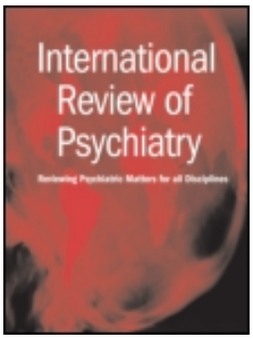

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"Otherness", otherism, discrimination, and health inequalities: entrenched challenges for modern psychiatric disciplines

Dinesh Bhugra[a], Alexander Smith[b], Michael Liebrenz[b], Antonio Ventriglio[c], Sam Nishanth Gnanapragasam[d], Ana Buadze[e], Max Pemberton[f] and Daniel Poulter[d]

[a]Institute of Psychiatry, Psychology and Neurosciences, Kings College, London, UK; [b]Department of Forensic Psychiatry, University of Bern, Bern, Switzerland; [c]University of Foggia, Italy; [d]South London and Maudsley Foundation NHS Trust, London, UK; [e]Department of Psychiatry, Psychotherapy and Psychosomatics, Psychiatric Hospital, Specialized Outpatient Clinic for ADHD, University of Zurich, Zurich, Switzerland; [f]Specialist Registrar, Camden and Islington NHS Foundation Trust, London

ABSTRACT

Identity is a complex concept that can be informed by various factors, involving biological, psychological, experiential, and social influences. Specifically, one's social identity refers to the ways in which individuals can adopt attributes from established collective categories, like cultural identities, ethnic identities, gender identities, and class identities, amongst others. Social identity can encompass unique and diverse interactions at an individual level, known as micro-identities, that may be selectively expressed, hidden, or downplayed, contingent on distinct sociocultural settings. However, the formation of social identity is recurrently defined in opposition to perceptions of the Other, which can entail adverse paradigms of marginalisation, stigma, and discrimination. Although this theory of Otherness has been developed across different fields, particularly sociology, it may be important in psychiatric contexts as it can engender inherent risk factors and mental health inequalities. Consequently, this paper seeks to bring attention towards these issues, exploring the construction of Otherness and its detrimental outcomes for psychiatry, such as systemic discrimination and disparities in therapeutic support, alongside recommended initiatives to mitigate against the effects of Otherness. This may require multifactorial approaches that include cultural competency training, interventions informed by micro-identities and intersectionality, patient advocacy, and structural changes to mental health policy.

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Identity, social identity, and micro-identities

As an essential aspect of human experience, identity is difficult to neatly define (Strauss, 2017). These intricacies are exacerbated by the rich heritage of philosophical inquiries in Eastern and Western traditions (Sollberger, 2013) and the role of contemporary technological advancements in forming online personas (Vincent & Lannegrand, 2022). Broadly speaking, identity could be considered to be our sense of self. This may include aspects such as the qualities, characteristics, beliefs etc which define an individual. These are strongly influenced by child rearing patterns and cultures in which an individual is brought up. Additionally, identity constitutes '[w]ho or what a person or thing is; a distinct impression of a single person or thing presented to or perceived by others; a set of characteristics or a description that distinguishes a person or thing from others' (Oxford English Dictionary, 2023). Common interpretations of identity may thereby incorporate three components: how I see myself, how others see me, and how I see others seeing me. Although in psychiatric settings the notion of identity may be similar to that of personality and is included in DSM-5 criteria for personality disorders (Schmeck et al., 2013), this paper will not thoroughly evaluate personality or pathological personality traits, but rather the general theory of identity as delineated above.

In historical frameworks, humans have conventionally been deemed to hold fixed and intrinsic qualities that can determine their sense of self (Zevallos, 2011). This tendency may be especially applicable in Western

CONTACT Dinesh Bhugra Dinesh.Bhugra@kcl.ac.uk Institute of Psychiatry, Psychology and Neurosciences, Kings College, London SE5 8AF, UK

intellectual traditions that have presupposed the static nature of identity; in such philosophical depictions, identity may rely on an innate human essence (Kung et al., 2016) or an egocentric mooring (Morris, 1994). However, contemporary scholarship has challenged this dialectic and underlined the diverse nature of selfhood, which can be influenced by interactions between biological, psychological, and sociocultural facets (Berry, 2007). Specifically, social identity theory recognises how people can possess multiple identities, linked to their recognition of affiliating with a particular social unit, such as their ethnic identity, gender identity, national identity, or class identity, amongst others (Hogg & Abrams, 1988; Tajfel & Turner, 1986). Importantly, the internalisation of these attributes may profoundly condition conceptions of the self (Zevallos, 2011). Social identities can augment psychological wellbeing, offer a sense of belonging and self-esteem, and may constitute a motivating factor for recovery from psychiatric morbidities, like substance use disorders (SUD) (Chen et al., 2021; Dingle et al., 2015).

