

# Manipulating practices

A critical physiotherapy reader

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## CHAPTER 6

# A critical perspective on stigma in physiotherapy: The example of weight stigma

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### **Abstract**

This chapter explores what might be learnt about physiotherapy by considering its intersection with stigma. Stigma was described by Goffman as a phenomenon whereby an individual has an attribute that is deeply discredited by society, and is rejected as a result as a result of the attribute; where “normal identity” is “spoilt” by the process of stigmatisation. From a post-structuralist critical perspective, stigma is not static or finite but is (re)constructed in various social, historical, cultural and political environments. A characteristic that is stigmatised in one context may not be in another. Considering this, the context of physiotherapy has the possibility to (re)create or (re)inforce stigmatisation of certain

attributes not only in ways that may reflect general societal stigma, but also in ways that may be specific to the profession. In this chapter, we discuss stigma in physiotherapy broadly, considering what it is about physiotherapy that may contribute to the discrediting of certain attributes. We use the example of weight stigma, a topical and little explored form of stigma that is becoming more evident in healthcare in the current climate of “the obesity epidemic”. We draw from empirical research, definitions and narratives of physiotherapy in different countries (particularly our home countries of Nigeria and Australia) to help examine weight stigma in physiotherapy. We explore how weight stigma is enacted in a physiotherapy context – a profession in which there is an inherent focus on bodies. We conclude with a discussion of possibilities for the physiotherapy profession to learn from a greater consideration of stigma.

## Introduction

*He [the physiotherapist] was very sporty and fit. Even though I'd been doing step aerobics I didn't feel very fit .... I think I have a stereotype that physios are very healthy and very fit and very slim and .... I feel like I'm not really like that... I guess that makes me feel sort of inadequate in a way.... It's almost like I started making lots of excuses.*

Hetti (pseudonym), from Setchell, 2015.

This chapter explores physiotherapy using a stigma lens. We argue that thinking critically about stigma can illuminate much about physiotherapy – in particular some of the psychological, social, political and power aspects of the profession. We highlight that traditional understandings of stigma tend to focus primarily on the psychological and interpersonal aspects of stigma (e.g., the essentialist understandings of Allport, and Adorno, and the symbolic

interactionism of Goffman) and do not sufficiently attend to broader contextual aspects. To further understandings of stigma in physiotherapy beyond the psychological/interpersonal, and to consider broader contextual issues, we draw on post structuralism (in particular Foucault) to engage a critical perspective. The epigraph above provides hints of some of these contextual factors: for example, it reveals that physiotherapy is constructed as health- and fitness-focussed. Often returning to the exemplar of weight stigma, we discuss how such constructions can have some (usually unintentional) negative effects, which we believe are little explored in the profession.

The epigraph, and other findings from the same study which involved interviews with patients about their experiences of attending physiotherapy, provide an opportunity to imagine what it might feel like for someone with a stigmatised characteristic (in this case being labelled “overweight”) to enter a physiotherapy clinic (Setchell, Watson, Jones & Gard, 2015). People in this study described their experiences of discomfort when attending a physiotherapy clinic including: sitting on a chair that is too small for them; seeing health promotion posters of thin people on the walls; observing sporty-looking people exercising in the Pilates area; meeting the physiotherapist who (like in the epigraph) was thin and sporty-looking; feeling like their body was exposed to judgement when they undress or are observed; and being told that their condition was due to their weight (*ibid*). These types of experiences, where the person feels judged (stigmatised) for a particular characteristic, are known to negatively affect people, including causing them to have poorer physical and psychological health outcomes; exercising less; having more disordered eating; and avoiding health care appointments – effectively being denied healthcare (Drury & Louis, 2002; Phelan et al., 2015). This chapter explores why patients might have these types of stigmatising experiences

in physiotherapy, and considers what physiotherapists might do to help create a more supportive environment for their clients. We have divided the chapter into two distinct sections. The first section is a theoretical introduction to stigma – and a critical exploration into why it might occur. The second section discusses the physiotherapy profession, highlighting how thinking critically about the nexus between stigma and physiotherapy can help develop new thinking and practices.

