

**INTERSECTIONALITY AND HEALTH CARE:
SUPPORT FOR THE DIVERSITY TURN IN RESEARCH AND PRACTICE****Janneke van Mens-Verhulst¹ & H. Lorraine Radtke²****Abstract**

The health care field (including feminist health care) recognizes that diversity is an issue. Evidence-based knowledge is needed to incorporate diversity into health care practices, but how best to conceptualize diversity remains a problem. Recent feminist scholarship highlights the need to conceptualize diversity in terms of intersectionality, but most conventional health care research that is diversity-sensitive only includes one or two social/identity categories. Intersectionality brings with it certain benefits but also certain challenges. The challenges include addressing what phenomena are presumed to intersect; how power relations can be included; and how complexity can be dealt with. After exploration of current research practices and solutions, we discuss the possible contributions of Intersectionality Theory to the diversity turn in health care.

Keywords: intersectionality, health care, power, diversity

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Despite growing interest in the significance of gender and culture for health care research and practice, the health care field has only begun to grapple with the challenge of dealing with socio-cultural differences. In particular, there has been relatively little engagement with the important debates on intersectionality to be found within the field of Women's Studies.

For us, 'intersectionality' is a special way of conceptualising differences as it pertains to a combination of identities (Brah and Phoenix, 2004, Collins, 1991; 1998; Crenshaw, 1989; Lorde, 1984; Phoenix, 1998; Smith, 1998; Stewart and McDermott, 2004; Williams, 1997; Yuval-Davis, 1997). The theory's origins lie in critiques of second wave feminism as ignoring or downplaying differences and treating multiple oppressions as the sum of distinct individual oppressions, where some oppressions are considered to be more important than others (Mann and Huffman, 2005). Instead, Intersectionality Theory posits that multiple oppressions are simultaneous (e.g., 'race' and gender and class, etc.), inseparable (e.g., the impact of 'race' cannot be isolated from the impact of gender), and intertwined (e.g., both 'race' and gender combine in their impact on everyday life). Thus, attention shifts from a woman's social location in relation to a number of individual social groups to her social location at the intersection of a complex set of social identities. There are now several different accounts of intersectionality. We discuss these distinctions further in the context of health care research.

However, there are very few instances where health care researchers take up an intersectionality perspective; mostly, individual researchers study simple combinations, e.g., elder women or migrant women, and use traditional research designs. Consequently, health care research is split into 'branches of difference' that compete for funding and have their own journals, conferences, and courses.

In this article, we explore how health care research and practice might benefit from Intersectionality Theory but also what limitations are involved. Such work entails breaking down disciplinary boundaries, in this case, the boundaries between the relatively new tradition of feminist theory and research within Women's Studies and the older scientific tradition within the Health Care research field (McCall, 2005). First, however, we address how the Health Care field, and particularly feminist health care research and practice have dealt with difference.

HOW THE HEALTH CARE FIELD HAS DEALT WITH DIFFERENCE

Within conventional health care research and policy, there is a call for more research that incorporates diversity concerns, for reasons both moral and practical. First, research results ought to allow for the establishment or development of treatment interventions. Second, these interventions must be adequate for different types of populations; not only adult, white, heterosexual-oriented, middle class men. Third, the interventions should avoid exacerbating existing social inequalities. For this, governments and health sector management are a driving force through their concerns with access, safety, and quality of health care services.

However, conventional approaches are quite limited in how they can deal with this. Traditionally, conventional health care presumed that its concepts and methods were universally applicable; some exceptions were made based on age and class and later for sex/gender. Today, interculturalization policies aim for equal access to health care services and equal treatment for individuals who have a varied ethnic/cultural background and/or are

immigrants, but the appropriate place of culture in health care remains a matter of debate. Practical problems, including difficulties with communication when there are language differences, dietary restrictions, and so on, appear to be at the forefront of concerns with diversity. More fundamental issues, like the meaning of health problems and how they are best treated in the context of a specific client, are of lesser concern. Of course, different health sectors (e.g., public, medical, mental) have different concerns about differences.

