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SELF-ESTEEM, STIGMA AND SOCIAL SUPPORT IN OCCUPATIONAL THERAPY

M. PASCARU[1] M.-I. RAȚIU[2]

Abstract: *Our work starts from the finding that, at present time, among the theorists and practitioners of occupational therapy, the need for a holistic model of approach is invoked. In such a model, the perspective of social psychology can have a decisive role. From the field of concepts and themes of social psychology, we have chosen to focus our attention in this paper on self-esteem, stigma and social support. Each of these concepts is briefly described and then related to the substantiation needs of occupational therapy, both at the theoretical level and at the level of intervention and training of professionals in the field.*

Key words: *occupational therapy, self-esteem, stigma, social support.*

1.Introduction

According to Ramsey (2004, p. 669), the psychosocial dimensions of human performance are fundamental to all aspects of occupation and occupational therapy, with every client and in all practice settings. The mentioned author believes that the psychosocial refers to the intrapersonal, interpersonal and social experiences and interactions that influence occupational behaviour and development.

Specialists noted at one point that despite the call for an integrative and holistic approach, in practice therapists may face numerous barriers to achieving such an ideal: the large number of cases, entrenched practices, limited client resources, staff constraints and budgeting. In addition, the occupational therapist lacks a holistic, client-centred approach that integrates biological, social, and psychological factors (Gentry et al., 2018, p. 1). The model referred to by Gentry and his colleagues includes seven factors: (a) injury characteristics; (b) socio-demographic characteristics; (c) biological factors; (d) psychological factors; (e) social-contextual factors; (f) intermediate biopsychosocial outcomes; (g) rehabilitation outcomes (Gentry et al., 2018, p. 3). Socio-demographic characteristics include, in this model, age, gender, race/ethnicity and socioeconomic status. Social-contextual factors include, among others, social support, stressors and the rehabilitation environment (Gentry et al., 2018, p. 4).

[1] "*1 Decembrie 1918"* University of Alba Iulia, mihaipascarupag@gmail.com
[2] *"Babeș-Bolyai"* University of Cluj-Napoca, madalina.ratiu@ubbcluj.ro

In this introductory context, it is mandatory to remember the fact that, through the integration of the psychosocial, a distinct branch of occupational therapy has developed over time, namely *psychosocial occupational therapy*. Works such as those by Linda Finlay (2004) or Nancy Carson (2020) reflect, for example, the shift from occupational therapy for people with mental illness to a wider range of concerns targeting psychosocial abilities/disabilities. There are even works that propose a *social occupational therapy*, such as the one signed by Lopes and Malfitano (2021). Social occupational therapy is intended to be oriented towards the valuing of broader social contexts such as cultural and community ones.

In this present work we aim at bringing to attention a series of elements that support the model of the holistic approach in occupational therapy by valuing the valences of applied social psychology.

The themes of social psychology are numerous, ranging from the approach to the problem of the self to that of the community, with exceptional approaches in the field of group life and dynamics. I have chosen only three of the themes for the present approach: self-esteem, stigma and social support. Self-esteem can determine the client's involvement in the occupational therapy intervention, but it can even be its object, as Ramsey (2004) also suggested. Stigma affects self-esteem and the social support that the occupational therapist must call upon in his/her specific intervention. When the therapist's mindset is marked by stigma, we already have a big problem, as will be seen below. Social support, especially that of family and loved ones, can mark the success and sustainability of the occupational therapist's intervention.

Before the short forays into the aforementioned topics, I considered it necessary to briefly present the issue of occupational therapy and its substantiation needs.

The conclusions of our paper will also support a multidisciplinary model in occupational therapy, also inventorying a series of consequences of such a model on the training of specialists in the field.

2. Occupational Therapy and its Foundations

Synthesizing a series of documents of international circulation, Andreea Schuster noted at one point that "occupational therapy is the profession concerned with promoting health and well-being through occupation", its primary purpose being that “to allow individuals' participation in daily activities” (Schuster, 2011, p. 4). Although the primary purpose of occupational therapy is the medical one, observes Glavan, the economic-social one is no less important, the occupational therapy stimulating the “self-confidence of the sick and the natural development of the personality” and, by correlating the medical recovery with the professional one, achieving the reinsertion as quickly as possible in patient’s social, economic and professional life (Glavan, 2019, p. 274).

