

DIVERSITY AND DIFFERENCE IN COMMUNICATION



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Book: Diversity and Difference in
Communication

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- Chapter 18 'Technology, selfhood and physical disability' by Deborah Lupton and Wendy Seymour
- Chapter 24 'Disability and communication: listening is not enough' by Sally French and John Swain

Introducing Diversity and Difference

This text focuses on issues of difference and diversity in a specific sense. Rather than analysing diversity in terms of *kinds* of communication and relationships, the focus here shifts to diversity in terms *the people* involved in interactions in care settings. Again, it is simple common sense to state that ‘good’ communication in health and social care services involves acknowledging and responding to the diverse needs and backgrounds of everyone involved, whether service users or staff. In the context of care services, it is not unusual for people to say, for example, that ‘everyone is different’ and ‘we aim to treat all our patients/clients/workers as unique individuals’. However, while agreeing that, at one level, ‘everyone is different’, and that each person brings a unique combination of needs, experiences and attributes to every interaction, in this course we shall claim that some ‘differences’ matter – or more accurately are made to matter – more than others, in people’s everyday experience of using and working in care services.

The kinds of ‘difference’ explored in this course are related to what are sometimes called people’s *social identities*: that is, their membership of particular groups that are said to share common experiences and needs. These include differences on the basis of ‘race’ and ethnicity, gender, disability, age and sexuality. What marks out these apparent differences from other kinds of diversity is both their importance in structuring people’s everyday experience, including their experience of health and social care services, and the ways in which they are used to define certain people as ‘other’, or as different from a supposed ‘norm’.



Figure 1: Welcome in different languages

Issues of diversity and difference have been an important focus of discussion and debate, and a significant strand in the development of policy and practice in the care sector since the 1970s. Starting with feminist and anti-racist campaigns in the 1970s and 1980s, there have been a range of initiatives, both at the level of government legislation (NHS Executive, 2000) and in terms of specific policy and practice guidelines, designed to combat prejudice and discrimination, and develop equality of access and participation. Issues of communication have played a large part in these debates and initiatives, arising from concerns about apparent ‘communication problems’ affecting particular groups of service users or staff. Many initiatives in the area of diversity have been designed to address and overcome such ‘problems’, whether this involves providing interpreters for people who do not speak English, producing literature in community languages, or installing hearing loops and Braille signs for people with hearing and visual impairments.

However, in what ways do issues of diversity and difference impact on interpersonal communication in the context of health and social care? Is diversity a ‘problem’ and if so, what exactly is the nature of the problem, and whose problem is it? How is the way people think about these practical issues influenced by different ways of thinking about the nature of ‘difference’, and how is it produced and perpetuated? Most importantly, perhaps, how should those involved in care services respond to issues of difference and diversity, and how can they ensure that all service users are able to participate fully in the range of interactions that take place in services on a day-to-day basis?

These are the kinds of questions explored in this course. Firstly the course looks at general issues of difference and communication, and the ways in which these impact on service users and staff. The next three sections each apply these ideas to a specific

dimension of 'difference': Section 5 discusses issues of ethnicity, Section 6 gender and Section 7 disability. Since ethnicity is arguably the focus of most debate in issues of diversity and communication, this is the longest section, and here many of the key issues of this course are developed. Our choice, as authors, of these three dimensions should not be taken as an indication that they are in any way more important than others that are not discussed in as much detail, such as issues of age, sexuality and class. The decision to focus on three dimensions of difference was made mainly on the grounds of limited space. However, we would argue that issues of ethnicity, gender and disability are sufficiently important, and that there is sufficient diversity between them, to help illuminate other areas that are not covered so extensively. Finally, although we discuss these dimensions separately for reasons of clarity, it is important not to forget the ways they intersect and overlap in people's actual experience.

To summarise, this course explores the following core questions.

Core questions

1. How should difference and diversity be understood in the context of interpersonal communication in health and social care?
2. What impact do issues of difference and diversity have on interpersonal communication in care services?
3. In what ways do issues of difference and diversity reflect and reproduce inequalities of power between social groups?
4. How should people in care services respond to the issue of difference and diversity, in the context of challenging inequality and discrimination?

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CHAPTER OVERVIEW

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1.1: A Communication ‘Problem’?

This course starts by exploring at a general level the relationship between ideas of ‘difference’ and issues of interpersonal communication. In the first activity, you will consider a brief case study that offers a way into discussing these issues, which can at times seem quite complex and entangled. The case study is taken from research into the health and social care needs of black communities in the Brighton, Hove and Lewes area in the south of England (Yazdani and Anju, 1994, quoted in Robinson, 1998, p. 92).

