Holism in Occupational Therapy: Elusive Fiction and Ambivalent Struggle

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Key Words: philosophy, occupational therapy • qualitative method

The profession of occupational therapy is said to have underpinnings of holistic, humanistic, and client-centered values. How does this claim translate into practice? This article reports on a qualitative study in which the practice experiences of 12 occupational therapists in the United Kingdom were explored. Through phenomenological analysis of interviews and participant observation data, the findings revealed that although holism is indeed valued, considerable uncertainty exists about what it actually means. The therapists studied seemed to understand holism and enact it in different, sometimes contradictory, ways. Further, each therapist's practice could be simultaneously reductionistic and holistic, depending on the perceived needs of the situation. Therapists struggled to negotiate the tensions between beliefs and practices and to cope with their uncomfortable feelings when they did not achieve their ideals. Although the occupational therapists in this study strove to be person-centered, the demands of their work context pushed them to be pragmatic and strategic.


The philosophical core of occupational therapy is humanistic, holistic, and client-centered (Hagedorn, 1995; Hemphill-Pearson & Hunter, 1997; Mayers, 1990). Patients and clients are seen as individuals with their unique values, skills, problems, needs, and wider cultural heritages. However, research has challenged the degree to which occupational therapy practice can be holistic given the realities of time, financial constraints, and hegemony of more reductionistic biomedical paradigms. This article reports on a qualitative study in which, as part of a broader exploration of the life world of occupational therapists in the United Kingdom, the extent to which therapists identified holism as underpinning their professional practice was examined.

Defining Holism

The term holistic comes from the Greek word holos meaning unity or oneness, wherein the whole is seen as more than the sum of parts (Popper, 1957). The concept has a long tradition in philosophy (see Hemphill-Pearson & Hunter, 1997, for a review of the literature). For example, Hippocrates stressed the interdependence of mind, body, and spirit and the need for harmony between people and their natural and social environments. However, with dominant ideological traditions of Judeo-Christianity and the sciences of Western Enlightenment, the practice of splitting mind, body, and spirit emerged. Even the early Greeks recognized the tension associated with this tendency. In the
The American Journal of Occupational Therapy

Charmides, Plato’s protagonist argues that it is “the great error of our day in the treatment of the human body, that physicians separate the soul from the body.” The physician must “try to treat and heal the whole and part together.”

This call for holism has continued through to the 21st century and has been applied particularly to the fields of medicine and health care. Engel (1980), for example, offered what he termed a biopsychosocial approach to health centered on the person’s experience of illness. He distinguished between professionals operating from a biomedical perspective, whom he saw as interested in analyzing humans in terms of smaller subsystems, and those taking a holistic perspective that focuses on humans and the larger systems within which we interact. Similarly, linking holism with general systems theory, Kielhofner (1992) saw holism as providing “a view of the world as a vast, integrated network of components in which parts are incorporated into wholes” (p. 63).

In reviewing literature that explores holistic approaches to health care (Barnitt & Pomeroy, 1995; Hemphill-Pearson & Hunter, 1997; McColl, 1994), four underlying assumptions can be discerned:

1. Humans should be viewed as unique, integrated beings where mind, body, and spirit are intertwined.
2. States of health and illness arise out of an interaction of physical, psychological, social, and environmental factors.
3. People have a self-healing capacity when they are able to take responsibility and determine what is needed for their own health.
4. Health care should aim to create lifestyles conducive to personal fulfillment, health maintenance, and integration within the environment.

**Occupational Therapy’s Holistic Values**

Concepts of holism pervade the occupational therapy profession. Hemphill-Pearson and Hunter (1997) argued for the need to recognize the interdependence of body, mind, emotion, and spirit. As Christiansen and Baum (1991) expressed it, “Because of occupational therapy’s focus on life performance, it is neither somatic, nor psychological, but concerned with the unity of body and mind in doing” (p. 9). Referring to practice in the United Kingdom, Finlay (1997b) understood occupational therapy as aiming to view and treat persons as complex whole beings, attending to emotional, cognitive, social, and physical aspects rather than honing in on isolated parts.