A defining concept in occupational therapy is that of occupation. Occupation, from the point of view of the field of occupational therapy, Popovici considered, can be analysed through the prism of fundamental characteristics of biological, psychological and social nature, the mentioned author first noting the fact that occupation "has a

basic role in maintaining and developing biological support of any human organism" (Popovici, 2005, p. 32). The influence of occupations on the psychological level is also "a particularly complex process, because practically there is no activity that does not cause changes on the mental level" (Popovici, 2005, p. 33). In this context, Popovici highlights a series of themes and problems that are also the focus of social psychology: occupation and self-image, occupation and stress or alienation. The social dimension of the occupation, writes Popovici, "mainly refers to the impact of the occupation on the structure, skills and social behaviours of the individual" (Popovici, 2005, p. 35). From this perspective, Popovici believes, the role of the occupational therapist, in the direction of supporting and social maturation of individuals, "can be expressed, either by involving them in social actions as diverse as possible, or by providing assistance to social groups, in order to integrate people with social adaptation difficulties" (Popovici, 2005, p. 36). An important remark in this context: even the title of Popovici's work suggests that occupational therapy can look at both people with impairments and people without impairments, in its content also finding references to people who remain without occupation at a given time, either due to job loss (unemployment) or due to old age (retirement).

Another fundamental concept in occupational therapy is that of the environment. Unlike medicine, which focuses on the person's illness, occupational therapy targets/must target the person and the environment. *Environment* is a complex notion, equally being able to speak of an environment that favours occupations and an environment that prevents different occupations, *disabling environment* (Law, 1991, p. 171). This is what the Canadian Mary Law wrote at one point regarding the situation in her country: "Individuals in Canada with a disability encounter environmental constraints that limit their active participation in the daily life of our communities. Fundamental inequities in participation and integration continue to exist and there is a need for a concerted effort to eliminate these disabling environments" (Law, 1991, p. 171). Several factors, such as the built environment, the social production of space, the classification of individuals based on norms, the perception of disability as deviance, the power of health disciplines and bureaucracy are analysed by Law to determine their contribution to the creation of these disabling environments.

From the above mentioned elements, it results that the environment can be physical and social. If, for example, we consider play in occupational therapy, the physical environment refers to space, arrangements and equipment. The social environment, according to Ray-Kaeser and colleagues, includes the individuals with whom the child plays, adults and peers, both familiar and unfamiliar people, who can support or influence the child's play (2018, p. 27).

The specialized literature often explicitly refers to increasing the quality of life through occupational therapy. Quality of life, including perceptions of stress and social participation, are seen as key areas of concern in occupational therapy intervention. As White et al. (2018) also note, therapists are uniquely positioned to provide services that directly impact the daily living needs reported by people living with, for example, chronic brain injury. In this case, intervention programs that promote community

reintegration and participation of the sick in community life are highlighted (White et al., 2018, p. 1).

All the things noted here, we believe, explicitly raise the issue of psychosociological foundation in occupational therapy. As I suggested before, there is almost no topic specific to social psychology that cannot be involved in this grounding. We chose, however, only three themes (self-esteem, stigma and social support), the most relevant in our opinion and in relation to the stated goals of occupational therapy centred on the client, occupation and environment, alike.

3. Self-esteem, Stigma and Social Support in Occupational Therapy

3.1. Self-esteem

In specialized literature, the concept of *self* is seen as essentially representing "the collection of beliefs about ourselves" (Iluţ, 2009, p. 315). The self, therefore, is closely related to the self-image, which represents, according to some authors, "the subjective form through which we get to know and represent our own person, with the set of traits, attributes and relationships with the natural and social environment" (Cristea, 2015, p. 201).

Self-esteem and image play a particularly important role in occupational therapy. For example, specialists in this field have highlighted the need to improve self-image in patients with depression or suicidal tendencies (Kuster and Wassinc, 1991) or in adolescents with disabilities (Adamson, 2003). An *affirmative model of disability* has even been proposed, a model in which disability is no longer seen as something negative, a fact that can facilitate the formation of a positive self-image in the client (McCormack and Collins, 2012). In turn, a positive self-image can be associated with increased self-esteem.

The phrase *self-esteem* „refers to the assessment in axiological terms of personal characteristics, of the characteristics you think you possess, that is, of how much you value yourself" (Iluţ, 2009, p. 323). It is appreciated that the level of self-esteem strongly affects performance in all activities, the mechanism of causal circularity works here particularly meaningfully: those with high self-esteem have more confidence, mobilize more and succeed better, which reinforces good opinion about oneself, while a low level of self-esteem increases the risk of failure, thus determining an even more gloomy view of one's own person (Iluţ, 2009, p. 326).