As specific differences have given way to the broader notion of diversity, conventional health care researchers (and policy makers) are faced with an enormous challenge of how to address this complexity within the available conceptual, methodological and organizational frameworks. Feminist health care research, on the other hand, is generally very sensitive to the exclusion of marginalized groups based on the history of women's exclusions from medical research and elsewhere as well as debates within feminism regarding the exclusion of minority women (Mens-Verhulst, 1991; 1998). In addition, from its inception it has challenged the assumed universal generalizability of health care research findings and approaches to practice. Furthermore, feminist health care research is usually attuned to power relations within the context of health care and is an explicitly emancipatory project. Feminists working in the health care field as researchers and practitioners have opposed medicalization, psychologization and trivialization of women within the health care system and gender oppression wherever it occurs (e.g., Bekker, 2003; Burman, 2004, 2005; Dickey, 2000; S. Wilkinson, 2000).

Conventional and feminist health care research and practice reflect a common concern with diversity, but also differ in some substantive ways. Areas of shared interest include the implications of socio-cultural differences for what is perceived to be a health problem, intervention methods and goals (i.e., the reduction or elimination of health complaints and adequate personal and social functioning), the therapeutic relationship and the organization of health care. Even the feminist health care interest in the clients'/patients' influence on the help they require has been noticed within the conventional health care system in the last fifteen years – witness the raising of patient-driven health care as a policy issue. Additionally, however, feminist health care focuses on client's living conditions; their geographical, temporal and historical location; emancipatory possibilities; the power dynamics in the relationship between practitioners and clients/patients; the possibilities for enabling alliances; and the constraining context of health care institutions. In general, feminists working in health care take a critical stance in their conceptualization of diversity by attending to hierarchies of difference, i.e., which differences are treated as 'normal' or desirable and which are treated as 'pathological' or undesirable. Nevertheless, the common ground of difference/diversity shared by feminist and conventional health care researchers and practitioners may offer an opportunity for feminists to keep gender on the health care agenda, i.e., to further the objective of gender mainstreaming; Intersectionality Theory may be a useful way to foster further ties.

THE DIVERSITY TURN IN HEALTH CARE

The case for diversity-sensitive health care research and practice is relatively easy to make in current times. Access, quality and safety for all people are at the forefront of practice concerns, although pressures come from different directions. For example, both a policy pressure for patient centred health care and a more bottom-up pressure for gender sensitivity and multicultural health care are based on arguments for equity, safety and quality within health care practice (McGee and Johnson, 2004; Mens-Verhulst, 2003; NIH, 1994; 1999; NIH, 2000; WHO, 2001; Wieringa et al, 2005).

Reflecting the significance of diversity for health care, there is now a journal entitled *Diversity in Health and Social Care*, which appeared in 2004 and has published four issues so far. The statement of the journal's aims and scope defines diversity in terms of a person's social location/identity ('culture, belief, disability, gender, race, and ethnicity'), but is also extended to include the context in which health care occurs and the many disciplines that contribute to professional health care practice. Practice-focussed, the journal nevertheless invites submissions that reflect the need for on-going review and debate of diversity as a concept informing practice. Clearly, naming the differences may well be an important starting point for taking them seriously, however, research and practice requires theorizing their relationships and implications. Delivering on the promise of the diversity turn depends on there being relevant evidence based knowledge.

Feminist health care researchers and practitioners have been at the forefront of calls to incorporate diversity into research and practice. Two examples are Ussher's (2000) edited collection that not only offers a broad survey of the latest developments in women's health but also makes an explicit argument for continued, special attention to women's health and Crossley (2000), who pits the mainstream bio-psychosocial model of health psychology against a critical health psychology that is contextual.

