Article

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Abstract

When people at risk of discrimination on multiple grounds or experiencing identity-based oppression meet healthcare and social services, their complex life stories often result in mistrust and prejudice. The aim of this article is to show how individuals themselves locate their multiple dimensions of difference in specific situations and contexts and how they perceive the ways in which healthcare and social services encounter them. We further point out how the different social divisions are enmeshed with and influenced by each other in given situations and contexts. The article points out that dynamics of mistrust and prejudice can not be overcome by treating people equally, as that approach would require abstracting from individuals' specificities and ignoring asymmetries in the relationship between institutions and their clients. As the article shows, what is required instead is a practice of creating trust and responding to individual differences societies produce. Methodologically, we worked with in-depth interviews conducted with 22 persons in the Geneva region (during 2012) who possessed at least two categories of difference related to their sexual orientation, their physical and psychological abilities, and/or their origins. The number of interviewed people was determined by the logic of saturation. Based on these 22 in-depth interviews with people at risk of discrimination on multiple grounds and experiencing identity-based oppression, this study describes dynamics of incomprehension between them and healthcare and social services and how they might be overcome.

Keywords: intersectionality, healthcare and social services, migration, disabilities, gender

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The search for individuality and explicit personal difference that have characterized our societies since the Renaissance (Martuccelli, 2010), combined with easier and therefore greater mobility, have led to increasingly complex life stories and people's ways of life and belonging. This increasing complexity has resulted in a multiplication of overlapping ties (Amselle, 2000; Walzer, 1985) and differences between individuals that cannot be accommodated by an egalitarian perspective.

Although confrontation with differences in terms of complex identities is an integral part of contemporary daily life, within the healthcare and social services

system people with challenging, unusual representations of social divisions are often treated with distance, hostility, and stigmatization. Furthermore, prioritizations between multiple dimensions of difference cause certain aspects of a complex identity to be suppressed, as for example when a migrant woman with a handicap is seen by healthcare and social services professionals as either a migrant or a person with an impairment, mostly depending on either what the institution specializes in or what is at stake for the professionals. In today's healthcare and social services system, patients or clients with complex identities, especially those including various characteristics of difference, are at risk of being treated disrespectfully, not being listened to, not being informed adequately, and not receiving treatment that is adapted to their needs.

As a result of the increasing complexity of pluralistic societies, perspectives that focus on multiculturalism and ethnic and cultural differences have given way to approaches that try to grasp this complexity with new concepts, as, for example, the diversity-management approach, which, however, often turns out to be more a means to improve economic efficiency than working conditions or services. For Faist (2009), social equality must be a central goal in diversity management if it is to be politically legitimate:

> Diversity needs to be grounded in both civil society, as a set of socio-moral resources of citizenship, and citizenship rights in order to become a politically legitimate approach. Otherwise diversity will remain a depoliticized management technique (p. 173).

Hannah and Vertovec, in the context of medical practice and cities, respectively, have gone further, leading the multiculturalism debate into the framework of *hyper-diversity* (Hannah, 2011) or *super diversity* (Vertovec, 2007), according to which differences are determining realities of societies, institutions, innovation, and change.

In the field of gender studies, the concept of *intersectionality*[1] (Crenshaw, 1991) already emerged over two decades ago. This concept interconnects gender analytically with other overlapping categories of social division (Lazaridis, 2000) that give rise to new identity-based oppressive forms on a matrix of domination (Hill Collins, 1986).[2]

In this regard, Yuval-Davis (2007) has even speaks spoken of multi-layered citizenships in order to situate citizenship in a wider context of belonging that "encompasses citizenships, identities and the emotions attached to them." According to this understanding, citizenship becomes an "embodied category, involving concrete people who are differentially situated in terms of gender, class, ethnicity, sexuality, ability, state in the life cycle, etc." (p. 561).

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[1] For an overview of the origins of the intersectionality approach and the current debate, see Lutz et al. (2011).

[2] *Oppression* means that institutions and society base their rules systematically on injustice (Ehrenreich, 2002, p. 272).

