Marginalization: A guiding concept for valuing diversity in nursing knowledge development

This article explicates marginalization as a guiding concept for the development of nursing knowledge that values diversity. The seven key properties of marginalization as it applies to the domain of nursing are (1) intermediacy, (2) differentiation, (3) power, (4) secrecy, (5) reflectiveness, (6) voice, and (7) liminality. Through examination of each of these properties, the relationship between marginalization and vulnerability is clarified, and by this means the relevance of marginalization for health is established. The implications for shaping future nursing research, theory, and practice related to the health of diverse populations are discussed. Key words: *diversity, marginalization, minorities, research, theory*

Joanne M. Hall, RN, PhD
Postdoctoral Fellow

Patricia E. Stevens, RN, PhD
Postdoctoral Fellow

Afaf Ibrahim Meleis, PhD, FAAN
Professor
Department of Mental Health
Community & Administrative Nursing
University of California, San Francisco
School of Nursing
San Francisco, California

THE FUTURE OF NURSING depends on the ability of the discipline to reach out to diverse communities and to meet the health needs of those most vulnerable. This article offers a conceptual direction for the development of nursing knowledge that will strengthen this ability. The authors draw from their individual and collaborative programs of research and theory development about vulnerable populations,[1-10] as well as from the critical and feminist social sciences literature, to introduce the concept of marginalization; identify and describe its key properties; propose its relationship to the concept of vulnerability; and discuss its implications for shaping future nursing research, theory, and practice related to the health and health care of diverse populations.

In the past decade, nursing has clearly identified the health of vulnerable groups as a priority.[10-14] There are, however, a number of constraints to knowledge development regarding vulnerable groups. These groups

Adv Nurs Sci 1994;16(4):23–41

are often hidden, stigmatized, lacking access to services, and mistrustful of the research process. Previous research has tended to ignore or pathologize many of these groups, with the result that extant health-related knowledge is most representative of the needs of Euro-American, middle-class males. For instance, biomedical researchers have frequently excluded women under the assumption that the menstrual cycle and pregnancy are "deviant" processes that confound results. Similarly, in general population surveys, findings from ethnic and racial groups other than Euro-Americans have often been deleted from the analysis, or arbitrarily grouped within an "other" category, because their numbers failed to meet statistical requirements.

With recent federal directives mandating inclusion of women and members of underrepresented ethnic and racial groups in research, these patterns of sampling are starting to change. But problems remain in terms of how data from these samples are analyzed. When findings from underrepresented groups are included, the analysis may not adequately capture the distinctiveness of their experiences if research questions have been posed from norm-based reference points that contain unexamined gender and cultural biases.[15,16] Including members of vulnerable groups within traditional research designs does not in and of itself provide adequate information about how health services need to be structured to meet their needs, nor does it reliably reveal health strengths and practices indigenous to these groups.[17] Access to care and culturally competent nursing decisions for vulnerable populations require conceptual frameworks and research methods that recognize and incorporate gender, sexual orientational, racial, cultural, social, political, and economic diversity.[18,19]

Traditional approaches to knowledge development that depend on assumptions of homogeneity, normality, and statistical reliability rather than accurate, coherent reflections of diverse human experience have limitations in generating culturally competent models of care. Large-scale quantitative studies tapping randomized national samples provide aggregate-level data that can inform nursing about general trends, but such data are of limited value in developing interventions for individuals, social networks, and diverse cultural communities. As a practice discipline, nursing requires means of inquiry that are durable and flexible enough to be applied in circumstances where statistical measures are unwieldy, too sweeping in their generalizations, nonspecific to the question at hand, or too economically burdensome in their requirements. By incorporating the concept of marginalization as basic to empirical and theoretical activities, nurses can build understanding about the complex linkages between vulnerability and health. As a guiding concept, marginalization promises knowledge development that is well grounded, cogent, justifiable, relevant, and meaningful to the diverse groups nurses serve.

CONCEPT DEFINITION AND DISTINCTION

Marginalization is a concept emerging from a focus on the characteristics, functions, and meanings of margins—that is, borders or edges. *Margins* are defined as the peripheral, boundary-determining aspects of persons, social networks, communities,

and environments. Margins are established in several ways: in contrast to a central point, according to the separations they maintain between the internal and external, or as distinctions between the self and others. From this perspective, persons are viewed as relatively different from the norm or as cast out to varying degrees from the societal "center" to its periphery. *Marginalization* is defined as the process through which persons are peripheralized on the basis of their identities, associations, experiences, and environments. *Marginality* is therefore defined as the condition of being peripheralized on these bases.

Marginalization is distinguishable from other related processes. Marginalization may involve gender, racial, political, cultural, or economic oppression. Marginalization and oppression are not equivalent terms, however. Although marginalization and oppression are frequently concurrent processes, marginalization can be viewed as inclusive of oppression, incorporating aspects of experience beyond power imbalances. In another sense, it is more specific than oppression, because it points to a particular set of dynamics through which oppression is concretized: those having to do with boundary maintenance. *Alienation* often accompanies marginalization, but this term is narrowly focused on the subjective experience of not belonging and so is less inclusive than the concept of marginalization. *Stigmatization* refers to the marking of "outsiders." Stigmatization is an aspect of marginalization, although it is not always present in every instance. For example, one may have a marginalizing experience, such as a myocardial infarction, which is not necessarily socially stigmatizing. *Segregation* refers to the physical separation of social groups but does not emphasize the notion of living at the edge that marginalization implies. These related concepts illuminate aspects of marginalization without necessarily replacing the unique perspective marginalization offers as a lens through which to view nursing phenomena.

PROPERTIES OF MARGINALIZATION

The seven key properties of the concept of marginalization as it applies to the domain of nursing are (1) intermediacy, (2) differentiation, (3) power, (4) secrecy, (5) reflectiveness, (6) voice, and (7) liminality. Through examination of each of these properties, the relationship between marginalization and vulnerability will be clarified, and by this means the relevance of marginalization for health will be established.