## Stigma

Research on the nature of stigma has spanned a number of disciplines, and many stigmatised characteristics, which may explain why there are many definitions of stigma. Crocker, Major, and Steele (1998) produced a widely-used definition: “stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context” (p. 505). Their definition, derived from Goffman’s 1963 symbolic interactionist stigma theories, outlines some of the major micro-social components of stigma: it is linked to an attribute, it involves negative judgement, it is social rather than individual, it does not reside within a person or the stigmatised characteristic but is produced in interactions with others, and it is not a static phenomenon but is created only in some contexts. Applied to this chapter’s exemplar of weight stigma, this definition highlights that people are judged negatively based on their perceived status as overweight, and that this conveys a devalued social identity in many contexts (at times including, as we will argue, physiotherapy). However, while useful, we believe there are a number of limitations to such definitions. To explore this issue, we will discuss and critique three mainstream approaches to understanding why stigma happens – and illustrate what they

might mean in the context of physiotherapy research on weight stigma. We have chosen these approaches because, while they are largely discredited as comprehensive theories, they continue to underpin most research into stigma, and are also part of what currently constitutes lay understandings of (and rationale for) stigmatisation (Dixon & Levine, 2012).

*Social cognition approaches* explain stigma as the result of the brain's oversimplification when processing the large amounts of information it receives about other people (Allport, 1954). By suggesting that all minds function similarly, these approaches present stigma as an inherent, essential part of being human. However, this theory cannot explain why only some people stigmatise. It cannot explain why some physiotherapists score highly on weight stigma tests, while others do not (Abaraogu, Duru & Setchell forthcoming; Setchell, Watson, Jones, Gard & Briffa, 2014). Further attempts to explain stigma include the *personality trait approaches* associated primarily with Adorno, Frenkel-Brunswick, Levinson, and Sanford (1950). As the name suggests, these theories posit that only people with certain personality types stigmatise; that is, the physiotherapists who stigmatise do so because they have a particular personality type. One critique of these approaches, however, is again their essentialism: they constitute personalities as static and do not allow for analysis of stigma that is incited in particular social or political contexts. Both the personality and the social cognition approaches are individualistic and cannot consider, for example, the societal or institutional production or perpetuation of stigma that has repeatedly been shown to be possible in experimental and real life conditions.

The final proposed way of understanding stigma we discuss is grounded in Goffman's symbolic interactionism. The *group membership approaches* focus on the effects on individuals of being part of a group (Tajfel & Turner, 1985). Those using these approaches argue that when people behave as members of a group

(e.g. physiotherapists) they react to other people according to their group's social beliefs in order to consolidate their own sense of identity, or as a result of cognitive simplifications (like the social cognition approaches). As a result, proponents argue that people give preferential treatment to those they identify as being part of the same social group to which they themselves belong and may stigmatise other people on the basis of perceived other group membership. Using this theory, physiotherapists (and other groups) are seen as inherently stigmatising – they might be expected to stigmatise people who are overweight (for example) if they are not seen to be similar to physiotherapists – thus constituting an outside “group”. While this group membership understanding of stigma is more complex, and takes social context into account more than other approaches we have outlined, stigma is still considered to be a by-product of cognitive simplifications (Tuffin, 2004). As a result, the same criticisms are relevant as for the social cognition approaches regarding the nature of stigma as inherent to human thinking (ibid). Some have also contested that this theory presents an oversimplified, static understanding of how groups operate, arguing that they are largely considered in isolation from wider contexts (Jenkins, 2008). For example, some cultures tend to *favour* people from other groups rather than stigmatise them (Gough & McFadden, 2013). In relation to physiotherapists and people who are considered overweight – this is a valuable approach to understand some of the stigma that might pass between the two groups, but the approach lacks the nuance to consider how broader institutional issues of power might be involved, or where these issues might vary (for example, what happens if a physiotherapist herself/himself is labelled overweight?).