In addition, there is a body of research adopting a multi-categorical starting point, e.g., Kobayashi's (2003) 'intersections-of-diversity' framework and Bekker's (2003) Multi-Facet Gender and Health Model. Besides, there are numerous studies with samples composed of individuals located at the intersections of one or more social categories, e.g., Meadows, Thurston, and Melton's (2001) study of immigrant women at midlife. Nevertheless, there is clear evidence that the health care field is struggling with the complexity of diversity (Wieringa et al., 2005). To achieve evidence-based knowledge, an adequate conceptualization of diversity is needed.

DEFINING DIVERSITY IN RELATION TO INTERSECTIONALITY

The most circumscribed view of diversity focuses merely on race and ethnicity. A less narrow, though still limited view also takes gender into account. In its broadest sense, diversity includes many possible social categories such as sexuality, age, dis/ability, class, and, in some cases, philosophy of life (Nkomo and Cox, 1997). Such categories are thought to serve an important function; they mark areas of similarity and difference, and as such, bear on questions of equality, individual rights, and social justice. Frequently, diversity refers to the context of minority group status. Importantly, however, one's affiliation with various social groups is thought to shape someone's sense of personal identity (both who one is and who one is not), and as a consequence, has widespread implications for someone's everyday life (Phoenix, 1998; Rummens, 2003).

Clearly, most people identify themselves or are identified by others as belonging to many different social groups across their lifetimes, but until recently, the relationships between the social categories were rather naively conceptualised as independent or perhaps additive. The hierarchical tradition within the human sciences frequently emphasizes a single, dominant identity/social location, for example, gender or nationality (Donaldson & Jedwab, 2003; Wilkinson, 2003). Nevertheless, various models have been adopted to conceptualize multiple identities that are independent of one another (Rummens, 2003). For example, a stacking approach treats each social identity as a separate layer within an individual's overall personal identity. It ignores the importance of each identity for the individual and treats each identity as independent of the others. Similarly, a radial approach, which puts the individual at the centre with various social identities radiating out from the core like spokes on a wheel,

does not posit any relationships among social identities or variations in their salience over time and context. Finally, a centrifugal approach postulates a core-self encircled by a series of independent social identities. Those closest to the centre are most important, but like the other two approaches, there are no connections assumed between the social identities. An intersectional approach, on the other hand, incorporates the notion of intersecting identities/social locations in the context of minoritization¹ and is therefore more promising for understanding the connections among identities (Rummens, 2003). It also offers a power-conscious diversity concept that could be utilized within both conventional and feminist health care frameworks. Consequently, it promises a critical diversity approach.

Although references to diversity abound in the Social and Health Sciences, Intersectionality Theory has primarily been a concern in relation to the study of women, Aboriginal people, immigrants, and people of colour (S. Wilkinson, 2003) where it focusses attention on the differences within the groups associated with a given category, e.g. 'racial' or gender groups. Its origins lie in Black Women's Studies with the view that Black women's lives could not adequately be understood purely from either a 'race' or a gender perspective, but the term itself originated with Crenshaw's (1989, 1991) analysis of the intersection of 'race' and gender in relation to violence against women of colour. At about the same time, Collins (1990) was writing about the intersection of 'race' and gender in terms of a 'matrix of domination' but has since also adopted the term 'intersectionality' (Collins, 1998).

Not surprisingly for such a new endeavour, 'intersectionality' has been taken up in a number of different ways. While it is beyond the scope of this article to explore all of these variations, we will concentrate on three issues that are especially relevant for the health care field. They pertain to fundamental assumptions that have consequences for the fit between Intersectionality Theory and established research/practice traditions within the health care field. First, what are the analytic concepts that are presumed to intersect? Second, how are power relations implicated? Third, how can the theoretical complexity associated with intersectionality be managed so that it is amenable to investigation and the production of evidence-based knowledge? In our exploration we will use the available examples of health care research explicitly informed by Intersectionality Theory, which turned out to be rather scarce. Those included are Burman (2004); Kirkham (2003); Dworkin (2005) and Pinto (2004).

WHAT IS INTERSECTING?