As highlighted by Wachter and colleagues, social identities can consist of heterogeneous elements (Wachter et al., 2015). These so-called micro-identities are critical in shaping internal behaviours, attitudes, and experiences, both inside and outside of respective communities. For instance, within a certain religion, people can hold unique beliefs and practices, or there may be intragroup variations in language and values that distinguish one individual from another in a single cultural or ethnic category. Therefore, the notion of micro-identities emphasises the complexity and diversity of human experiences within social units, rather than assuming that all members from the same society or culture will have identical macro-perspectives (Wachter, 2015). In this regard, micro-identities hold parallels with intersectionality, which examines how features of a person's social identity can intersect and relate to generate unique experiences of discrimination and privilege at a macro-structural level (Bowleg, 2012).

Us and them: the other and othering

As we have discussed, ideas of similarity and differences perhaps due to individuation can cultivate social solidarity and mental wellbeing. Yet, social identities can concomitantly impose a feeling of the Other, as they are often developed in opposition to diverse groups or peoples whom we perceive as separate from ourselves (Jensen, 2011; Okolie, 2003). Such binary trends are pervasive across various ontological, cultural, and scientific spheres, including biological sex (male/female), species (animal/human), profession (layman/expert), mental health (insanity/reason), and legal (criminal/non-criminal) (Bauman, 1991). This is further exemplified by culturally accepted representations of identity (Mannarini et al., 2020), per the dictionary quotations above: 'a set of characteristics or a description that distinguishes a person or thing *from others*' (Oxford English Dictionary, 2023) (our italics). Consequently, our sense of self is validated through differential hierarchies between 'me' and 'you', between 'us' and 'them' (Jensen, 2011). Even semantically, the former is positively affirmed as intrinsic, whereas the latter (the Other) connotes alterity and externality.

Othering typically necessitates the distillation of social identities into distinct classifications: the majority ingroup who embody hegemonic normativity and minority outgroups who may personify alien (and thus potentially subversive) identities. Generally, this correlates with established power dynamics, in that socially ascendent ideologies determine these dichotomies and subordinate the Other (Canales, 2000). Hence, Othering has been portrayed as a constituent part of colonialist and imperialist projects (i.e. the need to subjugate the Other) (Said, 1978), and can entail symbolic or material detriments, which may include discursive or purposeful discrimination, social ostracism, socioeconomic disenfranchisement, and societal stigmatisation and oppression (Powell, 2017; Staszak, 2009). These can appear in overt gestures or be encoded in deleterious institutional patterns that touch upon a composite amalgamation of policies, laws, and social practices (Akbulut & Razum, 2022). For example, Smith and colleagues contend that recent rhetoric and political actions around migrant populations have intensified Self/Other polarities (Smith et al., 2023) for political and nationalist reasons.

Nevertheless, just like the concept of identity itself, these distinctions may not always be fixed and can situationally fluctuate (Skovgaard-Smith et al., 2020). To use an everyday analogy, an oft-repeated line in the United Kingdom centres around the tennis player, Andy Murray: 'Andy Murray is Scottish if he loses, British if he wins' (Blackstock, 2020). Albeit somewhat flippant, this encapsulates the malleability with which Otherness can be integrated or relegated in daily discourse and is dependent on contextual patterns, or what researchers have described as 'moving others away/toward the in-group' (Bernache-Assollant et al., 2021); explicitly, in this instance, amidst a nationalistic framework. Kapuściński contends similarly, positing that circumstantial factors can determine whether

Others are to be deemed friend or foe at a given moment (Kapuściński, 2009). However, again, it is the socially dominant ideology that determines these dynamics (Staszak, 2009), which can result in the exploitation of minorities through Exoticism or cultural appropriation.