In summary, while the three approaches (social cognition, personality trait, and group membership) we have discussed above may account for certain occasions of stigma they all lack mechanisms to

understand the effects of political, cultural or historical variations on stigma, and do not directly consider the relevance of power (Gough & McFadden, 2013). As a result, they are not able to account for possible contextual aspects of stigma in physiotherapy. To address these issues, we draw from post-structuralist thinking, in particular work based on theories of the French post-structuralist philosopher Michel Foucault.

Foucault considered behaviour, interactions and feelings to be produced through discourses (ways of constituting knowledge through particular patterns of thinking and doing), which he saw as created by (and creating) not only social, but also political, cultural and historical contexts (Foucault, 1977, 1978). Applied to stigma, Hannem (2012) argued that this means stigma is not only socially, historically, culturally and politically situated, but also *created* or *recreated*. Stigma is not finite or static but may be (re)constructed in varying environments and linked to power inequalities.

Foucault's theories (particularly those on governmentality) contribute an understanding that power and governance are exercised not only by the state and its institutions, such as the army and police, but also by other institutions that are not traditionally seen as exercising power (Foucault, 1979). While never directly discussed by Foucault, other theorists such as Stacey Hannem have applied Foucault's thinking to stigma in ways that help to consider ostensibly power-neutral "institutions" such as physiotherapy (Setchell, Gard, Jones & Watson, 2017). For example, Hannem (2012) noted that stigma can come from the institutionalisation of ways of managing the perceived risk of a stigmatised attribute. While the institution often intends overtly to help "when the need for assistance is justified by the inherently 'different', 'risky' or 'tainted' characteristics of the population, stigma is created in the very agencies that are supposed to be providing help" (Hannem, 2012, p. 25). With characteristics identified as risky, certain "truths" are produced



that they (or the people that possess these characteristics) require management, or what Foucault would call “discipline”. Particular behaviours and bodies are thus valorised, allowing for other behaviours (e.g., exercising, dieting) and bodies (e.g., thin, muscular) to become considered “less-than”: in this way, power is interwoven into some forms of stigma. It is important to note, however, that this power moves in both directions; people who are stigmatised can resist individuals or institutions (Foucault, 1977). These theories on power provide an opportunity to explore this production of truth in the profession of physiotherapy that may result in stigma.

Post-structuralist perspectives provide insight into the socio-political reasons behind weight stigma in a contemporary context. Foucault argued that the ingenuity of the systems of power (or what he referred to as “regimes of truth”) that create the conditions for disciplining people who have particular characteristics is that any people, even those who possess the “risky” characteristic themselves, can take up a disciplining action. People are thus disciplined (or discipline themselves) to manage this socially produced risk-truth so that they are maintained as “productive citizens” to support the ‘greater good’ of society” (Farrugia, 2009). Therefore, a person can be seen as “unproductive” or “expensive” and can be held individually accountable for this lack of productivity (Foucault, 1978). This thinking can be applied to this chapter’s example of weight stigma, but it can also help understand aspects of other types of stigma found in physiotherapy such as chronic pain or disability stigma. Foucault (1979) argued that this way of viewing people is in line with neoliberal economic rationalist systems of governance, where there is a focus on individual (rather than state) responsibility for productivity.

Furthermore, Foucault highlighted an increase in medicalisation, where attributes that had not previously been considered “an illness” were subsequently deemed “abnormal” and the subject

of medical attention – and stigma (Gard & Wright, 2005; Lupton, 2012a). For example, Murray (2007) discusses medical constructions of fatness as “deviance”, and Tischner and Malson (2012) argue that health approaches to “obesity” often present fatness as a “failing”. Again, similar thinking has been applied to other forms of stigma such as disability stigma (Shildrick, 1996).