The growing complexity of differences in a pluralistic society also means that we are no longer faced with fixed and stable social groups or entities, but with complex identities in temporally changing contexts and social places, a change that needs to be considered analytically. For this purpose, Anthias (2013) has introduced a *translocational* approach in order to escape essentializing intersectional categories:

> A temporal and contextual analysis shifts attention away from fixities of social position (usually underpinned by assumptions about the primacy of the nation-state boundary), and enables a more *transnational* as well as more *local-based* lens. The idea of "translocation" thereby treats lives as being located across multiple but also fractured and interrelated social spaces of different types (p. 131).

Studies that focus on specific interlocking categories run the risk of essentializing categories such as gender, migration, or disability, but we also need to recognize that these categories carry related power effects, as Lutz, Herrera Vivar, and Supik (2011) have pointed out:

> On the one hand, one of the insights of post-structuralism is that identity categories (gender, "race", etc.) cannot be understood in an essentialist way, but at the same time the power effects generated by these categories are profoundly inscribed in historical and societal terms and, by virtue of the numerous overlaps between them, form the basis for the hierarchisation of groups and the formation of unequal social relations (p. 8).

Although each of these various social divisions have a separate ontological basis, they cannot be unbundled, as they are mutually constitutive and interactive (Bannerji, 1995, p. 156), even if in specific situations and contexts some might be of greater importance than others (Yuval-Davis, 2006, p. 203; 2007, p. 565). Consequently, in a given context a person's migration background is of central importance, while in another context that same person's sexual affiliation comes to the fore. For example, for an elderly migrant woman with dementia, the latter aspect of her complex identity might acquire greater meaning in her daily social life.

The analysis of complex and plural identities should not only focus on the everyday life of individuals—analyzing interlocking social categories and their unequal effects on individual lives and showing how their intersections produce unique configurations. It must also tackle "multiple discrimination" (Equal Opportunities, 2007), or—as Bilge (2010) argued—question, the identity-based oppression at the institutional level, "the ways in which multiple systems of power are involved within the production, organization and maintenance of inequalities" (p. 225).

In order to deal with complex and plural identities, we have to acknowledge that this complex causality requires us to recognize that categories are "multiple but not mutually independent" at both the individual and institutional levels (Hancock, 2007, p. 252).

Even though complex and plural identities are part of contemporary life and we speak of sameness in difference (Scott, 1988) or a *radical humanist* view that

emphasizes the common destinies of all humans (Goodley & Lawthom, 2005), particular differences need to be understood individually in order to avoid discriminating and being discriminated against. Furthermore, specialized fields of study often add only a new category to their disciplinary or thematic orientation—as, for example, when gender or disability studies examine migration—but ultimately the specialists do not leave their "home" and often, as a result, risk prioritizing their own "homemade" social division. Furthermore, it is often the categories themselves that become the focus, and not, as Crenshaw already argued more than twenty years ago, "the particular values attached to them and the way those values foster and create social hierarchies" (Crenshaw, 1991, p. 1297).

As Anthias has observed, the different academic debates "rarely meet or occupy the same terrain," since they rely on different writers and bibliographies (Anthias, 2013, p. 121). From our perspective, a prioritization of specific categories might not be able to grasp the identitary complexity that exists in today's societies. A dynamic intersectionality approach correctly attempts to acknowledge all existing differences and analyze the ways in which they mutually constitute each other.

The aim of this article is to show how individuals themselves locate their multiple dimensions of difference in specific situations and contexts and how they perceive the ways in which healthcare and social services encounter them.[3] Building upon Bilge's attempt to use the concept of intersectionality as an open "meta-principle, which requires to be adjusted and rounded out in respect of the particular fields of study" (Bilge, 2010, p. 69), we further try to point out how the different social divisions are enmeshed with and influenced by each other in given situations and contexts.

