Proud and Visible as Occupational Therapists

As occupational therapists, we provide an essential service to society. We assist people to lead productive, healthful, and creative lives. We remind the greater culture that every human has inherent value and worth and deserves the caring attention necessary to flourish. We understand the central importance of meaningful occupation to the physical, mental, and spiritual well-being of all people, and we work to change the current societal structure so that it affords all individuals access to meaningful occupations. We believe in human potential and understand the importance of assisting our clients in the process of empowerment. As occupational therapists, we deserve to stand visible and feel proud of the importance of our work and the ideas we profess. Are occupational therapists proud advocates of our profession?

Undoubtedly, many occupational therapists could answer this question with a resounding yes. Without the belief, energy, and commitment of occupational therapists throughout this century, our profession could not have grown and understood the importance of meaningful occupation to the physical, mental, and spiritual well-being of all people. Despite these advances, other questions are troubling. Why do so many of our colleagues still not know what occupational therapy is? Why do we still struggle to convince third-party payers and legislators of our value? Why are the voices of occupational therapists often not heard in treatment team meetings? Why do occupational therapists not promote our profession, as Rely did (1962), as one of the great ideas of the 20th century?

These questions point to an ongoing struggle within occupational therapy for personal and public recognition of the value and meaning of our work. Although many factors contribute to this struggle, two factors—ablebodism and sexism—have an especially strong effect on the identity of occupational therapy.

**Ablebodism**

*Ablebodism* refers to the negative and often uninformed attitudes of persons without disabilities or without obvious disabilities toward persons with obvious disabilities. *Saxton (1988)* pointed out that these attitudes range from rudeness to avoidance, from pity to resentment, or from vastly lowered expectations of the person to an all-pervasive awe. This complicated "ism" has a number of roots. To understand negative attitudes toward people with disabilities, we must examine our culture's attitudes toward people who are presently nondisabled. Within American culture, we face a tremendous emphasis on youth, beauty, and fitness. Many of us who are nondisabled are dissatisfied with our bodies because we do not meet the standards of beauty portrayed in popular media and popular ideals. Advertisements present a multitude of messages that our bodies are not attractive enough and that they need alterations ranging from dieting and make-up to plastic surgery and liposuction. Although this oppression regarding our bodies has been more obviously imposed on women (Brownmiller, 1984; Orbach, 1978; Wolf, 1991), fashion and fitness consciousness seems to be gaining momentum with men.

If it is so difficult for nondisabled people to appreciate their bodies, it is no surprise that many people experience discomfort with people who have physical differences and disabilities (and persons with disabilities face compounded self-image problems). Contact with persons who have disabilities can remind nondisabled persons that they are only temporarily nondisabled, that one day they will lose their current abilities and appearance—a terrifying thought, especially if they already feel unattractive and inadequate.

A second factor in the formula for ablebodism is the isolation of people with disabilities from the larger culture. Despite recent advances in the passage of the Americans with Disabilities Act (Bowman, 1992), barriers in the areas of education, employment, and accessibility continue to keep persons with disabilities separated from nondisabled persons. Increased contact with disabled persons has been noted as a factor affecting positive attitudes in nondisabled persons (Archison, Beard, & Lester, 1990; Berrol, 1984; Mitchell, Hayes, Gordon, & Wallis, 1984). Lack of experience, coupled with the aforementioned awkward feelings about bodies that are different, leaves many nondisabled persons uncertain of what to say or how to act around persons with disabilities. Because the disability is noticed so acutely, the uniqueness of the person is not noticed. Nondisabled persons often avoid disabled persons to
avoid this discomfort. Lack of contact with persons with disabilities means that many nondisabled persons lack information about disabilities and are out of touch with the everyday lives, struggles, challenges, and successes of these persons. They may think of persons with disabilities as less than human without realizing the many ways in which they are more similar to than different from nondisabled persons.

Occupational therapy focuses primarily on the everyday lives of persons with disabilities—the activities of daily living that temporarily nondisabled persons take for granted. Because most persons are out of touch with the everyday lives of persons with disabilities, it is difficult for them to comprehend what occupational therapy is. That anyone besides young children might need special adaptations or assistance with bathing, dressing, feeding themselves, getting to school, playing, or being productive is not easily understood by many persons.

Because women have been socialized to be the primary caretakers of children and bodily needs, it is not surprising that occupational therapy tends to be dominated by women. By society’s current standard, children might be considered disabled because of the assistance they require with activities of daily living (e.g., dressing, bathing, and feeding) and the special equipment they need to function independently (e.g., step stools and special spoons and bottles).

The high value that our culture places on independence is a third variable that contributes to ablebodism. Rugged individualism—handling daily life with minimal assistance—is emphasized in the United States. Dependence on others is considered a weakness. Feminist scholars are critical of this value in our society (Gilligan, 1982; McIntosh, 1985; Miller, 1987; Surrey, 1985). Separation and individualism without continued closeness in relationships and reliance on others are identified as detrimental to psychological well-being. In their article elsewhere in this issue, Brown and Gillespie suggest that, because persons with disabilities often need ongoing assistance in handling life tasks, occupational therapists should rethink the concepts of independence, dependence, and interdependence in their practice.