Example 1.1.1: Experiencing a communication ‘problem’

My main problem is communication. Because of the language problem often I feel dumb and can’t express my positive or negative feelings ... I stayed in hospital for two weeks. Two of the nurses neglected me. Of course I didn’t know whether it was because of my colour or because of the communication problem ... I am still not sure about the exact medical term of the operation.

(Source: Yazdani and Anju, 1994, cited in Robinson, 1998, p. 92)

Exercise 1.1.1

The speaker in case study 1 above is a Bangladeshi woman living in the UK. Having read the case study, think about the following questions.

1. What is the nature of the communication ‘problem’ experienced by the speaker?
2. Whose problem is it?
3. What are the consequences for the speaker?

Answer

Note that the speaker herself identifies the existence of a ‘problem’ and relates it specifically to ‘communication’. Initially, she analyses this as a problem of ‘language’. Presumably (although we do not have all the facts) she is referring to her perception that her spoken English is not sufficiently proficient to enable her to express her feelings as she would like to. She goes on to mention a specific experience, in which she was in hospital for two weeks. Here the precise nature of the problem becomes rather less clear. She says that two of the nurses ‘neglected’ her, and that she is unsure whether this was ‘because of my colour’ or because of the ‘communication problem’, by which presumably she means the language issue she mentioned earlier.

This raises the question of whether the real communication ‘problem’ was the woman’s inability to speak English, or the racism of some of the hospital staff, which resulted in them failing to communicate important information to her. That racism might have been expressed in a very direct way – simply by ignoring the patient ‘because of my colour’ – or more indirectly, by failing to provide the services (perhaps a bilingual worker or an interpreter) that would have made communication possible.

Whatever the nature of the ‘problem’, the consequences were potentially very serious, in that the speaker was discharged without knowing the precise nature of the surgical procedure she had undergone. A failure or breakdown in communication can lead directly to poor quality care being provided.

This brief case study demonstrates both the importance and the complexities involved in issues of communication and difference in the context of care. The questions were not straightforward, and they were designed to show the complex and contentious nature of the issues, rather than to produce easy answers. In a sense, how you answered the questions in Activity 1 depends on your understanding of the nature of ‘difference’ – whether of ethnicity, gender or disability – and both how difference is produced and how it should be responded to.

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1.2: Analyzing communication problems

Below are two very different responses to Case Study 1.

1. The main cause of the ‘communication problem’ was the Bangladeshi woman’s poor grasp of spoken English, which meant she was unable to communicate her needs clearly or to understand what was being said to her during her stay in hospital. She probably lacked confidence in herself, either because of her language difficulties or because of her cultural background. Perhaps the hospital could have done more to provide facilities to support her, but she also has a responsibility to improve her English, and maybe undergo some kind of confidence-building process to improve her ability to cope with the dominant culture.
2. The communication ‘problem’ arose because the hospital failed to address the indirect and direct racism inherent in its practices. Indirect discrimination was evident in the failure to take account of the diverse needs of patients, for example by ensuring bilingual workers or interpreters are available for the main community languages in the area. Direct racism was apparent in the way in which the two nurses ignored this particular patient. In addressing this problem, the hospital needs to ensure that all staff are trained in anti-racist practice and that positive steps are taken to ensure that all patients are treated equally, regardless of their ethnic, gender or other identities.

What is the main difference between these two responses, and how do they reflect contrasting approaches to issues of ‘difference’ and communication? One answer to this question is that the first approach locates the ‘problem’ in the patient herself and in the needs that derive from her ethnic and cultural background, while the second approach locates the problem in the racist attitudes and practices of the hospital. Of course, it could be argued that there is an element of truth in both responses, and that there is no need to choose between them. It may be the case *both* that the Bangladeshi woman has specific communication needs because of her cultural background *and* that part of the problem arises from the inadequate response of the institution to that identity. However, presenting the two approaches in this contrasting, if rather simplistic, way helps to demonstrate two fundamentally competing ways of understanding the nature of ‘difference’ – whether of ethnicity, gender or disability – and its link with issues of interpersonal communication.

Much of the discussion about issues of diversity in the context of health and social care has tended to concentrate on the apparent difference in communication styles or communication needs of particular groups, such as black people or disabled people. In the case study, there seemed to be a fairly clear-cut ‘difference’ related to the Bangladeshi woman’s ability to speak English, although the first response also suggested ‘needs’ related to confidence and cultural skills. However, even where spoken English is not a problem, there is often an assumption that members of particular ethnic groups (or women, or disabled people) have specific communication ‘styles’ or ‘needs’, simply because they belong to that group. An article by Theodore Dalrymple in the Anthology suggests an assumption that Indian women tend to be emotionally inexpressive. The clear implication being that this style of communicating – or, more accurately, failure to communicate – was directly related to their ethnicity and gender. Dalrymple also made generalisations based on age about the communication styles of older and younger British people, characterising the former as emotionally reticent and the latter as over-emotional. Other broad generalisations are often made about the ways in which people with learning disabilities communicate, and about their communication needs.