In reading the literature on intersectionality, one is struck by the variations in terminology. However, the various formulations of Intersectionality Theory seem to coalesce around the three concepts of identities, social categories, and power. By identifying three distinct concepts in the texts on intersectionality, we are not suggesting that they are independent. Indeed, Intersectionality Theory proposes that these conceptual categories are interrelated. Nevertheless, different writers have offered different points of emphasis and somewhat different analyses of the essentials of intersectionality. Those with a mental or psychosocial health care focus have drawn particular attention to identities and power. Burman (2004), for example, makes a case for the value of an intersectional perspective over one that focuses on a single dimension of difference by noting how the latter approach frequently reproduces existing power hierarchies. Moreover, in arguing for the importance of including gender *and* culture, she emphasizes how identities are shaped by culture. Indeed, this is another exercise of power, i.e., the regulation of identity through dominant cultural practices. Pinto (2004) draws primarily on identity and power in discussing the challenges faced by an adolescent dealing with health care providers. Nevertheless, she concludes that the intersection of gender

and age shaped the young woman's experience of illness. Those with a focus on the delivery of health care services, on the other hand, emphasized power and social categories. Kirkham and Anderson (2002) seek to develop a new approach to nursing scholarship (with implications for practice of course) that serves the marginalized, and Kirkham (2003) explored the challenges of intercultural nursing. Finally, in the one study with an epidemiological focus, the attention was on social categories. Dworkin (2005) builds an argument for an intersectional perspective in determining the 'surveillance categories' to be used in identifying who is vulnerable to HIV/AIDS. Thus, she draws almost exclusively on the discourse of social categories with the occasional reference to identity, as in gender identity, which assumes that being identified with a particular social category implies the corresponding identity.

For health care, the intersectional mantra² should at least contain the three bodily-related categories of age, gender and ethnicity; frequently, this should be extended to class and sexual identity. In epidemiology, there are accepted practices for marking age and gender, namely, chronological age and self-identified sex. Also, class has traditionally been marked by income, education, and occupation although gradually it is being acknowledged that education is the best indicator for women (see Moerman and Mens-Verhulst, 2004). In the Netherlands, ethnicity is officially marked by taking into account parents' and grandparents' country of birth. However, the consciousness is growing that a less standardized approach is desirable, for example, ethnicity unpacked as nationality, language, religion, genetics, (rate of) acculturation, sense of belonging, adherence to cultural practices, migration, generation of migrants, reasons for migration (colonial, economic or political); sex as organs, hormones or genes and gender as masculinity/ femininity, sex stereotypes, gender roles, rate of gender socialisation; age as a chronological, biological and/or social, and as a cohort indication.

In applying Intersectionality Theory to health care, it seems incongruous to ignore the biological. Biology, biological difference, and the body not surprisingly constitute a rather controversial topic in our attempts to draw on feminist theory to inform health care research and practice. Although traditional health care researchers and practitioners generally take biology and biological difference for granted, many feminists have adopted a critical stance. Indeed, women's health research tends to focus on socio-cultural processes and health and ignore the body (Birke, 2000; Kuhlman and Babitsch, 2002). As a feminist biologist, however, Birke (2000) describes herself as 'sitting on the fence'. On the one hand, she adopts a social constructionist stance and critiques the categories used to describe what goes on in the body, e.g., the gendering of hormones. On the other hand, she adopts a realist stance in exploring how environmental conditions, e.g., potentially toxic chemicals, affect what goes on in the body. She argues that this allows her to avoid biological determinism without ignoring biology altogether. Similarly, Kuhlman and Babitsch (2002) advocate a reconceptualization of the body as flexible and open to transformation but still material. Finally, Klinge and Bosch (2005) argue that the distinction between 'sex' as a matter of biological difference and 'gender' as a socially-produced difference is necessary within the health care field. For them, this is a strategic decision, enabling them to convince health researchers that gender sensitivity is essential for good health care and research. Consistent with the other two papers, they advocate 'a non-essentialist interest into what is happening in bodies' (p.391).