Methodologically, we worked with in-depth interviews conducted with 22 persons in the Geneva region who possessed at least two categories of difference related to their sexual orientation, their physical and psychological abilities, and/or their origins. The number of interviewed people was determined by the logic of saturation. Once a first analysis of the interviews produced a sufficiently differentiated understanding of their reality, we stopped searching for new people to interview. The people were found by using our established contacts among colleagues and students. The interviewed people agreed to the use of their interviews for scientific purposes.

Though we used these categories to choose the interviewees, we have not worked according to an additive logic of characteristics. Without falling into an anti-categorical approach of analysis, we have focused on the relational dynamics between our interviewees and the institutions with which they interacted, as described by the interviewees themselves. We wished to identify how the interviewees' unique specificity performed and eventually transformed relations and

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[3] In this article, we will only focalize on the individual's account, knowing that the perspective of the institutions is the other side of the question. We think, nevertheless, that it is possible to read through the narratives and the perception of discriminations at least partially institutional realities (Williams, 2004, p. 280).

institutional practices (Prins, 2006, p. 281). Our working hypothesis was that people with complex identities are confronted with similar problems induced by institutions that attempt to reduce complexity.

In our interpretation, we do not refer to fixed categories, but give full space to the complexity of the narratives that unfold in the individual life stories of differences, or—in the words of Christensen and Jensen (2012)—the "melting-pot where intersecting categories are inextricably linked" (Christensen & Jensen, 2012, p. 120). Nevertheless, we do not focus only on the individual perspectives, but also on the organizational and institutional manifestations of inequalities experienced by people who live with complex and plural identities. Without treating the "differential positionings and perspectives … as representatives of any fixed social grouping," our results might be a base for "common political emancipatory goals" (Yuval-Davis, 2006, p. 205), a main concern of the intersectionality approach, which also analyzes social structures, in particular the "organisational and institutional manifestations of power hierarchies and their effects upon individuals and groups" (Hill Collins, 2009, p. ix).

The interviews were conducted in two sessions. First, we talked with the interviewees about their life course in an attempt to gain their trust, and then we contacted them again for an interview on their experiences, bad and good, with institutions in the healthcare and social services system. The interviews were completely transcribed and the topics that emerged were submitted to a first exploration, which generated the codes of analysis. These codes were then used to organize the collected information in the relevant fields of interpretation around which this article has been structured.[4]

Three fields of analysis emerged during this work of codification: First we examined the transcripts from a biographical perspective. Our interviewees told us how experiencing identity-based oppression or living with multiple risks of discrimination impacted their life. Secondly, we put together concrete experiences of our interviewees and what they deduced from them. In this second section, we point out how experiences bring out coping strategies in the way they interact with institutions. Thirdly, we analyzed how they tried to influence oppressive patterns of the institutions as agent and what kind of change they promote.

The following sections present the results of the analysis of these three fields.

Living with Complex and Plural Identities

As we interviewed people twice, the interviewees, after they had told us their life stories in a biographical way, were more affirmative and critical about their experiences of identity-based oppression and discrimination in their second interview. From the first round of interviews, we learned something particularly relevant: People who live (multiple kinds of) discrimination develop an attitude to

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[4] For each excerpt, we indicate the name (which, for reasons of anonymity has been changed) of the person interviewed, the relevant code of the analysis, and the page in the report regarding that code (Cattacin & Domenig, 2013).

life that is characterized by a motivation to persevere in the face of difficulties. Typical statements that indicate this motivation included: "And I work in an environment that is pretty strong. You need to be strong! If you are weak, this is the end. They will get you down" (Camilla, Q1, 1); "My experiences in life have taught me a lot" (Samir, ASu1, 1); and "I think the most important is perseverance and courage, this is very important, and that really helped a lot" (Alain, Q1, 3).

Multiple discriminations or facing identity-based oppression seem to produce a dramatic choice: die or survive. Suicide as an exit strategy is known; voice or surviving as a strategy, less so. Our interviewees presented themselves as a motivational elite willing to change the relational dynamics to which they were subjected rather than accept their continuous relegation. This is not a material strategy, a Pavlovian survival strategy or an attempt to have better clothes or a nice apartment. It is a search for recognition. Our interviewees seek recognition to make sense in their lives.