The profession’s brand of holism also embraces other humanistic ideals. Occupational therapists seek to empower their clients by being client-centered and by having clients take an active role in the treatment process (Stein & Cutler, 1998). The client is seen “not as an object or thing to be manipulated, controlled, or made to conform but as a unique individual whose very humanness entitles him [or her] to choices in determining his [or her] own destiny” (Yerxa, 1967, p. 3). Yerxa (1983) contrasted occupational therapists’ holistic values with the more reductionistic values of medicine, arguing that despite occupational therapy’s proximity to the medical model, the profession remains ideologically separate. Occupational therapists, for instance, expect clients to participate actively in treatment, whereas medicine has, in general, preferred a more passive patient relieved of responsibility. Additionally, occupational therapists value being person-centered by seeking clients’ subjective perceptions of their problems, whereas medicine values objectivity and the use of scientific diagnosis.

**The Challenge of Applying Values in Practice**

Hemphill-Pearson and Hunter (1997) provocatively highlighted how the adjective holistic “has been revived and applied and misapplied to almost every human endeavor from jogging to home building” (p. 37). Pointing to a gap between ideas and practice in occupational therapy, McColl (1994) identified certain ambiguities and contradictions in understandings of the term holism. She suggested that although occupational therapists currently value holism, their behavior favors reductionism. McColl argued that a number of changes to the discipline of occupational therapy (in terms of its focus, relationships with others, context of treatment, and knowledge base) are required if it is to call itself a truly holistic profession.

Other literature seeks to explain the tensions between professional beliefs and occupational therapy practice. Fondiller, Rosage, and Neuhaus (1990) drew attention to the challenge faced by therapists who seek to pursue holistic practice within health care systems that are essentially unsupportive of their priorities. Conflicts emerge as cost containment is sought to be reconciled with the delivery of quality care. Shifts to more mechanical practice are seen, in part, as a function of the realities of the work setting where person-centered caring is being replaced by procedure-oriented, efficient routines (e.g., swift discharges to release bed space). Referring to the routinization and rationalization of health care, Peltoquin (1990, 1993) suggested that therapists who act as technicians and authoritarian parents reflect society’s preference for rational problem fixing, but this approach can compromise more personal, collaborative caring. Burke and Cassidy (1991) echoed these arguments, pointing to the changing nature of the therapist–client relationship in the context of practice in the United States. They highlighted the growing numbers of occupational therapists obliged to use reductionistic and technical protocol-driven approaches to treatment, in the process moving away from both holistic and individualized care.

Another strand of research argues that significant dilemmas confront some occupational therapists who work within the medical model context. Phillips (1996) explored
the emotional labor of nursing in terms of the tension of applying holistic health care in a society that holds biomedical paradigms in high regard. With reference to British practice, Barnitt and Pomeroy (1995) highlighted a longstanding conflict among health service professionals between the medical model and the psychosocial, or humanistic, model. Similarly, in the United States, Fleming and Mattingly (1994) suggested that "occupational therapists often find themselves torn between a concern to 'treat the whole person' and a concern to be credible within a medical world that pushes therapists to redefine problems and treatment goals in biomedical terms" (p. 296). Thus, the disjuncture between what therapists do and what they say they do is potentially problematic.

The push toward procedural and scientific routines can be understood, in part, as therapists’ pursuit of greater professional prestige. In Hubbard’s (1991) view, occupational therapists believe that they have limited professional standing compared with physiotherapists, with one explanation being that physiotherapy enjoys a higher status because its key concepts are more in tune with a medical model. Phillips (1996) noted the contrast between the discourse of caring and attempts by health professionals to raise their standing by buying into more prestigious biomedical and scientific paradigms. However, a counterrtrend is evident in the United Kingdom, where some health professionals in search of special status have adopted holism as their defining contribution. Because of this trend, the concept of holism has grown as a form of rhetoric designed to persuade others about the value of occupational therapy (Finlay, 1998).