Intermediacy

The first property, intermediacy, is the essence of marginalization. *Intermediacy* is defined as the tendency of human boundaries to act both as barriers and as connections. Intermediacy refers to the quality of "betweenness." This property can be illustrated by considering the human body as an organism with a center and an outermost boundary, the skin, which is also its most extensive sensory system. The skin is the periphery that acts as a barrier against the environment by protecting the center and as a connection to the environment by informing the center of conditions affecting survival. The human immunodeficiency virus (HIV) crisis has underscored the implications for maintaining the integrity of physiologic boundaries and reinforcing them via artificial barriers.

At the interpersonal level, margins mediate the physical and emotional safety of individuals as they interact with others. Psychic and emotional boundaries maintain integrity, uniqueness, autonomy, and value of the self in relation to others as well as offer opportunities for social connection.[20,21] Integral to the process of shaping these personal boundaries are individual perceptions, intellectual abilities, and cultural influences, including gender role expectations, religious beliefs, and ethnic values. For example, investigation of US women's self-definitions suggest that they maintain more open boundaries than do men, viewing themselves as more contiguous with, and responsible for, significant others.[22]

These observations indicate that margins are indeed intermediate, protecting and containing in some circumstances, connecting and extending in others. A logical nursing approach to health promotion is to view persons as having interrelated immunologic, physical, and social boundaries, any or all of which might be sites for intervention. Viewing persons and health from the standpoint of margins highlights the person–environment interface, which is consistent with nursing's perspective and germane to holistic and culturally grounded aspects of wellness, illness, and healing.

Differentiation

Differentiation, the second property of marginalization, is defined as the establishment and maintenance of distinct identities through boundary maintenance. "Mainstream" society is depicted as at the center of a community, and those relatively excluded from power and resources are at the periphery.[23–26] Diversity of identities increases with physical and social distance from the center. Experiences at the center are hypothetically homogeneous, normative, and predictable. Distinctions in identity and experiences of oppression "repel" individuals outward from the center. The edge is thus an experiential place in which peripheralized persons are distinct and isolated not only from the center, but also from one another. Their diversity is more palpable and more consequential.

"Mainstream" society is depicted as at the center of a community, and those excluded from power and resources are at the periphery. Diversity increases with physical and social distance from the center.

Differentiation has two aspects, the diversity of identity that is found at the periphery and the potential for stigmatization of those identities that differ from the center. In Western societies, the center of a community is the seat of hierarchical power and the conceptual location of the homogeneous "majority." People who differ from those at the center, or from the projected image of those at the center, are forced outward. It is through pressing those viewed as "outsiders" toward the periphery that the majority defines itself.[27] The marking or stigmatization of outsiders thereby provides the center with its identity.[28,29] By assigning negative values to marginalized persons and groups, those at the center reinforce their sense of belonging and belief in a singular, moral "reality." The dynamics of scapegoating has a long history in which selected "victims" who symbolically embody the sins of the majority are driven out of the societal center.[30] The scapegoats in centuries past—her-

etics, witches, and madmen—were ostracized, tortured, and sometimes executed to complete the ritual. Modern-day scapegoats include persons of color, gay men, lesbians, addicts, illegal immigrants, and persons infected with HIV.

Differentiation is a property of marginalization that takes into account not only the diversification of identity occurring among racial, social, and cultural groups, but also the varying degrees and types of peripheralization that occur within these groups. There is significant variability in acculturation and accommodation within immigrant groups, for example.[31] In another instance, persons of mixed race may be stigmatized by the groups their heritages represent. Conversely, lighter skinned persons of color may be more highly favored because they have access to opportunities proffered by the dominant Euro-American group.[32] Stigmatization is thus seen as a fluid, complex process; identities are given meaning and value according to their proximity to the centers and margins of relevant reference groups. The property of differentiation conveys that marginalization creates distinctions within distinctions, a multiplicity of identities that shift with varying political, economic, and social circumstances.

From a postmodern theoretical perspective, it can be argued that the societal center is empty, because no individual actually fits the projected image completely.[25] This perspective has been useful in countering hegemonic theories. Nevertheless, postmodernism is still predominantly the product of male European theorists; its rhetoric does not nullify the real existence of a powerful group at the center that continues to enforce policies from a central cultural and political position. The impact of these policies remains clearly visible in the daily lives of those at the periphery of the society.[33] In other words, it is indisputable that some people continue to be differentiated and peripheralized on the basis of visible marks, such as race, gender, appearance, and presence of disability; practices, such as religion, occupation, and sexual behavior; cultural identities, such as sexual orientation and ethnicity; associations, such as political affiliation and national origin; stigmatized illnesses and addictions; and social and economic statuses.

Power

The property of *power* is defined as influence exerted by those at the center of a community over the periphery and vice versa. Authority and control that flow from the center outward are demonstrations of hierarchical power. Innovation and resistance originating from those at the margins to affect the center are demonstrations of horizontal power. Cultural change is an oscillating movement from center to periphery and back again.[34] Innovations in political action, music, visual arts, fashion, humor, and language illustrate how those at the societal center frequently must look to the periphery for creative, original approaches. In a profit-based economy, those at the periphery depend on technologic and economic sustenance from the center. The center, in turn, depends on the periphery for labor, consumption of its products, and new ideas.

Inquiry and intervention often consider only the movement of power and knowledge from center to periphery, reducing marginalized persons to entities in need of "development"—that is, "welfare," education, and technical assistance. Some marginalized individuals are able to garner a measure of hi-

erarchical power, usually only to the degree that they compensate for or conceal their differences from the dominant cultural images and refrain from appearing powerful in their own right. Inequities in political, economic, and social resources are the basis for hierarchical power that sustains rulers, entrepreneurs, and bureaucracies at the expense of least-ranking groups, including residents of inner-city neighborhoods, Native Americans, unskilled laborers, low-income single mothers, children, and the homeless.

The power of the center depends on a relatively uncontested authority; visibility of marginalized populations presents a significant challenge.[25] The current debate about lifting the ban on sexual minorities in the military is a case in point. On one hand it seems a moot point, since gays and lesbians have always been in the military but have remained hidden as such. On the other hand, the integration of publicly acknowledged gays and lesbians into the military becomes a linchpin issue as it allows new counterimages to invade traditional hierarchical definitions of power as exclusively male and heterosexually identified. These counterimages are a source of horizontal power.