What does this mean for Intersectionality Theory and health care research? Clearly, one cannot hope to engage health care researchers without including the body as part of the analysis, and without paying attention to the biological aspects of the body. Bodies as a whole, or broken down into smaller dimensions, can be treated like the identity categories that up until now have been the focus of research on intersectionality. This has the advantage of treating the body category in an equivalent manner to other categories and avoiding the privileging of biology associated with biological reductionism. Moreover, the analysis would

focus on the intersection of biology and other forms of difference, thereby avoiding the binary of biology/environment.

POWER RELATIONS

Power relations are not typically in the foreground of traditional health care research. They appear implicitly however in concerns about the influence of poverty and violence on clients' health and response to treatment, equal access to health care, and the safety of treatments (e.g., the lack of sex specific knowledge may lead to incorrect medication being prescribed). Intersectionality Theory draws our attention to the presence of power relations throughout the health care field and the need for health care service providers and researchers to include an analysis of power in their work.

At first reading, Intersectionality Theory does not offer a new conceptualization of power. For example, Burman (2004) and Kirkham and Anderson (2002), and Kirkham (2003) draw from other theories, including postcolonial theory, feminist theory, anti-racist theory, and Foucault in their discussions of power relations within the context of intersectionality. Kirkham and Anderson (2002) concentrate on the politics of belonging, and the way both clients and practitioners may be 'othered' and excluded. One of the ways in which othering is practiced is through Eurocentric representations of 'us' as normal (in illness perception, health behaviour, etc.). Another is denial of the right to speak rather than being spoken for. They make the claim that health care contributes to an inequitable distribution of power and resources throughout society, when it could enact social change. Additionally, Kirkham (2003) shows how the politics of belonging are applied within the 'social fabric' of Canadian health care. Clients entering the hospital or clinic are subject to a complex array of regulations and practices, designed to deliver benefits. Who they benefit, is an interesting question, however. For example, visiting hours (with limitations in time and number of visitors) appear not to meet the needs of all clients. Clients who try to negotiate with medical staff (resisting normative health care practices, challenging the knowledge they are handed, and so on), however, are confronted with the control of the linguistic domain – by the claim that English is the normal language. Frequently, practitioners are complicit in these exclusionary processes. However, being themselves positioned in various ways within the hierarchies of the institution, they do not always take a superior position with respect to clients, and they also may resist the othering practices in their encounters on both an institutional and a societal level. Kirkham (2003) concludes that researchers are in a position to determine what constitute legitimate health problems to be studied and treated, and therefore to reduce the injustices. Thus, according to Kirkham and her colleague, Anderson, in simply being cognizant of relevant power relations, both health care researchers and service providers can ensure not only equity within the health care system but potentially support equity in society at large.

Burman (2004) makes a similar point but focuses on the production of particular power relations through dominant discourses that obscure certain health-related problems, impede adequate care, exacerbate certain health problems, and serve to exclude some people from the health care system. Health-related problems like domestic violence or female circumcision are obscured if culture is treated as separate from gender. Being defined as a private matter, as the concern of a particular cultural community, the 'culturally specific' practices go unquestioned. Adequate health care is impeded if the widespread discourses of specificity and specialisation lead health care providers to presume there will be cultural and language barriers in consulting room encounters with clients of varying cultural backgrounds. In not challenging what are in effect racist assumptions of difference, similarities are

overlooked and the withholding of desirable expertise is rationalized and sanctioned. Health problems may be exacerbated if discourses of specificity and specialisation result in an inevitable cultural matching of practitioners and clients. Namely, confidentiality may be a problem, particularly in small cultural communities, where the very knowledge that an individual has visited a particular health professional can publicly expose the nature of the individual's health problem. Furthermore, health practitioners from within the cultural community may not question accepted cultural practices that have negative consequences for health. Finally, policies and laws, e.g., regarding immigration and residency status, may result in certain women being excluded from the health care system. Burman (2004) advocates adopting the term 'minoritization' to replace terms like 'minority' or 'minority ethnic group' as an intentional discursive intervention, which 'highlights that groups and communities do not occupy the position of minority by virtue of some inherent property (of their culture or religion, for example) but rather come to acquire this position as the outcome of socio-historical and political process' (p. 305). Thus, Burman also highlights how attention to power relations within an intersectionality framework has direct implications for the delivery of health care services, which may in turn have broader consequences for cultural practices as well as laws and policies.