Other research, however, has not identified significant tension between holistic values and practice in medical contexts. In Australia, Adamson, Sinclair-Legge, Cusick, and Nordholm (1994) surveyed 378 occupational therapists and found that client-centered interaction, client responsibility, and holistic attitudes toward health care were valued above any biomedical approach. Age and years of professional experience also yielded significant differences between therapists in their accounts of practice, with the more experienced therapists tending to emphasize a humanistic approach.

Some researchers, however, challenge the degree to which occupational therapy practice can ever really be holistic. Barnitt and Mayers (1993) recognized the emphasis on holism given in academic programs in the United Kingdom but disputed whether it has any application in the field given the realities of time and financial constraints. Similarly, Finlay (1997a) contended that holism can only be aspired to within a wider treatment team and that pragmatic reductionism from individual professionals is to be expected. Describing how psychiatric nurses and social workers seek to embrace the concept of treating the whole person, Barker and Baldwin (1991) found their actual practice to be reductionistic and antiholistic. Holism, concluded these researchers, was "romantic fiction" (p. 174). In contrast, Barnitt and Pomeroy (1995) argued that holistic and reductionistic approaches should be seen to exist on a continuum rather than as competing alternatives.

Research Aim

Overall, although there is room to doubt whether practice can be holistic, the assertion that holism provides the foundation for occupational therapy is alive and well. But, to what extent do occupational therapists actually value and enact holistic practice? What exactly do they understand by the concept of holism? Do universal understandings of holism exist that can be applied to professional practice in different settings across cultural and national boundaries? These questions gave impetus to my doctoral research (Finlay, 1998), the purpose of which was to explore the life world of the occupational therapist in the United Kingdom. Although not specifically focused on the question of holism, this dimension, which is basic to occupational therapists’ understandings of the meanings of their practice, emerged strongly. It is these specific findings that are reported in this article.1

Method

Design

Qualitative methodology, in the form of in-depth, relatively nondirective interviews and participant observation, was used to access the meanings and experiences of individual therapists. A phenomenological approach (Giorgi, 1975) was adopted to describe the therapist’s life world, as opposed to explaining how or why the meanings arise. The therapists’ expressions of their worlds were both accepted (i.e., not morally judged) and assumed to reflect their perceptions of their life worlds. Throughout both the interview and the analysis, I, the researcher, attempted to “bracket,” or set aside, presuppositions and previous assumptions (on the basis of theoretical understanding and professional experience) in order to attend, genuinely and actively, to the therapists’ views. I strove to adopt an attitude of open-ended presence to the therapists’ stories as they unfolded.

Participants

Twelve occupational therapists practicing in the United Kingdom were studied. Nine were interviewed, and three

1This dimension of how therapists understand and enact holism emerged from a broader theme entitled, “Who Am I? The Fraught Search for an Occupational Therapy Identity.” Three further themes emerged on describing the life world of the occupational therapist: (a) “The Mission To Make a Difference: Enacting the Therapists’ Craft”; (b) “Negotiating the Boundaries: The Caring–Power Relationship”; and (c) “Safe Haven or Battleground? Collaboration and Conflict Within the Team.” Limited space prevents wider discussion of these broad, life worldly themes.
were shadowed as they went about their workday. The selection criteria of this (convenience) sample were that all participants were experienced therapists who had trained in the past 10 years and were not personally known to the researcher. All participants carried a clinical load, and some carried additional management roles. Contact names of potential therapist-participants were generated by local occupational therapy educators who had good occupational therapy networks. Those therapists selected worked in a range of health care contexts. Of the participants specifically named in this article, Karen, Anne, and Stephen worked in physical hospital settings that treat patients with a range of medical, surgical, and neurological conditions. Julie worked in a large psychiatric hospital. Mary and Susan were community mental health therapists, whereas Jane worked in the community in a social services department dealing with home care needs. The three participants I observed worked in contexts that were relatively unfamiliar to me, and I hoped that this additional participation experience would further enrich my understandings. To ensure confidentiality and anonymity, the names given in this article are pseudonyms and details about where the interviews and observations took place have been purposely blurred or omitted.