Based on these post-structural, critical perspectives on stigma, we argue for an emphasis on power, and the historical, political, cultural constructions or enactments of stigma. A post-structural perspective helps illuminate why weight stigma, for example, appears common in the west (Puhl et al., 2015) and has been less common, but is increasing, in the global south (Brewis, Wutich, Falletta-Cowden, & Rodriguez-Soto, 2011), and that weight stigma also differs with various other contexts such as gender or sexuality (van Amsterdam, 2013). A nuanced understanding of context is thus important to an exploration of stigma. In the next section, we highlight how the context of physiotherapy might intersect with stigma.

## Physiotherapy

Overall there has been little discussion about stigma in the physiotherapy literature. A small amount of research has been done on the stigmatisation of disability, mental illness and chronic pain (e.g., French, 1994; Probst & Peuskens, 2010; Synnott et al., 2015). To summarise, this research highlights two main points: stigma occurs in a number of situations in physiotherapy, and physiotherapists lack an understanding of the stigma that their patients might experience. There is an even smaller amount of research highlighting the claim that physiotherapists also are stigmatised (or self-stigmatised) for possessing various “othered” attributes. For example, physiotherapists hold self-stigmatising fears of gaining

weight (Setchell et al., 2014), discipline their own bodies to “maintain a healthy weight” (Black, Marcoux, Stiller, Qu & Gellish, 2012, p. 1424), and negotiate disability stigma (Atkinson, & Owen Hutchinson, 2005). This second body of research, although not the focus of this chapter, highlights that it is important to acknowledge that physiotherapists too can have bodies, behaviours or attributes that may be stigmatised. As we hope readers are already starting to see, a deeper consideration of stigma might illuminate much about physiotherapy – providing opportunities to enact social, psychological and political aspects of care towards rethinking aspects of practice that might produce stigma. We now examine physiotherapy reflexively to consider some relevant assumptions underpinning the profession thinking and practices.

The physiotherapy profession demonstrates many similarities across the world, despite some local variations. Similarities are evident in the self-definitions of professional bodies on their official websites. The Australian Physiotherapy Association (2015) defines physiotherapy as “a healthcare profession that assesses, diagnoses, treats and works to prevent disease and disability through physical means”. The physical focus of the Australian association is echoed by the Nigeria Society of Physiotherapy (2015), which defines physiotherapy as involving the “evaluation of patients through the administration of physical tests to determine the presence and/or extent of an injury prior to the use of physical modalities for preventive and therapeutic purposes”. However, this focus applies not only to our home countries. For example, the Chartered Society of Physiotherapy in the United Kingdom (2015) provides a similar, but somewhat broader, definition of physiotherapy as a profession that helps “people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice”. While seemingly an obvious point, it is interesting to note the repetition in these definitions of words such as “physical”;

“exercise”, “manual” and “injury”. While these words cannot reveal what happens in clinical practice, we argue that they do highlight an underlying institutionalised assumption in physiotherapy that physical issues are primary, and necessarily demand physical tests and physical treatments. We unpack and problematise this assumption in the remainder of this chapter and argue that it is a key issue that exploring stigma exposes in the profession.

Many physiotherapists would argue that this physical focus of the profession is changing. Certainly, in recent times there have been signs of a shift away from a purely physical approach in some sub-specialities. For example, there is growing awareness that conditions such as pain may also have psychological or social origins. However, relevant to considerations of stigma, there remains a notable absence of any discussion of the cultural, political or temporal factors involved in physical health. Theoretical and philosophical investigations of physiotherapy are scarce, and some authors argue that the profession lacks self-analysis (Wikström-Grotell & Eriksson, 2012), reflexivity (Trede, 2012) and acknowledgement of its historical and sociopolitical context (Shaw & DeForge, 2012). A small but growing number of authors (many of whom are included in this book) have begun to investigate the philosophical underpinnings of physiotherapy. We draw mainly upon the work of these critical physiotherapy scholars (and at times critical health literature from related fields) to discuss elements of the profession relevant to stigma. Here we apply the Foucauldian concept introduced earlier: that power and governance play out in physiotherapy, an institution that has not been traditionally thought of as a site of political power. We make visible the elements of the profession that can render stigma (with a particular focus on weight stigma) possible, salient and consequential. We introduce these topics under three sub-headings: “positivism”; “bodies, visibility and normality”; and “professional reflexivity”.