All the stories we heard about the experience of living with complex and plural identities have one thing in common: They all are testimonies of *misunderstandings* by professionals within healthcare and social services, whether because the professionals lacked the information necessary to be able to evaluate a situation adequately—because they failed to ask individuals anything or even listen to them— or because they realized that professionals could do much more for them if only they wanted to. Samir, an asylum seeker from Afghanistan who lives in Geneva with his family, described how he asked the social worker supporting him for a language course in vain:

> It's not only that she did not help me financially, but also that she never spoke about opportunities that exist outside of the social-welfare system. I think she even knew other pathways quite well, but she did not tell me and I still do not understand why (Samir AO3, 1).

Particularly striking is that the interviewees, living mainly in highly vulnerable and marginalized contexts, are strongly motivated by the desire for personal and social advancement —to improve what they consider an intolerable financial situation or to increase their autonomy, which has been limited by, for example, an impairment. They therefore have little sympathy for institutions that do not (or cannot) support these efforts. Asylum seekers in particular fail to understand why they do not receive support in their attempts to become economically independent even after they have achieved asylum.

Our interviewees are convinced that their complex and plural identities often leads institutions to prioritize and make choices without considering the whole personality: They first undertake a classification and then weigh the various perceived characteristics of difference. It is this work of classification that reproduces structurally, in the institutions, schemes of identity-based oppression.

Nila, a young, visually impaired woman from Afghanistan who lost her family of origin on the run and had filed an asylum application in Switzerland, believed she would receive more favourable treatment due to her visual impairment, although she had no illusions about this:

I am still an asylum seeker [laughs], but surely I would not have been favoured by social services if I hadn't been visually impaired. But my integration in Switzerland will be easier, even if it's hard today to acquire refugee status, and to work and earn money. But it is like that, and I have come to accept this. And I hope to one day be completely autonomous (Nila, RSu1, 3).

Furthermore our interviewees think that various differences perceived by the professionals may also lead to a feeling of uncertainty, especially when the specific attributes associated with one characteristic are inconsistent with those of another, as Jessica, a black, Jewish woman, impressively revealed:

The anti-black attitudes are that blacks are great kids, they are monkeys, they are unintelligent people, but they are not dangerous. But the anti-Semitic attitude is quite a different thing, considering that Jews are very smart, they are genetically attracted to money, and they are very dangerous. So there was a kind of cohabitation between two roots that were contrary to one another (Jessica, RSu2, 2).

In the case of a hospital admission with clear requirements—a surgery, for example—the complexity of differences seems to be reduced to a simple somatic problem and does not appear to pose any specific problem for the interviewees. On the contrary, the interviewees feel completely satisfied with the care, and even privileged that they receive the same medical treatment as everybody else. In such circumstances, it seems that a problematic interaction will only arise if the psychosocial complexity of a patient or client's different lifeworld comes to the fore. Only then do healthcare and social services professionals make use of different defence mechanisms, such as threatening loudly, not speaking at all, or simply using the bureaucracy as an excuse for not accommodating the given complexity. Goffman's account of psychiatric hospitals seems to continue to be a reality for some of our interviewees: The greater the number of interpretations that enter into the relationship, the more the risks of stigmatizing and degrading increase (Goffman & Helmreich, 1961).

The persons interviewed are well able to perceive such defence dynamics, and they bring them up again and again in their interviews, as they consider such behaviour patterns unfair, degrading, and ambiguous. The Brazilian Janeina, living in Geneva without a residence permit and suffering from a chronic pain syndrome, was—from her perspective—treated very well during her hospital stay, but she found the aftercare completely insufficient: "At this point, yes, I think – how to say – they could have done better monitoring, better 'investigation,' because despite the surgery, I still feel pain, and at the hospital, nobody knows anything about this" (Janeina, ASu1, 1).