Data Collection

For the nine participants who were interviewed, unstructured interviews lasting approximately 1½ hr each were used to gain information about their thoughts and beliefs about their work. To help put them at ease, the interviews took place in their own work contexts at a time and place of their choosing. The participants gave their consent to have the interviews recorded and, in return, were offered the full transcript of the interview on which they could comment. The participants were invited to describe their experiences of work in general. No specific question about holism was asked to avoid leading the participants unduly. Attempts were made to adopt an easy conversational style, and questions or requests for illustrations tended to be in response to topics initiated by the participant.

Participant observation, which involved shadowing three participants over the course of 4 weeks, was used to gather information about their day-to-day experiences. Observation notes of key interactions and discussions were written, with the participants’ knowledge, at regular intervals throughout each full workday.

A third source of data came from a field diary. This diary included field notes that I wrote before and after each interview or at the end of each day of observation and a reflexive diary in which I recorded introspections about my own experience as a researcher and mental health therapist.

Data Analysis

A separate, in-depth, phenomenological analysis was carried out on each participant’s interview. Common themes and meanings were then identified across the interviews. Using the analytical method suggested by Wertz (1983) and Giorgi (1975), I undertook repeated, systematic readings of the transcripts by first dwelling on the phenomenon (through empathetic immersion and reflection) and then describing the psychological structures (i.e., constituents, recurrent themes) that were present (Finlay, 1999). The observation data were similarly processed to provide a descriptive account of each participant’s daily work experiences and a qualitative analysis of emergent themes. No specific coding frames were used because I thought that these might unduly predetermine what I observed. In both interviews and observations, analyses proceeded from the particular to the general by retaining those features that were essentially invariant across the cases. The results of the analyses—both individual and general—related specifically to the theme of holism are presented here.

To promote analytical rigor and trustworthiness, reflexive analysis of my own feelings, reactions, beliefs, and assumptions was undertaken. Two research supervisors oversaw all stages of the research process, scrutinizing and commenting on both the data and my subsequent analysis. Two participants were also invited to comment on the analysis of their own interviews. Additional participant validation was not attempted because the other participants were not inclined to be involved in this more challenging and time-consuming way.

Findings

Three themes of meaning specifically related to holism emerged: (a) “The Celebration: Valuing Holism”; (b) “The Search: Working Out What Holism Means for Practice”; and (c) “The Struggle: Tensions of Applying Holism in Practice.” Each theme is illustrated here with a few quotations selected from the participants’ narratives to show how I have interpreted the data. These narratives reveal both implicitly and explicitly how the therapists have grappled with applying their holistic values in practice.

The Celebration: Valuing Holism

All the participants seemed to believe strongly that they needed to see their clients as individuals with unique biopsychosocial needs and particular personal and social histories. The participants located clients’ problems in the broader context of social roles, relationships, and environment. In these ways, they all seemed to clearly value holistic, person-centered approaches to therapy and to prize social models of treatment more than medical models.

For example, Mary described her clients as persons whose mental health problems were a product of their own social history and current relationship dynamics. Mindful of her holistic professional philosophy, she was careful to use the appropriate terminology in her interview, correcting herself when she thought she had lost sight of a person’s...
individuality: “She’s in her late 30s. Very checkered history....Her husband is an alcoholic...she was abused as a child...she was like a typical abuse—no she’s unique—it’s not typical abuse.”