Horizontal power is that which is exerted by the marginalized in resistance to the hegemony of the center. It is often best expressed in solidarity among marginalized persons, coalitions of diverse subgroups who challenge underestimations of their influence and prerogatives. Rather than rejecting, ignoring, or trying to destroy difference, these efforts at valuing diversity enrich movements for social change. Relating across human differences as equals creates power.[35]

A great deal of knowledge is situated at the margins. Subordinated groups create knowledge that enables them to resist oppression.[17] Of necessity, they know a great deal about their oppressors' ways of thinking; the converse is seldom true. For example, domestic workers are intimately familiar with their employers' needs and habits, while their employers may not even know the names of the workers' children or where they live.[36] Heterosexual people are often shocked to learn details of gay and lesbian subculture that has thrived in their cities for decades unknown to them. Gay men and lesbians have no such lack of knowledge about straight culture. Survival depends on the ability of the marginalized to at least emulate or mouth the values of the dominant culture. Beyond survival, knowledge about the dynamics and details of those at the hierarchical center can be a source of horizontal, liberating power for the marginalized. Thus, marginalization not only results in deprivation and powerlessness, but also can provide a locus of resistance and empowerment as well as the possibility for overturning oppressive, hierarchical power dynamics.[36]

Secrecy

A fourth property of marginalization is secrecy. *Secrecy* is defined as confining information to establish interpersonal bonds, maintain trust, and avoid betrayal. Secrecy both creates and characterizes marginalized social groups and environments.[37] Secrecy can be a means to coalition and protection for the marginalized as well as a process contributing to their marginalized status. While marginalized groups often have more knowledge about their oppressors' ways of thinking and being than is conversely true, the exclusion of those marked as outsiders by the center is often accomplished by with-

holding specific information from them that could increase their access to resources.[38] Those at the edges are often stymied by bureaucratic red tape because they do not know the "secrets" or shortcuts that insiders are privy to. Also, if members of marginalized groups do not have some modicum of influence over schools, media, and other cultural institutions, they cannot make their perspectives known outside their groups.[17]

Because the marginalized are often suspected of betraying the mainstream, they are forced to use secrecy, to hide their identities or activities, for survival. For instance, on the basis of identity alone, gay men and lesbians, Jews, and communists have all been investigated and blacklisted as traitorous groups in the United States.[39] Helping organizations such as social services, scientific research institutions, and public health departments reach out from the center to the periphery to encourage marginalized people to disclose their secrets,[40] to trust that their interests will be served.[41] But by design, many of these organizations are then forced to use the information they have gathered to betray the marginalized, as in cases of "welfare fraud," medical studies that reinforce racist assumptions, and health databases used to discontinue insurance coverage of individuals at risk.[37] "Passing" is a common form of secrecy used by immigrants, refugees, gay and lesbian persons, Jewish persons, and those espousing suspect political ideas.[42] They keep their identities secret by imitating majority appearances or behaviors, sometimes even including the fabrication of false names and personal histories. Passing should be understood not as an intention to mislead or defraud others, but as a means of protection and evasion of dangers associated with being discovered as an outsider.

Activities considered morally taboo at the societal center occur in marginalized environments under the cloak of secrecy. Marginalized environments include locations characterized by economic destitution; joblessness; physical dangers; social isolation; increased illness; and lack of access to health care, police protection, and other resources. Examples are areas near the borders of countries, abandoned urban slums, and streets where predatory adults locate runaway youths for sexual exploitation. In these borderlands, the potential for violence and illegal activity is escalated because the inhabitants have been betrayed and secreted away by the center. Those at the societal center who have power, property, and mobility exercise their privilege to engage marginalized people in exploitive ways while escaping the dangers and limitations of living in marginalized environments. The pace of exchange in illicit goods and services, such as narcotics, pornography, and the labor of sex workers and undocumented immigrants, is accelerated by the stark conditions in these fringe areas.

In locales of extreme conflict, boundaries are drawn more tightly and bonds are intensified via secrecy and intense loyalty. Social bonds are concretized in a worldview of "us against the world." Betrayal of one's peers in such groups is highly unacceptable. Interpersonal bonds forged in prisons and combat situations are examples of this intensified connection to peers. Perhaps a less obvious example is that of an African American, low-income lesbian couple who survive ostracism from both the Euro-American lesbian community and the general African American community through a fierce commitment to one another and a narrowing of their social world. Conditions

of secrecy can thus create intense relational bonds among members of marginalized groups and reinforce profound distrust of others, contributing to subsequent social isolation and privatization of individual experience.

Reflectiveness

As a consequence of stigmatized differentiation, disempowerment, and secrecy, marginalized persons have subjective experiences that distinguish them from more centrally located community members. The inner worlds of marginalized persons mirror the contradictions and pressures external to themselves and create the necessity for continual, purposeful introspection. Marginalized persons live "examined lives" out of necessity. The property of reflectiveness connotes both of these qualities, mirroring and introspection. *Reflectiveness* is defined as the fragmenting and conflicting psychic effects on marginalized persons of discrimination, privatization, isolation, invisibility, and fragmentation and the interior work that is required to understand and compensate for these effects.

A case in point is the plight of children who go through the marginalizing experience of being physically or sexually abused. They may take flight interiorly, compartmentalizing or dissociating negative experiences, sometimes to the extent that they develop alternate personalities to cope with the contradictions and pain they experience.[43] Such abuse, so well privatized and kept secret, can lead to a profound sense of isolation and inner fragmentation that may persist into adulthood. A substantial amount of psychic energy is bound up in internal processes that are needed to cope with and eventually to heal from such trauma.

The inner worlds of marginalized persons mirror the contradictions and pressures external to themselves and create the necessity for continual, purposeful introspection.