## Positivism

Positivism is underpinned by the idea that there is a stable, knowable reality that can be described through observation and is the underlying philosophy behind traditional scientific approaches to health research. Although physiotherapy practice is arguably grounded in both humanistic and scientific paradigms, the profession generally focuses on the biomedical scientific perspective grounded in positivism (Praestegaard & Gard, 2013; Setchell, Nicholls & Gibson, 2017). Parry (2004) argued that the adoption of this orthodox “medical model” dates back to gender-related historical constraints on the women who founded the profession and who were willing to “trade autonomy for orthodoxy, to carry out ancillary and subordinate tasks ... in exchange for recognition and patronage” (p. 310). Today, this positivist way of thinking is evident (for example) in the way that randomised controlled trials and systematic reviews are upheld as “gold standards” in the profession, to the marginalisation of other methodologies (Crosbie, 2013). Orthodox biomedical approaches are also reflected in the physical focus of the professional definitions we discussed earlier, and many aspects of physiotherapy-patient interactions.

Before continuing, we want to highlight that we do not intend to suggest that positivistic scientific endeavours are unimportant, or necessarily bad. Rather, like others, we propose that this type of science can only address some of the phenomena physiotherapists deal with, while also having some underexplored negative consequences. For example, Bolam and Chamberlain (2003) argued that positivism positions the health professional as the powerful “expert”. Recent literature discusses this “expert positioning” in physiotherapy, highlighting that physiotherapy practice is often primarily practitioner-centred, where the therapist often controls the direction, content and definition of “truths” in their interactions with patients (Hiller, Guillemin, & Delany, 2015). This expert

positioning can have ethical implications (Trede, 2006; Wikström-Grotell & Eriksson, 2012). For example, Bjorbækmo and Engelsrud (2011) argued that an “expert” perspective can be noted in extensive “testing” of children with disabilities. Using a phenomenological approach, the authors suggested that such testing transmitted the physiotherapists’ views of what was “important, correct or admirable” (p. 123), which could result in insecurity and lack of confidence of the patient in themselves. In a Foucauldian analysis of Danish physiotherapy practice, Praestegaard, Gard, and Glasdam (2015, p. 22) argued that when patients resisted physiotherapists’ “regimes of truth”, including those about body size, they were met with stigma and judgement from physiotherapists:

*These patients resisted the physiotherapists’ understandings and descriptions of body image, self-care and medicalization of the body. This means that the patients do not accept the premise for physiotherapeutic treatment, and even worse, they defy by not obeying. Accordingly, the physiotherapists meet these patients with judgmental and stigmatizing attitudes. Patients, who are not able to live in the politically defined, normative “healthy” way, are disapproved as they are regarded as not taking active responsibility for their own life. (p. 22)*

Another possible negative consequence of having a positivist perspective is that the health professional is often established as a scientific or “objective” observer, assumed to be free from subjective observations or moral judgements (Lupton, 2012b). Assumed objectivity or neutrality is likely to obscure the need for critical examination of the beliefs underlying healthcare practice. In particular, the social, cultural, power and political elements of practice may not be attended to (Eisenberg, 2012; Jorgensen, 2009). Patton and Nicholls (2014) posited that lack of attention to these elements might result in health professionals having difficulty observing judgement or stigma in their own attitudes or behaviour. This explains the findings

in the stigma studies that physiotherapists often overlook that stigmatised attributes such as fatness can potentially be assigned social, cultural and economic/political value (e.g., Setchell, Watson, Gard & Jones, 2016). As Nicholls and Gibson (2012) argued, these aspects may well be overlooked as “confounding factors” when employing a predominantly positivist perspective.