Participants’ comments frequently reflected the way they looked beyond the presenting clinical condition. Several stressed the need to envisage clients in terms of what they looked beyond the presenting clinical condition. “You see them at the end,” explained Stephen, “being able to function in normal life. To a certain degree, you can relate that back to your intervention, and it’s really satisfying.” Similarly, Jane expressed feeling thrilled when she enabled her clients’ lives to be transformed within their home environments:

A good week is when things go right for people, like someone gets a stair lift installed. I mean that is the great thrill of being a community occupational therapist....It’s seeing somebody who has fought for a year or so, has slept downstairs with a commode in one corner. Suddenly, their sitting room is all fresh and nice. They’ve got chairs again, the bed is back upstairs, and they’re going downstairs!

Often, excessive workloads constrained participants’ abilities to be fully holistic, but even in these circumstances, they tried to remain aware of and open to possibilities beyond medical concerns. For example, Anne seemed attuned to picking up personal motivations—a key component of her skill in communicating with clients. Within 1 minute of meeting one particular client, she grasped that the person was house-proud and did not want to lower her standards of housekeeping. Anne seemed to view clients more holistically on the occasions when it was especially relevant for effective intervention, such as when she sought information about a client’s home circumstances to ensure that the discharge home would be safe.

For some participants, holism was not even something one aimed for; it was what one was by definition, and this was a source of pride. Several participants considered themselves to be holistic simply because they saw occupational therapy (unlike many other professions) as a holistic profession because their training encompassed areas of mental health, learning disabilities, and physical disorders. As one participant explained, “The things I feel are important are—well, it’s all the jargon—it’s looking at them as the whole person....I have training in three areas...so I can look at that person as a whole.”

Susan was passionate about her holistic perspective, which she saw as being fundamentally tied to her occupational therapy identity. She believed that her holism offered additional insights not available to other team members:

I see very differently than some of my colleagues who come from a different discipline. I’m not saying that they don’t see the whole person, but it seems that the whole belief about really looking at people is something that as OTs, or as an OT, I feel I’ve got a much better grasp than some of the people that I work with.

The Search: Working Out What Holism Means for Practice

As the participants described their values and practice, it became clear that holism actually meant something very different to each person. The participants tended to merge different ideas, blending notions of humanism and person-centered, health-oriented practice into their personal versions of more general professional values. There was a sense that the participants were continually trying to work out what holism meant and to grapple with how to apply these values in practice. For Susan, being holistic meant being person-centered, nonjudgmental, and starting from what the client says: “The starting point is the person...their actual make-up, belief systems, their whole perception of what is the problem....If I really listen to the person, then I can really explore with them and put together an effective treatment program.”

Julie focused on her humanistic values and strove to be accepting of clients’ negative behavior and history. Believing her practice to have a strong existential foundation, she also encouraged clients to make active choices:

Highlighting the possibility of actively making choices rather than letting life happen to you, which is something I push quite a lot with virtually every client I deal with. So, it would be fair to say that my work also has a strong existential flavor.

In contrast, for Karen, holism meant viewing clients in terms of their whole physical body and physical movement patterns, not just focusing on the impaired aspect: “If you’ve got a bad foot, then it’s going to send the hips out and it’s going to send everything out. You need to look at the whole.”

Although holism can be a badge worn with pride, it may also hide a lack of clarity about the occupational therapy role. One participant explained her confusion as follows:

I love the idea that as occupational therapists, we try to be holistic and client-centered. But sometimes I wonder what it all means when I hear the nurses also saying the same thing. To be honest, I don’t really know what it means. I just try to look at the person—really focus—think of them in their own situations at home, with families. But am I offering something special? Then I have to ask myself, ‘Is what I’m doing really holistic?’ I guess a lot of the time I’m as reductionist as the next person. So what am I doing?