Persons marginalized on the basis of race or sexual orientation, for instance, internalize their own identities as well as the negative, stereotypic mainstream images of members of their categories,[44,45] which results in another kind of inner fragmentation, a splitting of the self-image.[46] This conflict regarding self-worth requires conscious, introspective effort to resolve, usually with the help of supportive others and the embracing of empowering, positive counterculture images. The experiences of internalized sexism, racism, and homophobia and their resolution are not often accounted for in theories of human growth and development, identity formation, and health promotion. Nevertheless, these processes occupy significant life space and time for members of marginalized groups. Lorde provided an eloquent example:

> Women of color in America have grown up within a symphony of anger, at being silenced, at being unchosen, at knowing that when we survive, it is in spite of a world that . . . hates our very existence outside its service. And I say symphony rather than cacophony because we have had to learn to orchestrate those furies so that they do not tear us apart. We have had to learn to move through them and use them for strength and force and insight within our daily lives. Those of us who did not learn this difficult lesson did not survive. And part of my anger is always libation for my fallen sisters.[26(p119)]

Those with hidden stigmatizing features and those who have limited mobility and access to others like themselves may have only stereotypes against which to compare themselves. Paradoxically, even those with visible attributes that make them different, such as skin color, can still be invisible. Invisibility, in this case, is the experience of not being seen or of being seen as an object.[33] The media reflects central images. The occasional Asian American, Latino, gay, or lesbian character in a film is often presented in a negative light, so that youths from these subgroups internalize very limited views of these persons.[47–49] Marginalized persons can feel like "the only one" who has transited particular stigmatizing experiences. If they do not come to develop knowledge of the heterogeneity within their category, they retain a sense of self-uniqueness that compounds their sense of isolation.[20]

Persons who embody several boundaries by virtue of multiple stigmas, cultures, or marginalizing experiences can feel even more displaced, more in between than those clearly in one group or another.[8,50–52] For example, the Latina refugee who is addicted, is HIV positive, and has a history of incest, experiences the alienating effects of gender, racial, social, and traumatic marginalization. The net result of these processes is a sense of profound delegitimization—that is, the sense of being an outsider in almost any group.[26] With the capacity to introspect can come the understanding that this sense of alienation is neither imagined nor a result of personal failure.

Marginalized persons not only have experiences that are distinct from those at the center, but also interpret reality differently. That is, they have particular standpoints about the ways in which they are oppressed. The capacity for reflecting on one's marginality is empowering in the sense that one can strategize more effectively with increased awareness of specific conditions of discrimination, isolation, privatization, and oppression. Reflectiveness can be a double-edged sword, however. The political consciousness it engenders increases the chances of survival and success. Yet those who have the ability to be reflective, but who lack sufficient social support and resources for addressing the fragmentation and isolation that they discover, may feel their marginalization even more intensely.

Voice

Marginalized persons and groups have ways of communicating that distinguish them from those at the center. Hierarchical power from the center, however, forces majority concepts to be expressed in the majority language, resulting in the devaluing of other voices. Marginalized persons and groups are thus silenced within the dominant stream of communication. Within this silence, however, are other forms of expression created and used by the marginalized. *Voice*, as a property of marginalization, is defined as the languages and forms of expression characterizing marginalized subcultures. Voice encompasses types of talk and ways of telling. Three examples of marginalized talk are "mixed talk," "back talk," and "new talk." A common way of telling is narrative.

As central concepts and terms become less applicable and meaningful, marginalized persons and groups "mix talk" in their attempts to understand their own experience and exert their own power. Words from the center are transformed and reframed by the

marginalized, creating a powerful counterlanguage, a "language of refusal" that resists through preservation of collective cultural memories.[36] Biculturalism and bilingualism facilitate exchange, which is the currency of value in many marginalized environments. Hybrid words and creolized or mixed languages, such as Pidgin, Tex-Mex, and Chicano forms of Spanish, meet the needs for cooperation and negotiation that are essential for survival. Speakers of mixed talk are in odd positions, however; theirs is a border language not fully validated by the centers of any of the cultures it mixes.[53]

Those at the center exert power through "misnaming."[35] For example, the tension between Euro-Americans and African Americans is sometimes called the "race issue," as if color differences are inherently problematic. From the standpoint of African Americans, the appropriate term is "racism"; the problem is not skin pigmentation, but domination of one group by another. To counter misnaming and other forms of exploitation, people reclaim words previously used to oppress, such as "queer" and "black," to reappropriate power and create intellectual and cultural space. "Back talk"[54] involves speaking to central, hierarchical authority from the standpoint of equality, questioning oppressive customs and cultural expectations. The marginalized are not expected to speak as equals to their "superiors" at the societal center, giving this type of talk the empowering element of surprise.

Marginalized experiences often lack precedents and do not correspond with frames of reference proffered by mainstream media, so marginalized persons coin new words to describe their experiences. "New talk" is also needed to achieve palpably intense expressions for painful qualities of marginalized experiences, to create an escape from them, or to compensate for having to speak in a language that is not one's own.[55] Sometimes new terms and symbols are incorporated into mainstream, central language, but usually the depth of their meanings remains enigmatic to those outside the particular subculture in which they were created. Subcultural argot, as a type of neologistic language development, thus maintains boundaries and secrecy and helps to preserve the safety of marginalized persons.

When the languages of marginalized groups have been barred from public and written discourse, their members construct and preserve experience in the form of storied knowledge: individual and collective counternarratives.[56] By relating actual episodes and mythic stories,[57] storytellers preserve the history of the group, provoke exchange of ideas, and meet political goals. A narrative is not a passive account of reality, but a form of mediation.[52] Through telling stories, narrators transact with an audience, changing the power relationship.[58] In fact, individual narratives take on collective significance because the experiences of marginalized persons occur in charged, narrowed contexts, so that each event is magnified and immediately politically significant.[55]

If culture does indeed change through oscillation between center and periphery, the narratives of those at the margins contain valuable information. Experiences at the margins represent aspects of the future and the past that are usually repressed in accounts emanating from the societal center. The stories marginalized people tell can thus illuminate histories that explain present

conditions of the larger society and suggest a range of future possibilities for development.