We want to be careful to clarify that we are not suggesting that positivism *necessarily* leads to behaviours such as practitioner-centred practice or positioning the therapist as an “expert”, nor that these ways of working always lead to less ethical practices. Rather, we wish to argue that in relation to the stigma, it is important to consider potential issues of power involved in positivism, which can be evident in some of the clinical expressions of this particular way of viewing the world.

## Bodies, visibility and normality

The body is clearly central to practice in physiotherapy. “Doing” physiotherapy involves closely observing bodies, touching bodies, and partial undress of the body. In clinical settings physiotherapists commonly comment on, assess, move bodies or body parts. Furthermore, they ask patients to be aware of their own bodies, so that, for example, patients can learn about and potentially change their postural or movement habits. This can involve physiotherapists encouraging patients to give visual attention to their bodies by observing themselves in mirrors or video recordings. Clinical interactions are frequently about two (or more) bodies interacting in close and intimate ways. We argue that these interactions are about the fleshy reality of bodies at least as much as about thinking about the vector a muscle exerts on a bone or the number of degrees a joint moves. The corporeal presence of bodies (and thus corporeal stigmatised attributes such as fatness) are thus routine and integral parts of physiotherapy.

While a physiotherapist might ostensibly focus on observing the movement of a joint, other elements of what they are doing have implications for the visibility of stigmatised characteristics. Returning to this chapter's example of weight stigma, the fatness of a body is likely to be more obvious because the physiotherapist may have removed clothing from the body, might be touching the body and looking closely at the body (Setchell et al., 2015). Increased visibility of this stigmatised attribute could have a number of effects on the consultation. Rolls of fat can become exposed, touched, and under the therapist's gaze (*ibid*) in ways that are rare in many other healthcare environments (e.g., dentistry or psychology) or most day-to-day interactions. Regardless of what the therapist is actually thinking, the way the body looks – including visible stigmatised characteristics – may become a particularly salient issue for people in physiotherapy contexts.

Despite the integral involvement of the body in physiotherapy, little theoretical or philosophical attention has been given to how the body is constructed, viewed and managed by the profession (Nicholls & Gibson, 2010). This is not unexpected when considering the predominantly physical focus of the definitions of the profession presented earlier in this chapter and the positivist theoretical perspective that underpins much of the thinking in the profession. Congruent with these theoretical underpinnings, Nicholls and Gibson (2010) argued that physiotherapists generally attend to the body in a biomechanical (or “machine-like”) way. For example, physiotherapy research and clinical work has placed much focus on the length of muscles, joint range of movement, the type of exercises to prescribe for a particular condition and physical function (Jorgensen, 2009; Thornquist, 2006). However, there are many other possible understandings of bodies that physiotherapy marginalises, such as the person's lived experiences of their body in health and illness, and the social, cultural or political meanings of



bodies, including stigma. The priority physiotherapists ascribe to various understandings of the body has important implications for clinical practice.

Using a Bourdieusian approach, Gibson and Teachman (2012) examined the biomechanical focus of the profession, arguing that physiotherapists put considerable effort into establishing what a “normal” body is. This effort can be seen in studies such as the *1000 Norms Project*, which aims to establish for physiotherapists what a “normal” range is in “healthy” humans in the areas of dexterity, balance, ambulation, joint range of motion, strength, endurance and motor planning (McKay et al., 2016). Looking at power from a Foucauldian perspective, considering who constructs what constitutes “normal” is very important, as these people have the power to decide who/what needs intervention (disciplining) to become more “normal”. As discussed by Nicholls and Gibson (2010), having a construction of a “normal” body in physiotherapy necessarily means an “abnormal” or “deviant” body is also established. When physiotherapy seeks a normatively functioning body it “disciplines” bodies that are “abnormal”. Notions of normality can contribute to negative self-identities, and potential stigmatisation, of those who are constructed as “not normal”.