Other participants similarly described their struggle to negotiate a valued occupational therapy role. Holism offered an identity to which they could cling. Sometimes, though, it was seen to provoke challenges from others. Stephen described his sense of humiliation when, in response to saying he treated clients holistically, a physician replied, “Do you do chiropody as well, then?”

The Struggle: Tensions of Applying Holism in Practice

Participants were conscious of certain “shoulds” buried within their holistic professional values, particularly those relating to the need to be client-centered, to value the individual. For some, this need translated into avoiding the use of words like patient and instead emphasizing person. Such actions were important because they offered a concrete way of operationalizing holism. Somehow, the words patient
and client were seen as derogatory—a pernicious label that must be avoided lest the work of these therapists be contaminated by dehumanizing, institutionalizing concepts. Said Susan, “We don’t use the term patient anymore. The client is a person, rather than a client.”

However, the reality of the participants’ daily practice meant that many of their clients were not treated as persons, leading the participants to feel uneasy. In such situations, the participants were all too aware that they were somehow “failing” to apply their more holistic professional values. They seemed to believe that they risked being exposed as charlatans. As one participant admitted:

I know what I should be doing, and it’s a far cry from what I am doing. I know I’m not doing proper OT. I have to pretend to attend to the person, but really, I’m calculating the minutes, the strategy. It’s kind of like I’m playing a part, pretending to myself even. I’m making them think I care about the whole of their lives, but really I’m trying to fix problems quickly. One day, I’ll be found out. They’ll spot that I’m not the client-centered therapist I’m supposed to be.

Another participant expressed her conflict as follows:

I believe I should always look beyond the presenting problem. If a patient has a physical problem, we also need to think about their feelings, their home situation. And I do try. But when you only have 10 minutes to do a quick assessment, what can you cover? I ask about how they’re managing at home, but it’s hardly holistic practice, is it? Am I failing them as a therapist? Am I expecting too much?

In different ways, the participants acknowledged the difficulty of reconciling the demands of their work with their own occupational therapy values. Each evolved his or her own way of coping, often splitting themselves into different identities and operating in distinct modes. For instance, one participant described the sense of being “warmly engaged and fully with” clients on one hand and becoming a “distant, calculating, clinical expert” within team meetings on the other hand.

In a different way, Stephen felt angry and frustrated at the way the management, financial constraints, and an excessive workload forced him to compromise and to practice at a superficial level. Management, he thought, did not value holistic practice, and he believed that he had to “toe the line” or face the possibility of losing his job. Pressure of referrals meant that he ended up giving clients what he called “bog standard” advice, that is, operating a kind of assembly line approach. Occasionally, however, he would have a chance to treat clients more fully. He preferred this model, when possible, he would embrace the latter.

Susan also felt frustrated. The community team she worked within was, she believed, insufficiently client-centered. She felt a tension between her holistic values as an occupational therapist and the tendency of the service to “force people into boxes.” She expressed finding it “really hard” when clients were expected to fit into what the service could provide rather than offering a service in response to individual need. So, she came to split herself into the different roles of “services representative who supported team values” and “client-centered therapist who distanced herself from the team,” depending on the situation.

Discussion

Analysis of these data indicates that holism as a philosophical concept and approach retains considerable force and value within the profession of occupational therapy. The participants seemed to prize the idea of approaching their work holistically and were not shy about asserting this publicly. But their understanding of holism varied considerably, and they enacted it in different, sometimes contradictory, ways—a point highlighted in the literature by McColl (1994) among others. In some cases, their practices emerged as simultaneously reductionistic and holistic, depending on the needs of the situation. Participants struggled to negotiate the tensions between theory and practice and to cope with their uncomfortable, uneasy feelings when they did not achieve their ideals of being holistic. My findings indicate that therapists’ experiences are more complex, intense, confused, ambivalent, and contradictory in practice than the literature suggests (Hemphill-Pearson & Hunter, 1997; Stein & Cutler, 1998).