A lack of communication and interaction skills on the part of the institutions in a context of complex and plural identities also seems to be at the root of the discrimination experienced by Camilla. Camilla was suspected by her doctor of having mistreated her child after having brought him in because of bruises, although she told him her child suffers from haemophilia. The doctor reported his suspicion to the competent authority, which immediately called child services. After having

realized his error, Camilla asked nothing else than an admission of the error and, thus, recognition of difference: "I told the doctor: 'I will not file a complaint. I have the right to complain, but I will not do it, but I want an apology from you and a paper that says that my son has the disease'" (Camilla, ASO2, 1).

Aram, an Iranian Kurd who probably suffers from posttraumatic stress due to torture, and who has since been accepted as a refugee in Switzerland, remembered how difficult it was for him not only to understand anything in general, but also to understand the actions of the specialists in particular: "I did not speak any French, so I was not able to understand the reasons behind their actions. They could have just brought in an interpreter and spent only thirty minutes in order to explain all this to me" (Aram, ILSo 2, 3).

Coping Strategies

The evidenced feeling of continuous misunderstandings influenced the concrete strategies our interviewees developed. As Szakolczai (Szakolczai, 2004) and de Gaulejac, Taboada Leonetti, and Blondel (2008) have pointed out, experiences are major references for the development of individual strategies to cope with continuously changing realities. In our interviews, we noted three different, possibly related, strategies in relation to institutions dealing with complex and plural identities: resignation, rage, and affirmation.[5]

In the *resignation* pathway—which does not entail renouncing action—people follow the expectations formulated by institutions and people in a higher position of power (a strategy reminiscent of Spivak's (1992) analysis of how the "subaltern speaks" and Goffman's example of "the blind" who turns his eyes towards the person he is addressing (Goffman, 1963, p. 127). Institutions and people in powerful positions are seen as impermeable, and the only way to deal with them is to accept their rules. In this way they approve patterns of identity-based oppression and contribute to their reproduction.

Samir, for example, after having failed to receive support for access to training on several occasions, had given up trying, and instead he projected his wishes for a better future onto his son:

> Every time I tried to bring forward my project, the results were always negative …. So the only thing that gives me hope for my life here now is the future of my son, that he will have a quiet life and peace (Samir, RSu 1, 1).

Aline, from France and with psychiatric and physical disabilities, described, with a twinkle in her eye, her inevitable adaptation to the institution as the only possible strategy of ever getting out again:

> The psychiatrist was a sort of a *Grand Manitou* that one could not see more than once a week, and then one had to say what he wanted to hear if

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[5] For this distinction, see the studies done on acting in situations of vulnerability (*weak agency*) by Soulet (2009), Chimienti (2009), and Bassolé (2014).

one ever wanted to go home and rebuild one's own *normal* life, because if they felt we were still vulnerable, they would not have let us out (Aline, RSo2, 5).

These strategies assume that institutions are systematically oppressive and do not change. Our interviewees try to use what they know of the institutions and people they meet to receive better treatment. If institutions identify one characteristic as the most important when dealing with users with complex identities, the users try to put forward that characteristic and thereby confirm oppressive structures.

Rage is a reaction against the inability to change institutions' ad hoc procedures and ways of communicating, and it results in a ceasing of communication. Aram probably intended mainly to express his rage when he felt he was not being treated with respect, even while knowing very well that doing so would only create additional difficulties:

> The judge asked me to remove my hat and look at him. I replied to him: "Even though I know—respecting you—I have to speak to you face to face, you did not respect me first, dishonouring me in front of all my children. So you did not respect me. In my culture, one must not behave like you against a man who is the father of six children. So I do not recognize you as a judge" (Aram, RSo2, 5).

Another example of rage can be found in this excerpt of Camilla. Camilla became angry when policemen in uniform did not respect her doing her work, and she had chosen to work with an organization that fights for more rights for prostitutes:

> We tried to make the police more respectful towards the girls; they would stop just to look at your nipples, no. When you are in uniform, you have to respect me if you want me to respect you. You might visit us as a client on the weekend—that's fine—but when you are in uniform, you must respect the uniform and also respect me (Camilla, RSo2, 1).