Exercise 1.2.1: Talking about communication and ‘difference’

Think about your own experience of using or working in health and social care services. What kinds of things do people say about the communication styles and needs of particular groups of people, whether because of their ethnicity, gender, disability, age or some other kind of ‘difference’?

Answer

Here are some examples reported by course testers.

- African–Caribbean people tend to use their bodies more expressively than white people when they’re communicating.
- Asian women lack confidence in talking to white workers.
- People with learning disabilities find speaking in groups very stressful.
- Women tend to let their emotions get the better of them when they’re under pressure.

These examples show there is a tendency in care services, as elsewhere in society, to associate membership of a particular group or category with specific ways of communicating, and particular communication needs.

These apparent differences in communication style are frequently represented as a ‘problem’ and as contributing, as in the case in [Activity 1](#), to a breakdown in communication. ‘Differences’ are seen as a problem if they mean service users are

unable to express their needs adequately or if they fail to understand (or they misunderstand) what they are being told by professionals. As a result, communication ‘differences’ are often presented as a barrier to the full participation of members of particular groups in services, whether as users or as workers.

The response to the existence of these apparent differences is often to provide specific facilities that enable better communication with particular groups, such as offering interpreters for non-English speakers or installing communication aids for some groups of disabled people. Beyond this, there is often an emphasis on training staff in ‘cultural awareness’ and in ‘cross-cultural communication’, which is designed to make workers aware of the diverse communication styles and needs of specific groups. The response may also include offering training in language skills, or more broadly in social and communication skills, for particular groups of service users. So, for example, women may be offered assertiveness training, or people of Asian origin may be taught confidence-building skills.

However, this raises fundamental questions about the nature of cultural and other ‘differences’. Are there really significant differences in communicating styles and needs between groups, based for example on ethnicity or gender? If so, what is their origin, and what is the most appropriate response? Is there an alternative way of viewing difference in relation to questions of interpersonal communication?

Key points

1. Issues of difference and diversity are often associated with communication ‘problems’ in the context of health and social care, contributing to the failure to deliver appropriate services and the creation of barriers to full participation for all groups.
2. Examining issues of communication and difference in depth raises important questions about the nature and cause of communication problems.
3. There is a widespread tendency to assume that members of particular groups have ‘different’ communication styles and needs.

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1.3: Ways of understanding 'difference'

The debate about the nature and causes of ethnic, gender and other 'differences' is complex and contentious. Here, for the sake of simplicity, two very broad and contrasting perspectives on the issue are presented. Understanding different theoretical perspectives on an issue is important, since these perspectives impact on and influence policy and practice. In this instance, the way in which 'difference' is understood has important consequences for how difference is responded to, whether by individuals or by organisations.

2.3.1 An Essentialist Perspective

One way of understanding apparent differences in people's behaviour and needs is to account for them as a direct result of their membership of a particular social group or category. For example, it might be suggested that a patient expresses herself in a very physical way because she is of African-Caribbean origin, and therefore because of certain innate biological or psychological attributes shared by all members of that ethnic group. Or it might be argued that a male manager behaves aggressively and competitively in a meeting because that is simply the way men are. According to this view, apparent differences in behavior are innate within the person, as a member of a particular group, and they remain fairly fixed and stable throughout their lives. Difference is seen as an 'essence', something belonging to the person which they bring to an interaction. Some essentialist arguments locate the roots of difference in people's genetic or biological make-up, while others identify upbringing and socialisation within the family (in the case of gender, for example) or within the social group (in the case of ethnicity and culture). Either way, what all essentialist views have in common is a tendency to see difference as working 'from the inside out', as something that is fairly fixed and stable within particular groups and the individuals who belong to them. As you might expect, essentialist approaches to issues of difference tend to be linked to various psychological perspectives. This does not mean everyone working within a psychological perspective can be labelled 'essentialist'. However, it is broadly true that a psychological perspective tends to see differences as residing within an individual or a group, rather than as the result of social processes.



Figure 1.3.1: The way we understand 'difference' determines how we respond to it in the context of health and social care

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1.4: The social construction of 'difference'

Social constructionists take issue with psychological accounts of human behaviour, criticising them for making universal generalisations and for having too great a focus on the individual. By contrast, a social constructionist approach sees behaviour as shaped by social context, and by issues of power and knowledge.