## Professional reflexivity

Considering the potential issues that we have outlined associated with positivism and the understandings of bodies, we suggest it is a matter of concern that authors have highlighted a lack of reflexive practice within the profession (Shaw & DeForge, 2012). Clouder (2000) has argued that this lack can be seen at an individual level where, unlike some other healthcare professions, reflexivity is not an established part of the practice and education of clinical physiotherapists. In some cases, clinical

*self-reflection* is encouraged (Patton, Higgs, & Smith, 2013) and has been taken up institutionally (Frith, Cowan, & Delany, 2015; Rowe, 2012). However, in discussing interviews and workshops with physiotherapists on the topic of self-reflection, Clouder (2000) highlighted that while participants often demonstrated the ability to reflect on the technicalities of practice (such as the success of treatment techniques), they found it difficult to consider their own subjectivity: “the clinician her/himself did not appear to be part of the reflective frame of reference. Even though self-awareness was clearly identified as important, there was – without exception – a transfer of attention to the client/patient” (p. 216). Similarly, Trede (2006) maintained that there is little prioritisation of a deeper individual reflexivity, such as consideration of social, philosophical, interpersonal, emotional, embodied or power elements of practice. We suggest that this could mean that physiotherapists are ill-equipped to recognise and respond to potentially complex or sensitive interactions involving stigma. There is also a lack of theoretical and philosophical reflexivity at the discipline level. For example, little attention is given to these factors in physiotherapy education curricula or research endeavours (Nicholls & Gibson, 2012; Setchell et al., 2017). Without these intellectual resources, the profession is likely to be unaware of its theoretical underpinnings; psychological, social and political issues such as stigma; and may struggle to find other ways of thinking about its practice.

## Conclusion

Thinking critically about stigma in physiotherapy opens up opportunities to think and practice otherwise in the profession. Investigating stigma in physiotherapy has an unsettling effect on some of the premises currently underpinning the profession: it

contributes to thinking and practice that questions the dominance of the body-as-machine focus of the profession. Questioning this focus supports calls for the profession to incorporate other elements such as the socio-political aspects of bodies and other things. It contributes to calls for more person-centred approaches to the individuals who seek our care. Encouragingly, this work has begun to be taken up in a number of areas. For example, a number of physiotherapists have argued for more reflexivity in education and practice. Both Patton et al. (2013) and Rowe (2015) argued that it is important to critically examine physiotherapy pedagogy to enhance clinical learning, and Nicholls and Gibson (2012) discussed the importance of philosophy in physiotherapy. Further, Grace and Trede (2013) suggested the need to rethink pedagogical approaches to incorporate philosophical knowledge. There are also a growing number of physiotherapists who are developing comprehensive theoretical insights into physiotherapy (Nicholls et al., 2016; Nicholls & Gibson, 2012; Setchell et al., 2017). This book also contains many examples of physiotherapists approaching the socio-political and philosophical aspects of the profession that can help physiotherapists build the theoretical resources to be aware of aspects of stigma discussed in this chapter. Broadly, this thinking matters politically. It is a challenge to an over-reliance on reductionist thinking, including powerful systems that preference individual blame for health conditions. This chapter supports other critical thinking that advocates a paradigm shift to a physiotherapy that incorporates broader considerations of the socio-political conditions that create the possibilities for issues such as stigma.

## Acknowledgments

Much of the material presented in this chapter is a reworked version of an unpublished section of Dr Setchell's PhD thesis, and a

small section has already been published in *Physiotherapy Theory & Practice* (permission has been granted by the journal to reproduce the content here).

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