Liminality

As a property of marginalization, liminality captures the sense of living and perceiving at the edge.[59,60] *Liminality* is defined as altered and intensified perceptions of time, worldview, and self-image that characterize and result from marginalizing experiences. Marginalization has a liminal quality in that it carries crucial consequences for human development, maintenance of self-esteem, and health promotion and restoration. The extremity of marginalizing situations clarifies the stakes involved. The loss of comforting, stabilizing identities during serious illness is a case in point. In such a transitional period, when individuals face life-and-death contingencies or irreversible changes in their lifecourse, they are likely to feel isolated from the societal center, if only for a limited period of time. But time is perceived in relation to the meanings attached to pressing concerns. Perceptions of the world and one's place in it may shift radically during illness, along with previously well-established priorities. Healers such as nurses are often present during these kinds of marginal, transitional experiences.[61] As witnesses to and facilitators of transitions, nurses are intermediaries between persons and their experiences, having both access to and influence on the perceptions and meanings attached to them.

Transitional experiences are often related and always have health implications.[62] They create openings, ruptures in the daily fabric of existence, in which new awareness can be gained and new strategies incorporated.[63,64] Health transitions may also be openings for further marginalization, with negative outcomes. For example, individuals who test positive for HIV may experience rejection by family and friends, loss of health insurance, depression, and ultimately a sense of hopelessness and depersonalization if their support needs are not met.

MARGINALIZATION, VULNERABILITY, AND HEALTH

Marginalization has health implications that can best be understood by explicating its relationship to the concept of vulnerability. Exploring the properties of marginalization exposes the linkages between vulnerability and health for those living at the edges of society and suggests that the health consequences of marginalizing experiences result not only from the perceptions of marginalized persons, but also from the contingencies of their environments.

Vulnerability is defined as the condition of being exposed to or unprotected from health-damaging environments.[10] One can be physically, psychologically, socially, and economically vulnerable to sources of illness. Vulnerability has negative and positive implications, as expressed in its two major aspects of risk and resilience. *Risk* is the increased potential for developing illness as a result of disproportionate exposure to damaging environmental factors. *Resilience* incorporates the capacities gained from person–environment interactions that foster survival.[65,66] Resilience includes not only genetic predispositions and learned abilities of persons, but also factors in their surroundings that enhance well-being. Many persons and groups who face adversity due to marginalization develop durable individual and collective survival strategies

There is significant variability in resilience among marginalized persons. Strategies, supports, and skills that are effective in one environment are not always effective in other circumstances.

in relation to their environments that differ from tactics used by those at the societal center.[23] They may also have personal or social characteristics that enhance their chances for successful development, health maintenance, and recovery, despite constraints. There is significant variability, however, in resilience among marginalized persons across adverse circumstances. Strategies, supports, and skills that are effective in one environment, at one stage of development, in response to one type of marginalization are not always effective in other circumstances.

Each of the properties of marginalization carries elements of risk and resilience that have health consequences. Intermediacy suggests that interpersonal barriers may be obstacles as well as sources of protection. Differentiation implies that diversity can be stigmatized by the central "majority" while honored and celebrated by members of one's group. Power refers to the negative impact of domination as well as the creative forces of coalition and solidarity. Secrecy involves fear of betrayal and exclusion via tight interpersonal bonding, yet also preserves trust and a sense of belonging. Reflectiveness reveals how social processes engender internal fragmentation, an awareness that can be demoralizing or empowering, depending on whether there is adequate support from others. Voice carries implications of being silenced and misunderstood as well as the possibility for positive, powerful expression. Liminality characterizes experiences that are often fraught with danger and yet may be invaluable opportunities for change and insight.

Although nurses often focus on risk in dealing with vulnerable populations, resilience is an important aspect of marginalization, because it fosters understanding of how individuals and groups creatively maneuver and use resources at hand to avoid illness and to maximize their chances for survival.[67] The health of those who are marginalized is relevant to that of the whole community, because marginalized persons comprise a community's most at risk, but perhaps most resilient, members. Without knowing the health-related responses of the marginalized, community health assessments will be sorely inadequate in estimating communicable and toxic disease threats and in suggesting solutions to problems stemming from social alienation, economic deprivation, and political repression. Access to health resources is only part of the struggle for marginalized persons. They must also have the political and economic resources to ensure their basic needs and the social legitimation and respect necessary to make decisions affecting their health.

IMPLICATIONS FOR NURSING RESEARCH, THEORY, AND PRACTICE

As a nursing concept, marginalization implies a deliberate focus on functions of boundaries; peripheralized persons; environments at the borders; and liminal, transitional human experiences, especially as each of these relates to health and illness.

This focus creates a unique lens through which to view nursing phenomena. By examining the margins, nurses can gain knowledge about the whole that has previously been unavailable to us. With marginalization as a guiding concept, inquiry can more accurately explicate the health and health care of diverse populations, because it helps us to avoid universalizing empirical and clinical approaches and impresses on us the need to approach members of marginalized groups with an ear to their experiences and an eye to their struggles.

Questions from the margins

The source and focus of questions for inquiry are uniquely shaped if one takes the perspective of the marginalized. Who are the people at the margins, and what risks do they face? What questions are relevant to those who have had little voice in shaping health sciences research? How might problems be renamed and reconceptualized according to the experiences of those who exist far from the societal center? What problems do specific marginalized individuals and groups identify regarding their own health? How do borders and boundaries function in relation to illness? Does life at the edge protect or expose? What interiorized perceptions and environmental contingencies guide marginalized persons as they make decisions about health behaviors? What strategies are most durable, and what environmental resources are most effective for marginalized persons in terms of health promotion, avoidance of illness, and recovery? How do hierarchical power dynamics affect the health of stigmatized groups? How does betrayal by the center become manifest in the daily experiences of marginalized youths? What factors contribute to survival and resilience in marginalized environments?

Marginalized persons are seldom directly consulted about their opinions and experiences, largely because most research models depend on hierarchical power dynamics in which predetermined information is elicited from representative "subjects" under conditions that are designed to "control for" variables considered extraneous or confounding. Such processes constrain participants and mold the findings to fit the conceptual framework of the researcher. Members of marginalized groups often avoid participation in research because they find the atmosphere and conduct of research to be adversarial, lack an investment in the research questions, or mistrust researchers' motives.[17] Questions about the genetic patterns of sickle cell disease, for example, are not equally valued by scientists and those affected by the disease. The latter are probably more concerned about access to services, pain relief, and improvements in daily functioning. These client-oriented questions seem very much within the realm of nursing inquiry.

