Increasing awareness of stigmatization: advocating the role of occupational therapy

Ryan A. Domer

The University of Toledo

Follow this and additional works at: http://utdr.utoledo.edu/graduate-projects
Increasing Awareness of Stigmatization: Advocating the Role of Occupational Therapy

Ryan A. Domer

Faculty Mentor: Beth Ann Hatkevich, Ph.D., OTR/L

Site Mentor: Sr Michelle Toth, Ed.D.

Department of Rehabilitation Sciences

Occupational Therapy Doctorate Program

The University of Toledo

May 2012

Note: This document describes a Capstone Dissemination project reflecting an individually planned experience conducted under faculty and site mentorship. The goal of the Capstone experience is to provide the occupational therapy doctoral student with a unique experience whereby he or she can demonstrate leadership and autonomous decision-making in preparation for enhanced future practice as an occupational therapist. As such, the Capstone Dissemination is not formal research.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Framework for Policy Analysis</td>
<td>5</td>
</tr>
<tr>
<td>The Issue</td>
<td>8</td>
</tr>
<tr>
<td>Analysis of the Issue</td>
<td>14</td>
</tr>
<tr>
<td>Advocacy Efforts</td>
<td>22</td>
</tr>
<tr>
<td>Conclusions</td>
<td>24</td>
</tr>
<tr>
<td>References</td>
<td>25</td>
</tr>
<tr>
<td>Appendix A: Draft of “The Issue Is . . .”</td>
<td>28</td>
</tr>
<tr>
<td>Appendix B: Stigma: Occupational Therapy Questionnaire and Response Frequencies</td>
<td>45</td>
</tr>
<tr>
<td>Appendix C: Annotated Bibliography</td>
<td>50</td>
</tr>
</tbody>
</table>
Introduction

State the Purpose of the Paper

The purpose of this paper is to increase awareness of stigmatization, along with advocating an essential role for the profession of occupational therapy to address the psychosocial barriers that are introduced by stigma. Particularly, this paper will result in a scholarly written article and be submitted for publication in the *American Journal of Occupational Therapy* (AJOT) “The Issue Is” format. The contextual information discussed in this paper has been gained through an extensive review of relevant literature, unstructured observations and personal interactions, questionnaires, and semi-structured interviews. From information gained, it has been found that stigma introduces psychosocial barriers that can hinder a person’s ability to live a meaningful and purposeful life with the highest level of independence attainable (see Appendix A for further details about this issue).

Briefly Describe the Policy, Issue, or Professional Trend to be Discussed

What is stigma? Coined by Erving Goffman, the term stigma describes the situation of an individual who is disqualified from full social acceptance (Goffman, 1963, p. 9). While it is understood that everyone throughout society happens to become a stigmatized subject at one instance or another due to his or her unique attributes, there are individuals (or sub-populations) who are more commonly stigmatized than others. Stated by Race:

People who are commonly at risk of devaluation, and therefore social exclusion [those who are commonly stigmatized] . . . include: those with some form of impairment of body, mind, or sense; those whose behavior is considered disordered; people who are visibly different (i.e., very tall, very short); people who are or represent anti-establishment; those who are living below the poverty
line; those with low levels of skill; and those not assimilated into the dominant culture for reasons such as religion, race, age, ethnicity, language, value system, immigrants, and migrants (as cited in Davys & Tickle, 2008, p. 358).

The scholarly written article will discuss some of the common psychosocial barriers that stigmatized individuals encounter (see Appendix A for draft of scholarly written article). Specifically, stigmatization has been found to negatively impact an individual’s occupational performance(s) and impede his or her acquisition of meaningful and purposeful social role(s).

**Identify the Framework that will be Used to Analyze the Issue**

With stigma being a conceptual term, it introduces and describes psychosocial mechanisms that negatively impact an individual’s occupational performance(s) and impede his or her acquisition of social role(s). In order to address such mechanisms, Anne Mosey’s Role Acquisitional frame of reference will be utilized.

The Role Acquisitional frame of reference has been designed to specifically guide the practice of occupational therapy by “linking learning theories, the reality aspect of purposeful activities [occupations], and the process of acquiring specific skills needed for successful interaction in the environment” (Mosey, 1986, p. 443). This frame of reference is an appropriate tool to guide interventions for individuals who have not learned how to participate in required social roles or who wish to participate in desired roles more effectively (Mosey, 1986, p. 450). It is also applicable for individuals who are experiencing difficulty with role transitions or those who must learn how to participate in their social roles in a different manner (Mosey, 1986, p. 450).
Framework for Policy Analysis

Explain the Framework that will be Used to Analyze the Issue

The American Occupational Therapy Association (AOTA, 2008) defines occupational performance as:

the act of doing and accomplishing a selected activity or occupation that results from the dynamic transaction among the . . . [individual], the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities (p. 672-673).

Aside from personal attributes, occupational performances contribute to an individual’s social identity; they result in an individual’s acquisition of social roles. Roles are “sets of behaviors expected by society, shaped by culture, and . . . further conceptualized and defined by . . . [an individual]” (i.e., parent, student, employee, etc.) (AOTA, 2008, p. 674).

With the latter mentioned, a holistic perspective needs to be adopted in order to guide interventions for individuals who cannot successfully participate in a required or desired social role (such as stigmatized individuals). The Role Acquisitional frame of reference “is addressed to some aspects of motor and cognitive function, in particular those aspects enabling the individual to complete a variety of tasks successfully; to social interaction; and to all of the occupational performances” (Mosey, 1986, p. 450).

Theoretically, the Role Acquisitional frame of reference is grounded on five parts: the nature of the individual of interest, learning needs, processes of learning, typical and atypical development, and the performance of purposeful occupations (Mosey, 1986). It is with the theoretical base that the Role Acquisitional frame of reference can help identify role qualities inherent in all human beings. Being primarily grounded on learning mechanisms in order for an
individual to acquire the necessary skills to function in his or her social environment, the Role Acquisitional frame of reference helps identify barriers towards the acquisition of such skills (Mosey, 1986). With an understanding that stigmatization introduces psychosocial barriers that impede an individual’s acquisition of social role(s), the frame of reference’s sociological and psychological perspective can help stigmatized individuals learn ways to surpass such barriers (Mosey, 1986).

**Discuss how this Framework has been Used in the Past to Analyze Issues**

Literature directly citing the Role Acquisitional frame of reference is limited; however, Schindler, Connor, and Griffiths document its efficacy in a study that was published in the year of 1995 (as cited in Schindler, 2004, p. 21). In their study, the Role Acquisitional frame of reference was used to guide an intervention that allowed an unemployed male who was diagnosed with schizophrenia to gain the necessary task and interpersonal skills to obtain a job (a role) in the community (Schindler, 2004).

Schindler (2008) also notes that Role Development, a set of guidelines for clinical practice, is primarily based on Anne Mosey’s Role Acquisitional frame of reference, and empirical evidence supports the use of such guidelines for successful development of skills and social roles. For example, a “quantitative pretest-posttest study incorporated 84 men diagnosed with schizophrenia who were equally divided into experimental and comparison groups,” and it examined the efficacy of a program that was based upon Role Development (Schindler, 2008, p. 138). The study “indicated that participants in the Role Development program demonstrated a statistically significant . . . [increase] in task skills (p < .05), interpersonal skills (p < .05), and role functioning (p < .05) when compared with participants in the comparison group” (Schindler, 2008, p. 138).
Like Anne Mosey’s Role Acquisitional frame of reference, Loury (2005) also highlights the notion that social roles are dependent upon an individual’s present and past skill attainment. In *Racial Stigma and its Consequences* (2005), Loury states that racial stratification is the result of skill disparities due to “developmental resources . . . [being] mediated through race-segregated social networks” (p. 5). With the latter stated, it is further reasoned that African Americans are more likely to take on the social role of being a criminal due to lack of opportunities to acquire skills (Loury, 2005).

**Describe how Occupational Therapy Practitioners can Use this Framework**

Occupational therapy practitioners are encouraged to use Anne Mosey’s Role Acquisitional frame of reference; however, with an understanding that the frame of reference aims to teach individuals skills in order to participate in required and/or desired social roles, all scholarly literature that pertains to the acquisition of skills and social roles may be relevant to addressing the psychosocial barriers that are introduced by stigmatization (Nelson, personal communication, April 21, 2012). Again, stigmatization has been found to negatively impact an individual’s occupational performance(s) and impede his or her acquisition of meaningful and purposeful social role(s). Any efficacious research that documents successful interventions in the acquisition of skills and social roles may be of interest to the occupational therapy practitioner (see Appendix A for additional discussions about acquisition of skills and social roles).
The Issue

Identify and Discuss the Issue, Describing the Historical Background and how the Issue has Evolved Over Time

Noted by Jones, the word *stigma* comes from the Greeks, and it refers to marks on the skin made by a pointed object, or tattoo (as cited in Smith, 2007, p. 463). Neuberg, Smith, and Asher (2000) state:

> Ancient Greeks would slice and burn criminals and traitors to denote their immortality or lack of fitness for regular society, . . . and an individual bearing a stigma was to be discredited, scorned, and avoided [socially excluded] . . .. This practice [is] a behavioral manifestation of the more general process of psychological stigmatization—the process of cognitively marking an individual as possessing a negative characteristic so discrediting that it engulfs others’ views of the individual (p. 31).

Taking a biocultural approach, “the ubiquitous human practice of stigmatizing certain others is rooted primarily in the biologically based need to live in effective groups” (Neuberg et al., 2000, p. 33). With the idea that group living is adaptive for survival and gene transmission, “people will stigmatize those individuals whose characteristics and actions are seen as threatening or hindering the effective functioning of their groups” (Neuberg et al., 2000, p. 34). Kurzban and Leary (2001) further note: “historians, anthropologists, and political scientists tend to agree that social exclusion [stigmatization] is characteristic of human cultures around the world and throughout recorded history” (p. 191).

While taking the aforementioned into consideration, it can be affirmed that stigmatization may serve as a functional social phenomenon. The issue, however, is that stigmatization may
also serve to be a dysfunctional social phenomenon that negatively impacts an individual’s occupational performance(s) and impedes his or her acquisition of meaningful and purposeful social role(s).

There are two types of stigma: public stigma and self-stigma (Abdullah & Brown, 2011). Public stigma refers to a discriminatory response and self-stigma refers to the internalization of public stigma (Abdullah & Brown, 2011). Self-stigma leads to negative emotional reactions, such as shame, low self-esteem, and diminished self-efficacy (Corrigan, 2007). Each type of stigma interacts with one another and they exacerbate the occurrence of the negative effects of stigmatization (Abdullah & Brown, 2011).

In today’s society, individuals tend to stigmatize one another based upon erroneous beliefs due to lack of knowledge. With this mentioned, a number of public stigmas are ungrounded and they cause unnecessary distress for stigmatized individuals. For example, Dawn Christensen, Executive Director of The Sight Center of Northwest Ohio and a woman who is visionally-impaired, explained the number of distressing barriers that she had to surpass in order to prove to her physician that she was able to independently care for her newborn child (personal communication, March 6, 2012)

Another example of stigmatization based upon erroneous beliefs is provided by Temple Grandin, Ph.D. During a lecture, a group discussion was held about the types of behaviors that tend to ostracize individuals who have autism. It was further discussed that others misperceive (stigmatize) such individuals as not having the ability to acquire appropriate social skills, which in turn, limits their opportunities throughout life (i.e., education, work, etc.) (personal communication, January 26, 2012) (see Appendix A for additional examples of stigmatization).
How has stigma evolved over time? Weiss, Ramakrishna, and Somma (2006) state, “the concept of stigma has been attracting increased attention among health professionals and the general population” (p. 277). While the human practice of stigmatizing others may seem to be an engrained cognitive-behavioral adaptation, Crocker, Major, and Steele reiterate Goffman’s conceptualization of stigma by stating that the stigmatization of human attributes is dependent upon social settings and cultural norms (as cited in Lewis, Thomas, Blood, Castle, Hyde, and Komesaroff, 2011, p. 1350). Moreover, being dependent upon social settings and cultural norms, the stigma that surrounds a particular human attribute may change (i.e., the stigma may increase or lessen in “severity,” or even be “shed”) (Burris, 2008).

Aside from the evolution of stigmas that surround particular human attributes, Al Cravin, Associate Professor at Adrian College, highlights that the use of medical terms, such as *mentally retarded*, are developing a negative connotation and tend to stigmatize individuals with a disability (personal communication, January 24, 2012). Moreover, it is further reasoned that the word, *mentally retarded*, has been wrongfully used throughout society as a synonym for the word, *stupid*, and campaigns exist that support the elimination of the word, *mentally retarded*, in everyday speech (Cravin & Whitehouse personal communication, January 24, 2012).

With an understanding that stigmatization serves as both a functional and dysfunctional social phenomenon, everyone throughout society happens to become a stigmatized subject at one instance or another. With an ever-changing society, stigmatic issues will continue to evolve.

**Identify and Describe the Individuals Involved in the Issue**

In order to learn about the stigmatic issues that negatively impact an individual’s occupational performance(s) and impede his or her acquisition of meaningful and purposeful social role(s), information was gained through unstructured observations and personal
interactions, questionnaires, and semi-structured interviews. The following is a list of individuals involved in this advocacy effort.

- Sr Michelle Toth, Ed.D., Chief Executive Officer of The Providence Center. 1205 Broadway St., Toledo, Ohio 43609. (Interviewed January 11, 2012).
- Anonymous consumers of welfare services at The Providence Center. 1205 Broadway St., Toledo, Ohio 43609. (January 17, 2012 – April 18, 2012).
- Scott Whitehouse, Executive Director of The HOPE Community Center. 431 Baker St., Adrian, Michigan 49221 (Interviewed January 24, 2012).
- Al Cravin, Master of Science in Education with specializations in Health Education and Special Education, Associate Professor at Adrian College. (Interviewed January 24, 2012).
- Temple Grandin, Ph.D., Professor of Animal Sciences at Colorado State University. (January 26, 2012).
- Anonymous individuals who have intellectual disabilities at The HOPE Community Center. 431 Baker St., Adrian, Michigan 49221. (February 2, 2012 – April 18, 2012).
- Danielle Brogley, Director of Programs at Wood County Committee on Aging. 305 North Main St., Bowling Green, Ohio 43402. (Interviewed February 17, 2012).
- Anonymous consumers of services at Wood County Committee on Aging. 305 North Main St., Bowling Green, Ohio 43402. (February 23, 2012 – April 20, 2012).
- Anonymous Member of Narcotics Anonymous (Interviewed March 1, 2012).
Anonymous Member of Al-Anon (Interviewed March 2, 2012).

Dawn Christensen, Executive Director of The Sight Center of Northwest Ohio. 1002 Garden Lake Parkway, Toledo, Ohio 43614 (Interviewed March 6, 2012).

Jacqueline Metz, Volunteer Coordinator/Administrative Assistant at Wood County Committee on Aging. 305 North Main St., Bowling Green, Ohio 43402. (Interviewed March 8, 2012).

Identify and Describe the Public or Private Organizations/Systems that Affect the Issue

Generally, society as a whole affects the issue of stigmatization. Within the United States of America, social power is exercised and normative expectations are present (Hayes & Hannold, 2007). Individuals who cannot attain a certain level of social power or meet socially normative expectations are not able to effectively function within the mainstream of society, and they soon become stigmatized based upon their attributes that contribute to their social shortcomings. For example, individuals who receive welfare services are commonly misperceived (stigmatized) as not being employed or employable (Toth, personal communication, January 11, 2012).

The media represents a powerful force in shaping an individual’s beliefs and values. With this mentioned, “research examining newspapers, movies, and television finds a largely consistent picture, indicating that individuals with mental illness are rarely portrayed in a positive light” (Pescosolido, Martin, Lang, & Olafsdottir, 2008, p. 435). The media portrays individuals with a mental illness as dangerous, unpredictable, and incompetent (Pescosolido et al., 2008). It is due to the media that social misperceptions of individuals with a mental illness leads to them being commonly stigmatized.

Aligned with Goffman’s definition of stigma, Hayes and Hannold (2007) note that “the medical model embraces the notion of able-bodiedness and able-mindedness, reducing . . . [an
individual] with a disability to a dysfunctional body in need of care” (p. 360). The objectification of individuals with a disability leads to dehumanization, which in turn, leads to stigmatization. The medical model gives way to a focus on what is wrong or abnormal with an individual with a disability, and his or her characteristics and actions may be seen as threatening or hindering the effective functioning of the social “norm.”

