What Has Stigma Got to Do with Physiotherapy?

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A few years ago, I attended a professional development session to learn techniques to treat the sacroiliac joint. Unsurprisingly, the techniques involved palpation and visual examination of the low back and pelvic areas. Afterward, one of the other physiotherapists mentioned that some of the techniques would be very difficult to conduct on someone who was overweight. Another then said that she really did not like touching people who were overweight; she found it “disgusting.” Comments such as these led me to consider what effects these ways of thinking might have on physiotherapy encounters and to subsequently develop an ongoing interest in the intersection between physiotherapy and stigma.

The sacroiliac techniques we learned that day I have since used often, and quite comfortably, on people of all sizes. Would this have been different if I thought the techniques would be difficult to perform on people whom I considered overweight? Perhaps this perceived difficulty might have changed my competence in using these techniques, or I might not have used them on larger people. And what of the disgust or revulsion toward fatter flesh that one colleague mentioned? Might feelings such as these affect clinical interactions?

Despite the global importance of the profession, there has been little discussion about stigma in physiotherapy. What literature exists has focused on particular stigmatized attributes rather than broader considerations of stigma. For example, several studies and theoretical investigations (including some of my own) have claimed that physiotherapists inadvertently stigmatize particular characteristics, such as aspects of disability, mental illness, persistent pain, and obesity.^{1–8} The authors of some of these investigations have also argued that physiotherapists (again inadvertently) lack an understanding of the stigma people might experience, thereby sometimes creating negative consequences for those they treat.^{1,5,6} As a physiotherapist in one of my studies⁶ said, “I haven’t thought about how [larger patients] would feel coming to see me. Ever.” The results of these studies, and the lack of literature overall, suggest that there may be benefits to fostering greater attention to issues such as stigma for the profession – and, more important, those we serve.

HOW CAN PHYSIOTHERAPISTS DEVELOP A GREATER UNDERSTANDING OF STIGMA?

A helpful start might be to look at what stigma is—and does. Defining stigma is more complex than it might appear. Crocker and colleagues^{9(p. 505)} produced a widely used definition: “Stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context.” Their definition outlines some of the major components of stigma: It is linked to a characteristic, it involves negative judgment, it is social rather than individual, it does not reside within a person or the attribute but is created in interaction with others, and—what is perhaps most important—stigma is not a static phenomenon; it is produced in some contexts, but not in others.

Building on this definition, others (particularly those from critical perspectives) have argued for a stronger emphasis on the political and cultural creation of stigma.¹⁰ They have argued that certain characteristics are stigmatized at particular times as a product of prevailing ways of thinking in a society; less power (social, political, economic) is available to those who are stigmatized.¹¹ Still others have asked for a stronger emphasis on the embodied, material, and affective elements of stigma.¹² Focusing on these elements shows that stigma is more than simply a concept or attitude. Instead, part of stigma is its effect on a person’s body and mind (e.g., higher levels of depression and cortisol levels in those who are stigmatized, feelings of disgust in those who stigmatize).^{3,13,14} This thinking also reveals that stigma is evident in objects in the environment (e.g., equipment that fits only some bodies, images of thin people used in advertising),⁷ in what a person can do, and in how a person can live (e.g., reduced employment opportunities, social standing, dating opportunities).¹⁵ In health care specifically, stigma is apparent in decision making, interpersonal interactions, care judgments, personal perceptions, quality of professional practice, avoidance of health care by those who feel stigmatized, and a lack of trust in health care providers.¹⁶

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To summarize, a characteristic or person does not inherently possess stigma; rather, what or who is stigmatized (and how) is produced by prevailing social, cultural, and political circumstances, and stigma has effects on (and through) both people and objects in an environment. As a result, acknowledging stigma clarifies the importance of broadening the focus of physiotherapy beyond biomechanical concerns to encompass psychosocial, cultural, and political factors.¹⁷ Attending to these aspects of clinical practice provides an understanding that physiotherapy often involves watching, measuring, and assessing a client's body, which is likely to inadvertently increase the exposure to and focus on physical characteristics, some of which—such as weight and disability—are stigmatized. This focus is particularly salient in the context of stigma because physiotherapy often strives to make “abnormal” bodies more “normal” by improving (e.g.) abnormal gait, range of movement, and patterns of breathing.¹⁸ Also relevant is that physiotherapy predominantly follows a medical model, in which clinicians are assumed to be objective observers. This assumed objectivity means that therapists might not notice their potential for subjective judgments¹⁹ and may neglect to identify where they perpetuate stigma or might be perceived as stigmatizing.