A second reading of Intersectionality Theory suggests that it offers a notable contribution to the conceptualization of power relations and renders visible some important issues related to health care. Firstly, theorizing that power relations do not consist of the simple binary, oppression/dominance, illuminates how a given woman client may be advantaged in some respects and disadvantaged in others. This is as relevant for white women as for women of colour. For example, a White well educated woman may be living in poverty and have a disabling disease such as Multiple Sclerosis that means she requires the use of a wheel chair. Secondly, emphasizing that power relations shift with context and over time allows that although this woman may have the agency to negotiate the health care services she receives, she may not be able to resist a change in hospital policy that decrees mixed-sex hospital rooms even though sharing her room with men makes her feel very threatened. Thirdly, such a framework enables one to see the relationships between different systems of power and to trace possible alliances between clients and practitioners, on a personal, institutional and/or societal level, e.g., between women (being white or coloured) or between clients in poverty (being women or men).

Finally, combined with the constructionist stance, Intersectionality Theory makes an important contribution in leading health care researchers and clinicians to ask the question 'how are we doing power?' in addition to questions such as 'who is in a position to exercise power?' 'who is recognized as the expert?', 'who is resisting the regulations and how?', 'whose interests are served by particular regulations and practices within health care institutions?'

MANAGING COMPLEXITY

Clearly, incorporating an intersectionality perspective in health care research and practice may seem daunting in the face of the numerous differences that might be meaningful in a given context. At the extreme, the issue of complexity becomes the question: 'how ubiquitous or contingent are intersections of social locations assumed to be?' (Browne and Misra, 2003). Those taking the ubiquitous position assume that the intersection of, e.g., ethnicity and gender is always relevant and to be reckoned with. Those taking the contingent position treat intersectionality as a hypothesis, i.e., ethnicity and gender are viewed as separate dimensions of difference that may be related; evidence for this relationship is sought in the outcomes of

various combinations. It requires little discussion to conclude that the contingent position fits better with the health care field, given the emphasis on evidence based knowledge.

Apart from ubiquity, there is the question of how intersectional diversity within health care research can be dealt with conceptually and methodologically. Beginning with conceptual considerations, McCall (2005) made an important distinction between those who take a critical approach toward categories (i.e., the anticategorical and intracategorical stances) and those who take them up albeit provisionally (i.e., the intercategorical stance). The critical approach is rooted in long-standing feminist critiques of binaries, such as male/female, and essentialist thinking, which perpetuate social inequalities. Here complexity is handled either by studying social locations at the intersection of a number of categories or exploring the diversity within a particular social group. On the other hand, the intercategorical stance focuses attention on the inequities and power relations between social groups. Both approaches, however, require some decision about which distinctions are relevant and pose the question of relevance.

Management of complexity obviously may be achieved by reducing the number of categories or dimensions to those that are relevant (Stewart & McDermott, 2004). Decisions regarding relevance could be based on considerations of a research project's goals (i.e., description vs. explanation), the practical aim of the researcher/clinician (i.e., support for policy vs. diagnosis or treatment/intervention), the type of practice and client (i.e., physical, mental, or public health), constraints of the proposed statistical analyses, and the outcomes of any preliminary investigations. Perhaps indicative of the history of Intersectionality Theory where the original concern was the intersectionality of 'race' and gender, few of the articles we have cited explicitly discuss the conceptual limits of intersectionality beyond acknowledging that there are other social positions besides 'race' and gender. One exception is Dworkin (2005) who developed an argument for incorporating sexuality along with 'race' and gender in epidemiological research on HIV/AIDS. Another interesting observation comes from M'Charek et al. (2005) who took a clinical perspective and noted that the relevance of social categories varies between diagnostic and treatment settings. While general practitioners see social categories as an important resource for them to make the best health risk assessments, service providers in the hospital setting recognize their relevance in limited situations, i.e., when patients are unable or unwilling to following prescribed treatments perhaps due to unfamiliarity with the language of the medical setting or due to 'lifestyle habits'. Thus, the conceptualization of complexity has only begun and will require considerable development if intersectionality is to become a useful perspective within the health care field. Strategically, this is likely to grow out of existing practices, but a critical perspective is essential to avoid reproduction of problematic power relations.