**Identify and Discuss any Groups or Organizations that are Already Involved in the Issue**

There are established private and public organizations, campaigns, and support and advocacy groups that aim to tackle stigma. In response to the Surgeon General’s call for approaches to overcome stigmas attached to mental disorders, President George W. Bush launched The New Freedom Commission on Mental Health in 2002 (Pinto-Foltz & Logsdon, 2009). The Commission strives to help individuals with mental disorders lead normal lives similar to individuals without mental disorders (Pinto-Foltz & Logsdon, 2009, p. 32). Additionally, the U.S. Department of Health and Human Services Substance Abuse and Mental Health Service Administration (SAMHSA) has adopted an initiative to reduce the stigmas towards mental health disorders (Pinto-Foltz & Logsdon, 2009).

In response to the health disparities within the United States, the U.S. Department of Health and Human Services (n.d.) has drawn a goal in the Healthy People 2020 framework to achieve health equity, eliminate disparities, and improve the health of all groups. Within the framework, stigmatization is acknowledged to be a major barrier for individuals in need of receiving proper healthcare services. Particularly, stigmatization introduces a barrier for individuals who are in need of reproductive and sexual healthcare services, and interventions are being designed, implemented, and evaluated as a means to reduce the rates of transmission of sexually transmitted infections.
The Global Network of People Living with HIV/AIDS (GNP+) and the Asia Pacific Network of People Living with HIV/AIDS (APN+) (n.d.) are global networks that aim to improve the quality of life for individuals living with HIV/AIDS. Particularly, they address the stigmatization of HIV/AIDS by empowering infected individuals through education on human rights, along with supporting their response to stigma, discrimination, and the consequences of such (see Appendix A for additional examples of organizations that are involved in this issue).

**Identify the Resources that Exist Related to this Issue**

There are a number of resources that specifically address the issues that are introduced by stigma. Particularly, there is scholarly literature that focuses on the dysfunctional issues that stigmatization introduces to individuals, which is growing in abundance. There are also a number of publicly accessible websites via the Internet that identify and discuss common stigmas (i.e., those that are attached to mental disorders, HIV/AIDS, obesity, etc.); information about stigma is mere a “click” away from being obtained.

**Analyze the Issue**

**Analyze the Issue Using the Selected Framework**

Generally, the Role Acquisitional frame of reference provides a psychosocial lens to examine the acquisition of social roles, and researchers who study stigmatization also utilize this type of lens. For example, Biernat and Dovidio (2000) explain that the cognitive and affective processes of stigmatization are a function of discriminatory attitudes, and such attitudes are “less solid” towards individuals who acquire a wide variety of social roles. Utilizing Anne Mosey’s Role Acquisitional frame of reference, the occupational therapy practitioner can formulate evaluative questions and identify areas for observation to hone in on the impacts that stigmatization has on a client’s acquisition of social roles. After the necessary information has
been gained through questioning and observation, the practitioner can then identify any dysfunctional behaviors by resorting to the outlined categorical continuums, such as that of interpersonal skills. When addressing any dysfunctional behaviors that are introduced by stigmatization, the outlined postulates regarding change can help guide the therapeutic process.

Through the administration of questionnaires, individuals who consume welfare services were asked questions particular to whether or not they felt that others stigmatized them. Due to consuming welfare services, three individuals indicated that they felt others wrongfully perceived (stigmatized) them as being lazy, unemployed (or not seeking employment), addicted to drugs or alcohol, having a criminal background, and unable to live independently due to lack of knowledge or skills.

Additionally, one individual who consumes welfare services indicated that he or she has difficulty in establishing a home due to being avoided by others; two individuals indicated that he or she has difficulty in establishing employment or education due to being avoided by others; and two individuals indicated that he or she can recall a time in the past when feelings of shame or embarrassment prevented him or her from not wanting to consume welfare services (an act of self-stigmatization).

Maintaining a focus on those who consume welfare services, one individual highlighted the stigmas that surround one’s beliefs, values, and spirituality. As an atheist, the individual discussed how others perceived (stigmatized) him as being evil after discovering his perspective on life (personal communication, February 2, 2012). Moreover, the individual also noted that he felt a sense of detachment from those who hold a different viewpoint (personal communication, February 2, 2012).
Another individual who consumes welfare services discussed how she has been stigmatized due to her health condition. Particularly, she mentioned that others perceive (stigmatize) her as being a “freak” after noticing her elongated fingernails (personal communication, January 25, 2012). The individual continued to explain that she has a health condition that pertains to nerves manifesting in her fingernails, and she does not have the necessary funding to receive a surgical procedure to address her condition (personal communication, January 25, 2012).

Elderly individuals were also asked questions particular to whether or not they felt that others stigmatized them via questionnaires. Due to being elderly, four individuals indicated that they felt others wrongfully perceived (stigmatized) them as being unable to live independently, unable to properly care for themselves, and unemployable. Furthermore, one elderly individual mentioned that false beliefs held by others (stigmatization) has negatively impacted his ability to attain a job, as he is currently seeking employment (personal communication, March 22, 2012).

Additionally, one elderly individual who has multiple sclerosis discussed how others perceive (stigmatize) her as having a contagious health condition (personal communication, February 17, 2012). She continued to explain that the utilization of assistive devices, such as a cane for mobility, introduced a misperception of having a contagious disease by those who lack knowledge (personal communication, February 17, 2012). Moreover, it was also discovered that the elderly individual despises the idea of wearing her supportive leg brace because it is aesthetically distasteful (an act of self-stigmatization) (personal communication, February 17, 2012).

During a semi-structured interview with an individual who is a member of Narcotics Anonymous (NA), it was found that she strives not to disclose her past issues of addiction to
others until a strong relationship has been formed due to fears of being perceived in a bad light (stigmatized) (personal communication, March 1, 2012). Moreover, a semi-structured interview via telephone with the individual’s mother, a member of Al-Anon, revealed that in the past she (the mother) refused to disclose having a daughter with new acquaintances due to feelings of shame and embarrassment (an act of self-stigmatization) (personal communication, March 2, 2012).

Another semi-structured interview with an individual who is a breast cancer survivor explained the stigmatization that surrounds cancer. She discussed the fear and anxiety that she holds due to the “dooming” label(s) that are attached to the disease (personal communication, February 1, 2012). Continuing, she also noted that she dislikes wearing a compression garment to prevent lymphedema because it “advertises” to others a personal health condition (an act of self-stigmatization) (personal communication, February 1, 2012). She further explained that friends who are cancer survivors also dislike wearing compression garments because of fears that their careers will be terminated (an act of self-stigmatization) (personal communication, February 1, 2012).

In order to address the aforementioned dysfunctional issues introduced by public stigmatization and self-stigmatization, stigmatized individuals are in need of acquiring appropriate coping skills. Particularly, stigmatized individuals are in need of acquiring skills to cope with the discriminatory attitudes and behaviors that they may encounter through their social interactions with others, along with skills to avoid negatively internalizing such discriminatory attitudes and behaviors (Dovidio, et al., 2000). With this mentioned, it has been found that if individuals who are discriminated against negatively internalize such behavior, then he or she may not take steps towards improving their own personal status (Ruggiero & Taylor, 1995).
When providing interventions, occupational therapy practitioners need to consider some of the primary problem areas that are associated with negative internalization, such as grief, role disputes, role transition, and interpersonal deficits (Oswald & Mazefsky, 2006). Moreover, occupational therapy practitioners should focus on helping stigmatized individuals identify the problems associated with the onset of negative internalization, along with identifying interpersonal problems related to negative internalization (Oswald & Mazefsky, 2006).

To help stigmatized individuals protect their self-worth, occupational therapy practitioners should teach them how to make selective comparisons (Shih, 2004). Particularly, it has been found that stigmatized individuals who do not compare themselves to advantaged groups increase their self-efficacy (Shih, 2004). “By changing their standards of comparison, stigmatized individuals are able to ameliorate perceptions of inequity and relative deprivation” (Shih, 2004, p. 179).

Occupational therapy interventions should also include teaching stigmatized individuals how to detach themselves from their stigmatized identity (Shih, 2004). For example, an individual can identify himself or herself by attributes such as, ethnicity, gender, religion, having a stigmatized chronic disease, etc., and those who can detach themselves from their stigmatized attribute can then identify themselves in accordance to their non-stigmatized attributes (Shih, 2004). This acquired skill has been found to help stigmatized individuals’ become more resilient to stress-related illnesses and depression (Shih, 2004).

Additionally, occupational therapy practitioners should encourage stigmatized individuals to increase their interaction with others who share the same stigmatized attribute(s) (i.e., individuals who find themselves being stigmatized due to having HIV/AIDS should join support groups). With this mentioned, stigmatized individuals are “less likely to buy into the negative
messages received from society about their stigmatized identity,” and they are likely to function at a higher level (Shih, 2004, p. 181).

Along with the interventions that aim to help individuals cope with stigmatization, it is also necessary for occupational therapy practitioners to teach such individuals how to become self-advocates (Christensen, personal communication, March 6, 2012). “Self-advocacy involves knowing when and how to approach others in order to negotiate desired accommodations, so as to achieve mutual understanding, fulfillment, and productivity” (Shore, 2004, p. 22). Occupational therapy practitioners should focus on teaching stigmatized individuals about their needs, along with the appropriate amount of disclosure that they provide to others, in their quest to receive any necessary accommodations that may be required in order to successfully perform desired occupations and acquire a desired social role (Shore, 2004).

In order to play an effective role in addressing dysfunctional stigmatic issues, occupational therapy practitioners need to have an understanding of stigmatization. As a means to assess the aforementioned, a mailing list was obtained from the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board on February 10, 2012, and an online questionnaire was emailed to a sample of all occupational therapists listed in the Northwest region of Ohio. A total of 85 occupational therapists responded to the questionnaire over a period of two weeks and the response frequencies were figured (see Appendix B for the response frequencies to all of the items on the questionnaire).

It was found that 83 out of 85 (97.7%) participants feel that it is necessary for occupational therapy practitioners to understand what stigmas are, along with feeling that it is necessary to understand the negative impact(s) that stigmatization can have on a client’s engagement in and performance of daily occupations. It was also found that the majority of the
participating occupational therapists feel that they are knowledgeable about stigmatization. Moreover, 75 out of a total of 82 (91.4%) participants either strongly agree or agree to the item, “I feel that they (stigmas) can introduce barriers towards independent living for clients.” Out of 83 occupational therapists responding to the item, “I feel that they (stigmas) can negatively impact a client’s quest to adopt or successfully fulfill meaningful and purposeful roles,” 78 (94.0%) either strongly agree or agree.

When questioned about practicing in accordance to ethical standards, 50 out of 84 (59.5%) occupational therapists either strongly agree or agree to the item, “I can recall a time when I felt an ungrounded sense of defeat for a client due to their diagnosis;” 34 out of 84 (40.5%) either strongly agree or agree to the item, “I can recall a time when I felt an ungrounded sense of defeat for a client due to their age;” 18 out of 82 (22.0%) either strongly agree or agree to the item, “I can recall a time when I felt an ungrounded sense of disinterest in the provision of occupational therapy services to a client with a known criminal background;” and 19 out of 84 (22.7%) either strongly agree or agree to the item, “I can recall a time when I felt an ungrounded sense of disinterest in the provision of occupational therapy services to a client due to their personal belief(s) or way(s) of living.”

Taking the above findings into consideration, the occupational therapy practitioners’ self-reported knowledge about stigmas and stigmatization is encouraging. Moreover, their self-reported knowledge is supportive of the idea that the profession of occupational therapy can hold a position to address stigmatic issues.

The respondents’ attitudes towards their clients, however, highlight a concern because a risk of stigmatic behaviors is present. As noted by Neuberg et al. (2000), stigmatic behaviors are a manifestation of the more general process of psychological (attitudinal) stigmatization (p. 31).
Occupational therapy practitioners who objectify their clients based upon particular attribute(s) (i.e., diagnosis, age, personal beliefs, etc.) may have a discriminatory (stigmatic) attitude towards them, which in turn, prevents the practitioner from adopting a holistic perspective and providing optimal occupational therapy services.

Identify and Discuss Implications for Occupational Therapy

It is the goal of the AOTA Centennial Vision for the profession of occupational therapy to become more “powerful, widely recognized, science-driven, and evidence-based” (Baum, 2006, p. 10). In order for occupational therapy to become more powerful, the profession needs to become widely recognized by making advances. By becoming more involved in the psychosocial sciences, such as addressing stigmatic issues, occupational therapy practitioners may advance the profession by increasing the areas of practice and research. With this mentioned, the practitioners may further contribute to the growing abundance of scholarly literature that discusses the efficacy of both old and new interventions to address the dysfunctional issues of stigmatization.

It is with the implementation of efficacious interventions that occupational therapy may become more of an evidence-based practice, along with introducing more scientific inquires in order to keep the profession advancing in a more powerful direction.

Occupational therapy practitioners also provide services to a number of different sub-populations, so they need be aware of stigmatization. With an awareness and understanding of stigmatization, occupational therapy practitioners may strengthen the client-practitioner relationship. The primary goal of occupational therapy practitioners is to help individuals live a meaningful and purposeful life through the engagement in everyday occupations, and addressing stigmatic issues may contribute to the goal by supporting the delivery of optimal therapy services.
Advocacy Efforts

Identify Specific Strategies that will be Used to Address this Issue

As a means to advocate the contextual information discussed in this paper, it will be further edited and submitted for publication in the *American Journal of Occupational Therapy* (AJOT). Specifically, this paper will be edited in accordance to the AJOT guidelines of “The Issue Is…” format. During the editing phase, additional formatting options will be taken into consideration (i.e., whether or not it would be more appropriate to submit this paper for publication in accordance to the AJOT guidelines of a Feature-length article). If this paper is not accepted for publication in the AJOT, other routes of advocacy will also be explored, such as submitting it for publication in *OT Practice* or *OT Advance*. Given that the purpose of this paper is to increase awareness of stigmatization, along with advocating an essential role for the profession of occupational therapy to address the dysfunctional issue(s) that are introduced by stigma, the contextual information may also be disseminated at occupational therapy conferences (i.e., Ohio Occupational Therapy Association) for a continuing education seminar.

Additional ways to increase awareness of stigmatization, along with advocating an essential role for the profession of occupational therapy to address stigmatic issues, include the following:

- Creating a blog, forum, or joining an advocacy and leadership group to discuss stigmatic issue(s) via OT Connections. This will allow for open discussion upon stigmatization to take place over the Internet, which has the potential to draw the attention of a larger audience.
- Formally or informally discuss the stigmatic issue(s) with co-workers within the healthcare field, which includes sharing the information with all human service providers
(i.e., not limited to occupational therapy practitioners). This may help promote the delivery of healthcare services that are more client-centered, along with potentially creating a stronger relationship between the interdisciplinary healthcare team.

- Formally discuss the stigmatic issue(s) within the occupational therapy curriculum. This may include advocating that the Accreditation Council for Occupational Therapy Education (ACOTE) incorporate a standardized level of education upon stigma for occupational therapy programs.

**Identify to Whom the Advocacy Efforts Would be Directed**

The primary audience for the information discussed in this paper is individuals within the occupational therapy profession. Particularly, the audience includes occupational therapy practitioners, researchers, educators, students, and advocates.

**IdentifyWhich Level of Government, Business, Professional Organization, etc. You Would Direct Your Efforts Towards**

Refer to section of: *Identify Specific Strategies that will be Used to Address this Issue.*

**Describe the Funding that Would be Necessary to Carry Out These Advocacy Efforts and Identify Which Sources Would be Available**

Funding for the aforementioned advocacy efforts is not necessary; however, stipends provided by the national and/or state occupational therapy associations may help cover any travel and/or boarding costs for disseminating the dysfunctional issue(s) introduced by stigma at occupational therapy conferences.
Conclusions

There is no doubt that stigma introduces dysfunctional issues, which negatively impacts an individual’s occupational performance(s) and impedes his or her acquisition of meaningful and purposeful social role(s). Given the occupational therapy practitioner’s scope of practice, he or she can hold a position to address the stigmatic issues that stigmatized individuals are confronted with. With utilization of a holistic frame of reference, such as the Role Acquisitional frame of reference, occupational therapy practitioners can successfully help stigmatized individuals acquire the necessary skills in order to live a meaningful and purposeful life with the highest level of independence attainable.
References


Appendix A: Draft of “The Issue Is . . .”

The Issue Is…

Increasing Awareness of Stigmatization: Advocating the Role of Occupational Therapy

Ryan A. Domer

The University of Toledo

Key words: Centennial Vision, stigma, role, barrier, issue
The Issue Is… Increasing Awareness of Stigmatization: Advocating the Role of Occupational Therapy

In response to the Surgeon General’s call for approaches to overcome stigmas attached to mental disorders, President George W. Bush launched The New Freedom Commission on Mental Health in 2002 (Pinto-Foltz & Logsdon, 2009). The Commission strives to help individuals with mental disorders lead normal lives similar to individuals without mental disorders (Pinto-Foltz & Logsdon, 2009, p. 32). As the U.S. Surgeon General acknowledges the dysfunctional issues that stigmatization introduces to individuals throughout society, all healthcare professionals should inquire about what stigmas are. This paper will aim to increase the awareness of stigmatization, along with its dysfunctional issues, for occupational therapy practitioners. In addition to increasing awareness, this paper advocates a role for the occupational therapy practitioner to address the negative impacts that stigmatization has on an individual’s ability to live a meaningful and purposeful life.