Othering and discrimination

Othering can manifest itself in many guises and proliferate stereotypes and prejudices based on divergences (either real or perceived) between social entities (Staszak, 2009). Stereotyping and creating national characters is a form of short-cuts so that individuals do not have to expand their view. Rüsen's observation is that the division of 'us' versus 'them' can provoke ethnocentrism, as people tend to assign positive and negative qualities to the variations between themselves and the Other (Rüsen, 2004). Accordingly, Karimi has illustrated how Otherness is embedded in Islamophobic and antisemitic sentiment (Karimi, 2022). Significantly, stereotyping and discrimination towards ethnic minority populations can be particularly pronounced when hegemonic structures face existential threats, such as during the COVID-19 pandemic (Li & Nicholson, 2021). Consequently, discrimination based on race, ethnicity, or nationality might be a by-product of the construction of the Other (Said, 1978), especially given racism is relational, mutable, and precedes the history of races (Bethencourt, 2013). This may be underpinned by the associations between racism, xenophobia, and overt and covert power dynamics (Bhugra & Bhui, 1999).

Beyond racism and xenophobia, the perpetuation of Othering can culminate in discrimination predicated on different social identities. Alongside these ethnic and racial communities, people with disabilities may be exposed to discursive and material Othering in the workplace (Mik-Meyer, 2016). Additionally, patriarchal and heteronormative structures still endure in many societies, where masculinised hegemony can fortify gender-based inequalities. This is signified by the continuation of prominent gender pay gaps in capitalist systems (Kochar, 2023) and the proliferation of anti-gender politics globally (Butler, 2021). People who do not conform to binary definitions of biological sex, such as intersex individuals, have faced invasive medical procedures aimed at 'normalising' their identity (Carpenter, 2018). Likewise, as Rothmann and Simmonds illustrate in educational settings, as the predominant societal modus, heteronormativity can render people who identity as lesbian, gay, bisexual, or transgender (LGBT) vulnerable to social exclusion and prejudices (Rothmann & Simmonds, 2015). These can be revealed through acts of discrimination, including hate crimes (Flores et al., 2022) and systemic biases within institutions, like the media. In this regard, press reporting can enflame tensions towards LGBT individuals through pejorative depictions and discursive discrimination (Nartey, 2022).

Otherness and mental health disparities

Across varying healthcare disciplines, Othering and discrimination can have deleterious implications for professional relationships, therapeutic outcomes, help-seeking behaviours, and patient wellbeing (e.g. Hyman, 2009; Roberts & Schiavenato, 2017; Williams & Sternthal, 2010). This can exacerbate health inequities through entrenched power dynamics and infrastructural care pathways oriented towards social majority ingroups. Analogously, Western Exoticism and the exploitation of Otherness has affected aetiological investigations, reinforcing cultural differences in health-related research (Antić, 2021). Self/Other binaries can produce negative health outcomes at an individual level or present institutional impediments to healthcare, access through insufficient resourcing or restrictive policies and laws. As Akbulut and Razum (2022) indicate, inequalities may be accelerated by numerous mechanisms that perpetuate alterity, including communicatively (e.g. a paucity of culturally tailored materials or language barriers), spatially (e.g. a dearth of available healthcare institutions in given areas or insufficient/insecure housing), or socioeconomically (e.g. limited educational, employment opportunities, and social capital or a lack of healthcare entitlements).

From a psychiatric perspective, disparities are evident in the provision of mental health care for certain minority populations. Using the United Kingdom as an example, Black adults have been found to exhibit the lowest treatment rates of all ethnic identities (6% compared to 13% for White British individuals) (McManus et al., 2016; Wallace et al., 2016; NHS Digital, 2022). When mental health support is sought by minority communities, there can be stark discrepancies in therapeutic outcomes and recovery based on ethnicity (NHS Digital, 2016). Individuals who identity as Black or Black British were detained over four times more than White people and Black people are four times more susceptible to receive restrictive interventions, including isolation measures (NHS Digital, 2022).