Those arguing from a critical social perspective would criticise essentialist accounts of difference for several reasons. First, they would argue that there is a danger of making sweeping generalisations about particular groups, such as women, black people or older people, that cannot be substantiated. According to these critics, essentialist approaches tend to see ethnic and other groups as homogeneous and to overlook diversity *within* groups. Moreover, they would argue that such an approach risks ignoring important similarities *between* groups, in its drive to identify clear differences. Following on from this, a third criticism is that an essentialist view mistakenly sees the boundaries between groups as fixed and unchanging, when in fact they are dynamic and socially constructed (for example, see Ahmad, 1996).

A critical social approach, rather than looking for the origins of apparent differences *within* individuals or groups, focuses instead on the ways in which differences are 'produced' in a social context and as a result of social processes. If essentialists view difference as a 'something' that resides inside people and influences the ways they interact, those adopting a more social model regard difference as a *process* by which people are 'differentiated', or constructed as different.

At the most basic level, this approach suggests that different kinds of context play an important role in the process of producing difference. Dalrymple's characterisation of Indian women as emotionally reticent could be criticised on the ground that such behaviour might be specific to the immediate context, rather than a symptom of some innate cultural 'difference'. It could be suggested that the immediate interactional context – women from a marginalised group visiting a white, male doctor – might play a part in 'producing' what appeared to be a lack of emotional openness. A different kind of interactional context – for example, a consultation with an Asian woman doctor – might result in very different communicative behaviour.

An important element in the interactional context is the relationships of power between those involved, and this too needs to be considered as a factor in the production of 'difference'. In considering why people communicate in a particular way in a particular context, we need to look at the ways in which inequalities of power, based for example on race, ethnicity or disability, are at work in that setting.

One example of a critical social perspective is social constructionism: briefly, the notion that the ways in which we think and talk about phenomena such as interpersonal communication reflect the dominant ideas of our society and culture. Ideas of Michel Foucault have been extremely influential in debates about 'difference'. Foucault argues that the ways in which people think about, classify and categorise experience is influenced by wider social discourses, and that these reflect and reproduce relationships of power within society. So, for example, he argues that discourses of mental health in western societies have changed significantly over the past 200 years, and that this reflects changing power relationships and the interests of particular groups (Foucault, 1967). Categories such as 'the mad' or 'the mentally ill' refer not to unchanging 'facts out there' but to changing social constructions of the world. There is a good example of this in Foucault's work on the history of sexuality, in which he claims that although same-sex relationships are known to have existed in nearly all societies throughout history, the category of 'the homosexual' and 'homosexuality', with all that flows from it, is an invention of 19th-century European medical discourse (Foucault, 1981).

Turning to apparent 'differences' based on ethnicity, gender or disability, a Foucauldian approach would argue that such differences are socially constructed. Different societies categorise and classify people in particular ways – for example as 'black' or 'Asian' or 'women' or 'disabled' – and then use those categories to explain so-called differences between them. Social constructionists would argue that 'you find what you're looking for', and that if you imposed a different set of labels, you might find other differences – or similarities. Moreover, as explored further in Section 4, constructions of difference are never innocent or neutral. The ways in which people are categorised – 'gendered' or 'racialised', for example – tends to reflect the interests of those doing the categorising, who usually have the greater power.



Figure 1.4.1

Does this mean there are no ‘real’ differences between people, on the basis of their gender, ethnicity or disability, that impact on their experience of communication? What about the ‘language problem’ in the case study in Activity 1? Surely the Bangladeshi woman’s lack of English was a ‘fact’ that meant that her communication needs were different from those of the majority, English-speaking population? Responding to this, social constructionists would not deny that particular individuals have a range of different abilities, needs and experiences. However, labelling this woman’s language abilities as ‘different’ is undeniably a construction – the product of a particular social context. Perhaps it is stating the obvious to say it would not represent a ‘difference’ if she was in hospital in Bangladesh, or using a service in the UK that had a significant number of Bangla-speaking staff. Moreover, her language abilities only become a ‘problem’ in a particular context: a context in which the hospital has failed to make provision for the language needs of all members of the local community. Activity 1 posed the questions: what is the communication problem, and whose problem is it? Social constructionists would add two more questions: who is constructing this situation – and this person – as a ‘problem’, and what kind of power relationship is reflected and reproduced in the process of doing so?

Key points

1. There are varied and competing ways of understanding issues of difference and diversity.
2. An essentialist perspective views differences as innate and as either biologically or psychologically determined, or as the result of socialisation within a particular group.
3. Essentialism has been criticised for overlooking diversity within groups and similarities between groups.
4. A social constructionist perspective views difference as a process rather than an essence, and understands it as being produced in social contexts and constructed within wider discourses of knowledge and power.

