. As described in section 4., Othering already produces a semantic exclusion by constructing semantic distinctions between Us and Them and creating a symbolic hierarchy of belonging. Canales does not analyze how the Other is constructed, nor does she look at the conditions that are decisive for the construction process so that one can speak of Othering. At least, the notion of IO remains theoretically unconvincing, and it cannot be derived from the primary literature on Othering (Said, 1978; Spivak, 1985).

(2) IO, or role-taking strategy, should produce changes primarily on an interaction level. Reducing Othering on an interactional level neglects essential dimensions of Othering, such as structural, societal, historical, legal, or discursive dimensions. Furthermore, and this is particularly problematic, the sole focus on interactions creates the assumption that Othering arises at this level due to stereotypical attitudes. The cause is often sought in socialization processes rather than structural conditions derived from historically grown dominance relations. Interventions that follow this approach aim to create changes primarily in certain groups' attitudes. The idea of role-taking pursues precisely this goal. In addition, groups whose attitudes need reflection and change must inevitably be named and addressed. Finally, it is unclear where the interest and motivation should come from to undergo such an elaborate process of reflection and whether IO can work when accessing coveted and limited resources.

It remains questionable whether awareness-raising interventions

addressed at individuals are sufficient to change or overcome socially prevailing excluding tendencies of Othering. 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 disregarded.

6. Conclusion – research and intervention needs

In conclusion, we hold the following four premises for the investigation of relevant mechanisms of Othering and its intervention, using refugee/migration status as a key driver of Othering and particularly illustrative example for similar processes in other marginalized population groups:

1) Othering operates as a discursive practice and occurs on multiple levels. By producing knowledge about who is (non-)belonging, Othering makes certain groups socially visible as Others in distinction to a We. Othering processes are particularly powerful in referring to migrant minorities because of their high discursive visibility (refugees and migrants are visible minorities). 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, and Islam. Each may produce powerful narratives/contexts that are present and operative in all areas of society.
   ⇒ *To investigate health inequalities caused by Othering, it is necessary to include the semantic-symbolic construction of Others, which means the dominant discourse, in this case, on refugees and migration.*
2) Othering creates and perpetuates a dominance relation between Non-Others and Others and leads to inequality in several dimensions (Intersectionality). For example, refugees experience unequal treatment on different levels and along different categories (gender, migration status, religion, race, etc.). Othering intensifies existing hierarchies and is often misunderstood as relating merely to a process between individuals. At least as important are structural consequences of Othering. From a public health perspective, they can relate e. g. to law (when there are entitlement restrictions for particular groups) or health service provision (when homogenous institutional structures are maintained).
   ⇒ *The research on the relationship between Othering and health inequalities requires the consideration of intersectionality and power structures derived from socially and historically grown hierarchies.*
3) Othering feeds premises, ascriptions, expectations, and notions of normality in research on, and in care for, minorities which are difficult to identify due to being seen as normal.
   ⇒ *Due to the contextual flexibility of Othering, its* seemingly *rational forms, and its seemingly plausible effect, a comprehensive conceptualization of Othering for its empirical analysis is required.*
4) Intervention concepts that plead for inclusion and diversity as social opening processes, and in particular the opening of health care institutions, can only succeed if theoretical and empirical insights concerning the effects of Othering are considered when designing opening processes and are implemented in appropriate (preventive) structures. For intervention concepts to be successful, it is necessary to point out historical structures of Othering and dismantle their continuing causes.
   ⇒ *Interventions against Othering require deconstructive concepts – this means foremost deconstructing the normality of the We manifested in institutionalized and embodied knowledge.*

Ethical statement

Neither primary data for human nor for animals were collected for this research work.

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CRediT authorship contribution statement

Nurcan Akbulut: Project administration, Formal analysis, Conceptualization, Investigation, Writing – original draft. **Oliver Razum:** Funding acquisition, Supervision, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The work is literature-based and done by a theoretical examination of relevant primary literature on the subject.

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