Internationally, similar patterns have been observed; during the COVID-19 pandemic, Thomeer and colleagues examined how minority ethnic groups in the United States had higher unmet psychiatric needs than White Americans (Thomeer et al., 2023). Again in the United States, Prins et al. suggested that psychiatric screening tools in detention environments were less effective in identifying symptoms in ethnic minorities (Prins et al., 2012). Research by Keum and colleagues as presented in this volume shows the level of racism against the Chinese population in the time of Covid. Minorities with SUD in Switzerland had greater risks for co-morbidities, like human immunodeficiency virus, due to therapeutic inequalities (Liebrenz et al., 2014). Furthermore, mental health treatment may be scant amongst different social units, including LGBT individuals (Godfrey et al., 2022), people with disabilities (Cole, 2006), and socioeconomically disadvantaged communities (Subramaniam et al., 2021).

Concerns about the accessibility of psychiatric care for minorities are accentuated by epidemiological data in distinct social categories. For instance, a recent meta-analysis indicates that lesbian and gay people and bisexual individuals had elevated susceptibility for depression, anxiety, alcohol use disorder, and suicidality compared to heterosexuals (Wittgens et al., 2022). Transgender persons appear to have a higher incidence of depressive symptoms and suicide attempts compared to non-transgender LGB individuals (Su et al., 2016). Likewise, people with disability have increased rates of depression and anxiety, with a lifetime diagnosis of depression at 15.5% and anxiety at 11.1% (Okoro et al., 2011); one study determined that adults with disability are five times more likely to experience mental distress as compared to those without disabilities (Cree et al., 2020).

Notably, minority groups often face a range of distinctive psychopathological risk factors compared to the dominant social identities, which can aggravate minority-based stressors as has been seen in minority stress (see Ricci et al. and Torales et al. in this volume) (also see Edbrooke-Childs & Patalay, 2019). At an individual level, Othering and discrimination may engender negative cognitive effects, such as executive functioning impairments (Ozier et al., 2019). Othering can have a sizable influence on self-image, with DeWilde et al. showing how experiences of Otherness can worsen psychological stress (DeWilde et al., 2019). Analogously, Otherness may lead individuals to adjust behaviours based upon social encounters and subsequent self-reflection; a person may present or conceal different micro-identities professionally compared to their behaviour with friends or family to avoid stigmatisation and Othering. A famous line from T.S Eliot succinctly captures this phenomenon, humans recurrently 'prepare a face to meet the faces that we meet' (Eliot, 1998).

In certain settings, people can engage in 'covering' (i.e. downplaying a stigmatised identity) or 'passing' (i.e. hiding a stigmatised identity) (Goffman, 1963). Whilst identity concealment can constitute a social negotiation strategy, such practices could conceivably serve to reinforce Otherness, enhancing personal emotions of guilt or shame and internalised stigma (Hatzenbuehler & Pachankis, 2016), which can have an adverse impact on psychosocial functioning. Further, the cultural appropriation and exploitation of Otherness by hegemonic structures can have harmful psychological implications as demonstrated in the beauty industry (Awad et al., 2015).

Recommendations for psychiatric disciplines around Otherness and health disparities

Although in multiple fields such as sociology (e.g. Zevallos, 2011) and public health (Akbulut & Razum, 2022), there have been recommendations for how to refine and apply the concept of Otherness, to the authors' knowledge, its relevance within modern psychiatric disciplines is not comprehensively understood. Instead, we suggest that there should be increased awareness towards the notion of Otherness as it could potentially allow psychiatrists to better understand discriminatory patterns and influence multifactorial mental health initiatives at an individual and systemic level. Based on the evidence above, these could be envisioned with the aim of mitigating discriminatory and stigmatising paradigms towards minorities and promoting help-seeking and treatment provisions in neglected communities.

For us, as a foundation for improved sensitivity around Otherness and discrimination, cultural competency must be emphasised as a central component of psychiatric training and systematically incorporated into residency programmes (Bäärnhielm & Schouler-Ocak, 2022). Equally, clinicians may need to be encouraged to undertake regular cultural sensitivity training as part of their occupational responsibilities (Qureshi et al., 2008) and bias mitigation strategies should be adopted more holistically (Moreno & Chhatwal, 2020). This could help inform empathy and inclusivity, allowing specialists to broaden their knowledge of patient perspectives within the therapeutic alliance (Bhugra et al., 2017).