Stigma

What is stigma? Coined by Erving Goffman, the term stigma describes the situation of an individual who is disqualified from full social acceptance (Goffman, 1963, p. 9). Individuals stigmatize one another (and themselves) based upon their unique attributes (i.e., being an African American, female, homosexual, etc.), which is an attempt to sustain his or her personal perception of desirability. There are two types of stigma: public stigma and self-stigma (Abdullah & Brown, 2011). Public stigma refers to a discriminatory response and self-stigma refers to the internalization of public stigma (Abdullah & Brown, 2011). Self-stigma leads to negative emotional reactions, such as shame, low self-esteem, and diminished self-efficacy.
Each type of stigma interacts with one another, and they exacerbate the occurrence of the negative effects of stigmatization (Abdullah & Brown, 2011).

In today’s society, individuals tend to stigmatize one another based upon erroneous beliefs due to lack of knowledge. With this mentioned, a number of public stigmas are ungrounded and they cause unnecessary distress for stigmatized individuals. For example, Dawn Christensen, Executive Director of The Sight Center of Northwest Ohio and a woman who is visionally-impaired, explained the number of distressing barriers that she had to surpass in order to prove to her physician that she was able to independently care for her newborn child (personal communication, March 6, 2012). The physician was stigmatizing Ms. Christensen. He held an erroneous belief that individuals who are visionally-impaired require assistance throughout their everyday occupational performances.

Danielle Brogley, Director of Programs at Wood County Committee on Aging (WCCOA), provides an additional example of stigmatization based upon erroneous beliefs. She discussed a program that WCCOA offers as a means to give elderly individuals the opportunity to date and form intimate relationships with one another (personal communication, February 17, 2012). Ms. Brogley continued to explain how younger individuals hold an erroneous belief that the elderly sub-population is not interested in dating, or that younger individuals perceive (stigmatize) the idea of elderly individuals dating as being strange (personal communication, February 17, 2012).

The HOPE Community Center located in Adrian, Michigan, is another example of an organization that is tackling the stigma(s) surrounding individuals who have an intellectual disability. The organization frequently hosts workshops that aim to give others insight about such individuals, and it is through the efforts of education that erroneous beliefs (stigmas) about
individuals who have an intellectual disability may be reduced (Whitehouse, personal communication, January 24, 2012).

**What Feeds Stigmatization?**

Generally, society as a whole affects the issue of stigmatization. Within the United States of America, social power is exercised and normative expectations are present (Hayes & Hannold, 2007). Individuals who can not attain a certain level of social power or meet socially normative expectations are not able to effectively function within the mainstream of society, and they soon become stigmatized based upon their attributes that contribute to their social shortcomings. For example, individuals who receive welfare services are commonly misperceived (stigmatized) as not being employed or employable (Toth, personal communication, January 11, 2012).

The media also represents a powerful force in shaping an individual’s beliefs and values. With this mentioned, “research examining newspapers, movies, and television finds a largely consistent picture, indicating that individuals with mental illness are rarely portrayed in a positive light” (Pescosolido, Martin, Lang, & Olafsdottir, 2008, p. 435). The media portrays individuals with a mental illness as dangerous, unpredictable, and incompetent (Pescosolido et al., 2008). It is due to the media that social misperceptions of individuals with a mental illness leads to them being commonly stigmatized.

Aligned with Goffman’s definition of stigma, Hayes and Hannold (2007) note that “the medical model embraces the notion of able-bodiedness and able-mindedness, reducing . . . [an individual] with a disability to a dysfunctional body in need of care” (p. 360). The objectification of individuals with a disability leads to dehumanization, which in turn, leads to stigmatization. The medical model gives way to a focus on what is wrong or abnormal with an individual with a
disability, and his or her characteristics and actions may be seen as threatening or hindering the effective functioning of the social “norm.”

Al Cravin, Associate Professor at Adrian College, also highlights that the use of medical terms, such as *mentally retarded*, are developing a negative connotation and tend to stigmatize individuals with a disability (personal communication, January 24, 2012). Moreover, it is further reasoned that the word, *mentally retarded*, has been wrongfully used throughout society as a synonym for the word, *stupid*, and campaigns exist that support the elimination of the word, *mentally retarded*, in everyday speech (Cravin & Whitehouse personal communication, January 24, 2012).

**Stigma and Occupational Performance**

The American Occupational Therapy Association (AOTA, 2008) defines occupational performance as:

the act of doing and accomplishing a selected activity or occupation that results from the dynamic transaction among the . . . [individual], the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities (p. 672-673).

Aside from personal attributes, occupational performances contribute to an individual’s social identity; they result in an individual’s acquisition of social roles. Roles are “sets of behaviors expected by society, shaped by culture, and . . . further conceptualized and defined by . . . [an individual]” (i.e., parent, student, employee, etc.) (AOTA, 2008, p. 674).

With an understanding that public stigma introduces a sociological barrier (discriminatory attitudes and behaviors) and self-stigma introduces psychological barriers (negative internalization), an individual’s occupational performance(s) are negatively impacted
(Abdullah & Brown, 2011). With a negative impact on occupational performances, an individual’s acquisition or successful fulfillment of social roles is impeded.

**Inquiring About Stigma**

**Individuals Who Consume Welfare Services**

Through the administration of questionnaires, individuals who consume welfare services were asked questions particular to whether or not they felt that others stigmatized them. Due to consuming welfare services, three individuals indicated that they felt others wrongfully perceived (stigmatized) them as being lazy, unemployed (or not seeking employment), addicted to drugs or alcohol, having a criminal background, and unable to live independently due to lack of knowledge or skills.

Additionally, one individual who consumes welfare services indicated that he or she has difficulty in establishing a home due to being avoided by others; two individuals indicated that he or she has difficulty in establishing employment or education due to being avoided by others; and two individuals indicated that he or she can recall a time in the past when feelings of shame or embarrassment prevented him or her from not wanting to consume welfare services (an act of self-stigmatization).

Maintaining a focus on those who consume welfare services, one individual highlighted the stigmas that surround one’s beliefs, values, and spirituality. As an atheist, the individual discussed how others perceived (stigmatized) him as being evil after discovering his perspective on life (personal communication, February 2, 2012). Moreover, the individual also noted that he felt a sense of detachment from those who hold a different viewpoint (personal communication, February 2, 2012).
Another individual who consumes welfare services discussed how she has been stigmatized due to her health condition. Particularly, she mentioned that others perceive (stigmatize) her as being a “freak” after noticing her elongated fingernails (personal communication, January 25, 2012). The individual continued to explain that she has a health condition that pertains to nerves manifesting in her fingernails, and she does not have the necessary funding to receive a surgical procedure to address her condition (personal communication, January 25, 2012).

**Individuals Who Are Elderly**

Elderly individuals were also asked questions particular to whether or not they felt that others stigmatized them via questionnaires. Due to being elderly, four individuals indicated that they felt others wrongfully perceived (stigmatized) them as being unable to live independently, unable to properly care for themselves, and unemployable. Furthermore, one elderly individual mentioned that false beliefs held by others (stigmatization) has negatively impacted his ability to attain a job, as he is currently seeking employment (personal communication, March 22, 2012).

Another elderly individual who has multiple sclerosis discussed how others perceive (stigmatize) her as having a contagious health condition (personal communication, February 17, 2012). She continued to explain that the utilization of assistive devices, such as a cane for mobility, introduced a misperception of having a contagious disease by those who lack knowledge (personal communication, February 17, 2012). Moreover, it was also discovered that the elderly individual despises the idea of wearing her supportive leg brace because it is aesthetically distasteful (an act of self-stigmatization) (personal communication, February 17, 2012).

**Individuals and Substance Use Disorder**
During a semi-structured interview with an individual who is a member of Narcotics Anonymous (NA), it was found that she strives not to disclose her past issues of addiction to others until a strong relationship has been formed due to fears of being perceived in a bad light (stigmatized) (personal communication, March 1, 2012). Moreover, a semi-structured interview via telephone with the individual’s mother, a member of Al-Anon, revealed that in the past she (the mother) refused to disclose having a daughter with new acquaintances due to feelings of shame and embarrassment (an act of self-stigmatization) (personal communication, March 2, 2012).

**Individuals Who Are Cancer Survivors**

Another semi-structured interview with an individual who is a breast cancer survivor explained the stigmatization that surrounds cancer. The individual discussed the fear and anxiety that she holds due to the “dooming” label(s) that are attached to the disease (personal communication, February 1, 2012). Continuing, she also noted that she dislikes wearing a compression garment to prevent lymphedema because it “advertises” to others a personal health condition (an act of self-stigmatization) (personal communication, February 1, 2012). She further explained that friends who are cancer survivors also dislike wearing compression garments because of fears that their careers will be terminated (an act of self-stigmatization) (personal communication, February 1, 2012).

**Individuals Who Have Autism**

During a lecture on the topic of autism with Temple Grandin, Ph.D., a group discussion was held about the types of behaviors that tend to ostracize individuals who have autism (personal communication, January 26, 2012). It was further discussed that others misperceive (stigmatize) such individuals as not having the ability to acquire appropriate social skills, which
in turn, limits their opportunities throughout life (i.e., education, work, etc.) (personal communication, January 26, 2012).

**The Occupational Therapy Practitioner**

In order to play an effective role in addressing dysfunctional stigmatic issues, occupational therapy practitioners need to have an understanding of stigmatization. As a means to assess the aforementioned, a mailing list was obtained from the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board on February 10, 2012, and an online questionnaire was emailed to a sample of all occupational therapists listed in the Northwest region of Ohio. A total of 85 occupational therapists responded to the questionnaire over a period of two weeks and the response frequencies were figured.

It was found that 83 out of 85 (97.7%) participants feel that it is necessary for occupational therapy practitioners to understand what stigmas are, along with feeling that it is necessary to understand the negative impact(s) that stigmatization can have on a client’s engagement in and performance of daily occupations. It was also found that the majority of the participating occupational therapists feel that they are knowledgeable about stigmatization. Moreover, 75 out of a total of 82 (91.4%) participants either strongly agree or agree to the item, “I feel that they (stigmas) can introduce barriers towards independent living for clients.” Out of 83 occupational therapists responding to the item, “I feel that they (stigmas) can negatively impact a client’s quest to adopt or successfully fulfill meaningful and purposeful roles,” 78 (94.0%) either strongly agree or agree.

When questioned about practicing in accordance to ethical standards, 50 out of 84 (59.5%) occupational therapists either strongly agree or agree to the item, “I can recall a time when I felt an ungrounded sense of defeat for a client due to their diagnosis;” 34 out of 84
(40.5%) either strongly agree or agree to the item, “I can recall a time when I felt an ungrounded sense of defeat for a client due to their age;” 18 out of 82 (22.0%) either strongly agree or agree to the item, “I can recall a time when I felt an ungrounded sense of disinterest in the provision of occupational therapy services to a client with a known criminal background;” and 19 out of 84 (22.7%) either strongly agree or agree to the item, “I can recall a time when I felt an ungrounded sense of disinterest in the provision of occupational therapy services to a client due to their personal belief(s) or way(s) of living.”

Taking the above findings into consideration, the occupational therapy practitioners’ self-reported knowledge about stigmas and stigmatization is encouraging. Moreover, their self-reported knowledge is supportive of the idea that the profession of occupational therapy can hold a position to address stigmatic issues. The respondents’ attitudes towards their clients, however, highlight a concern because a risk of stigmatic behaviors is present. Noted by Neuberg, Smith, & Asher (2000), stigmatic behaviors are a manifestation of the more general process of psychological (attitudinal) stigmatization (p. 31). Occupational therapy practitioners who objectify their clients based upon particular attribute(s) (i.e., diagnosis, age, personal beliefs, etc.) may have a discriminatory (stigmatic) attitude towards them, which in turn, prevents the practitioner from adopting a holistic perspective and providing optimal occupational therapy services.

**Role Acquisitional Frame of Reference**

Occupational therapy practitioners are encouraged to use Anne Mosey’s Role Acquisitional frame of reference; however, with an understanding that the frame of reference aims to teach individuals skills in order to participate in required and/or desired social roles, all scholarly literature that pertains to the acquisition of skills and social roles may be relevant to
addressing the psychosocial barriers that are introduced by stigmatization (Nelson, personal communication, April 21, 2012). Again, stigmatization has been found to negatively impact an individual’s occupational performance(s) and impede his or her acquisition of meaningful and purposeful social role(s). Any efficacious research that documents successful interventions in the acquisition of skills and social roles may be of interest to the occupational therapy practitioner.

Theoretically, the Role Acquisitional frame of reference is grounded on five parts: the nature of the individual of interest, learning needs, processes of learning, typical and atypical development, and the performance of purposeful occupations (Mosey, 1986). With the frame of reference being primarily grounded on learning mechanisms in order for an individual to acquire the necessary skills to function in his or her social environment, barriers towards the acquisition of such skills are acknowledged (Mosey, 1986). With an understanding that stigmatization introduces both sociological and psychological barriers that impede an individual’s acquisition of social role(s), the Role Acquisitional frame of reference’s sociological and psychological perspective can help stigmatized individuals learn ways to surpass such barriers (Mosey, 1986).

The frame of reference has been designed to specifically guide the practice of occupational therapy by “linking learning theories, the reality aspect of purposeful activities [occupations], and the process of acquiring specific skills needed for successful interaction in the environment” (Mosey, 1986, p. 443). The Role Acquisitional frame of reference is an appropriate tool to guide interventions for individuals who have not learned how to participate in required social roles or who wish to participate in desired roles more effectively (Mosey, 1986, p. 450). It is also applicable for individuals who are experiencing difficulty with role transitions or those who must learn how to participate in their social roles in a different manner (Mosey, 1986, p. 450).
Occupational Therapy Interventions

Generally, the Role Acquisitional frame of reference provides a psychosocial lens to examine the acquisition of social roles, and researchers who study stigmatization also utilize this type of lens. For example, Biernat and Dovidio explain that the cognitive and affective processes of stigmatization are a function of discriminatory attitudes, and such attitudes are “less solid” towards individuals who acquire a wide variety of social roles. Utilizing Anne Mosey’s Role Acquisitional frame of reference, the occupational therapy practitioner can formulate evaluative questions and identify areas for observation to hone in on the impacts that stigmatization has on a client’s acquisition of social roles. After the necessary information has been gained through questioning and observation, the practitioner can then identify any dysfunctional behaviors by resorting to the outlined categorical continuums, such as that of interpersonal skills. When addressing any dysfunctional behaviors that are introduced by stigmatization, the outlined postulates regarding change can help guide the therapeutic process.

Particularly, stigmatized individuals are in need of acquiring skills to cope with the discriminatory attitudes and behaviors that they may encounter through their social interactions with others, along with skills to avoid negatively internalizing such discriminatory attitudes and behaviors. With this mentioned, it has been found that if individuals who are discriminated against negatively internalize such behavior, then he or she may not take steps towards improving their own personal status (Ruggiero & Taylor, 1995).

When providing interventions, occupational therapy practitioners need to consider some of the primary problem areas that are associated with negative internalization, such as grief, role disputes, role transition, and interpersonal deficits (Oswald & Mazefsky, 2006). Moreover, occupational therapy practitioners should focus on helping stigmatized individuals identify the
problems associated with the onset of negative internalization, along with identifying interpersonal problems related to negative internalization (Oswald & Mazefsky, 2006).

To help stigmatized individuals protect their self-worth, occupational therapy practitioners should teach them how to make selective comparisons (Shih, 2004). Particularly, it has been found that stigmatized individuals who do not compare themselves to advantaged groups increase their self-efficacy (Shih, 2004). “By changing their standards of comparison, stigmatized individuals are able to ameliorate perceptions of inequity and relative deprivation” (Shih, 2004, p. 179).

Occupational therapy interventions should also include teaching stigmatized individuals how to detach themselves from their stigmatized identity (Shih, 2004). For example, an individual can identify himself or herself by attributes such as, ethnicity, gender, religion, having a stigmatized chronic disease, etc., and those who can detach himself or herself from their stigmatized attribute can identify himself or herself in accordance to their non-stigmatized attributes (Shih, 2004). This acquired skill has been found to help stigmatized individuals become more resilient to stress-related illnesses and depression (Shih, 2004).