In occupational therapy, for example, the case of children with developmental coordination disorder (developmental coordination disorder), children with motor difficulties that prevent them from acquiring functional and school skills, was analysed. The data suggested that in the case of these children we could also be dealing with low self-esteem. In such situations, occupational therapists turn to group therapy. Results indicate that although these groups may produce little improvement in motor skills, there may be an associated increase in children's self-confidence and self-esteem (McWilliams, 2005, p. 393). A number of procedures and instruments for measuring self-

esteem in children with whom occupational therapists work have been proposed in previous years (Willoughby, King, & Polatajko, 1996).

Authors such as Javed, Shawana and Haroon (2020) have pointed out that occupational therapy may also be necessary for those suffering from disorders caused by traumatic events. They aimed at children who were victims of abuse, and for whom occupational therapy techniques based on verbal interactions with the therapist do not show a high degree of efficiency due to the lack of trust and the emotional difficulties encountered: the feeling of uselessness, shame or lack of trust.

Interspersed between self-esteem and productivity is *self-efficacy*. This "denotes the evaluation of the individual regarding whether or not he/she is able to solve certain tasks, achieve his/her proposed goals, face and overcome certain difficulties" (Iluţ, 2009, p. 360).

Specialists in occupational therapy draw attention to the need to evaluate self-efficacy because "alarming discrepancy between the occupational performance skills developed in the clinical setting and the degree to which the client willingly puts these skills to· use outside the clinical environment" has sometimes been observed, this discrepancy being given precisely by the client's perception of self-efficacy (Gage et al., 1994, p. 783). As a result, the cited authors propose a measurement tool suitable for occupational therapists to assess the perceived self-efficacy of the clients they work with.

3.2. Stigmatization

Very often, self-image and self-esteem are closely related to the existence/non-existence of a stigmatizing family, community or organizational context.

A large part of the studies in the field of community psychology, observe Page and Lafreniere, refer to the phenomenon of *stigmatization*, "that is, the labelling of a person as deviant or *different* from certain points of view" (Page and Lafreniere, 2005, p. 294).

As occupational therapists, professionals deal with people who are stigmatized, Taylor wrote at one point (1991, p. 406). Numerous studies have been conducted in relation to the confrontation between occupational therapy and stigma. For example, in the Australian occupational therapy space, a study was conducted among young people with psychotic disorders. Through a focus group with young people from this category, the following aspects were identified: (1) a significant decrease in internal and external control of life at the onset of the disease; (2) the effects of labelling and stigmatization on interpersonal relationships; (3) the change in self-perception brought about by the effects of stigmatization. These are aspects that are recommended to be taken into account in group interventions supported by occupational therapists (Lloyd, Sullivan and Williams, 2005).

In 2002, the American *Journal of Occupational Therapy* published a study among parents of children with motor disabilities. The analysis of the collected data reveals parents' belief in the limitation of children's social participation in the context of stigma (Segal et al, 2002).

In 2017, Stergiou-Kita and colleagues published a shocking meta-study on workplace stigma and discrimination among cancer survivors. The authors found that myths about cancer (it is contagious and always fatal) persist and can create misperceptions about the employability of survivors, potentially leading to self-stigma. Workplace discrimination could include employment discrimination, harassment, job reassignment, job loss, and limited career advancement. Strategies to mitigate stigma and discrimination in the workplace include education, advocacy and anti-discrimination policies. In this context, it is appreciated that occupational therapists can raise awareness of workplace issues and advocate on behalf of cancer survivors for different strategies to mitigate discrimination and stigma (Stergiou-Kita et al, 2017, p.8).

There are other studies that talk about self-stigma, associated with low self-esteem. Of course, self-stigma is also of interest to the occupational therapist. A study by Fung, Tsang and Corrigan (2008) also proves this. According to this study, a high level of self-stigmatization is associated with poor patient attendance at treatment.

The issue of stigma can even affect occupational therapists. Starting from such a finding, some universities in the world propose special courses for the formation of an anti-stigmatizing attitude in students in the field. This is also the case of the National Cheng Kung University in Tainan, Taiwan, which has experimented with organizing a course aimed at stigmatizing people with disabilities. Known tools of social psychology such as the social distance scale were used in the specific measurements of the experiment. The experiment demonstrated the positive impact of the course on decreasing social distance and reducing various forms of stigmatization of people with disorders/disabilities (Ma and Hsieh, 2020, p. 6). Years before, the problem was somewhat similar in Canada, where there was talk of the need for more frequent direct contact of occupational therapy students with people suffering from various mental illnesses precisely in order to reduce possible stigmatizing attitudes (Krupa, 2008, p. 203). In the same terms, the question had already been raised in Australia, where it was found that the misconceptions of occupational therapy students were associated with anxiety in front of people with mental illness (Lyons and Ziviani, 1995).