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1.5: 'Difference' and identity

If differences on the basis of gender, ethnicity and disability are socially constructed, how should people view their identities, for example as men, or disabled people, or people of African–Caribbean origin? Where do such identities come from, and how useful are they in explaining people's experience of communication in care services?



Figure 1.5.1

Foucault's ideas about changing discourses, and the ways in which they construct people's view of the world, can be applied to issues of ethnicity and gender. The dynamic and fluid nature of ethnic and gender categories is apparent even in the language and terminology used to describe people. Think, for example, about the different labels that have been used to describe black people of Caribbean heritage living in the UK over the past 50 years, and about the different meanings attached to those labels. Terms such as 'Negro', 'coloured', 'West Indian', 'black' and 'African–Caribbean' have different connotations. Firstly, each term has included and excluded different sets of people. 'West Indian' implicitly excluded people from Caribbean countries that had not been British colonies, for example, while 'coloured' and 'black' were also applied at various times to people of African and Asian origin. Some terms referred to skin colour, others to national or geographical origin. Some terms had strongly negative connotations, or their connotations changed over time. Moreover, the terms had different meanings for different people. Avtar Brah describes how the term 'black', which was originally pejorative, was taken up and used as a source of pride and as a political identity. It was also assumed for political reasons for a time by people of Asian, Turkish and Arab origin resident in the UK (Brah, 1992). More recently, and as a result of complex political and cultural processes, religion has played a greater part in the ways in which both society classifies people and people identify themselves. So in some contexts the term 'Muslim' now assumes greater importance than other 'ethnic' classifications, such as Asian, Arab or North African, with which it intersects.

These examples point to the contextual nature of identities. Another example of this is how different identities become important for people in different settings, as you will see when issues of ethnicity are explored later. Stuart Hall, a leading writer on issues of culture and identity, suggests that the word 'identifications' is preferable to the term 'identities', reflecting a view that identity is a process rather than something fixed and unchanging (Hall, 2000). Furthermore, assuming an identity takes place in a social context. As Hall makes clear, the identities that people take on always come with a history and are to some extent 'given' by society, although people may attribute different meanings to them.

The next activity is an opportunity to reflect on your own social identities, and the meanings they have for you.

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1.6: Reflecting on Identity

Exercise 1.6.1

0 hours 20 minutes

How would you describe your identity or identities? What kind of words would you use to describe yourself in terms of:

- gender
- ethnicity
- age
- class?

You may also want to describe other aspects of your identity that are important to you, such as nationality or regional identity, sexuality, religious or political beliefs, occupation or voluntary roles, family roles, interests and abilities, and so on. Use as many or as few terms as you like.

When you have made some notes in answer to this question, think about the following questions.

- Which of these identities (one or more) is / are the most important to you at this point in your life – and has this changed overtime?
- Would you have described your identity / identities differently 10 or 20 years ago? In what way?

Answer

We asked members of the course team, and some other people we know, to complete this activity. Here are some aspects of people's identities as they saw them.

- Male, white, middle-aged, working class
- I get into difficulty when I try to describe my nationality. Being born in England of Irish parents, I was made to feel Irish when I was growing up – as a matter of pride from my parents and discrimination from others. It was an identity I didn't talk about all through my 20s and 30s. Living in Ireland for three years confused my identity further since I could not relate to the culture 'back home'. So now I'm London Irish or European and I'm happy with that.
- I needed to think about this question for some time as there are so many different aspects to my identity. I would describe myself as an African/Caribbean woman born in the UK. In terms of age I am middle-aged and I guess in terms of my current profession and location I am middle class but my parents were working class and migrated from Jamaica to the UK in the 1950s. I am a mother, wife, sister, daughter and friend – which are all important aspects of my identity. Professionally I am a senior lecturer with The Open University.
- A woman, white (Northern Irish), born and brought up in the West Midlands, middle-aged, working-class background.

This is what people said about which identities were most important and the ways in which this had changed overtime.

- The most important things to me are my job, and being good at it, coming from a working-class background in Birmingham, being a good cook, a vegetarian and an ethical consumer. On the negative side, I have a disability which affects my mobility, and I am single with no family.
- Parent would be more out front 10 years ago.
- All of these identities are important to me at this point in my life and the challenge I have is being able to give space and time to the competing demands that each aspect of my identity poses. My ideal would be to have a life that was completely balanced and allowed the opportunity for each identity to be fully expressed and actualised... Twenty years ago I didn't have children and had a different occupation, working as a manager of health promotion services in the NHS, but I would have described my identities in the same way.
- Ethnicity is an identity that has taken on new importance. Although I am a Canadian, I worked for many years in race relations in California. Because I am white and talked like many other white people, I was indistinguishable from the dominant group there. Now living in the UK, I can't hide my 'accent', my different background, views and values. For the first time, I have a more real understanding of what it's really like to be different in ways you can't hide. Being different, I have found, often means 'less than', because of assumptions that I am an American, about my intelligence, education, values – especially right now.