Additionally, occupational therapy practitioners should encourage stigmatized individuals to increase their interaction with others who share the same stigmatized attribute(s) (i.e., individuals who find themselves being stigmatized due to having HIV/AIDS should join support groups). With this mentioned, stigmatized individuals are “less likely to buy into the negative messages received from society about their stigmatized identity,” and they are likely to function at a higher level (Shih, 2004, p. 181). Occupational therapy practitioners should also encourage stigmatized individuals to develop a close relationship between other family members, as it can
contribute to resilience to adversity (Shih, 2004). This is particularly important for stigmatized children due to their immature insecurities.

Along with the interventions that aim to help individuals cope with stigmatization, it is also necessary for occupational therapy practitioners to teach such individuals how to become self-advocates (Christensen, personal communication, March 6, 2012). “Self-advocacy involves knowing when and how to approach others in order to negotiate desired accommodations, so as to achieve mutual understanding, fulfillment, and productivity” (Shore, 2004, p. 22).

Occupational therapy practitioners should focus on teaching stigmatized individuals about his or her needs, along with the appropriate amount of disclosure that he or she provides to others, in their quest to receive any necessary accommodations that may be required in order to successfully perform desired occupations and acquire a desired social role (Shore, 2004).

**Implications for the Profession of Occupational Therapy Addressing Stigma**

It is the goal of the AOTA Centennial Vision for the profession of occupational therapy to become more “powerful, widely recognized, science-driven, and evidence-based” (Baum, 2006, p. 10). In order for occupational therapy to become more powerful, the profession needs to become widely recognized by making advances. By becoming more involved in the psychosocial sciences, such as addressing stigmatic issues, occupational therapy practitioners may advance the profession by increasing the areas of practice and research. With this mentioned, the practitioners may further contribute to the growing abundance of scholarly literature that discusses the efficacy of both old and new interventions to address the dysfunctional issues of stigmatization. It is with the implementation of efficacious interventions that occupational therapy may become more of an evidence-based practice, along with introducing more scientific inquiries in order to keep the profession advancing in a more powerful direction.
Occupational therapy practitioners also provide services to a number of different sub-populations, so they need be aware of stigmatization. With an awareness and understanding of stigmatization, occupational therapy practitioners may strengthen the client-practitioner relationship. The primary goal of occupational therapy practitioners is to help individuals live a meaningful and purposeful life through the engagement in everyday occupations, and addressing stigmatic issues may contribute to the goal by supporting the delivery of optimal therapy services.
References


Appendix B:
Stigma: Occupational Therapy Questionnaire and Response Frequencies

Dear Respondent,

Coined by Erving Goffman, the term stigma describes the situation of the individual who is disqualified from full social acceptance (Goffman, 1963, p. 9). “The need to challenge stigma, in relation to HIV or mental illness or issues of disability, is a recurring theme in the pronouncements of the leading organizations of the medical profession” (Fitzpatrick, 2008, p. 294). Stigmas introduce barriers that prevent people from either seeking or receiving optimal healthcare services.

The purpose of this needs assessment is to gain insight into the barriers that stigmas introduce to those who receive occupational therapy services. With this mentioned, it is thought that the philosophy behind the practice of occupational therapy can introduce an important role in managing the negative impacts of stigmatization. As an occupational therapy practitioner, your responses to this survey are important due to your professional experiences; your responses are confidential.

Please, answer the following questions that pertain to your knowledge of stigmas/stigmatization

- I feel that I have a good understanding of what stigmas are. n = 85
  
  Strongly Agree.........40 (47.1%)
  Agree..................43 (50.6%)
  Unsure..................2 (2.4%)
  Disagree...............1 (1.2%)
  Strongly Disagree.....0 (0.0%)

- I feel that it is necessary for occupational therapy practitioners to understand what stigmas are and the negative impact(s) that they can have on a client’s engagement in and performance of daily occupation(s). n = 85
  
  Strongly Agree.........52 (61.2%)
  Agree..................31 (36.5%)
  Unsure..................2 (2.4%)
  Disagree...............0 (0.0%)
  Strongly Disagree.....0 (0.0%)
• I feel that I am knowledgeable about the negative impact(s) that stigmas may have upon a client’s engagement in and performance of daily occupation(s).  \( n = 85 \)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>24</td>
<td>28.2%</td>
</tr>
<tr>
<td>Agree</td>
<td>55</td>
<td>64.7%</td>
</tr>
<tr>
<td>Unsure</td>
<td>6</td>
<td>7.1%</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

• I feel that I am knowledgeable about the importance and the use of person-first language as a means to avoid ‘labeling’ a client due to their health condition (i.e., physical disability, mental disorder, etc.).  \( n = 85 \)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>55</td>
<td>64.7%</td>
</tr>
<tr>
<td>Agree</td>
<td>29</td>
<td>34.1%</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

• I feel that I am knowledgeable about the many terms that can be perceived as being derogatory by a client.  \( n = 85 \)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>25</td>
<td>29.4%</td>
</tr>
<tr>
<td>Agree</td>
<td>51</td>
<td>60.0%</td>
</tr>
<tr>
<td>Unsure</td>
<td>9</td>
<td>10.6%</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Please, answer the following questions that pertain to stigmas and occupation

• With my understanding of stigmas, I feel that they can introduce barriers towards independent living for clients.  \( n = 82 \)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>28</td>
<td>34.1%</td>
</tr>
<tr>
<td>Agree</td>
<td>47</td>
<td>57.3%</td>
</tr>
<tr>
<td>Unsure</td>
<td>7</td>
<td>8.5%</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
With my understanding of stigmas, I feel that they can have a negative impact on the family members of a client (or any other person who is closely associated with a client). n = 84

- Strongly Agree: 38 (45.2%)
- Agree: 44 (52.4%)
- Unsure: 0 (0.0%)
- Disagree: 2 (2.4%)
- Strongly Disagree: 0 (0.0%)

With my understanding of stigmas, I feel that they can negatively impact a client’s quest to adopt or successfully fulfill meaningful and purposeful roles. n = 83

- Strongly Agree: 36 (43.4%)
- Agree: 42 (50.6%)
- Unsure: 3 (3.6%)
- Disagree: 3 (3.6%)
- Strongly Disagree: 0 (0.0%)

With my understanding of stigmas, I feel that they can negatively impact all eight areas of occupation as outlined in the Occupational Therapy Practice Framework (i.e., ADL, IADL, rest and sleep, education, work, play, leisure, and social participation). n = 83

- Strongly Agree: 25 (30.1%)
- Agree: 46 (55.4%)
- Unsure: 7 (8.4%)
- Disagree: 5 (6.0%)
- Strongly Disagree: 0 (0.0%)

Please, specify (if any) which areas of occupation you feel may be negatively impacted by stigmas (check all that apply): n = 83

- ADL: 49 (59.0%)
- IADL: 59 (71.1%)
- Rest and Sleep: 47 (56.6%)
- Education: 74 (89.2%)
- Work: 81 (97.6%)
- Play: 64 (77.1%)
- Leisure: 67 (80.7%)
- Social Participation: 80 (96.4%)
With my understanding of stigmas, I feel that the profession of occupational therapy can play a major role in addressing any negative impact(s) that stigmas may have on a client. n = 84

Strongly Agree.......27 (32.1%)
Agree..................46 (54.8%)
Unsure...............11 (13.1%)
Disagree..............0 (0.0%)
Strongly Disagree....0 (0.0%)

Please, answer the following questions that pertain to stigmas and the practice of occupational therapy

Practicing in accordance to ethical standards, I find myself making a strong effort to use person-first language when communicating with others as a means to avoid ‘labeling’ a client due to their health condition (i.e., physical disability, mental disorder, etc.). n = 84

Strongly Agree.........50 (59.5%)
Agree....................32 (38.1%)
Unsure..................1 (1.2%)
Disagree................1 (1.2%)
Strongly Disagree.....0 (0.0%)

Practicing in accordance to ethical standards, I can recall a time when I felt an ungrounded sense of defeat for a client due to their diagnosis (i.e., physical disability, mental disorder, etc.). n = 84

Strongly Agree.........9 (10.7%)
Agree...................41 (48.8%)
Unsure..................23 (27.4%)
Disagree...............11 (13.1%)
Strongly Disagree.....1 (1.2%)

Practicing in accordance to ethical standards, I can recall a time when I felt an ungrounded sense of defeat for a client due to their age. n = 84

Strongly Agree.........5 (6.0%)
Agree...................29 (34.5%)
Unsure..................15 (17.9%)
Disagree...............30 (35.7%)
Strongly Disagree.....6 (7.1%)
• Practicing in accordance to ethical standards, I can recall a time when I felt an ungrounded sense of disinterest in the provision of occupational therapy services to a client with a known criminal background. \( n = 82 \)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>3</td>
<td>3.7%</td>
</tr>
<tr>
<td>Agree</td>
<td>15</td>
<td>18.3%</td>
</tr>
<tr>
<td>Unsure</td>
<td>20</td>
<td>24.4%</td>
</tr>
<tr>
<td>Disagree</td>
<td>39</td>
<td>47.6%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>7</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

• Practicing in accordance to ethical standards, I can recall a time when I felt an ungrounded sense of disinterest in the provision of occupational therapy services to a client due to their personal belief(s) or way(s) of living. \( n = 84 \)

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
<td>4.8%</td>
</tr>
<tr>
<td>Agree</td>
<td>15</td>
<td>17.9%</td>
</tr>
<tr>
<td>Unsure</td>
<td>12</td>
<td>14.3%</td>
</tr>
<tr>
<td>Disagree</td>
<td>45</td>
<td>53.6%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>8</td>
<td>9.5%</td>
</tr>
</tbody>
</table>
Appendix C: Annotated Bibliography

Literature About Stigmatization


Abstract. The current literature on the problem of mental illness stigma in the United States must be expanded to better account for the role of culture. This article examines the relationship between mental illness stigma and culture for Americans of American Indian, Asian, African, Latino, Middle Eastern, and European descent. In this review, culture refers to the shared beliefs, values, and norms of a given racial or ethnic group. The reviewed literature indicates that there are differences in stigma among the various cultural groups; however, explanations as to why these differences exist are scant. Qualitative and quantitative studies indicate that cultural values are important with regard to stigma, particularly for Asia Americans and African Americans. Less is known about the interaction between cultural values and mental illness stigma for other cultural groups. Continued research in the area requires better organization and more exploration of the role of cultural history and values as they relate to mental illness stigma. To that end, a detailed, systematic approach to future research in the area is proposed.

Summary and Significance. This source is helpful because it distinguishes between two types of stigmatization: public stigma and self-stigma. Public stigma refers to a discriminatory response and self-stigma refers to the internalization of public stigma. Self-stigma leads to negative emotional reactions, such as shame, low self-esteem, and diminished self-efficacy. It discusses that each type of stigma interacts with one another, and they exacerbate the occurrence
of the negative effects of stigmatization. This source can simply help illustrate why stigmatization is a psychosocial phenomenon that needs to be addressed in order to promote well-being for all individuals throughout society.


**Abstract.** Background: This cross-sectional study is aimed at describing and investigating empowerment and its relationships with level of engagement in daily activities and community life, experienced stigma, psychopathology, and quality of life among people with mental illness entering supported employment.

**Method:** The following scales were administered to 120 persons: Empowerment Scale, Profiles of Occupational Engagement Scale, Manchester Short Assessment of Quality of Life Scale, Rejection Experience Scale, and Brief Psychiatric and Rating Scale.

**Results:** Higher scores of empowerment were associated with fewer symptoms and experienced stigma, a higher level of engagement in daily activities and community life, better quality of life and having work rehabilitation. Self-efficacy and self-esteem were in particular significantly correlated to depressive symptoms. Descriptive statistics enveloped the group of participants that said ‘Yes I want to work’ with a somewhat high mean score for empowerment, level of engagement, and quality of life, but a low mean score with regard to both symptoms and experienced stigma.

**Conclusions:** This study advocates the importance of evaluating empowerment in supported employment research and practice. The findings suggest the importance of taking into account
not only monetary aspects of having a job but also social and psychological aspects such as empowerment, reduction in experienced stigma, and community integration.

**Summary and Significance.** This article discusses the importance of occupational engagement/performance in addressing the symptoms of mental disorders. Increasing occupational engagement (i.e., time spent performing daily activities) has been found to decrease the symptoms that occur with mental disorders. Additionally, it has been found that increasing occupational engagement in terms of empowerment moderates stigmatization. The study discussed in this article simply implies a supportive role for the profession of occupational therapy, given its conceptual groundings. This source is helpful because it highlights ways in which to reduce the dysfunctional issues that stigmatization introduces. Teaching stigmatized individuals means to empower themselves can increase their occupational performances. Moreover, it supports the idea that profession of occupational therapy can play a role in addressing the dysfunctional issues that are introduced by stigmatization.


**Abstract.** This paper is a report of an integrative review to explore the way in which disability has been considered in the multidisciplinary health and nursing literature. In the multidisciplinary health and nursing literature, two ways are presented in which disability can be understood: the traditional, functional perspective and a more contemporary, social perspective. Computerized databases of the CINAHL, Proquest Nursing and Allied Health Sources, EBSCO and Evidence Based Medicine Reviews Multifile and Cochrane databases were conducted for
papers published in English in the period 1963–2007 using the keywords ‘models of disability’, ‘disability and nursing research’ and ‘theories of disability’. An integrative review was performed and, of the 11,578 papers identified, 65 were included. The concept of functional disability refers to an individual who is physically ‘disabled’ and unable to perform expected roles. The concepts of social stigmatization and normalcy are associated with functional disability. In contrast, social disability concerns functional limitations within an individual’s experience of living with disability, examining how socially constructed barriers actually ‘disable’ people. Conventionally, disability research has been conducted from an etic perspective. Researchers contend that a shift towards an understanding from the emic perspective is needed for disability research to be emancipatory. Adoption of a social perspective is necessary to inform an understanding of disability that addresses stigmatization and oppression. Research-informed nursing practice, complemented by supportive health and social policies, could transform the experience of living with disability.

**Summary and Significance.** This article addresses that ‘disability’ is due to environmental barriers. Moreover, it explains that the stigma behind the word ‘disability’ persists from society’s focus on functional ‘disability’, which arises from a comparison to what is ‘normal’. In other words, society simply tends to focus on an individual instead of the social environment. With the above mentioned, this source is helpful because the discussion that takes place is supportive of a role for an occupational therapist in the area of social stigmas; an occupational therapist takes environmental factors into consideration when managing a client’s health condition. It also highlights the importance of gaining insight upon stigmatization for the occupational therapy practitioner, as he or she provides services to individuals who have a disability (a commonly stigmatized sub-population).

Abstract (Introduction). A man walks into a bar. He gets into a conversation with a friendly group of people he soon realizes are non-smokers. Indeed, they come to this bar because it has an unofficial smoking ban, a fact he discovers when his companions make a big deal of glowering in the direction of a neighboring table where a couple has lit up. This is a problem for our man, because he smokes two packs day and needs a cigarette now. With a flush of shame, he faces the gap between the good person he thinks himself to be and the loser his companions would see were he to expose his addiction. He pleads another appointment and heads out to the street to light up. Has this man experienced stigma? Would it be a good thing if he has? And, if so, is it ethical for public health agencies to actively promote the stigma of being a smoker? In his article in this Special Issue, “Stigma and the ethics of public health: not can we but should we”, Ronald Bayer argues that the answers are yes, yes and, under some circumstances, yes (Bayer, 2008). I believe he is wrong on every count. In building an argument around the idea that stigma is a matter of degree, he misses what makes stigma so bad – the core of the ethical question – but also why stigmatizing even clearly harmful health behavior is a losing public health practice – the key issue of policy.

Summary and Significance. The author of this article reinforces the concept of stigma introduced by Goffman, as he concludes that the mechanisms that lie behind stigma are harmful, primitive, and emotionally destructive (p. 475). Particularly, it is stated: “people who inflict shame are very often not expressing virtuous motives or high ideals, but rather a shrinking from their own human weakness and a rage against the very limits of human life” (p. 475). It is also
stated: “those with a ‘constantly precarious’ identity, self-discrimination, concealment, withdrawal and other forms of stigma management become a routine; their own actions may, in fact, subject them to a much greater distress than any behavior of normals (Link & Phelan, 2011; Scambler, 1989)” (p. 574). The discussion that takes place throughout the article simply supports a need to address stigma. This source is helpful because it highlights the dysfunctional issues that stigmatization introduces. It highlights the reality of public stigma and self-stigma, along with the ethical dilemma that healthcare practitioners need to consider. While the occupational therapy practitioner promotes health and well-being, it is important to consider the client’s personal choices in order to provide client-centered occupational therapy interventions (aside from what the practitioner deems appropriate).