3.3. Social support

The term *social support*, noted Lafreniere and Kramer, generally refers to the resources we receive from those around us, the specialists identifying some essential characteristics that make social support effective: 1) the *size* of the social network in which we are integrated, related to the number of friends or family members we have around us; 2) the *quality* of relationships and 3) the way we know how to use social support, the extent to which *we feel comfortable* asking for help from those around us (Lafreniere and Kramer, 2005, p. 200).

Social support, Lafreniere and Kramer considered, fulfils several functions in our lives, in relation to these functions having to do with: 1) *emotional support* (empathy, love, safety); 2) *esteem support*, when others show us that we are valued for what we represent, despite the mistakes we sometimes make; 3) *instrumental support* (e.g. money, help); 4) *informational support* (advice, suggestions, feed-back), 5) *network*

support, when we have the feeling of belonging to a group that shares our interests (Lafreniere and Kramer, 2005, 201).

According to Lafreniere and Kramer, several studies show that emotional support is extremely important, especially when it comes from a life partner, friends or family, its absence having negative consequences on the person's ability to adapt, informational support being perceived as useful, but only when it comes from professionals (Lafreniere and Kramer, 2005, 201).

Research claims that the evaluation and development of social support, as a component of the intervention specific to occupational therapy, can improve the degree of the patient's community participation, as is the case with people who have survived a stroke (Beckley, 2007). The study carried out by Isaksson, Lexell and Skär (2007), emphasizes the importance of social support in the rehabilitation of people who have suffered, for example, a sudden and major injury. Social support has also been shown to play an important role in veterans' well-being and social relationships, so occupational therapy practitioners can engage veterans in meaningful activities that allow for social interaction, such as volunteering in the community (Kinney, Graham, & Eakman, 2020).

4. Conclusions and Openings

To outline some conclusions and openings of this work, we will use some directions of action proposed by the promoters of the biopsychosocial model (Gentry et al., 2018). Occupational therapists, Gentry and colleagues believe, can explore situational characteristics that may influence the rehabilitation process, which may include working in partnership with clients to identify perceived barriers to accessing needed support and/or participating fully in care or other specific situations, the concerns the client might have (Gentry et al., 2018, p. 10). Perceived barriers can also relate to self-image, esteem or self-efficacy, as defined above. The evaluation made by the client's occupational therapist with whom he/she is going to work, we believe, must also take into account aspects, meaning that the therapist needs to master and properly use tools specific to the evaluation of self-esteem, image and efficacy. Given the rehabilitation environment, the cited authors believe, occupational therapists can work to reduce the psychosocial sequelae of identified impairments and facilitate adherence to the care plan by addressing social-contextual factors. One of these factors, we believe, is stigmatization, for its measurement psychology has the necessary tools (the social distance scale, for example) and this tool must also be well mastered by the occupational therapist. An important recommendation of the specialists cited above refers to structuring the therapy sessions in such a way that other clients, other professionals or the client's family can also participate, meaning that the family will be informed about the diagnosis, the role of occupational therapy, the progress made along the way and the necessary support (Gentry et al., 2018, p. 10). In addressing social supports, Gentry and colleagues note, occupational therapists can work with clients to identify potential support resources, including family, friends, physical and virtual support groups, religious groups, and volunteer organizations. In addition, the cited authors state that therapists can work to identify and educate clients about appropriate

professional resources, including health care providers (primary care and specialists), rehabilitation and therapy providers, and psychological and counselling services, among others. (Gentry et al., 2018, p. 10). The need for the occupational therapist to provide the client with adequate informational support is suggested here.

Of course, occupational therapists, even during their training as students, know that the interventions specific to their profession target both the client and the environment in which they live. However, our impression is that often only the physical aspects of the environment are taken into account and less the psychosocial ones. A change of perspective at this level must be doubled, we insist, by the opening of the environment notion to the psychosocial field, coupled with a good preparation for the evaluation and a change of the latter. We also support the idea of *advocacy* work that therapists must promote in combating stigma and discrimination of their clients, which also means good training in sociology and social policies.

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