- Ten or 20 years ago I would have laid more emphasis on my role as a mother and nurse and midwife since those dominated my life. In 1990 I would also have called myself a full-time postgraduate student. As a younger mother after the birth of the second child, I would say that my identity was consumed by being a mother.

Although we cannot know the details of your answer, we would guess that your response reflected some of the complexities and tensions in the above examples. Some conclusions that we drew from this activity are discussed below.

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1.7: Aspects of Identity

Every person has a range of identities, according to how they see themselves (and how others see them) in terms of gender, ethnicity, sexuality, age, and so on. This means that seeing an individual in terms of one aspect of their identity – as a black person, for example, rather than as (say) a black working-class woman who is also a social worker, a mother and a school governor – is inevitably reductive and misleading.

Identities are dynamic

The identities people assume, and the relative importance they attach to them, change over time because of both personal change in their lives and change in the external world (for example, as a result of changing ideas about disability). Consequently, identity should not be seen as something ‘fixed’ within people.

Identities have different and changing meanings

Aspects of identity may have different meanings at different times in people's lives, and the meanings that they attribute to aspects of their identity (for example, ethnicity) may be different from the meaning it has for others (for example, being black may be a source of pride for you, but the basis of someone else's negative stereotyping).

Identities are contextual and interactional

Different identities assume greater or less importance, and play different roles, in different contexts and settings, and in interactions with different people. Different aspects of people's identity may come to the fore in the workplace and in the home, for example, while people might emphasise different aspects of themselves to different people (and different people may see different identities when they meet them).

Identities are negotiated

In constructing their identities, people can only draw on terms that are available in society at that time, which have meanings and associations attached. However, people may attribute different meanings and importance to those labels. This means people always negotiate their identities, in the context of the different meanings attached to them.

Taking this view of identity, as a social process that people engage in, rather than as a fixed essence inside them, is not to deny that particular identities are extremely important for certain groups and individuals. Being a Sikh, or a woman, or gay, may feel like the most important and ‘deepest’ part of you. However, a more dynamic and social model of identity is useful because it makes it difficult to reduce people to any one aspect of their identity, or to use social identity as a way of explaining every aspect of their behaviour and needs, including their communication needs and behaviour.

Key points

Social identities, whether based on ethnicity, gender, disability or other factors, should be seen as:

- lural
- dynamic
- contextual
- negotiated
- produced in social and interactional contexts.

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1.8: 'Difference', power and discrimination

These first few sections have emphasised the point that differences are always produced in a social context, and that a key part of that context is power relationships. As pointed out earlier, a key element of Foucault's social constructionist approach is that the way in which people are categorised in society (for example, by gender, ethnicity or age) involves an exercise of power that reflects the ideas and interests of dominant groups. One of the key arguments against essentialist views of difference is that they reflect, and at the same time help to perpetuate, inequalities of power and status.

Section 3 noted that the ways in which the terms used to describe people from certain ethnic, geographical or national backgrounds have changed significantly over time. In addition in the British context, the labels attached to people seen as 'minorities' have always been defined by the white majority, that is by those with power. Labelling a group of people as 'different' in some way can itself be seen as an exercise of power, a way of putting people 'in their place' and fixing them there. Defining an individual primarily in terms of their apparent ethnic identity – for example as black, or African-Caribbean, or Asian – is a way of defining them as 'different' from a supposed white 'norm', and of playing down any similarities with others. The same can be said of attaching labels to people on the basis of a supposed disability, or sexual preference, or age.



Figure 1.8.1

The construction of people in terms of their supposed 'differences' from an imagined 'norm' or 'majority' tends to involve making sweeping generalisations about people on the basis of categories such as their ethnicity or gender. Individual differences, as well as similarities across groups, are lost as people are seen primarily as disabled, or 'elderly', or gay, for example. Decisions about individual needs, such as those relating to health and social care services, are then based on widely shared assumptions about people belonging to that group.

Often, these generalisations about groups – or stereotypes – are negative, since they reflect the differential power between those in the 'majority' and those categorised as 'minorities' or 'different'. So, for example, women may be defined as less rational than men, or black people as less intelligent than white people: in these instances, men and white people respectively are characterised as the 'norm'. These negative stereotypes both reflect existing inequalities – patterns of sexism and racism in society – and at the same time help to perpetuate them, for example by denying women and black people access to jobs that require a 'cool head' or complex intellectual skills. In other words, stereotyping people as 'different' can lead to discrimination.