**Abstract.** Persons growing up with chronic illness or physical disability face critical and often stigmatizing physical, psychological, and social challenges that persist into adulthood and result in their experiencing themselves as different from others. The communication surrounding those with chronic health conditions has a major impact on this experience of difference and on holistic health and well-being. A grounded theory analysis of eight autobiographical narratives of persons with chronic conditions revealed four themes characterizing the experience of difference in reference to the communication that surrounded it, and demonstrated that their authors, in and through their communication, were active agents in reconstructing and redefining their own and others’ understandings of different selves. A grounded theory of shifting reconstructions of different self emerged from this analysis.
Summary and Significance. This source is helpful because it provides evidence that healthcare providers are in need of consistent education and training that sensitizes them to respectful, supportive, affirming communication with their patients (a means to avoid dysfunctional stigmatic issues when providing therapeutic interventions). It also addresses the importance and the value behind seeking out and listening well to patients’ illness narratives. With this mentioned, an occupational therapist’s holistic approach to practice presents a supportive role in fulfilling such need(s).


Abstract. Stigma can greatly exacerbate the experience of mental illness. Diagnostic classification frequently used by clinical social workers may intensify this stigma by enhancing the public's sense of “groupness” and “differentness” when perceiving people with mental illness. The homogeneity assumed by stereotypes may lead mental health professionals and the public to view individuals in terms of their diagnostic labels. The stability of stereotypes may exacerbate notions that people with mental illness do not recover. Several strategies may diminish the unintended effects of diagnosis. Dimensional approaches to diagnosis may not augment stigma in the same manner as classification. Moreover, regular interaction with people with mental illness and focusing on recovery may diminish the stigmatizing effects of diagnosis.

Summary and Significance. This source is helpful because it discusses the impact that the medical model has upon individuals in terms of stigmatization. It further discusses the need to adopt a more social based model in order to reduce the negative effects of labeling individuals.
by their disorder/disability. This source continues to identify ways in which to address the
dysfunctional issues of stigmatization may be addressed (i.e., coping and empowerment).


In T. Heatherton, R. Kelck, M. Hebl, & J. Hull (Eds.), The social psychology of


Abstract (Introduction). No abstract or introduction.

Summary and Significance. The author of this chapter discusses ways in which
people justify their stigmatizing thoughts and behaviors; it is due to “moral, ethical, legal, social,
natural, and logical” justification that individuals continue to reject, avoid, and inferiorly treat
others despite their attempts to actively avoid thoughts and behaviors of stigmatization (p. 126).
Crandall also reinforces the idea that socially, every individual experiences “the alienation,
rejection, exclusion, embarrassment, and feeling of separateness that come from being different,
devalued, and demeaned” (everyone experiences stigmatization) (p. 126). The discussion that
takes place in this chapter expresses the reality that stigmatization is a social function that may
not be completely eradicated; however, the negative consequences of stigmatization need to be
acknowledged and addressed. “Suppression of stigmatization is costly. It requires energy, it
requires cognitive vigilance, and it creates emotional ambivalence and anxiety. The effects of
suppression point to the clear value of a justification ideology: it can reduce ambivalence and
anxiety, it relieves tension, and it may thus create a pleasant affect state” (p. 142). This source is
helpful because highlights the dysfunctional issues that stigmatization introduces. It can illustrate
a clear picture of the sociological and psychological mechanisms of stigmatization for the reader,
which can lead to a deep understanding of how easy it is to stigmatize others, along with stigmatizing himself or herself, due to the nature of mankind.


**Abstract.** No Abstract

**Summary and Significance.** This source is helpful because it discusses “the need to challenge stigma, in relation to HIV or mental illness or issues of disability . . .” (294). It continues to discuss the shifting trends of stigmatized populations, along with anti-stigmatic processes/phenomenon that have helped weaken social barriers that stigmas introduce for such populations (or even detach stigmas from populations). The author also notes that the medical profession plays a “leading role in promoting stigma where it continues to sanction discrimination and social exclusion” (294).


**Abstract (Introduction- Back Flap).** Stigma is an illuminating excursion into the situation of persons who are unable to conform to standards that society calls normal. Disqualified from full social acceptance, they are stigmatized individuals. Physically deformed people, ex-mental patients, drug addicts, prostitutes, or those ostracized for other reasons must constantly strive to adjust to their precarious social identities. Their image of themselves must daily confront and be affronted by the image, which others reflect back to them.

Drawing extensively on autobiographies and case studies, sociologist Erving Goffman analyzes the stigmatized person’s feelings about himself and his relationship to “normals.” He
explores the variety of strategies stigmatized individuals employ to deal with the rejection of others, and the complex sorts of information about themselves they project. In *Stigma* the interplay of alternatives the stigmatized individual must face every day is brilliantly examined by one of America’s leading social analysts.

Erving Goffman (1922-1983) was professor of sociology at the University of California at Berkeley and the University of Pennsylvania. Of his many books on social interaction, the best known is *The Presentation of Self in Everyday Life*.

**Summary and Significance.** This source is helpful because it can be utilized as a primary source that details the issue at hand (stigmatization). It discusses the negative social and psychological impacts of both public stigmatization and self-stigmatization; it includes key concepts that center on stigmatization. Additionally, to help describe the negative impacts of stigmatization, Erving Goffman includes a number of autobiographical workings produced by stigmatized persons. This source simply provides a conceptual framework that introduces and describes the mechanisms of stigmatization.


**Abstract.** A reconceptualization of stigma is presented that changes the emphasis from the devaluation of an individual's identity to the process by which individuals who satisfy certain criteria come to be excluded from various kinds of social interactions. The authors propose that phenomena currently placed under the general rubric of stigma involve a set of distinct psychological systems designed by natural selection to solve specific problems associated with sociality. In particular, the authors suggest that human beings possess cognitive adaptations
designed to cause them to avoid poor social exchange partners, join cooperative groups (for purposes of between-group competition and exploitation), and avoid contact with those who are differentially likely to carry communicable pathogens. The evolutionary view contributes to the current conceptualization of stigma by providing an account of the ultimate function of stigmatization and helping to explain its consensual nature.

**Summary and Significance.** This source is helpful because it supports the idea that stigmatization serves both as a functional and dysfunctional social phenomenon. The authors further note that “historians, anthropologists, and political scientists tend to agree that social exclusion [stigmatization] is characteristic of human cultures around the world and throughout recorded history,” which highlights the idea that stigmatization may never be completely eradicated in society (p. 191).

**Lewis, S., Thomas, S., Blood, R., Castle, D., Hyde, J., & Komesaroff, P. (2011). How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A qualitative study. Social Science & Medicine, 73, 1349-1356.**

**Abstract.** Obesity stigma exists within many institutions and cultural settings. Most studies suggest that stigmatizing experiences have a negative impact on individuals’ health and social behaviors and outcomes. However, some studies indicate that obesity stigma can motivate individuals to lose weight. Limited research has examined weight-based stigma from the perspective of obese individuals, including their perceptions of, and responses to, the different types of weight-based stigma they face in their daily lives. This study advances knowledge about weight-based stigma by documenting how obese adults (mostly female) described the different
types of obesity stigma that they faced, how they responded to this stigma, and how different types of stigma impact on health and social wellbeing. Semi-structured, qualitative interviews were conducted between April 2008 and March 2009 with a diverse sample of 141 obese Australian adults. Guided by Link and Phelan’s (2006) categorization of different types of discrimination, participants’ experiences could be grouped into three distinct types of stigma: 1) Direct (e.g. being abused when using public transport); 2) Environmental (e.g. not being able to fit into seats on planes); and 3) Indirect (e.g. people staring at the contents of their supermarket trolley). Participants described that more subtle forms of stigma had the most impact on their health and social wellbeing. However, it was the interaction between direct, environmental and indirect stigma that created a barrier to participation in health-promoting activities. Participants rarely challenged stigma and often blamed themselves for stigmatizing experiences. They also avoided situations where they perceived they would be stigmatized and constantly thought about how they could find a solution to their obesity.

**Summary and Significance.** This source is helpful because it discusses the stigma(s) that surround the sub-population of individuals who are obese. It also highlights the ethical dilemma that healthcare professionals encounter when taking stigmatization into consideration. This is important because occupational therapy practitioners who do not address issues of stigmatization may actually be promoting health and well-being for their clients (a functional mechanism); however, due to the negative internalization that stigmatization introduces to clients (a dysfunctional mechanism), the occupational therapy practitioner may be obligated to address stigmatic issues.

58(549), 294.

Abstract (Introduction). Nearly a century and a half after the destruction of the institution of slavery, and a half-century past the dawn of the civil rights movement, social life in the United States continues to be characterized by significant racial stratification. Numerous indices of well-being—wages, unemployment rates, income and wealth levels, ability test scores, prison enrollment and crime victimization rates, health and mortality statistics—all reveal substantial racial disparities. . . . So we have a problem; it will be with us for a while; and it behooves us to think hard about what can and should be done (Loury took these opening words from his previous work in The Anatomy of Racial Inequality, pp. 3-4).

Summary and Significance. Although this article focuses on the consequences of racial stigma, it is helpful because it highlights a thought that African Americans cannot realize their full human potential (p. 1). With this mentioned, it can be further implied that African Americans may have difficulties in achieving desired roles, as roles are defined by human characteristics and behaviors. The article also discusses cyclical processes (based upon thoughts and behaviors) that likely maintain stigmas. “. . . Access to developmental resources is mediated through race-segregated social networks, an individual’s opportunities to acquire skills depend on present and past skill attainments by others in the same racial group” (p. 5). The aforementioned words simply support a role for the profession of occupational therapy to address the issues of stigmatization, along with supporting the use of Anne Mosey’s Role Acquisitional frame of reference to guide therapeutic interventions that help stigmatized individuals acquire the necessary skills to surpass stigmatic barriers.

Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and
school staff among adolescents with mental health disorders. *Social Science and Medicine, 70*, 985-993.

**Abstract.** Stigma directed at adolescents diagnosed with emotional and behavioral disorders by individuals in their interpersonal network likely undermines their wellbeing, yet little is known about their subjective stigma experiences. In particular, the prospect of diagnosed youth experiencing prejudice and discrimination by family members has not previously been examined. This study examines adolescents’ perceptions of being treated ‘differently’ because of mental health problems by family members, peers, and school staff. Qualitative analysis of narratives from mixed method interviews with 56 adolescents in a mid-western US city demonstrated variation in the perceived extent and nature of stigma and in contextual factors perceived as promoting or protecting from stigmatization, depending on the interpersonal domain. The greatest number of participants experienced stigmatization in relationships with peers (62%); this often led to friendship losses and transitions. Participants reporting no peer stigmatization often reported socializing with others “in the same boat” or concealing problems—methods of avoiding potentially stigmatizing interactions. Close to half (46%) described experiencing stigmatization by family members, which often took the form of unwarranted assumptions, distrust, avoidance, pity, and gossip. About one third (35%) of participants reported stigma perpetrated by school staff, who expressed fear, dislike, avoidance, and under-estimation of their abilities. Fortunately, 22% reported “different” treatment by school staff, but this treatment was interpreted as positive and supportive.

Results showed that perceived stigmatization in one domain was associated with perceived stigma in other domains. The results suggest that efforts to combat stigmatization of youth with mental health disorders must help family members, peers, and school staff overcome their
inclinations to make negative assumptions and discriminate against these youth.

**Summary and Significance.** This article discusses the realities of stigmatization among the youth who have mental health problems. Among the sample being studied, statistics illustrate a real need to address stigmas. This source is helpful because it supports the idea that occupational therapy practitioners need to be aware of the dysfunctional issues that are introduced by stigmatization. Given that occupational practitioners provide services to children, along with practicing within a school-based setting, they can help address such issues. Additionally, given their client-centered and family-centered approaches towards practice, an occupational therapist can take an active role in educating a young client’s caregivers to help them abandon negative and discriminating assumptions. Simply put, this source adds to the abundance of scholarly literature that supports a role for an occupational therapist in the area of stigmatization.


**Abstract (Introduction).** No abstract or introduction.

**Summary and Significance.** This source is helpful because it highlights both the functional and dysfunctional issues that stigmatization introduces. It reasons why the sociological phenomenon is nearly impossible to eradicate, given the nature of mankind. The authors of this chapter refer to the ancient Greeks who would socially denote the inferior with physical markings (i.e., with use of branding irons, knives, etc.). With this mentioned, it is implied that the concept of stigma arose from such cognitive (purposeful) acts, and those who
were stigmatized were to be “discredited, scorned, and avoided” (p. 31). The authors also note that people throughout society may be marked in favorable, nonstigmatizing ways (i.e., labeling a person as a “hero”). It is with an understanding of these two different processes of marking (or labeling) people throughout society, that one can further understand that “stigmatization . . . represents one end of the continuum of the process of assigning positive or negative labels [or markings] to those we come across, and then valuing or devaluing them as their labels [or markings] warrant” (p. 31). Taking a biocultural approach, the authors reason that stigmatization serves a deep-rooted functional need for humans to live in effective groups—“labeled ‘ultrasociality’ by Campbell (1982) . . . [the need to live in effective groups] generally facilitates individuals’ abilities to eat well, build shelters, acquire knowledge, find mates, raise children, and protect themselves from rival species and bands of other humans” (p. 35). Those who cannot effectively contribute to the needs of a social group soon become stigmatized as nonreciprocators (i.e., thieves who actively violate the norm; the physically disabled who introduce a burden to the group through no fault of their own) (p. 37).


Abstract. Aims: Little is currently known regarding treatment barriers amongst problematic drug users not in structured treatment. Much previous work accessed samples entering treatment or predates recent service changes. This study sought to access a ‘hard to reach’ out of structured treatment population, exploring reasons for not seeking treatment.
Methods: A total of 43 drug users, self-selected as problematic and not currently in structured treatment, were identified via advertising at low-threshold services in Norfolk, and using snowballing methods. Qualitative focus groups and interviews were conducted. Data were thematically analyzed aided by NVivo software. Findings: Key reported barriers to treatment are organized around system, social and personal/interpersonal dimensions. Barriers included perception of a long waiting time, stigma, and a perceived lack of understanding. Social barriers relating to localized group membership were particularly important. Conclusions: Identified barriers confirm previous research, sampling a new out of structured treatment rural population. Perceived barriers persist despite recent changes to treatment services. This could be addressed by improved advertising of service expectations and waiting times. Participants suggested, amongst other things, drop in clinics, increased primary care provision and outreach services to capture problematic drug users not in treatment. Simple practices including appointment reminders and flexibility over urine testing may improve treatment retention.

**Summary and Significance.** The authors discuss a number of barriers that prevent people who have a drug problem from seeking/receiving treatment. Particularly, the authors write that treatment seekers tend to visit their general practitioners as opposed to available specialized treatment centers (i.e., fear of others knowing about their ‘hidden’ problem due to receiving services from such centers). With this mentioned, the treatment seekers are not able to receive the proper, specialized care required due to their general practitioner’s lack of understanding of their treatment needs (or the general practitioner is unwilling to treat their drug problem). This source is helpful because it supports the idea that occupational therapy practitioners need to be aware of the dysfunctional issues that are introduced by stigmatization, along with the importance of treating clients/patients holistically. This source provides implicit
support for a role for occupational therapists in the provision of potential drug treatment interventions outside of a ‘stigmatizing’, specialized substance-abuse treatment center.


**Abstract.** During the last decades, the living conditions for young people with disabilities have changed dramatically in Sweden, as well as in other parts of the Western world. The boundaries between what is considered normal as opposed to different have become less clear as a result of these changes. This has been followed by new problems regarding integration and changing patterns of marginalization. The aim of this study was to gain a deeper understanding of the ways in which young adults’ social identity is shaped by their dual belongings: to the category of individuals with disabilities as well as to mainstream society. In- depth interviews were carried out with 15 young adults with mental disabilities and mild intellectual disabilities occasionally combined with various forms of social problems. The analysis focused on the ways in which the young adults related to what they describe as normal and different as well as their strategies for navigating between them. The data was subsequently divided into three categories: Pragmatic Navigators, Critical Challengers, and Misunderstood Rebels, which reflect the ways in which the respondents describe themselves and the perspective they have developed to manage their existence.

**Summary and Significance.** This source supports the idea that the word ‘disability’ has a stigma behind it. Clients who are different from mainstream society in terms of their physical and cognitive abilities try to avoid being labeled ‘disabled’. With this mentioned, healthcare
professionals are often seen as opponents instead of helpers. This perspective is introduced because clients are simply fearful of losing a desired social identity. In turn, this thought gives way to their disregard towards seeking adequate and supportive help. This source is helpful because it introduces the idea that occupational therapy practitioners need to be aware of the dysfunctional issues that stigmatization introduces. Given that the field of occupational therapy delivers services to the sub-population of individuals who have a disability, this source helps explain that practitioners need to take stigmatic issues into consideration. The discussion that takes place in this source also supports a role for an occupational therapy practitioner in the area of stigmatization, given that the field has a holistic, client-centered approach.