The Struggle for Identity and Role

In their different ways, the participants aspired to be holistic. They seemed to see a holistic approach as a key dimension of their professional identity, a dimension about which they felt good. Holism was something that defined them and set them apart, in a favorable sense, from other team members. Sometimes, the participants seemed to resort to using holism as professional rhetoric; they could use the concept like a badge in their mission to persuade others about the worth and value of occupational therapy. However, in everyday practice, these self-definitions were regularly challenged as the participants struggled to meet ideals given the reality of their essentially reductionistic work contexts.

What happens to therapists when they sell out their values by practicing in more reductionistic ways? My findings suggest that the participants became confused about their roles and uncomfortable about their feelings when they perceived themselves as failing to be holistic. If occupational therapy is valued for its holism, what is its value when practice is reductionistic? Is this still occupational therapy? As Fleming and Mattingly (1994) suggested, the dilemmas that surround holism relate, in part, to a broader lack of confidence and clarity regarding the occupational therapy role.
When participants fought against reductionistic practice (e.g., Susan), they sometimes felt alienated and disconnected from their more reductionistic colleagues. When feeling undervalued by others, some (e.g., Stephen) sought to be accepted by operating in ways that would be appreciated, as Hubbard (1991) and others have found, ways that often led them to offering more clear-cut, reductionistic services to clients. Therapists, then, are caught in a dilemma. Should they follow their professional values and struggle against others’ ways of thinking, or should they respond to the demands of the situation and struggle with their personal values? This is the “unease at the heart of . . . practice” (p. 298) that Fleming and Mattingly (1994) captured; this is the ambivalence about the phenomenological aspects of practice versus biomedical aspects that arises, in part, from professional image dilemmas and “the politics of maintaining respect and not causing trouble for oneself” (p. 297).

Complex, Contradictory Clinical Reasoning

The participants revealed a way of viewing clients that was multilayered, complex, and sometimes contradictory. In particular, they moved regularly between different identities, for instance, Stephen’s way of moving between a discharge technician and a rehabilitation therapist. That therapists operate simultaneously in several modes, both holistic and reductionistic, seems to follow the pattern indicated in the clinical reasoning literature. Mattingly’s (1994) exploration of how occupational therapists think in terms of “blurred frames”—biomedical and phenomenological—is particularly relevant here. Fleming’s (1994) work on the three-track mind also endorses the idea that therapists approach their work from several simultaneous worldviews.

One interesting instance of contradictory responses was the way several participants (particularly those working in mental health) rejected, but still used, medical diagnoses to categorize their clients. The statement, “we treat people not patients” was a commonly expressed sentiment, and rejecting the use of diagnoses was seen as part of resisting more reductionistic medical treatment models. Contrary to such statements, however, the participants labeled clients in other ways, which, in turn, seemed to result in unreflective and stereotyped treatments. One participant was particularly outspoken against using diagnostic categories, believing they devalued the person and obscured his or her needs: “I see her as a person in her own right….Having a psychiatric label does little for your value as a person….I don’t find them useful.” Yet, this participant went on to admit to applying set treatment packages for global categories rather than for individual problems (e.g., for low self-esteem). Carrying out fully individualized treatment programs did not seem to her to be a practical option given her routinized work context.

Although the participants seemed to strive to view clients holistically as individuals, they also used numerous other labels and stereotypes. Comments such as “she’s a sweetie” or “he’s just being attention seeking” were not uncommon. I recognized these points in earlier findings of how occupational therapists often revealed themselves to be judgmental when identifying good and bad patient groups, examples being a therapist who said that she “preferred not to treat drug addicts” and another who suggested that all of his forensic patients were “bastards” (Finlay, 1997a).

The Impact of the Social Context

To make sense of the complexities of occupational therapists’ clinical reasoning, considering the broader social and health care context is also necessary. It seems clear that the practical realities of the work context make it difficult to resist being reductionistic. The realities of work pressures mean that therapists feel the need to compromise and be strategic about their interventions. At the very least, they have to go underground (Fleming & Mattingly, 1994) with their holistic practice, redefining problems and treatment in more reductionist, biomedical terms.

