The Relationship Between Pretheoretical Assumptions and Clinical Reasoning

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This single-case study explored what internal beliefs or commitments one therapist holds about the nature of reality and how those beliefs influence her delivery of occupational therapy services. Data were collected through three in-depth interviews and through observation of the therapist conducting treatment sessions.

Results suggest that the therapist's view of reality can be categorized into four areas: (a) what she believes about ultimate reality; (b) what she believes about life, death, and eternity; (c) what she believes about human nature; and (d) what she believes about the nature of knowing. The findings also suggest that this core worldview informs how the therapist frames clinical practice and how she delivers occupational therapy services. Further, both the therapist's view of reality and her clinical practice are deeply rooted in her sociocultural experiences. This case study provides a rich description of the interrelatedness of sociocultural context, worldview, and clinical reasoning.

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The discussion of clinical reasoning and its relation to the use of conceptual frameworks, to assumptions underlying treatment techniques, to the integration of theory and practice, or to tacit knowledge is now a familiar one within occupational therapy (Barris & Kielhofner, 1985; Gillette & Mattingly, 1987; Kretting, 1985; Lau & McCall, 1989; Mattingly, 1989, 1991a, 1991b; Neuhaus, 1988; Parham, 1987; Reed, 1984; Rogers, 1983, 1986; Schell & Cervero, 1993). Historically, the discussion of clinical reasoning has followed the medical profession's investigation of diagnostic reasoning among physicians (Elstein, 1976; Elstein, Schiefe, & Sprafka, 1978; Fleming, 1991a, 1991b; Kassirer, Kuipers, & Gorry, 1982; Neuhaus, 1988; Rogers & Masagatani, 1982). More recently, the discussion of clinical reasoning has begun to focus on reasoning in occupational therapy on the basis of the uniqueness of the profession's fundamental philosophy and the treatment context (Burke & Depoy, 1991; Crepeau, 1991; Fleming, 1991a, 1991b; Mattingly, 1989, 1991a, 1991b; Schell & Cervero, 1993; Schwartz, 1991). Regardless of the specific focus being considered, clinical reasoning has been recognized as a key component of clinical expertise (Kassirer et al., 1982) or clinical mastery (Depoy, 1990). Clinical reasoning is considered the determinant of quality patient care (Rogers, 1983), the means to help students connect theory with practice (Rogers, 1986), and the distinguishing characteristic between lay person and professional (Parham, 1987). Further understanding of this multifaceted phenomenon has implications for education programs (Cohn & Frum, 1988; Neistadt, 1992), program development, staff development, staff supervision, and occupational therapy management (Schell & Cervero, 1993).

The importance of clinical reasoning is clearly established. However, many facets of the reasoning process require further investigation, including the role that the personal context plays as a shaper of reasoning (Schell & Cervero, 1993). In attempting to describe one component of the personal, internal context for reasoning, this study explored an individual therapist's worldview as an influence on theory and action.

The concept of worldview has its roots in philosophy. The term was widely used to mean "a global outlook on life and the world" (Wolters, 1989, p. 15) or "a total vision of life" (Griffioen, 1989, p. 84). A worldview is often understood as personal or communal, pretheoretical commitments about the relationship of self to others, and the relation of humans to the nonhuman world (Holmes, 1983).

Olthius (1989) reported an increasing awareness of
how worldview affects our perceptions of the world and our actions in the world. Olthius agreed with Griffioen that “all theorizing is, to an important degree, regulated by visions stemming from the pre-theoretical realm” (Griffioen, 1989, p. 106). These underlying assumptions about life and reality are shaped largely by the personal-cultural-historical context in which one lives (Van Belle, 1980).