While many marginalized communities are asking for research that is "traditional" enough to be persuasive to policymakers and program funders, they want more-inclusive, participatory methodologies. One key to success in knowledge development with diverse populations is to invite marginalized people to talk at length about the health problems they face, the obstacles that block their access to health care and other resources, and what they believe is needed to remedy their situations. While this seems almost too simple to be efficacious, the truth is that it is rarely done in research or practice in any discipline.

Relevant design

Designs for inquiry also change when one is guided by the concept of marginalization. Knowledge development is no longer restricted to traditional research, but includes individual therapeutic alliances, group forums, storytelling, participatory research, political action, and any other means by which understanding is expanded and theory is developed by engaging marginalized persons and groups in the process. Research is a communal endeavor, and the knowledge it yields is public property. This means that professional researchers and clinicians should synchronize their efforts with the needs and prerogatives of marginalized persons and refrain from unilaterally imposing preselected projects and solutions.[68]

As Collins said, "One cannot use the same techniques to study the knowledge of the dominated as one uses to study the knowledge of the powerful."[17(p751)] She suggested that it requires more ingenuity to examine the standpoint of marginalized persons, who have had to create independent ways of knowing and doing to survive outside the center. Traditional research methods often force members of marginalized groups to objectify themselves, displace their own motivations, and confront researchers who have more social, economic, and professional power than they. Studies of incidence and prevalence of various diseases, for instance, target marginalized groups, but often only as reservoirs of infection and danger, stigmatizing them in the process. One example is research about violence that emphasizes the high rates of homicide among young men of color without a thorough understanding of the contexts and conditions of these young men's lives. Stigmatizing stereotypes about marginalized groups can persist in spite of empirical results, as in studies of female sex workers and the HIV epidemic in the United States. An increased prevalence of the virus has not been supported in the data, yet the nearly indestructible stereotype that these women are dangerous disease carriers has persisted.[69]

It is the authors' contention that microscopic descriptions of experiences at the margins hold the promise of capturing the specificity, scope, and variability of health-related phenomena in ways that measures of central tendency simply cannot. Seldom are those at the margins studied in their own habitats, from their own perspectives, as experts on their own lives. Research that aims to describe marginalized persons uncovers not only needs but also strengths and innovative strategies for survival that such persons and their social networks create. For example, studies demonstrating how individuals thrive despite stigmatizing illness yield important information about basic health-maintenance strategies. Because of the harsh conditions at the periphery, workable health-promoting strategies developed there are likely to be stable and also potentially effective for those existing nearer the center.

Language is of critical importance in the design of inquiry. Language about the processes of research and theory as well as language expressing the content of findings should be meaningful and understandable to both researchers and consumers. Using rigid methods of data collection, such as forced-choice questionnaires or highly structured interview formats, may be a way of silencing marginalized people. This is especially true when the terminology used re-

flects researchers' preconceived notions about what is relevant. For example, researchers might draw blank stares if they ask low-income women what their concept of "wellness" is. On the other hand, such persons may have a lexicon of their own terms that are relevant to the concept of wellness, such as "surviving," "getting through," and "listening to your gut feelings." Theory development should use language that functions as a bridge between the substantive knowledgebase of the discipline and actual contexts of health-related phenomena, achieving a necessary level of abstraction without losing the diversity, intensity, and particularity of marginalized experiences.

Sampling to enhance diversity

The casting of probability-based statistical nets over communities may fail to recognize heterogeneity at the boundaries and the increasing differentiation of experiences from center to periphery. Statistical methods assume that persons are analogous to identical "cells" in a grid that can be accurately accessed through randomization, a process ensuring that each cell has an equal chance of being tapped. Communities are less like grids and more like unique organisms, exhibiting diverse characteristics and processes in each of their parts. Communities are not oceans of identical fish to be snared in random sampling nets. Communities are made up of many interacting subcultural groups, which in turn comprise unique individuals situated in particular contexts.

The casting of probability-based statistical nets over communities may fail to recognize heterogeneity at the boundaries and the increasing differentiation of experiences from center to periphery.

The care taken in choosing where to sample the tissue for a biopsy is analogous to planning research that respects persons and communities in their organicity and complexity.[70] Microscopic margins of biopsied tissue samples provide comprehensive information about the whole body—that is, the nature of illness, its extent, and even its outcome. In another analogy, even small changes in peripheral structures of the body, such as size, shape, color, texture, and movement of extremities, can reveal central functions. Likewise, sampling at the margins can be informative about the health of the whole community. But special efforts need to be made to represent the diversity at the margins, which is greater than at the center. This may require overrecruitment of various marginal subgroups using a theoretically sound scheme to adequately explore "bites" of the heterogeneous edges versus the homogeneous center.

Innovative approaches including time and resources for building trust, collaborating with community members, and power sharing are needed for research and knowledge development with groups who have had to construct layers of secrecy to protect themselves and with those who participate in highly stigmatized activities. Conventional approaches to preserving the safety and confidentiality of research participants may not be adequate for specific marginalized groups. In these cases, protective strategies must be carefully designed and incorporated at each phase of the research process.