So attributing fixed 'differences' to people is not a neutral process but one that both reflects and reproduces inequalities of power and status. The next activity is an opportunity to reflect on your own experience of prejudice and discrimination.

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1.9: Experiencing Prejudice and Discrimination

Exercise 1.9.1

Look again at your answer to Activity 3. Now think of an experience when an aspect of your identity (for example, in terms of ethnicity, gender, disability, class, sexuality or age) resulted in you:

- being discriminated against or badly treated by comparison with others
- being treated more advantageously than others in a similar position
- being placed in a position of power over others.

Answer

Here is an example from a course team member, which you may want to compare with your own answer.

I grew up with the reality of poverty and anti-Irish prejudice. Later, as a nurse, I found that I was in an inferior position to male doctors and was even bullied and harassed by senior staff. This was part of the culture of being a young nurse. As a senior nurse, I was often in charge of shifts, so that power was afforded to my position. Later in life, as a midwife, I acted as an advocate to the women in my care and challenged oppressive behaviour towards them. I was often consulted over care decisions and seen as someone who was powerful and assertive.

Individual examples of prejudice and discrimination should not be seen as isolated or free-floating. Within organisations, stereotypes and prejudice are often dismissed as the attitudes of a small minority, and instances of discrimination as ‘isolated incidents’. However, a social model of difference would view them as reflecting wider institutional patterns and structures. Stereotypical views held by individuals do not materialise out of thin air. They often reflect deeply rooted social attitudes, which are themselves grounded in processes of oppression and exclusion going back hundreds of years. For example, stereotypes about African, Caribbean and Asian people can be seen as deriving ultimately from Britain’s long involvement in slavery and colonial exploitation (Fryer, 1984). Similarly, feminists argue that negative images of women have their origins in patriarchal structures and practices going back millennia (Abbott, 2000).

Processes of racism and sexism play a part in producing and perpetuating supposed ‘differences’ between people based on their ethnicity and gender. Moreover, as you saw in the case study in Activity 1, these processes of prejudice and discrimination can lead directly to people’s diverse needs not being met appropriately. Adopting this approach does not mean denying the existence of difference, but acknowledging that responding to difference also means challenging and changing practices and structures that exclude and disadvantage people on the basis of supposed ‘differences’ from the norm.

This discussion is developed further in the next three sections with specific reference to issues of ethnicity, gender and disability.

Key points

1. Attributing fixed ‘differences’ to particular groups of people can be seen as part of a process that reflects and reproduces inequalities of power.
2. Stereotypes of people based on their social identities tend to be negative and to define them in relation to their difference from an imaginary ‘norm’.
3. Stereotypes can lead to prejudice and discrimination, which themselves reflect and perpetuate wider processes of oppression, such as sexism and racism.

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CHAPTER OVERVIEW

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Thumbnail:pixabay.com/photos/barack-obama-2011-1159790/

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2.1: 'Race', Ethnicity and Communication

As noted in the Introduction, much of the debate about difference and diversity in health and social care has focused on issues of 'race' and ethnicity. It is perhaps the area that first comes to mind when there is discussion about issues of communication and difference in care services, but it is also an area where the arguments are most complex and contentious.

As you saw in Section 1, 'racial' or ethnic diversity has often been constructed as a 'problem' for health and social care services, rather than as a cause for celebration and affirmation. Your work on Section 1 demonstrated the important part played by language and terminology in the construction of differences. Nowhere is this truer than in the area of 'race' and ethnicity, where attention has been focused on 'using the right words'. It is not uncommon for meetings and staff development sessions on anti-racism to get 'hung up' on issues of terminology, with white workers in particular anxious to discover what are the 'correct' or 'appropriate' terms that should be used for certain ethnic groups. Although this can sometimes be a distraction from facing up to racism at a structural level, it reflects an intuition that language *is* important in constructing the ways in which issues of 'race' and ethnicity are approached.

Since there is often much confusion about the terms 'race' and 'ethnicity', this section begins with a brief analysis of how they are used, and how they are used in this course. At the outset, we should say there is a growing body of literature on these issues, and how these terms and concepts are used does not stand still but is perpetually being revisited and redefined (Barker, 1981; Brah, 1996; Hall, 1992; Gilroy, 2000; Gunaratnam, 2003a).

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2.2: 'Race'

The word 'race' has largely been discredited in academic and policy discussions. You will notice that in this course, as elsewhere in the course, we have adopted the now common practice of putting the term 'race' in inverted commas, or 'scare quotes' as they are sometimes tellingly known. This is to indicate that, in current thinking, the idea of there being distinct 'races' and that human beings can be divided up on 'racial' grounds has been discredited. Racial thinking was at its height in the 19th and early 20th centuries and was associated with the ideologies of empire and colonialism. Ideas about distinct racial groups with distinct characteristics were developed to support the notion that some 'races' (those of white, European origin) were innately superior to others (usually 'non-white races' of African or Asian origin).