**Abstract.** Historically, there has been an exaggerated fear related to infection compared to other conditions. Infection possesses unique characteristics that account for this disproportionate degree of fear: it is transmitted rapidly and invisibly; historically, it has accounted for major morbidity and mortality; old forms reemerge and new forms emerge; and both the media and society are often in awe. Because, in an outbreak, the patient is both a victim and a vector, and because there exists the potential for infringement of personal rights in order to control an outbreak, infection may be viewed (and has been depicted in popular culture) as a foreign invasion. During recent outbreaks, fear, denial, stigmatization and loss have been recorded in the implicated individuals. Stigmatization and discrimination may further involve ethical correlations, and attempts to address these issues through activism may also have unwarranted effects. Public health initiatives can address the public’s fears by increasing health literacy,
which can contribute to reducing stigmatization.

**Summary and Significance.** This source discusses the fears that surround infectious diseases. Moreover, patients who have an infectious disease become stigmatized targets. This source is helpful because it states that there is a need to address stigmas that affect this subpopulation. With an understanding that occupational therapy practitioners deliver services to all types of sub-populations, including those who have an infectious disease, he or she needs to be aware of the stigmatic issues that surround infectious diseases.


**Abstract.** A resurgence of research and policy efforts on stigma both facilitates and forces a reconsideration of the levels and types of factors that shape reactions to persons with conditions that engender prejudice and discrimination. Focusing on the case of mental illness but drawing from theories and studies of stigma across the social sciences, we propose a framework that brings together theoretical insights from micro, meso and macro level research: Framework Integrating Normative Influences on Stigma (FINIS) starts with Goffman’s notion that understanding stigma requires a language of social relationships, but acknowledges that individuals do not come to social interaction devoid of affect and motivation. Further, all social interactions take place in a context in which organizations, media and larger cultures structure normative expectations which create the possibility of marking “difference”. Labeling theory, social network theory, the limited capacity model of media influence, the social psychology of prejudice and discrimination, and theories of the welfare state all contribute to an understanding
of the complex web of expectations shaping stigma. FINIS offers the potential to build a broad-based scientific foundation based on understanding the effects of stigma on the lives of persons with mental illness, the resources devoted to the organizations and families who care for them, and policies and programs designed to combat stigma. We end by discussing the clear implications this framework holds for stigma reduction, even in the face of conflicting results.

Summary and Significance. The authors of this article discuss some of the many different theories that aim to describe the mechanisms of stigmatization. They further attempt to combine such theories into a broader, conceptual framework as a means to enhance research pertaining to the eradication of the social and psychological barriers introduced by stigma. This source is helpful because it reasons why stigma exists and continues to persist. It is also concluded that one of the best ways to address the barriers introduced by stigma is through a macro-level approach, which implies that advocacy efforts towards social equality and justice need to be strengthened.


Abstract. In light of increasing cross-communication and possible coalescence of conceptual models of stigma and prejudice, we reviewed 18 key models in order to explore commonalities and possible distinctions between prejudice and stigma. We arrive at two conclusions. First, the two sets of models have much in common (representing ‘‘one animal’’); most differences are a matter of focus and emphasis. Second, one important distinction is in the type of human characteristics that are the primary focus of models of prejudice (race) and stigma (deviant behavior and identities, and disease and disabilities). This led us to develop a typology
of three functions of stigma and prejudice: exploitation and domination (keeping people down); norm enforcement (keeping people in); and disease avoidance (keeping people away). We argue that attention to these functions will enhance our understanding of stigma and prejudice and our ability to reduce them.

**Summary and Significance.** This source is helpful because the authors highlight the differences between two terms that are commonly utilized as synonyms, and it can help explain the concept of stigmatization. The authors compare and contrast conceptual models of stigma and prejudice as a means to highlight whether or not the two concepts describe the same social phenomena. Although there are differences between the two concepts, the authors found that the mechanisms that each aims to explain greatly overlap one another. As a means to highlight distinct differences between the concepts, the authors conclude that prejudice is primarily concerned with exploitation and domination (keeping people down); stigma is primarily concerned with norm enforcement (keeping people in) and disease avoidance (keeping people away) (p. 365).


**Abstract.** As the expanding field of drama therapy continues to develop alongside conventional psychiatry, there is a growing movement to improve assessment and diagnosis beyond the existing medical model. As such, this article presents an alternative approach that endeavors to blend a conceptualization of role theory with traditional psychopathology. This article attempts to combine the Taxonomy of Roles and the *Diagnostic and Statistical Manual of*
Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) in order to make diagnostic classification less stigmatizing for the client. The point of view presented is that by identifying role qualities inherent in all human beings, treatment staff, families, and society can begin to view the mentally ill in relation to themselves, rather than as some ambiguous “other.” As the client recognizes, identifies with, and learns to relate to a broader repertoire of roles (beyond “sick person”), he or she is better prepared to engage in therapy. Barriers to treatment begin to crumble. Using the case presentation of one client in a continuing day treatment program, this paper explores a strengths-based approach to diagnosis that reflects – and treats – the whole person.

Summary and Significance. This source is helpful because the author highlight a primary source that introduces stigmatization. The author highlights that the DSM introduces stigmatization due to its focus on behavioral symptoms of mental disorders. Moreover, the author of this article discusses a point of view that is supportive of the role acquisition model of practice. Continuing with this thought, the author suggests that “a convergence of the conceptualization of the DSM-IV-TR (2000) and the Taxonomy of Roles” generates a more appropriate diagnostic tool (p. 64). The convergence can introduce a holistic lens that aims at decreasing stigmas that surface from the present, narrow focus on undesirable symptoms and weaknesses, which is characteristic of using the DSM independently. Directly quoted, Roten states: “Taxonomy [of Roles] provides a way for the diagnostic process to focus more on the ‘person struggling with the mental illness than the illness itself‘ (Davidson, 2003, p. 14), thus complementing the DSM-IV-TR (2000) to provide a more holistic diagnostic tool” (p. 64).

group members perceive the discrimination that confronts them. Journal of Personality and Social Psychology, 68(5), 826-838.

Abstract. Two experiments examined how disadvantaged group members perceive the discrimination that confronts them. Women reacted to negative feedback after receiving information about the probability that they had been discriminated against. In both experiments, attribution to discrimination was a function of situational ambiguity. When discrimination was certain, participants attributed their failure to discrimination. When discrimination was ambiguous, however, participants minimized discrimination and attributed their failure to themselves. The second experiment investigated the role of perceived control in the minimization of personal discrimination. Results indicated that disadvantaged group members were reluctant to blame their performance on discrimination because they were placing control for their outcomes in the hands of others rather than their own.

Summary and Significance. This source is helpful because it addresses the dysfunctional issues introduced by public stigmatization and self-stigmatization, and it highlights that stigmatized individuals are in need of acquiring appropriate coping skills. Particularly, it discusses that stigmatized individuals are in need of acquiring skills to cope with the discriminatory attitudes and behaviors that they may encounter through their social interactions with others, along with skills to avoid negatively internalizing such discriminatory attitudes and behaviors. With this mentioned, it has been found that if individuals who are discriminated against negatively internalize such behavior, then he or she may not take steps towards improving their own personal status.

Sanders, B. (2011). The effect of attitudes and stigma on the willingness to seek treatment for
Abstract. This study examined the attitudes and stigma toward psychotherapy and medication. It was hypothesized that participants would endorse higher levels of stigma towards psychotherapy than medication. Approximately 200 students were surveyed at Texas State University, using an investigator-designed questionnaire intended to assess stigma towards mental health treatment. Paired t-tests were run to compare responses on survey questions that differed only in terms of a focus on medication or psychotherapy. A significantly more negative attitude towards psychotherapy was found in areas of parental use of treatment, and self-attitudes. Attitudes about friends’ use of different treatment forms were found to be non-significant. When an analysis of variance was run for ethnic differences, there was a significant difference in medication-related attitudes between White and Hispanic participants.

Summary and Significance. This source discusses the stigma that surrounds those who have a mental disorder. Findings indicate that there is a stronger stigma for those who receive psychotherapy treatment when compared to those who receive treatment via medication. The study also addresses the problem of self-stigma, which gives way to internalized thoughts that prevent someone in need of mental health services from seeking/receiving such services (intrinsic factors versus extrinsic factors of stigmatization). This source is helpful because it highlights an implied concern: given the historical background of the occupational therapy profession (providing services to those with mental disorders), could potential patients/clients be reluctant to seek/receive occupational therapy services? Practicing holistically, however, an occupational therapist addresses both the mental and physical concerns of an individual. With this understanding, could the profession of occupational therapy counter the self-stigmatizing
thoughts that prevent those in need of mental health services by discovering any hidden, underlying issues of self-stigmatization for those who seek services that address physical disorders/disabilities? The answer to the two aforementioned questions are yes.


Abstract. Although stigmas appear throughout history, even in present-day virtual communities, an explanation of stigma communication has yet to be offered; this essay attempts to do just that. This essay argues that stigma communication includes specific content: marks, labels, responsibility, and peril, in order to induce affective and cognitive responses to create stigma attitudes, to generate protective action tendencies, and to encourage the sharing of these messages with others. Stigma messages bear the following attributes: they provide cues (a) to distinguish people, (b) to categorize distinguished people as a separate social entity, (c) to imply a responsibility for receiving placement within this distinguished group and their associated peril, and (d) to link this distinguished group to physical and social peril. Different qualities of stigma messages, moreover, evoke different emotions (disgust, fear, and anger) that motivate people to access relevant social attitudes, form or bolster stigma attitudes, and to remove the stigmatized threat. Stigma attitudes encourage the sharing of stigma messages with others in a network, which may, subsequently, bond in-group members.

Summary and Significance. This source is helpful because it helps explain why stigmatization may not be eradicated in society. Moreover, it highlights the idea that stigmatization serves both as a functional and dysfunctional social phenomenon. It provides support that individuals stigmatize one another due to his or her personal perception of
Stigmas must be shared to be so considered, such that they ‘spoil’ interactions not only at an individual level, but also at a group level” (p. 63). Moreover, the authors suggest a theory for the development of social stigma based upon three components: (1) function, (2) perception, and (3) social sharing (p. 73). Under their theory, stigma requires an initial functional impetus with a goal of avoiding threat to the self; the initial function is then accentuated through perception and subsequently consolidated at a social level through social sharing of information; the end result is a sharing of stigma, such that stigmatization becomes a part of the society that creates, condones, and maintains such attitudes and behavior (p. 73).
Abstract. This article compares experiences of social isolation and perceptions of belonging between lower-income and higher-income people. We conducted individual interviews with 60 higher-income and 59 lower-income study participants and six group interviews with 34 low-income participants from two Canadian cities. Subsequently, a representative sample of 1,671 lower- and higher-income participants was surveyed by telephone. Income was a consistent predictor of measures of isolation and sense of belonging to the community: lower-income people experienced greater isolation and a lower sense of belonging than did higher-income people. Poverty shaped low-income people’s perceptions and experiences of stigmatization and isolation.

Summary and Significance. This source introduces a need to address social stigmatization particular to homelessness and poverty. Throughout literature, it is well documented that those who are homeless likely suffer from mental health conditions. Moreover, it is also well documented throughout literature that those who suffer from mental health conditions are often stigmatized. With these thoughts mentioned, there is further evidence provided that documents the social barriers that stigmatization introduces. The information discussed in this source is helpful because it discusses a need take a holistic approach towards clinical practices in order to address the dysfunctional issues that are introduced by stigmatization. With an occupational therapy practitioner’s holistic approach, such social barriers can be addressed in non-traditional community settings that serve the homeless.


Abstract (Introduction). There is a great urgency to understand more fully the linkages
between stigma, prejudice, discrimination and health to aide in the development of effective public health strategies. A goal of the US Healthy People 2010 program is to eliminate health disparities among different segments of the population (DHHS, 2002). Prejudice and discrimination are believed to be important contributors to the production of health disparities (IOM, 2002). It is difficult to pick up a consensus report on mental illness or HIV/AIDS without finding numerous references to the ways the stigmatization of these health conditions undercuts prevention and treatment efforts (DHHS, 2003; USAID, 2000).

For this reason, in September 2006, the Health & Society Scholars Working Group on Stigma, Prejudice, Discrimination and Health convened scholars across the social and health sciences who study the social and psychological processes of stigmatization and prejudice. The objective of this conference was to strengthen collaboration across disciplines, discuss challenging conceptual issues, and identify the most pressing research objectives facing this relatively new line of inquiry. Driving discussions was the budding idea for a Special Issue that would attempt to bridge disparate research traditions in stigma, on the one hand, and in prejudice and discrimination on the other. As editors of the Special Issue, we believe the importance of this endeavor lies in missed opportunities for conceptual coherence and for capitalizing on insights generated from each research tradition and possibly, to an underestimation of the impact of stigma and prejudice on health. Several exciting manuscripts emerged from the conference making up the content of this Special Issue…

**Summary and Significance.** This source is helpful because the authors discuss the implications that stigma, prejudice, and discrimination have on health (stressors). Through an extensive review of relevant literature, the authors highlight a need to address the three aforementioned concepts as a means to effectively address the dysfunctional social and
psychological issues that they introduce. With the above mentioned, a number of negative implications that stigma, prejudice, and discrimination have on health are highlighted; however, positive implications are also discussed (i.e., certain health conditions that are stigmatized, such as obesity, can help reinforce healthy behaviors). The authors also imply that there is a need for society to be educated on stigma, prejudice, and discrimination as a means to gain personal insight into some of the subconscious behaviors that feed the mechanisms behind stigma, prejudice, and discrimination.


**Abstract.** The diversity perceptions of human service professionals may be critical indicators of effective service provision. Specifically, this study explored the disability perceptions of counselors, rehabilitation providers, and teachers (N = 172) enrolled in a large, southeastern university. A 76% response rate was achieved in the study, indicating clear differences by human service providers’ preparation area and perceptions of disability type. Implications for preparation and future research are discussed.

**Summary and Significance.** The authors of this study found that special education/rehabilitation providers are more accepting and less anxious in the provision of services to individuals with physical and mental disabilities when compared to counselors and general educators. The authors further discuss that the findings of the study support the ‘preparation effect theory’, which attempts to predict a human service provider’s attitude towards individuals with physical and mental disabilities based upon areas of professional preparation.
This source is helpful because it supports a role for the profession of occupational therapy to address the dysfunctional issues that stigmatization introduces. It also implies that occupational therapy practitioners may be less likely to stigmatize their clients, which can allow for the delivery of optimal therapeutic services.


Abstract (Introduction). No abstract or introduction.

Summary and Significance. This source is helpful because it highlights the fact that the U.S. government acknowledges the dysfunctional issues that stigmatization introduces. In response to the health disparities within the United States, the U.S. Department of Health and Human Services has drawn a goal in the Healthy People 2020 framework to achieve health equity, eliminate disparities, and improve the health of all groups. Within the framework, stigmatization is acknowledged to be a major barrier for individuals in need of receiving proper healthcare services. Particularly, stigmatization introduces a barrier for individuals who are in need of reproductive and sexual healthcare services, so interventions are being designed, implemented, and evaluated as a means to reduce the rates of transmission of sexually transmitted infections.


Abstract. As a feature of many chronic health problems, stigma contributes to a hidden
burden of illness. Health-related stigma is typically characterized by social disqualification of individuals and populations who are identified with particular health problems. Another aspect is characterized by social disqualification targeting other features of a person’s identity—such as ethnicity, sexual preferences or socio-economic status—which through limited access to services and other social disadvantages result in adverse effects on health. Health professionals therefore have substantial interests in recognizing and mitigating the impact of stigma as both a feature and a cause of many health problems. Rendering historical concepts of stigma as a discrediting physical attribute obsolete, two generations of Goffman-inspired sociological studies have redefined stigma as a socially discrediting situation of individuals. Based on that formulation and to specify health research interests, a working definition of health-related stigma is proposed. It emphasizes the particular features of target health problems and the role of particular social, cultural and economic settings in developing countries. As a practical matter, it relates to various strategies for intervention, which may focus on controlling or treating target health problems with informed health and social policies, countering the disposition of perpetrators to stigmatize, and supporting those who are stigmatized to limit their vulnerability and strengthen their resilience. Our suggestions for health studies of stigma highlight needs for disease- and culture-specific research that serves the interests of international health.