Sexism

Sexism dovetails with ablebodism in contributing to the low visibility and status of occupational therapy, in which 93% to 95% of professionals are women. Saxton and Howe (1987) identified a number of parallels between the oppression of women and disabled people: “Both groups are seen by others as passive, dependent, and childlike; their skills are minimized and their contributions to society undervalued” (p. xii). Thus occupational therapy not only serves undervalued persons, those with disabilities, but is also dominated by undervalued workers. Is it any wonder that occupational therapists do not always stand proud and visible about our work?

Sexism conveys to women that they are less capable, less intelligent, and essentially less important than men. Evidence of sexism is readily noted in the political, social, and economic structures in this country. Current estimates are that college-educated women earn 59 cents for every dollar that their male counterparts earn (Faludi, 1991). Despite advances of the women’s movement and the men’s movement, women still perform 70% of the unpaid work related to parenting and housework (Faludi, 1991). The political structure in this country is still overwhelmingly dominated by men, with women making up 5% of the Congress and about 17% of the state legislatures (Smeal, 1991). Violence to women further exemplifies one of the most horrific effects of sexism in our culture. The Congressional Record (1991) reported that in the United States a woman is raped every 6 minutes and beaten every 18 seconds. Although women have made many gains in this century, the oppression of women continues in this country and throughout the world.

Perhaps one of the most crippling effects of any oppression occurs when oppressed persons begin to internalize and believe negative stereotypes about themselves. How many of us, as women, doubt our competence, our value, and our intelligence? How many of us find that our internal critic is our own worst enemy? A number of scholars (Freire, 1970; Pheterson, 1986; Sherover-Marcuse, 1986) described this process of self-negation and self-doubt as internalized oppression. A sense of powerlessness is at the root of this phenomenon and may explain the acquiescence of women in our society to subordinate roles, especially within the patriarchal system of medicine and health care.

Besides the toll that internalized oppression takes on a person’s self-worth, “members of an oppressed group often mistreat each other in an unconscious imitation of their own suffering” (Sherover-Marcuse, 1986, p. 4). Despite some of the progress of the women’s movement, women still fail to fully support other women as they strive to move out of their oppression. Although progress has been made, Bass’s statement holds true that “women are also terrified by female strength, women judge success in women to be the worst sin, women force women to be ‘unselfish’” (1982, p. 7). This feature of internalized oppression follows the concept of divide and conquer. If women were not divided against each other, the oppression of women could not be maintained.

As female occupational therapists, we need to examine the role sexism has played in the development of our self-concept and our attitudes toward other women. We deserve to take pride in who we are as persons and as professionals, to fully appreciate all our strength and to acknowledge areas for improvement and growth without being too hard on ourselves. We will have to offer as well as receive support and appreciation from our colleagues and coworkers for the internalized and the externalized oppression of women to be eliminated. This support can provide us with the energy to challenge the limits of sexism in the personal, professional, and political spheres of our lives.

Pathways to Pride and Visibility

Gilfoyle (1986) has been a tremendous advocate for occupational therapists to address their own self-esteem, not just that of their clients. She stresses the strong relationship between self-esteem and leadership and demonstrates how good leaders care for themselves and their constituency. As more occupational therapists discover the reservoirs of self-esteem within and take on greater professional leadership, occupational therapy will continue to flourish. Again,
we must support one another for this leadership to be built and sustained.

Benham (1988) found that occupational therapists tend to hold favorable attitudes toward persons with disabilities. In researching attitudes of occupational therapy students, Estes, Dever, Hansen, and Russell (1991) found that there was no major difference between these students and medical technology students upon entering their respective curricula. However, occupational therapy curricula had an important effect on the development of positive attitudes toward persons with disabilities in occupational therapy students.

A similar study conducted by Lyons (1991) provided contradictory information about the attitudes of occupational therapy students. In comparing occupational therapy undergraduates with business undergraduate students, Lyons, like Estes et al., found no significant difference in the attitudes of freshmen and found no variation in the attitudes of occupational therapy students during successive years of education. However, those students who had contact with persons with disabilities beyond the caregiver–care receiver relationship had far more positive attitudes than those who did not. This study confirms the work of Donaldson (1980), which indicated that interactions are much more likely to be successful when the person with the disability is of equal or higher status than the nondisabled person.

The results of these studies suggest that occupational therapists ought to continue to examine and improve our attitudes. The true test of eliminating any oppression, whether it be racism, antisemitism, ageism, or ableism, is the degree to which we eliminate barriers and welcome people who are different into our lives as friends, partners, and family members. Contact with people with disabilities solely in the helper role may perpetuate ablebodism.

If occupational therapists are to be proud and visible, we need to eliminate the effects of both sexism and ablebodism from our self-image. We need to be advocates for equal rights of all people. Pheterson (1986) defined pride as "self-acceptance and self-respect...[it] carries with it an indignation against the abuse of any human being, including oneself, and a vast resource for perseverance and righteous struggle. Most fundamentally, pride derives from deep love for oneself and for life." (p. 148). She defined visibility as "being oneself fully, openly, undefensively and expressively" (p. 148). I encourage all occupational therapists to engage in the process of becoming fully visible and proud of the important work we do. ▲

References


Bowman, J. (1992, February 27). Focus: ADA—What you need to know. OT Week, 6, pp. 16-17.


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