CONCLUSIONS AND IMPLICATIONS

Considerations of stigma contribute to concerns that the profession is under-theorized and lacks criticality, and they extend the work that is beginning to consider how to address this critique.^{20–22} The benefits of this kind of professional reflexivity are numerous. They include reconsideration of some of the basic assumptions and established practices in physiotherapy to determine their relevance to, or value for, providing whole-person, compassionate care. For example, the profession's privileging of particular practices, such as evidence-based practice,²³ which reinforce ideas of objectivity, might be reconsidered, adapted, or added to. There are small signs of a shift toward this broader approach, with some areas of physiotherapy selectively adopting a bio-psychosocial approach.²⁴ However, even a bio-psychosocial approach is insufficient to address important factors relevant to stigma because it does not take into account cultural, historical, and political elements. Recent physiotherapy research has seen similar calls for a reconsideration of education and theory. For example, both Patton and colleagues²⁵ and Rowe²⁶ have argued that it is important to critically examine physiotherapy pedagogy to enhance clinical learning, and others have discussed the importance of philosophy in physiotherapy.²⁷

Stigma is complex; there is no one “right” way of adapting physiotherapy practice that will work in every circumstance to consider stigma. Yet having an understanding of socio-political concepts such as stigma gives physiotherapists intellectual resources that enable them to better assess the unique situations they encounter. A

greater awareness of stigma encourages physiotherapists to be flexible, to be attentive to the perspectives of patients who have experienced stigma, and to be more conscious and diverse in their choices of communication and environment. Developing a nuanced understanding of the interactional, psychological, social, cultural, and political aspects of stigma can help cultivate more agile, person-centred, and ethical work practices.

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Qu'est-ce que la stigmatisation a à voir avec la physiothérapie?

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Il y a quelques années, j'ai assisté à une séance de perfectionnement pour apprendre des techniques de traitement de l'articulation sacro-iliaque. Sans surprise, les techniques nécessitaient la palpation et un examen visuel de la région lombaire et pelvique. Par après, l'un des autres physiothérapeutes a mentionné que certaines de ces techniques seraient très difficiles à appliquer sur une personne en surcharge pondérale. Une autre a ajouté qu'elle n'aimait pas toucher les personnes en surpoids, qu'elle trouvait cela « dégoûtant ». Les commentaires de ce genre m'ont amené à réfléchir aux effets que ces façons de penser pourraient avoir sur les séances de physiothérapie et à m'intéresser à la relation entre la physiothérapie et la stigmatisation.

Les techniques sacro-iliaques que nous avons apprises ce jour-là, je les ai souvent appliquées depuis, sans problème aucun, sur des gens de toute taille. Est-ce que le résultat aurait été différent si j'avais dans l'idée que les techniques seraient difficiles à appliquer sur les patients qui étaient selon moi en surpoids? Peut-être cette impression de difficulté aurait-elle altéré ma maîtrise de ces techniques, ou peut-être ne les aurais-je pas du tout employées sur des gens en surpoids. Qu'en est-il du

dégoût ou de la répulsion causés par les tissus adipeux que ma collègue avait mentionnés? Ces réactions se traduisent-elles dans les interactions cliniques?

Malgré l'importance de la profession partout dans le monde, on a peu abordé la question de la stigmatisation en physiothérapie. Le peu de littérature qui existe s'est intéressé à des attributs particuliers faisant l'objet de préjugés, plutôt qu'aux préjugés dans leur ensemble. Par exemple, selon un certain nombre d'études et d'enquêtes théoriques (dont certaines de mon cru), les physiothérapeutes stigmatisent involontairement des caractéristiques particulières, comme certains aspects des handicaps, des maladies mentales, des douleurs persistantes et de l'obésité.^{1–8} De plus, selon les auteurs de certaines de ces enquêtes, les physiothérapeutes (toujours involontairement) comprennent mal la stigmatisation que peuvent vivre certaines personnes, ce qui entraîne des conséquences négatives pour les patients qu'ils traitent.^{1,5,6} Comme l'a dit un physiothérapeute dans une de mes études⁶ : « Je n'avais jamais réfléchi à la manière dont les patients en surpoids se sentent lorsqu'ils viennent me voir. » Les résultats de ces études, et le manque d'études en général, nous portent à croire

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