**Summary and Significance.** Directly quoted: “. . . diverse contexts of stigma and conditions that are stigmatized are required to serve the practical interests of health research, disease control, and community action” (p. 3). This statement highlights the importance of conducting research relative to the dysfunctional issues that stigmatization introduces. With this mentioned, the authors’ advocate the need for studies that are relative to designing, implementing, and evaluating efficacious interventions to address the dysfunctional issues that
stigmatization introduces. This source is helpful because it provides support for the field of occupational therapy, as it is a profession that provides healthcare services. Additionally the following quote supports the idea that the holistic perspective of occupational therapy is needed to address the dysfunctional issues that are introduced by stigmatization: “Like the affected individual, others in the family, because of their association with that person, may themselves be targets of stigma through a process Goffman described as courtesy stigma” (p. 6). Given that the occupational therapy practice is both client-centered and family-centered, the aforementioned statement simply implies a role for an occupational therapist to address the dysfunctional issues that are introduced by stigmatization. The article continues with a focus on common healthcare practices (i.e., precautionary practices) that stigmatize patients/clients, which can highlight ways in which the occupational therapy practitioner can prevent himself or herself from stigmatizing a client.
Literature Supportive of Occupational Therapy to Address Stigmatization and the Utilization of Anne Mosey’s Role Acquisitional Frame of Reference


Abstract (Introduction). The Occupational Therapy Practice Framework: Domain and Process, 2nd Edition (Framework–II) is an official document of the American Occupational Therapy Association (AOTA). Intended for internal and external audiences, it presents a summary of interrelated constructs that define and guide occupational therapy practice. The Framework was developed to articulate occupational therapy’s contribution to promoting the health and participation of people, organizations, and populations through engagement in occupation. It is not a taxonomy, theory, or model of occupational therapy and therefore must be used in conjunction with the knowledge and evidence relevant to occupation and occupational therapy. The revisions included in this second edition are intended to refine the document and include language and concepts relevant to current and emerging occupational therapy practice.

Implicit within this summary are the profession’s core beliefs in the positive relationship between occupation and health and its view of people as occupational beings. “All people need to be able or enabled to engage in the occupations of their need and choice, to grow through what they do, and to experience independence or interdependence, equality, participation, security, health, and well-being” (Wilcock & Townsend, 2008, p. 198). With this aim, occupational therapy is provided to clients, the entity that receives occupational therapy services. Clients may be categorized as

- Persons, including families, caregivers, teachers, employers, and relevant others;
• Organizations, such as businesses, industries, or agencies; and

• Populations within a community, such as refugees, veterans who are homeless, and people with chronic health disabling conditions (Moyers & Dale, 2007) . . .

**Summary and Significance.** This source is helpful because it serves as the guiding framework for the practice of occupational therapy. It provides key definitions that can be used to help support the groundings of Anne Mosey’s Role Acquisitional frame of reference, along with defining how an individual acquires his or her social identity. Moreover, it can further help reason how individuals acquire a stigmatized social identity. The American Occupational Therapy Association defines occupational performance as: “The act of doing and accomplishing a selected activity or occupation that results from the dynamic transaction among the . . . [individual], the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities (p. 672-673). Aside from personal attributes, occupational performances contribute to an individual’s social identity; they result in an individual’s acquisition of social roles. Roles are “sets of behaviors expected by society, shaped by culture, and . . . further conceptualized and defined by . . . [an individual]” (i.e., parent, student, employee, etc.) (p. 674).


**Abstract (Introduction).** No abstract or introduction provided.

**Summary and Significance.** This source is helpful because it introduces ways in which the profession of occupational therapy can strengthen its position with the healthcare industry, along with becoming a widely known professional practice. With the profession of occupational
therapy addressing stigmatization, practitioners may add to the scholarly literature that discusses the topic of stigmatization, along with implementing and evaluating the efficacy of new interventions to address the dysfunctional issues that the sociological phenomenon introduces. As it is the goal of the AOTA Centennial Vision, the profession of occupational therapy may become more “powerful, widely recognized, science-driven, and evidence-based” (p. 10).


Abstract (Introduction). No abstract or introduction.

Summary and Significance. The authors of this chapter discuss the process and functions of stereotyping; “the process of generalizing from an observable physical characteristic to a set of assumed traits is an essential aspect of the more general process of ‘stereotyping’ (p. 88). Moreover, the authors also state: “Stereotypes are involved in stigmatization to the extent that the response of perceivers is not simply a negative one (i.e., dislike of ‘devalued identity’), but also that a specific set of characteristics is assumed to exist among people sharing the same stigma (i.e., the stigma evokes a social identity) (p. 89). With the above mentioned, stereotyping simply refers to the cognitive and affective processes (those that elicit a negative perception) of stigmatization (p. 89; 95). The authors further add that role division is another factor that may determine the extent to which a stereotype becomes associated with a stigma; “when individuals with a particular stigma can be found in a wide variety of roles and across many contexts (as is true of many visible and concealable stigmas), the ground for stereotype development is less solid” (p. 93). This source is helpful because the
discussion that takes place implicitly supports the idea that acquiring roles (the aim of the Role Acquisitional frame of reference) may help stigmatized individuals surpass the sociological and psychological barriers that are introduced by stigma. With this mentioned, the source also implies a role for the profession of occupational therapy to address the dysfunctional issues that are introduced by stigmatization; occupational therapy practitioners provide interventions that help individuals acquire social roles by improving an individual’s occupational performances.


Abstract.

**Aims:** Social inclusion is important to an individual’s health, quality of life and sense of wellbeing. In today’s society, there is an understanding that is the social, economic and cultural barriers encountered by people with impairments that cause disability. Health-care professionals are well-placed to identify these barriers and the potential for supporting the development of valued roles for their clients, to engender social inclusion.

**Methods:** This article examines the concepts of social exclusion, social inclusion and their relevance to health, wellbeing, and valued social roles. The theory of social role valorization—which was developed within society—is discussed and the criticism of this theory is explored. A framework based on this theory is then presented. This framework incorporates these principles and can be used by health professionals across a range of practice settings as a legitimate starting point from which to support the acquisition of socially valued roles, which are integral to inclusion.
**Conclusions**: Supporting the development and maintenance of valued roles is an intrinsic role for all health-care professionals, and it is hoped that this framework to assist the acquisition of valued social roles may be implemented in therapy and rehabilitation settings. Further exploration of the practical implementation of this framework is suggested.

**Summary and Significance.** This article discusses an initiative to transition from a medical model to a social model as a means to address the barriers introduced by disability. This source is helpful because it highlights a need for healthcare practitioners to develop a holistic perspective when delivering human services. With an understanding that the practice of occupational therapy steers away from the medical model, along with addressing both client and environmental factors, it can be implied that the authors support the profession. It is also highlighted that adopting a social model can help address the barriers that are introduced by stigma, as the authors primary focus is on social inclusion for people who have a disability. With this mentioned, it can be implied that Anne Mosey’s Role Acquisitional frame of reference can guide appropriate occupational therapy interventions that address the dysfunctional issues that are introduced by stigmatization.


Abstract (Introduction). No abstract or introduction.

Summary and Significance. The authors of this chapter define stigma as “a social construction that involves at least two fundamental components: (1) the recognition of difference based on some distinguishing characteristic, or ‘mark’; and (2) a consequent devaluation of the
person” (p. 3). They further state that “the major negative impact of stigmatization normally resides not in the physical consequences of the mark, but rather in its social and psychological consequences” (p. 5). The authors also propose a conceptual framework that attempts to locate the analysis of stigma within the larger context of social-psychological processes; within the conceptual framework are three dimensions: (1) perceiver-target, (2) personal-group-based identity, and (3) affective-cognitive-behavioral response (p. 9). This source is helpful because it introduces a conceptual framework that helps organize the mechanisms of stigmatization for analysis. With an understanding that Anne Mosey’s Role Acquisitional frame of reference takes both a sociological and psychological perspective, this source supports the use of it to analyze and address the mechanisms of stigmatization.


Abstract. The aims of this paper are to analyze the role of medical and health professions in creating and establishing the disability category. We also explore how the diagnosis, measurement, and treatment of disability have contributed to stigmatization and promoted social, political and economic inequality. Theories from a variety of disciplines are used to examine the ways that medicine and the health-related professions have contributed to the oppression of people with disabilities, including the maintenance of a ‘medical/knowledge power differential,’ reinforcement of the ‘sick role,’ and objectification of people with disabilities. We also explore opportunities for empowerment versus ‘sick role’ status. The medical and health professions are uniquely positioned to promote the empowerment of people with disabilities as active partners in
their own health care. Replacing the biomedical model of disability with a socio-political model that prioritizes disease/health care management, wellness and prevention of further disability as opposed to treatments aimed at curing disability could facilitate the empowerment process.

**Summary and Significance.** The discussion throughout this article aims to blame the biomedical model of practice for introducing and continuously feeding the stigma that surrounds the ‘disabled’ population. Moreover, the authors state that a socio-political model of practice should be adopted. This source is helpful because it is supportive of the profession of occupational therapy, given that the profession steers away from the biomedical model. Moreover, an occupational therapist does not aim to treat a condition like other healthcare practitioners who take a biomedical approach; an occupational therapist simply aims to aid in the management of a condition. The idea of utilizing a socio-political model of practice also supports the use of the Anne Mosey’s Role Acquisitional frame of reference, as it takes a sociological and psychological perspective in order to guide the formulation of holistic interventions.


**Abstract (Introduction).** The psychosocial of occupational therapy are those areas of human function that enable the individual (a) to perceive the world as comprehensible, safe, responsive to personal action, and a source of need satisfaction; and (b) to engage in various required and desired social roles on the basis of these perceptions. Psychosocial components do not include an individual’s physical capacity to act in relation to the environment. Although the latter is an important part of the occupational therapy process, it will not be addressed in this
text. Rather, this text will explore the knowledge, skills, and attitudes that are fundamental to adaptation irrespective of the individual’s current physical status . . .

**Summary and Significance.** This source is helpful because it serves as the primary source that discusses Anne Mosey’s Role Acquisitional frame of reference. Theoretically, the frame of reference is grounded on five parts: the nature of the individual of interest, learning needs, processes of learning, typical and atypical development, and the performance of purposeful occupations. With the frame of reference being primarily grounded on learning mechanisms in order for an individual to acquire the necessary skills to function in his or her social environment, barriers towards the acquisition of such skills are acknowledged. With an understanding that stigmatization introduces both sociological and psychological barriers that impede an individual’s acquisition of social role(s), the Role Acquisitional frame of reference’s sociological and psychological perspective can help stigmatized individuals learn ways to surpass such barriers. The frame of reference has been designed to specifically guide the practice of occupational therapy by “linking learning theories, the reality aspect of purposeful activities [occupations], and the process of acquiring specific skills needed for successful interaction in the environment” (p. 443). The Role Acquisitional frame of reference is an appropriate tool to guide interventions for individuals who have not learned how to participate in required social roles or who wish to participate in desired roles more effectively (p. 450). It is also applicable for individuals who are experiencing difficulty with role transitions or those who must learn how to participate in their social roles in a different manner (p. 450).

In this commentary, we critically review the contribution of the sociologist Erving Goffman (1922-1982) to understanding recovery from problem drug use. Previous research has indicated that drug users have a ‘spoiled identity’ and must restore a ‘normal’ or ‘unspoiled identity’ in order to recover. This argument has been linked to Goffman’s classic work on *Stigma: Notes on the management of a spoiled identity* [1963, Harmondsworth: Penguin]. Despite its evident appeal, linking recovery to repairing a spoiled identity has a number of problems. These include the derogatory connotations of ‘spoiled’, and the fact that the ‘momentary’ spoiled identity that Goffman likely intended is easily lost to a more ‘totalizing’ spoiled identity, from which it can be difficult for individuals to escape. Given such shortcomings, we consider how Goffman’s broader dramaturgical work might contribute to our understanding of recovery processes. Dramaturgy, which focuses on the performative aspects of selfhood and the relational and situational nature of identity, suggests ways that the individuals can work on their identity (and recovery) projects without over-prioritizing abstinence. We suggest that dramaturgy is more useful than the notion of repairing a spoiled identity for understanding and facilitating recovery. Nonetheless, it has limitations and other sociological perspectives provide fertile ground for future debate.

**Summary and Significance.** The authors of this article discuss Goffman’s concepts about stigmas/stigmatization, along with ways in which the concepts may be misinterpreted. Particularly, the authors discuss the interpretations of Goffman’s concepts to describe the recovery process for drug users. They highlight that Goffman’s concept of dramaturgy, which focuses on the ‘doing’ that gives rise to a person’s identity, is a better explanation of the many
different ‘acts’ that an individual performs when socializing with others while being able to maintain a personally desired identity. This source is helpful because it supports the use of Anne Mosey’s Role Acquisitional frame of reference. Given that the frame of reference takes a holistic perspective, it can be implied that it introduces an appropriate lens to examine the relationship(s) between stigmas/stigmatization, occupational performance(s), and drug use. Moreover, it also supports the frame of reference because it (the frame of reference) aims to help individuals acquire social roles, which contributes to one’s social identity.


**Abstract.** The present article provides an overview of the best-developed interventions for child and adolescent internalizing disorders characterized by anxiety and depression. The review emphasizes interventions that fall into established efficacy categories, but also addresses briefly several other promising treatment procedures. Research on the treatment of child and adolescent depression has not yielded interventions with clearly established efficacy, although there are a number of treatment approaches that may be characterized as possibly efficacious. The treatment of child and adolescent anxiety disorders, on the other hand, includes a number of interventions with good empirical support. While the field is clearly advancing, there remain important deficits and limitations with regard to the evidence base for interventions addressing child internalizing disorders.

**Summary and Significance.** This source is helpful because it highlights strategies that can help individuals address the dysfunctional issues that are introduced by stigmatization. When providing interventions, occupational therapy practitioners need to consider some of the primary
problem areas that are associated with negative internalization, such as grief, role disputes, role transition, and interpersonal deficits. Moreover, this source introduces teaching strategies for occupational therapy practitioners. It discusses that interventions should focus on helping stigmatized individuals identify the problems associated with the onset of negative internalization, along with identifying interpersonal problems related to negative internalization.


Abstract (Introduction). The focus of this chapter is upon the relationship between stigma and prosocial behavior. According to Crocker, Major, and Steele (1998), “a person who is stigmatized is a person whose social identity, or membership in some social category calls into question his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others” (p. 504). In his pioneering treatise, Goffman (1963) identified three general types of stigma: abominations of the body (e.g., physical deformities, disease afflictions), moral character stigmas (e.g., a criminal record, addiction to drugs), and tribal stigmas (i.e., membership in a discredited social group). Prosocial behaviors may be generally defined as actions that benefit others. In this chapter, we argue that people display an inherent aversion to stigmatized persons and that this aversion represents a psychological barrier that must be overcome for prosocial behavior to take place. The aversion to stigmatized persons is found in both immediate affective responses and stereotypical beliefs about the potential hazards related to coming into contact with stigmatized persons. Below we will scrutinize evidence for these two types of aversion to stigmatized persons and will then examine the roles of attributions as
potential contributors to and moderators of stigma aversion. Finally, we will describe a dual-process model of reactions to stigmatized persons that casts these psychological reactions into a framework of reflexive and deliberative processes. The relevance of reflexive and deliberative processes for prosocial behaviors toward stigmatized persons will be examined.

**Summary and Significance.** This source is helpful because it provides information that supports the need to address stigmas. It also introduces ways in which aversive behaviors towards stigmatized populations can be decreased, which can be applied to those who serve others (i.e., healthcare professionals such as occupational therapists). The chapter introduces a number of models to analyze the mechanism(s) of stigmatization, which can help address the barriers that prevent people from successfully fulfilling desired roles (compliments Anne Mosey’s Role Acquisitional frame of reference). This chapter also discusses reactions to stigma based upon implicit (the thinking) and explicit (the expressing) attitudes. It addresses the dissociations between the aforementioned two types of attitudes, and adds that personal experience with a particular stigma causes the attitudes to converge. It further discusses theories upon stigma aversion such as an evolved mechanism for the reduction of contracting contagious pathogens, avoidance of people who are incapable of reciprocal altruism, and a human’s desire to belong to groups (stigma-by-association). Continuing upon the subject of stigma aversion, it has been found that instructing people to try to be more sympathetic towards a stigmatized group decreases their aversive behavior.

**Pinto-Foltz, M., & Logsdon, C. (2009). Reducing stigma related to mental disorders:**

Abstract (Introduction). Twenty percent of Americans suffer from mental disorders, but most do not receive treatment. Stigma is an important barrier to mental health treatment and recovery. This article aims to summarize current national initiatives to reduce stigma, clarify the current knowledge of stigma-reducing interventions, and provide recommendations to nurses on implementing and investigating stigma-reducing interventions.