Reflexive involvement

Reflexive involvement refers to establishing and maintaining solidarity with the marginalized throughout the knowledge development process. Research, theory, and practice with marginalized persons and groups can be obstructed by a lack of trust, understandable in the light of secrecy, stigmatization, and other dynamics associated with marginalization. Investigators can feel betrayed when marginalized persons conceal information or fail to comply with their instructions. Marginalized persons can feel betrayed when research findings are not disseminated and used to improve their daily lives, but are instead used to justify repressive policies. They can also feel betrayed when health services are inaccessible, culturally incongruent, or abruptly withdrawn after the research project is ended. Marginalized persons resent the "rip and run" practice of extracting data to support the theoretical interests and career advancement needs of researchers without a reciprocal process. Reflexive involvement makes nurses accountable for providing participants with the opportunity to speak freely in their own words, the power to affect the design of investigations and interventions, and compensation for individual and community involvement.[70-72]

The properties of marginalization ought to be viewed not as obstacles to the research process, but rather as elements of a framework for assessing the safety, sensitivity, relevance, and empowering capacity of a given approach to inquiry. Establishing trust is not merely an interpersonal issue. It involves changing the images of research and institutional health care practice that are etched in the minds of marginalized groups through a long history of exploitation, exclusion, and misrepresentation. In fact, these images cannot really be changed until the structures that perpetuate them are changed.[73]

The fragmenting and isolating effects of stigma, secrecy, and mistrust require nurses' compassionate, partisan commitment to the interests of marginalized groups.[68] To develop knowledge with marginalized persons and groups who have been so frequently silenced within the dominant stream of communication, nurses need to identify and investigate other forms of expression that they have created and used. Knowledge may be gained through emotions rather than words, verbal performance rather than text, political action rather than cognitive appraisal, or behaviors of a daily life of work and caring rather than answers to standardized questions.

Marginalized people often tell through stories, theorize through narratives.[74] Eliciting and analyzing narratives, therefore, provide a channel of communication between the marginalized and the community as a whole. Such inquiry not only constitutes research, but also functions as mediation. Telling one's story without the language constraints inherent in questionnaires and structured interviews is empowering for marginalized persons, because it overcomes the invisibility and silencing they are so familiar with. Most narratives not only relate actual experiences, but also convey interpretive reflections on those experiences. Narratives therefore represent processes of self-inquiry that allow for the sharing of power in research and practice.[75]

• • •

Knowledge development includes all of the processes that generate theory to guide

nursing practice. Theory should not be a collection of static concepts generated from within the discipline, accounting only for majority-based, norm-referenced observations. Theory should have currency as vivid, substantive reflections of the full spectrum of human experience from margin to center.[76] Marginalization as a guiding concept provides direction for scholarship that embraces this diversity and requires the revision of extant models of inquiry as well as promotion of entirely new methods. The concept of marginalization, as it has been explicated here and related to the larger concept of vulnerability, breaks new ground for nursing from which we can conduct future inquiry about the health of complex, culturally diverse communities.

REFERENCES

1. Hall JM. Alcoholism recovery in lesbian women: a theory in development. *Sch Inq Nurs Pract.* 1990;4(2):109–122.
2. Hall JM. An exploration of lesbians' images of recovery from alcohol problems. *Health Care Women Int.* 1992;13(2):181–198.
3. Hall JM. How lesbians recognize and respond to alcohol problems: a theoretical model of problematization. *ANS.* 1994;16(3):46–63.
4. Hall JM, Stevens PE, Meleis AI. Developing the construct of role integration: a narrative analysis of women clerical workers' daily lives. *Res Nurs Health.* 1992;15(6):447–457.
5. Meleis AI. Community participation and involvement: theoretical and empirical issues. *Health Serv Manage Res.* 1992;5(1):5–16.
6. Meleis AI. Theory testing and theory support: principles, challenges and a sojourn into the future. In: Neuman B, ed. *Research with Neuman's System Model.* Norwalk, Conn: Appleton & Lange. In press.
7. Stevens PE. Marginalized women's access to health care: a feminist narrative analysis: *ANS.* 1993;16(2): 39–56.
8. Stevens PE. Protective strategies of lesbian clients in health care environments. *Res Nurs Health.* In press.
9. Stevens PE. HIV prevention education for lesbians and bisexual women: a cultural analysis of a community intervention. *Soc Sci Med.* In press.
10. Stevens PE, Hall JM, Meleis AI. Examining vulnerability of women clerical workers from five ethnic/racial groups. *West J Nurs Res.* 1992;14:754–774.
11. American Nurses' Association, Cabinet on Nursing Research. *Directions for Nursing Research: Toward the 21st Century.* Kansas City, Mo: Author; 1985.
12. Meleis AI. Directions for nursing theory development in the 21st century. *Nurs Sci Q.* 1992;5(3):112–117.
13. Oberst MT. Nursing in the year 2000: setting the agenda for knowledge generation and utilization. In: Sorensen GE, ed. *Setting the Agenda for the Year 2000: Knowledge Development in Nursing.* Kansas City, Mo: American Academy of Nursing; 1986:29–37.
14. U.S. Department of Health and Human Services. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Washington, DC: Author; 1990. U.S. Dept of Health, Education, and Welfare publication PHS 91-50213.
15. Smith A, Stewart AJ. Approaches to studying racism and sexism in black women's lives. *J Soc Issues.* 1983;36(3):1–15.
16. Zambrana RE. A research agenda on issues affecting poor and minority women: a model for understanding their health needs. *Women Health.* 1987;12(3–4):137–160.
17. Collins PH. The social construction of black feminist thought. *Signs J Women Culture Society.* 1989;14:745–773.
18. American Academy of Nursing. Expert panel report: culturally competent health care. *Nurs Outlook.* 1992;40:277–283.
19. Stevens PE. Who gets care? Access to health care as an arena for nursing action. *Sch Inq Nurs Pract.* 1992;6(3):185–200.
20. Frable DES. Being and feeling unique: statistical deviance and psychological marginality. *J Pers.* 1993;61(1):85–109.
21. Markus H. Self-schemata and processing information about the self. *J Pers Soc Psychol.* 1977;35:63–78.
22. Gilligan C. *In a Different Voice: Psychological Theory and Women's Development.* Cambridge, Mass: Harvard University Press; 1982.
23. Anzaldua G, Moraga C, eds. *This Bridge Called My Back: Writings by Radical Women of Color.* 2nd ed. New York, NY: Kitchen Table Press; 1987.
24. Derrida J. *Writing and Difference.* Chicago, Ill: University of Chicago Press; 1978.
25. Ferguson R. Introduction: invisible center. In: Ferguson