Many writers in this field argue that 'race' is socially constructed, as part of a process in which individuals are assigned to particular 'racial' categories (Banton, 1977; UNESCO, 1980; Miles, 1982, 1989). Certain physical characteristics, such as skin colour, become markers of social difference, as part of a process of 'racialisation' in which the concept of 'race' is given specific social meaning. People assigned to a particular 'racialised' group are perceived to have specific characteristics: for example, black people may be deemed to be better at some sports than white people, but also not as intelligent. In fact a great deal of early scientific research on 'race' focused on trying to determine intelligence by examining the size of the brain in different 'racialised' groups (Huxley and Haddon, 1935; Jensen, 1969; Eysenck, 1971; Banton, 1977; Barkan, 1992). This research was inconclusive and no 'racial' differences were found.



Figure 2.2.1

However, there are some genetic differences between groups of people which seem to have a geographical origin. For example, some inherited disorders are more prevalent in certain areas of the world and in communities that have migrated (Weatherall, 2001). Thalassaemia is more prevalent in Greek-Cypriot communities, whereas cystic fibrosis is more prevalent in North European communities (Ward, 2001). Some writers (for example Jensen, 1969; Eysenck, 1971) argue that this demonstrates the reality of 'racial differences'. However, others have argued that such 'differences' are largely insignificant, and that in fact there are more genetic differences within 'racial groups' than between them (Woodward, 1997). According to the sociologist and psychodynamic writer Michael Rustin:

'Race' is both an empty category and one of the most destructive and powerful forms of social categorization ... differences of biological race are largely lacking in substance. Racial differences go no further, in their essence, than superficial variations in bodily appearance and shape – modal tallness of different groups, colour of skin, facial shape, hair, etc. Given the variations that occur within so-called racial groups ... it is hard to

find any significance in these differences except those which are quite arbitrarily assigned to them ... Racial differences depend on the definition given to them by the other – that is to say, on the definition of the other- and the most powerful definitions of these kinds are those which are negative – definitions that we can call racist. -Rustin, 2000, pp. 183, 184

More significant than any minor genetic differences is the way in which supposed 'racial' differences have been used to explain people's behaviour and to place them in a hierarchy in society. To quote social policy writer Esther Saraga:

From a social constructionist perspective what is important is the ways in which these terms link together to produce a social relation, which organizes how people are placed in society. From this viewpoint, to construct groups of people into 'races' involves a threefold process:

- 1. Human populations are divided into discrete categories on the basis of variations in physical features.*
- 2. Meaning is ascribed to this physical variation and it is then said to be possible to know the potentialities, behaviours, needs and abilities of a person on the basis of their 'racial' belonging.*
- 3. This social process of categorization and classification is then said to be a product of nature – that is, racial division is said to be natural.*

Saraga, 1998, pp. 99–100

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2.3: Ethnicity

By contrast with ‘race’, ‘ethnicity’ is still widely used to describe differences between groups, although like ‘race’ it is a contested term. The terms ‘ethnic’ and ‘ethnicity’ are commonly used to denote groups of people who share common national or geographical origins, values and beliefs, and customs and traditions. Unlike the notion of ‘race’, ethnicity does not imply innate biological differences but rather similarities derived from belonging to, or being brought up as part of, a specific group (Nazroo, 1997).

As with all terms in this area, there is a need to be wary about how ‘ethnicity’ is used. Sometimes the word ‘ethnic’ is misused to denote ‘otherness’ from the (white British) norm, as in the terms ‘ethnic dress’, ‘ethnic food’ and ‘ethnic music’. This assumes that white people do not have an ethnicity, and constructs ethnicity as pertaining only to minority groups. Often the category ‘white’ is used in the UK context to obscure differences between people from a wide range of ‘ethnic’ groups, such as Irish or Italian. Moreover, the idea of ‘ethnicity’ assumes that everyone can be categorized as belonging to one, fixed grouping, which can then be used to explain their behavior and needs. But some people are of dual or mixed heritage and do not fit neatly into the categories offered, thus calling into question the whole process. How should you define your ethnicity if one of your parents is African and the other white (like the former US President Barack Obama), for example, or if you are both black and Jewish?



Figure 2.3.1: US President Obama has mixed African and white heritage. (pixabay.com/photos/obama-bar...nt-man-356133/)

Is ethnic identity a useful concept in thinking about people’s interactions in care settings?

In Activity 3 you reflected on your own identity. How easy or difficult was it to define your ethnicity? How important was your ethnicity to you? The next activity is an opportunity to focus specifically on your ethnic identity.

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