Alongside these proposals, the relationship between micro-identities and mental health needs to be further expanded and more widely understood. For example, depending on a person's micro-identities, they may

face different levels of stigmatisation in the context of mental illness, which may need to be accounted for in stigma-reduction interventions (Wachter et al., 2015). For us, this topic warrants detailed attention, especially since intersectional methods for treatment and stigma mitigation might require targeted, flexible, and complex interventions (Oexle & Corrigan, 2018). To that end, psychiatric associations could run dedicated workshops or produce and disseminate best-practice guidelines focussing on intersectionality and micro-identities in therapeutic programmes. Presently, researchers have identified the scarcity of available consensus statements on intersectionality and psychiatric care, especially in relation to sexual minorities (Huang et al., 2020). Likewise, international collaborations between psychiatrists and psychotherapists could nurture the clinical applicability of intersectionality across diverse national frameworks.

As Otherness can lead to discrimination and stigmatisation, which in turn can impede help-seeking, bespoke care pathways could be designed with this in mind and optimised to provide a safe and enabling environment. Previous therapeutic initiatives have shown promising results in minority groups, including successful online interventions and community-based programmes (Liebrenz et al., 2014; Pachankis et al., 2020). Similarly, integrated approaches using culturally and linguistically tailored strategies have been advantageous in certain environments (Sanchez et al., 2016). Here, there may be a valuable duties for cultural brokers in translating and interpreting relevant messaging (Moreno & Chhatwal, 2020). Moreover, Sayce argues for a reconceptualisation of treatment goals, that encompass both recovery and social inclusion as core objectives (Sayce, 2001). Successfully implementing these strategies would need additional investment from governments, healthcare providers, and the taxpayer, who all must recognise the necessity of robust policymaking to reduce health inequities in psychiatry. In the authors' view, this may be a particularly challenging message in the current 'cost of living crisis' and therefore, the role of patient advocacy on the part of psychiatrists could become increasingly pronounced (Kirmayer et al., 2018).

Finally, decreasing institutional disparities and the effects of Otherness in mental health policy will demand the introduction of proactive measures. Healthcare structures often do not recognise the importance of proven preventive factors, like stable housing and social capital, which should be better represented in policy proposals. Dutta highlights how minorities presently have limited opportunities to be included in policy debates (Dutta, 2016). Hence, structural changes to recruitment processes may be necessary to ensure inclusive clinician bases and enable individuals from minority groups to fulfil management or decision-making positions. Data collection around care quality and mental treatment using self-classification of social identities could be essential for tracking temporal progress and changes in enhanced care provisions (Bragazzi et al., 2022). Studies have shown that rates of psychiatric disorders are higher in LGBTQ+groups in comparison with the general population (Dinos et al., 2021, Wittgens et al., 2022) and as equality is brought in by law rates start to go down (Hatzenbuehler et al., 2010). This clearly indicates that otherness is an important factor and consequent otherism is probably more important than simple racism, homophobia, bi-phobia etc. Although this would need to be conducted sensitively to ensure it did not lead to adverse outcomes in specific social groups, such schemes could offer critical insights to policymakers and mental health providers. Accordingly, researchers have called for the creation of a bespoke governmental agency to be responsible and accountable for minority health and health disparities; this body could take the lead on these programmes, directing appropriate resources, regulatory attention, and awareness (both professional and public) to address extant inequalities (Bhugra et al., 2020).

Conclusion

Social identities can cultivate collective belonging between individuals, but they can simultaneously produce polarising binaries and a sense of Otherness. In our view, psychiatrists need to be aware of the mechanisms of Othering as they can contribute to the marginalisation and discrimination of minority groups. In turn, this can produce healthcare disparities and impinge upon the availability and accessibility of therapeutic support. Resultantly, we believe it is essential for the field of psychiatry to develop a deeper understanding of these issues, emphasising empathy and cultural humility, and increasing professional and institutional awareness towards the stigmatising paradigms of Otherness. In doing so, mental health specialists can provide effective and inclusive treatment for individualised patient needs and work towards more equitable environments that celebrate inclusivity, accentuate clinical diversity, and promote social justice.

Disclosure statement

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