The participants who worked within acute hospital settings (e.g., Stephen) and faced considerable workload pressures to get through large numbers of patients a day, tended to classify their patients in more stereotyped ways. In their view, they had neither the time nor (arguably) the need to get to know the persons behind the labels. Even in these settings, however, it became clear that the more the therapists engaged in treatment, as opposed to just assessment, the more the patients were seen as persons and the therapists could attend to their wider personal and social needs.

That therapists, in order to cope with workload pressures, pragmatically adopt procedure-centered treatments has been well documented in the literature (Barnitt & Mayers, 1993; Burke & Cassidy, 1991; Mattingly & Fleming, 1994). My research lends support to the view of Barnitt and Pomeroy (1995) that the extent to which therapists are reductionistic or holistic is not so much a philosophical choice as a strategic one. That therapists consciously make this choice would seem, however, to be open to question. It is important to recognize that the social context, including wider health care practices and ideologies, can be influential in different ways (Pelouquin, 1990). However, the social context is not a straightforward influence. Some participants who worked in biomedical contexts embraced more reductionist scientific models of treatment, while at the same time they celebrated their holistic occupational therapy practice. That the participants may have unintentionally absorbed different competing discourses throughout their varied careers probably explains, at least in part, their self-contradictory holistic—reductionist practices.

Evaluation of the Study

This qualitative study has offered a glimpse into how 12
occupational therapists practicing in the United Kingdom understand and enact holism. An attempt has been made to capture some of the complex clinical reasoning and multiple meanings of the participants’ experiences of holism in practice. The strength of the study lies in its use of both longitudinal and cross-sectional data, which has resulted in relatively rich description. Drawing on direct quotations, the participants’ voices lend authenticity. The study has also sought to pursue a careful and rigorous application of the research method, allowing, as far as possible, the phenomena to manifest themselves. The bracketing process, whereby I sought to avoid predetermined aspects, was designed to ensure that I, the researcher, avoided finding only what was expected a priori.

The trustworthiness of the findings has been strengthened by the triangulation of methods (use of interview, observation, and diary data) and through introspection about what feels right. Additional validation has come from testing out ideas with research supervisors and two of the participants. The fact that the findings are consistent with a large body of health care literature is reassuring.

The research was undoubtedly influenced by my own values, interests, and experiences in terms of both the data collection and the interpretive analysis. Rather than attempting to overcome this influence, I attempted to recognize and use the added insight that came from also being an occupational therapist. My own experience with the sense of unease that comes when colluding with reductionistic practice is a particular insight that informed the research.

Conclusion
This study has shown how 12 occupational therapists celebrate their holistic values even as they struggle to define what this means and to negotiate the tensions among beliefs, theory, and practice. Holism, this study suggests, remains for many occupational therapists an elusive fiction. At the same time, becoming mired in debate over whether occupational therapy is a holistic profession emerges as a somewhat futile activity. The picture is more complex and dynamic. Holism carries multiple meanings that emerge in different contexts; therapists must grapple with the ambivalences of the situation as they strive for the greatest measure of holism possible within severe constraints.

Findings from this research suggest that rather than falling back on simplistic assertions that occupational therapists are holistic, we need to understand that holism means different things, at different times, to different people (and professions). More research into how therapists understand holism in practice is called for. In particular, the internal and external factors that enable occupational therapists to be holistic, or that push us into reductionistic practice, need to be examined further. It would be useful for therapists to be able to distinguish those situations where it is practical and beneficial to take a holistic approach and those where it may be unnecessary. Rather than striving unsuccessfully to be holistic and then feeling a sense of failure, therapists could be empowered by recognizing how different levels of both reductionistic and holistic practice emerge out of, and coexist within, a broader social context.

References