R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:9–18.
26. Lorde A. *Sister Outsider*. Freedom, Calif: Crossing Press; 1984.
27. Becker H. *Outsiders*. New York, NY: Free Press; 1963.
28. Goffman E. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall; 1963.
29. Jones EE, Farina A, Hastorf AH, Markus H, Miller DT, Scott RA, French R. *Social Stigma: The Psychology of Marked Relationships*. New York, NY: W.H. Freeman; 1984.
30. Szasz T. *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*. New York, NY: Delta; 1970.
31. Meleis AI, Lipson JG, Paul S. Ethnicity and health among five Middle Eastern immigrant groups. *Nurs Res*. 1992;41(2):98–103.
32. Hurtado A. Relating to privilege: seduction and rejection in the subordination of white women and women of color. *Signs J Women Culture Society*. 1989;14(4):833–855.
33. Wallace M. Modernism, postmodernism and the problem of the visual in Afro-American culture. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:39–50.
34. Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990.
35. Lorde A. Age, race, class and sex: women redefining difference. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:281–288.
36. hooks b. Marginality as site of resistance. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:241–244.
37. Akerstrom M. *Betrayed and Betrayers: The Sociology of Treachery*. New Brunswick, NJ: Transaction Publishers; 1991.
38. Simmel G; Wolff K, trans. Secrets as creators of social bonds. In: Wolff K, ed. *The Sociology of Georg Simmel*. New York, NY: Free Press; 1964:307–355.
39. Adam BD. *The Survival of Domination: Inferiorization and Everyday Life*. New York: Elsevier; 1978.
40. Foucault M; Hurley R, trans. *The History of Sexuality: Vol One. An Introduction*. New York, NY: Random House; 1978.
41. Harding S. Introduction: Is there a feminist method? In: Harding S, ed. *Feminism and Methodology*. Bloomington, Ind: Indiana University Press; 1987:1–14.
42. Ponse B. *Identities in the Lesbian World: The Social Construction of Self*. Westport, Conn: Greenwood Press; 1978.
43. Herman JL. *Trauma and Recovery*. New York, NY: Basic Books; 1992.
44. Memmi A. *Dominated Man: Notes Toward a Portrait*. New York, NY: Orion; 1968.
45. Nungesser LG. *Homosexual Acts, Actors, and Identities*. New York, NY: Praeger; 1983.
46. Bhabha HK. The other question: difference, discrimination and the discourse of colonialism. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:71–88.
47. Rofes EE. *"I Thought People Like That Killed Themselves": Lesbians, Gay Men and Suicide*. San Francisco, Calif: Grey Fox Press; 1983.
48. Russo V. *The Celluloid Closet: Homosexuality and the Movies*. New York, NY: Harper & Row; 1987.
49. West C. The new cultural politics of difference. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:19–38.
50. Hall JM. Alcoholism in lesbians: developmental, symbolic interactionist and critical perspectives. *Health Care Women Int*. 1990;11(1):89–107.
51. King DK. Multiple jeopardy, multiple consciousness: the context of a black feminist ideology. *Signs J Women Culture Society*. 1988;14:42–72.
52. Minh-ha T. Cotton and iron. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:327–336.
53. Anzaldua G. How to tame a wild tongue. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:203–212.
54. hooks b. Talking back. In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:337–340.
55. Deleuze G, Guattari F. What is a minor literature? In: Ferguson R, Gever M, Minh-ha T, West C, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, Mass: MIT Press; 1990:59–70.
56. Personal Narratives Group, eds. *Interpreting Women's Lives: Feminist Theory and Personal Narratives*. Bloomington, Ind: Indiana University Press; 1989.
57. Britton BK, Pellegrini AD, eds. *Narrative Thought and Narrative Language*. Hillsdale, NJ: Erlbaum; 1990.
58. Todd AD, Fisher S, eds. *Gender and Discourse: The Power of Talk*. Norwood, NJ: Ablex; 1988.
59. Hallstein AL. Spiritual opportunities in the liminal rites

of hospitalization. *J Religion Health.* 1992;31(3):247–254.
60. Van Gennep A. *The Rites of Passage.* Chicago, Ill: University of Chicago Press; 1960.
61. Turner V. *Forest of Symbols: Aspects of Ndembu Ritual.* Ithaca, NY: Cornell University Press; 1967.
62. Chick N, Meleis AI. Transitions: a nursing concern. In: Chinn PL, ed. *Nursing Research Methodology: Issues and Implementation.* Rockville, Md: Aspen Publishers; 1986:237–257.
63. Mies M. Towards a methodology for feminist research. In: Bowles G, Klein RD, eds. *Theories of Women's Studies.* Boston, Mass: Routledge & Kegan Paul; 1983:117–139.
64. Stanley L, Wise S. *Breaking Out: Feminist Consciousness and Feminist Research.* Boston, Mass: Routledge & Kegan Paul; 1983.
65. Garmezy N, Masten AS. Stress, competence and resilience: common frontiers for therapist and psychopathologist. *Behav Ther.* 1986;17(5):500–521.
66. Rutter M. Psychosocial resilience and protective mechanisms. *Am J Orthopsychiatry.* 1987;57(3):317–331.
67. O'Brien ME. Pragmatic survivalism: behavior patterns affecting low-level wellness among minority group members. *ANS.* 1982;4(3):13–26.
68. Stevens PE, Hall JM. Applying critical theories to nursing in communities. *Public Health Nurs.* 1992;9(1):2–9.
69. Corea G. *The Invisible Epidemic: The Story of Women and AIDS.* New York, NY: HarperCollins; 1992.
70. Hall JM, Stevens PE. Rigor in feminist research. *ANS.* 1991;13(3):16–29.
71. Anderson JM. Reflexivity in fieldwork: toward a feminist epistemology. *Image J Nurs Sch.* 1991;23(2):115–118.
72. Oakley A. Interviewing women: a contradiction in terms. In: Roberts H, ed. *Doing Feminist Research.* London, England: Routledge & Kegan Paul; 1981:30–61.
73. Clare J. A challenge to the rhetoric of emancipation: recreating a professional culture. *J Adv Nurs.* 1993;18:1033–1038.
74. Christian B. The race for theory. *Feminist Stud.* 1988;14(1):67–79.
75. Mishler EG. *Research Interviewing: Context and Narrative.* Cambridge, Mass: Harvard University Press; 1986.
76. Hooks B. *Feminist Theory: From Margin to Center.* Boston, Mass: South End Press; 1984.