Summary and Significance. This source is helpful because it highlights that stigmatization is a major issue that introduces social barriers towards seeking/receiving appropriate healthcare services. The authors state that the focus on stigma reduction is fairly new, and they make recommendations for future research, such as programs based upon theoretical frameworks. With this mentioned, use of the Role Acquisitional frame of reference may prove to be an effective framework that can guide interventions to address the dysfunctional issues that are introduced by stigmatization. The authors also discuss interventions (i.e., personal interaction, education, etc.) that have been found to help reduce mental disorder stigmatization. Moreover, the authors discuss government initiatives that aim to reduce stigmas/stigmatization that surround people who have mental disorders.


Abstract. People with severe and persistent mental illness often experience a disruption in the development of social roles, and the skills within these roles. Role Development, a set of guidelines for practice, is an intervention to develop roles and skills. The purpose of this study was to continue to examine the efficacy of this intervention. Ten people attending two community mental health programs participated in evaluation and treatment based on Role
Development. Quantitative pretest and posttest measures were used. Qualitative components were incorporated to get a sense of the experience involved in developing roles and skills. Quantitative results indicated statistical significance (p<.05) in the development of roles and skills. Qualitative data reveal multiple trends experienced by the participants. This study contributes to the evidence-based knowledge regarding development of roles and skills for persons living with severe and persistent mental illness.

Summary and Significance. The author discusses the efficacy of guidelines that have been developed in order to acquire desired social roles. Findings conclude that Anne Mosey’s Role Acquisitional frame of reference can guide effective interventions that pertain to the acquisition of roles for people who have a severe mental disorder. This source is helpful because Anne Mosey initially described the frame of reference as not being appropriate to guide occupational therapy interventions for clients who have severe and persistent impairments (that it should be utilized in conjunction with another appropriate frame of reference). Specifically, the author states: “community-dwelling people diagnosed with severe and persistent mental illness will demonstrate increased task skills, interpersonal skills, and social roles when involved in a one-to-one intervention based on Role Development” (p. 16). This source provides support that the Role Acquisitional frame of reference can be utilized for a number of stigmatized sub-populations.

Abstract (Introduction). The development of roles is a universal process that continues through the course of our lives. Typical development of roles has been discussed by many theorists and related to significant events (e.g., marriage) and to the stages (e.g., adulthood) of our lives. Much has also been written about the manner in which typical development of roles can be adversely affected by trauma, injury, and atypical development of roles by addressing four areas: role theory, the development of roles in individuals diagnosed with schizophrenic disorders, the development of task and interpersonal skills in relation to the development of roles in forensic settings, and the development and documented use of Role Development.

Summary and Significance. The author discusses the historical development of Role Theory, along with highlighting Anne Mosey’s work on the development of the Role Acquisitional frame of reference. Moreover, the author discusses the efficacy that supports interventions that address the development of social roles for people who have mental disorders. From a review of relevant literature, the author notes: “Current thinking is that a variety of roles can have a positive influence on an individual’s ability to function in society. Multiple roles equip a person to deal with a wide variety of situations and to compensate for disappointment in one role by succeeding in others” (p. 5). With an understanding that stigma introduces barriers to the development of desired social roles, the context of this article further highlights a need to address stigma. This source is helpful because it supports the use of the Role Acquisitional frame of reference to guide efficacious interventions. Particularly, the frame of reference will be utilized to guide occupational therapy interventions that address the dysfunctional issues that are introduced by stigmatization.

Schulte, A. (2002). Consensus versus disagreement in disease-related stigmas: A
comparison of reactions to aids and cancer patients. *Sociological Perspectives, 45*(1), 81-104.

**Abstract.** Theories about disease-related stigma may be classified in two categories: the behavioral model, which compares diseases or statuses of different types, assumes that stigmas arise from the actions of the stigmatized, and predicts consensus among observers; and the cultural conflict model, which compares the symbolic attitudes of observers, defines stigmas as social constructions, and expects disagreements in reactions. I employ a factorial survey to contrast these models. In a sample of university students (N = 600), respondents were presented with descriptions of individuals with AIDS, cancer, or "no disease." Gender role attitudes were also included as a measure of symbolic attitudes. Many of the results follow the culture conflict model in which interactions between gender role attitudes and type of disease affect the level of stigma. However, other results lend support to the behavioral model because the respondents' gender role attitudes do not explain differences in responses based on disease type.

**Summary and Significance.** This source discusses how stigmas develop and persist. Particularly, it supports the thought that stigmatization can be partially managed by those who are targets of such negative, ostracizing social attitudes. With this mentioned, this source is helpful because it supports the idea that Anne Mosey’s Role Acquisitional frame of reference can help explain why occupational engagements are an important equation in whether or not stigmas persist. Moreover, there is a cyclical process that involves behaviors and attitudes that feed on one another, and the Role Acquisitional frame of reference is grounded upon this idea (a role is identified by occupational performances/behaviors).

Shih, M. (2004). Positive stigma: Examining the resilience and empowerment in
Abstract. The traditional literature on stigma focuses on identifying factors contributing to the harmful impact of stigmas on the lives of stigmatized individuals. This focus, however, cannot explain the many cases of individuals possessing a stigmatized identity flourishing in our society. This article investigates the processes that successful stigmatized individuals use to overcome the harmful consequences of stigmatization. Specifically, this article reviews three processes: (1) compensation; (2) strategic interpretations of the social environment; and (3) focusing on multiple identities that have been identified in the literature to help stigmatized individuals handle prejudice and discrimination. Moreover, successful individuals adopt an “empowerment” model as opposed to a “coping” model when dealing with stigma. In other words, successful individuals view overcoming the adversities associated with stigma as an empowering process, as opposed to a depleting process. This discussion underscores the importance of adopting a new approach to gain a fuller understanding of the experience of being stigmatized.

Summary and Significance. This source is helpful because it discusses ways in which stigmatized individuals can address the dysfunctional issues that stigmatization introduces. Furthermore, it also addresses ways in which the occupational therapy practitioner can teach stigmatized individuals’ skills (the aim of Anne Mosey’s Role Acquisitional frame of reference) to cope with the dysfunctional issues that are introduced by stigmatization. This source highlights that in order to help stigmatized individuals protect their self-worth, occupational therapy practitioners should teach them how to make selective comparisons. Particularly, it has been found that stigmatized individuals who do not compare themselves to advantaged groups
increase their self-efficacy. “By changing their standards of comparison, stigmatized individuals are able to ameliorate perceptions of inequity and relative deprivation” (p. 179). Occupational therapy interventions should also include teaching stigmatized individuals how to detach themselves from their stigmatized identity. For example, an individual can identify himself or herself by attributes such as, ethnicity, gender, religion, having a stigmatized chronic disease, etc., and those who can detach himself or herself from their stigmatized attribute can identify himself or herself in accordance to their non-stigmatized attributes (Shih, 2004). This acquired skill has been found to help stigmatized individuals’ become more resilient to stress-related illnesses and depression.


**Abstract (Introduction).** No abstract or introduction provided.

**Summary and Significance.** This source is helpful because it introduces ways in which the occupational therapy can address the dysfunctional issues that stigmatization introduces through interventions. It further highlights that self-advocacy may help stigmatized individuals acquire desired social roles. Research shows that “self-advocacy involves knowing when and how to approach others in order to negotiate desired accommodations, so as to achieve mutual understanding, fulfillment, and productivity” (p. 22). Occupational therapy practitioners should focus on teaching stigmatized individuals about his or her needs, along with the appropriate amount of disclosure that he or she provides to others, in their quest to receive any necessary accommodations that may be required in order to successfully perform desired occupations and acquire a desired social role.

**Abstract.** This article aims to present an Oppression Model describing how and explaining why doctors sometimes take up the role of oppressor in clinical practice, and to furthermore create change by proposing alternatives. The model is intended to increase awareness of power issues in medical practitioners, thus creating an urge for empowering practices. Design: The Oppression Model is constructed by theoretical reasoning, inspired by empirical findings of doctor-as-oppressor from a Norwegian research project with users of psychiatric services. The model is composed of the chosen theoretical elements, assembled as a staircase model. The model is intended to give descriptions and explanations and foster change relevant to oppressive processes in clinical practice, and is mainly relevant when meeting patients from vulnerable or stigmatized groups. An Empowerment Track is conceptualized in a similar way by theoretical reasoning. The Oppression Model describes a staircase built on a foundation of objectifying, proceeding by steps of stereotypes, prejudice, and discrimination up to the final step of institutionalized oppression. An Empowerment Track is proposed, built on a foundation of acknowledgement, proceeding by steps of diversity, positive regard, and solidarity towards empowerment. It represents, however, only one of several possible ways of proceeding in developing empowering practices. To conclude, keeping the Oppression Model in mind during patient encounters may help the busy clinician to counteract oppressive attitudes and actions.

**Summary and Significance.** This source is helpful because it discusses the realities behind stigmatization within the healthcare profession. It addresses the importance of open-
mindedness and self-awareness particular to vulnerable clients who are often stigmatized targets. A model, the Empowerment Track, is drawn in an attempt to illustrate a client-centered practice that promotes solidarity and empowerment in contrast to discrimination and oppression. The concepts behind the Empowerment Track support the utilization of the Anne Mosey’s Role Acquisitional frame of reference because it holds a holistic perspective, which can help address the stigmatizing issues that are introduced (or amplified) by healthcare practitioners. With this mentioned, the information within the source further supports a role for an occupational therapy practitioner to address the dysfunctional issues that are introduced by stigmatization.


**Abstract.** Before the 20th century, female urinary incontinence was a problematic disease because it presented a medical challenge (it was difficult to treat before the advent of surgical techniques) and prevented women from fulfilling their roles as spouses and caretakers. The latter was particularly troublesome during the 19th century when Western women (i.e., white, middle/upper class, Protestant women) were expected to follow rigid, socially constructed gender roles, especially within the private microcosm of the family unit. Incontinent women of childbearing age had no place in the hierarchy of Euro-American society and were thus constructed as impure, polluted, and sexually undesirable. This stigmatization of the incontinent body not only marginalized the medical needs of the suffering woman but also characterized her as an unfeminine, contaminated, and repulsive object to be ostracized and excluded from the social rituals that defined selfhood.

**Summary and Significance.** This source discusses the history behind the stigma that
persists for females with urinary incontinence. Specifically, the stigma is that women who have the condition cannot fulfill their role(s) as spouse or caretaker. This thought, however, was introduced during the years in which socially constructed roles stressed the notion that a woman’s physiology determined her place in society. With this mentioned, physicians also stigmatized females with urinary incontinence, stressing that they were hopelessly incurable (before the advent of surgical techniques). Now, to this present day, women still feel uncomfortable discussing urinary incontinence with their healthcare providers (estimated that less than 50% of today’s women report urinary incontinence to their physicians). This source is helpful because it simply illustrates the significance of social roles; a patient will jeopardize his or her health in an attempt to ‘fulfill/maintain a social expectation’. It supports the theoretical groundings of Anne Mosey’s Role Acquisitional frame of reference, given that it aims to help individuals’ fulfill/maintain desired social roles.


Abstract. The theoretical construct of stigma has received much attention in psychiatric disability research, leading to the development of widely used measures. Such measures have had real world impact in that they allow for the assessment of stigma change efforts. The study of stigma has not received the same level of attention for persons with intellectual disabilities. In this manuscript we evaluate existing measures of intellectual disability stigma through a systematic review of the literature. Twenty-four scales were reviewed and evaluated. Findings indicate a paucity of stigma measures based on theoretical conceptualizations pointing to a need
for further development of measures to pursue the study of public, self, and family stigma as related to intellectual disability.

**Summary and Significance.** The authors discuss the stigmas (public stigma, self-stigma, and associative stigma) that surround those who have intellectual disabilities, along with the social barriers that such stigmas introduce. For example, the authors write: “Stigma has been cited as one of the potential barriers to the delivery of adequate services to this population [intellectual disabilities] (Giall, Kroese, & Rose, 2002), resulting in poorer treatment, rejection, and devalued roles within society (Corrigan et al., 2003)” (p. 750). The authors further refer to a public hierarchy of preference toward disability, and they state that persons who have either a mental illness or intellectual disability are consistently the most highly stigmatized groups (p. 3). Although the primary purpose of this article is to address a need for instrumentation that measures the several types of stigma surrounding the intellectually disabled population (i.e., public stigma, self-stigma, and associative stigma), it is helpful because it also implies a supportive role for an occupational therapist in mediating the negative impacts of stigmatization (given that the profession provides services to those who have intellectual disabilities). It also implies support for the use of the Role Acquisitional frame of reference to help guide interventions aimed at mediating the negative impacts of stigmatization (i.e., the authors state that stigmas introduce barriers, such as devalued social roles).
Literature That Helps Guide the Development of Questions for Needs Assessment


Abstract (Introduction). The Code of Good Practice for NGOs Responding to HIV/AIDS (the ’Code’) defines Stigma and Discrimination in the following way:

Stigma is a process of producing and reproducing inequitable power relations, where negative attitudes towards a group of people, on the basis of particular attributes such as their HIV status, gender, sexuality or behavior, are created and sustained to legitimatize dominant groups in society. Discrimination is a manifestation of stigma. Discrimination is any form of arbitrary distinction, exclusion or restriction, whether by action or omission, based on a stigmatized attribute. To effectively address HIV-related stigma and discrimination it is essential that:

- individuals know about their rights, and are supported to respond to stigma, discrimination and their consequences;
- communities are supported to examine the nature and impact of stigma and discrimination and play an active role in preventing and eliminating stigma and discrimination;
- people living with HIV (PLHIV) are engaged in raising awareness about HIV-related stigma and discrimination;
- institutions, such as workplaces and healthcare settings, are supported to promote non-discrimination through effective workplace polices and programs, and;
- laws and policies do not stigmatize PLHIV and members of affected communities.

Summary and Significance. The Code of Good Practice for NGOs Responding to HIV/AIDS (the ’Code’) is grounded on principles that help inspire organizational change. The Code uses the term NGO out of convenience, which refers to not-for-profit and non-government organizations. The Code is guided by the following key principles: assisting NGOs to improve
the quality and cohesiveness of work and accountability to partners and beneficiary
communities; fostering greater collaboration between the variety of NGOs now actively engaged
in responding to the AIDS pandemic; and renewing the 'voices' of NGOs responding to HIV by
enabling them to commit to a shared vision of good practice in programming and advocacy. With
this mentioned, the Code has developed assessment tools to help identify problems with
organizational practices. Of particular interest is a developed assessment tool that addresses the
problems of stigma and discrimination that are associated with people living with HIV/AIDS.
This source is helpful because it can guide the formulation of questions that focus on gaining
necessary information from stigmatized sub-populations in order to conduct a needs assessment.
Particularly, it can help guide the formulation of questions that pertain to the negative impacts
that stigmatization has on an individual’s occupational performances, which can assess whether
or not the profession of occupational therapy can play a role to address the dysfunctional issues
that are introduced by stigmatization.

**Phillips, K. (2011). Conceptual development of an instrument to measure the internalized
stigma of aids based on the roy adaptation model. Nursing Science Quarterly, 24(4),
306-310.**

**Abstract.** In this column the author describes the development of an instrument to measure
internalized stigma of HIV/AIDS based on the self-concept adaptive mode of the Roy adaptation
model. The Internalized Stigma of AIDS Tool is a 10-item instrument that is derived from the
physical self (body sensation and image) and personal self (self-consistency, self-ideal and
moral- ethical-spiritual self) as set forth by Roy. An overview of the Roy adaptation model and
the theory of the person as an adaptive system illustrates how this instrument was derived.
Summary and Significance. This article discusses the importance of utilizing a theoretical base to formulate questions for a research instrument. Moreover, it discusses the formulation of questions that measure internalized stigma. Generally, this source is helpful because it can guide the formulation of theoretically-based questions that focus on gaining necessary information from stigmatized sub-populations in order to conduct a needs assessment. It can help guide the formulation of questions that pertain to the theoretical groundings of occupational therapy, which can assess whether or not stigmatization negatively impacts an individual’s occupational performances.


Abstract (Introduction). HIV-related stigma and discrimination (S&D) has accompanied the AIDS epidemic from the start. Fear of and actual experience with stigma and discrimination reduce an individual’s willingness to practice prevention, seek HIV testing, disclose his or her HIV status to others, ask for (or give) care and support, and begin and adhere to treatment. As efforts to address S&D increase, so does the need for a set of standard tested and validated S&D indicators. Yet measures that can both describe an existing environment, and evaluate and compare interventions, are lacking…

Summary and Significance. This document addresses the need for standardized assessments to evaluate efforts that aim to reduce stigmatization. Although it is particular to the HIV/AIDS pandemic, some of the data collection items that are outlined in the document can be generalized. This source is helpful because the assessment items being discussed can help guide the development of other items (questions) that focus on gaining information from different
stigmatized sub-populations, both at the community-level and at the provider-level (those
providing healthcare services who may exacerbate stigmatization).