The *affirmation* pathway results from the experiences people have had with legal matters. Through these experiences, they have learned to refer to their own rights and use established procedures for their own ends. Janeina, for example, argued that her social worker did not have any right to criticize her for receiving social welfare because she had an officially recognized right to it:

> I agree, we are in this country illegally, and we nevertheless benefit from health insurance, a service for the Swiss. But to provide support structures for people in need is to grant them the right to use them. Once this right is given to users, you cannot tell them that they do not have the right to use them. If the state provides social support, it is not up to the social worker to criticize this help (Janeina RSo2, 1).

Dam used sometimes unusual methods of communication that were more adapted to his personal skills and resources in order to exercise his rights: "Sometimes I prefer to appear there in person. Because on the phone it's very easy for them to say they don't have the time right now to listen to me. That's why I prefer face-to-face communication" (Dam, RSo2, 3). Our interviewees also reflect on institutions' poor

handling of existing resources. In particular, they criticize institutions for not adequately recognizing their abilities, as here with the homosexual and deaf Yves, who could not understand why he failed to find work only because of his handicap:

> Responsible persons should normally see a deaf person once in action, in order to be able to evaluate if our handicap is really a problem for the job. Days of testing where experts are put in front of the deaf candidates, and the experts are only there to check how we work. Maybe that's what should be done (Yves, RO3, 2).

Alain, a wheelchair user of French origin, proposed that, in order to make sure that the right measures are implemented, those with mobility impairments should be the ones who define the problems that disable them:

> I think, when it's the people with a handicap explaining their problems, at this moment adaptations, accessibilities will be implemented. Because people without mobility impairments are not yet aware of our real problems, so that's why we should explain everything to them, so that they understand our problems better. And then the adjustments might occur (Alain, RO3, 4).

Agency

The reflexivity of our interviewees is also concerned with the processes of institutional change and they way they face identity-based oppressive structures. They underline three different ways professionals within institutions may interact with them in a respectful and adequate way.

First, they underline the importance of listening to their stories, problems, and feelings. When the asymmetry of institutional experiences is transformed into a more symmetric relationship between professionals and clients, people with multiple characteristics of difference feel themselves to be understood and develop trust in the institution, as Alain pointed out:

> Regarding the hospital, I would say it has been like a home with parents, like a real family, because people have turned out to be open towards me, and they listened to me. They asked questions without being indiscrete, they gave information, they tried to find a solution. And they tried to exchange a smile, just in order to build trust (Alain, ILSo3, 3).

This more symmetric relationship is especially present in the hospital sector, which generally has higher professional standards and where staff often work with specialized services and interpreters, as Emin illustrated here, recounting his positive experience with a physician:

> From the operation to the present, I am satisfied. It was important to find a doctor who is really able to listen to me. Although we had a language problem, he listened attentively, and he tried to find the right words so that we could understand each other (Emin, IlSo2, 2).

Second, our interviewees formulate as further good practices institutions' or professionals' explicit willingness to test, evaluate, and judge their skills in order to give everybody a chance. Pedro, developmentally disabled and originally from

Spain, insisted on this point and was even convinced that he would soon have his chance:

> They have proposed to find out whether I am able to live on my own or not, and I think I might be able to. I have lots of experience of autonomy; it is not like others who have no abilities. I go to the market and sell our vegetables, and I am able to count the money and give change. This is an achievement for me, and my safety belt (Pedro, ILSt3, 3).

Pedro's example is particularly interesting from the point of view of our analysis of complex and plural identities, because he insists on his difference vis-à-vis others in the same situation—and in this way introduces a distinct point of view on what could be, and often is, seen as sameness.

Evaluating someone's particular skills in a constructive and fair way permits both sides of the relationship to carefully examine judgments, and then confirm or change them. This evaluation entails not only entering into a mutual learning process, but also considering new solutions and procedures in the way specific questions have to be handled.