Methodologically, the critical approach identified by McCall (2005) leads to research on the historical development of categories, discourse and narrative analyses, and ethnographic explorations (e.g., Kirkham, 2003). The intercategorical stance, on the other hand, is associated with critical realism and assumes that existing social inequalities will put limits on the outcome of research comparing various social groups (e.g., Dworkin, 2005). Hence, research formulated within this approach entails the systematic comparison of multiple categories and the subcomponents of those categories. McCall (2005) concludes that the problem of intersectionality is not adequately addressed by any of the methodologies adopted to date. Instead, she argues that a truly feminist, interdisciplinary methodology is needed. In the meantime, health care researchers and practitioners can utilize familiar methods that may at least offer partial understanding of the significance of intersectionality. In contrast, Stewart and McDermott (2005) advance 'methodological plurality' itself as a means of addressing complexity. In our view, this is consistent with the current status of the literature, i.e., various

methodologies have been adopted to manage the complexities of intersectionality. Nevertheless, an on-going challenge will be to develop decision rules for such pluralism.

CONCLUSIONS

Intersectionality Theory regrettably does not offer an ideal framework to address difference/diversity within the health care field. The researcher or clinician who seeks a ‘how-to’ manual on intersectionality will go away frustrated. As our discussion of the three issues above makes clear, there is much variety in both theory and method. On the one hand, one might argue that this variety may be an advantage in that, regardless of theoretical orientation, researchers and clinicians can take up intersectionality in their work. This could work to advance the integration of feminist thinking within traditional health care frameworks with the potential for transformation. On the other hand, all this plurality could lead to obfuscation of the primary concern that Intersectionality Theory was developed to address, i.e., inequities sustained by failure to explore the lives of people located at the intersection of multiple dimensions of difference. Consequently, one restriction on methodological and conceptual plurality must be attentiveness to power relations.

In our view, one of the most important potential contributions of Intersectionality Theory to the health care field is the mainstreaming of power. Such a critical perspective on diversity could have a number of benefits. To begin with, it might counter the tendency to reduce patients to biological entities and instead focus attention on the person in a social relational context. We are not suggesting herewith that biology is irrelevant; indeed, one of the challenges associated with Intersectionality Theory is how to integrate biology. Moreover, a more sophisticated analysis of power relations afforded by considering intersecting social locations may prevent the problematic prioritization of some differences over others, e.g., prioritizing ethnicity over gender. Furthermore, within health care research and practice, there might be more questioning of taken-for-granted differences and similarities as well as similarities that may be overlooked in the face of salient differences. The current diversity literature focuses almost exclusively on difference, which paradoxically serves to produce more difference and exclusions, e.g., in calls for ‘culturally specific’ health care services and service providers. As a consequence, the emancipatory possibilities enabled through the forging of alliances based on similarities are relatively unexplored. Finally, it invites researchers as well as clinicians to adopt self-reflexive practices and consider the implications of their commonalities and differences in relation to research participants and clients.

Notes

1. We borrow this term from Burman (2004). It turns attention to the power relations involved and emphasizes the dynamic nature of those relations. The more familiar ‘minority group status’ connotes a fixed position and renders invisible those who are privileged.
2. This metaphor is borrowed from Knapp (2004), who uses it to pit an unthinking acknowledgement of ‘race-class-gender’ where practice does not change versus intersectionality. Our utopian vision is to embed an intersectionality perspective into traditional and feminist health care research practices so that they are transformed and sensitivity to diversity becomes virtually taken-for-granted.

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