Finally, our interviewees insist that they must be informed about their rights. Unless healthcare and social services professionals advocate on their behalf, people at risk of discrimination on multiple grounds have little chance of leaving their position as victims. Larissa told us that it was important for her to encounter such an attitude of advocacy and, as a result, receive important information:

> So I went to the social welfare office in Geneva. I met a very nice lady there who administered to my needs. She told me that I have the right to claim different types of social assistance, and I did not know that, even though I had already been living in Switzerland for over two years.… And so the lady told me what my rights were about in my situation, all the different types of social assistance that exist and all these things … (Larissa, ILSt3, 2).

It is not only being informed about their rights, but also being treated fairly that is seen as an essential aspect of respect that has to become standard within all institutions. Diego told us, "The care I received here was good. The same care as every Swiss would have received, too, the same medical examinations. They treated and cared for me very well. The x-ray, I even did ultrasounds" (Diego, ILSt3, 3).

The difficult task of changing identity-based institutional patterns by challenging it in a constructive way is part of a learning process that people at risk of discrimination and oppression face in concrete situations. These individuals are rarely aware of these difficulties, as they perceive figuring out how to influence an institutional exchange in their favour as an acquired skill. Chatel and Soulet described this skill as *weak agency*, the strategic capacity of vulnerable people to see possibilities for improving their situations even in desperate situations (Chatel & Soulet, 2003).

Discussion

Our exploration suggests that the encounter between healthcare and social services and people at risk of discrimination and oppression is marked by their earlier adverse experiences (Kareem & Littlewood, 1999 [1992], p. 23). As Culley (2006) argued, health professionals must always remember

> that when we meet clients they may well have been subjected to a variety of racisms, both individual and institutional, which may impact on their health status, their access to health-care, their feelings about using health services and their subsequent interactions with healthcare providers (p. 151).

These previous experiences cannot be cancelled and are present in interactions with institutions. An attitude or an institutional rule assuming that all users are to be threatened in the same way would mean that all experiences are the same. That is why it is fundamental that institutions do not address people according to the (potentially oppressive) egalitarian approach (Spade, 2013, p. 1034), as the relationship between the institution and the individual is not neutral. The stories count, as Jim explained: "That's the problem. It's a kind of equitability that might create injustice" (Jim, ILSu1, 1).

Working with people with plural and complex identities requires unconditionally openness and the ability to listen to the stories they have to tell; to meet them with respect and empathy; and, last but not least, to support their personal development and wish to change their lives. It means to accept und take into consideration their own way of reading society that is marked by a permanent lack of recognition and a simple-minded reduction to single attributes of their complex and plural identities; as a consequence, they often feel misunderstood in the interaction, and they suffer from the lack of interest in their specific characteristics and skills—attributes that could also be read as valuable for a pluralist society.

Their struggle for recognition of plural and complex identities is seldom supported by social or political structures, as those are normally specialized only in one identitary aspect as migration, gender, or disability. That is the reason why our interlocutors develop their own individual strategies to survive and their special tactics and tricks to manage healthcare and social services in order to move forward. In doing that, they often become accomplices of oppressive structures, even if their common goal is to be respected in what they are and be supported to achieve their rights for a life in dignity—and they do not want to be blocked by institutions on their journey ahead.

An appropriate view on plural and complex identities means for healthcare and social services not to essentialize pluralism and complexity and for these institutions to recognize their own tendency to discriminate against anything that is different. The most important prerequisite for achieving this goal is a capacity to put into question its own activities in terms of day-to-day practice at all levels. Regulations and institutional standards may also help to transform healthcare and social services into better advocacy organizations; but in the end, we need most of all for healthcare and social services providers to have more professional and appropriate knowledge

that allows them to avoid discrimination and promote more equitable care. Indeed, healthcare and social services professionals must become more aware of all the possible differences that might be at stake when someone is entering an institution, assuming that ultimately everybody in a pluralistic society is shaped by various and changing identities, with different social divisions such as gender, class, migration, disability, age, and others.

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