The objective of this study was to explicate another piece of the clinical reasoning puzzle—the role an underlying worldview plays in influencing the reasoning process of an occupational therapist. It explores the following questions: What assumptions might be classified as pre-theoretical commitments or as constituents of one’s worldview? What is the relationship of a therapist’s pretheoretical commitments (i.e., worldview) to his or her practice? Do these starting assumptions serve as a way of influencing clinical decisions? This study will follow the tradition of research that has used qualitative methodologies to investigate clinical reasoning (Argyris & Schön, 1974; Mattingly, 1989; Rogers & Masagatani, 1982; Schön, 1987).

**Literature Review**

**Clinical Reasoning as Theoretical Rationale**

Scientific reasoning is the component of clinical reasoning associated with a therapist’s ability to present a rationale for the chosen treatment approach (Rogers, 1983, 1986; Schell & Cervero, 1993). It describes the decision-making process for selecting or changing a treatment approach and for understanding why a treatment technique may produce certain results (Parham, 1987). This model of reasoning is based on the assumptions that cause-and-effect relationships exist in most treatment strategies. The reflective practitioner is aware of the scientific basis for the treatment approach and articulates the conceptual theories for why the treatment is considered effective (Parham, 1987). Mattingly (1991a, 1991b) described this type of reasoning as applied science or applied theory, both of which are characteristic of reasoning in the medical profession. In this applied theory style of cognitive processing, the diagnosis and associated dysfunction serve as the basis for evaluation, prediction of outcome, and chosen treatment (Rogers & Masagatani, 1982). This method of framing clinical problems is considered to be important and essential in practice; however, applied theory or applied scientific reasoning alone may be insufficient for many clinical situations (Mattingly, 1991a, 1991b; Schell & Cervero, 1993).

**Clinical Reasoning When Theoretical Rationale Is Inadequate**

Schön (1983, 1987) and Mattingly (1989) explored what reasoning processes an occupational therapy practitioner may use when scientific knowledge is inadequate or incomplete for making decisions about intervention. One method of arriving at a treatment strategy has been described as reflection-in-action (Schön, 1983, 1987). Reflection-in-action occurs when a therapist experiments with the current clinical scenario. The therapist observes the current situation, explores new ways of shaping the problem, and chooses a tentative plan of action. The therapist repeatedly monitors the results of the action, modifies variables on the basis of those clinical results, reframes the problem and changes the approach again as needed, and reevaluates the results (Parham, 1987; Rogers, 1986).

Following Schön’s theory of reflection-in-action, Mattingly (1989) described the narrative reasoning process as the means of reflecting on past clinical events as well as shaping future treatment decisions. In her study, therapists used story as the vehicle for reflecting on what happened in practice, why it happened, and the importance of its happening. Through clinical stories, therapists sought to understand the connection between outward actions and internal motivation factors (also cited in Mattingly, 1991a, 1991b). Therapists also projected story or plot onto clinical situations and, in so doing, envisioned a certain future for a patient. This projected story served as the larger context that guided the selection of treatment activities. The therapists would then reconstruct the story or plot when they experienced a conflict between the events they expected and what actually occurred in the treatment process.

**Clinical Reasoning as Pragmatic Reasoning**

Schell and Cervero (1993) reviewed pragmatic reasoning as another component of a therapist’s thinking process. Pragmatic reasoning considers the impact of personal and practice constraints on clinical decision making. Variables such as the organizational, economical, architectural, political, and social components of service delivery are believed to substantially influence treatment reflection and action. Additional key components of the clinical reasoning process noted by Schell and Cervero included internal personal factors, such as a therapist’s personal paradigm.

**Clinical Reasoning as Stemming From a Pretheoretical Foundation**

Occupational therapy literature refers to underlying and often tacit, culturally mediated beliefs about reality, the human body, disability, and the relationship of the material world to the nonmaterial world that serve as an informing framework for therapeutic approaches (Krefting, 1985; Mattingly, 1989; Mattingly & Gillette, 1991; Mosey, 1981; Rogers, 1983). Philosophers Polanyi (1946, 1958), Grene (1969), and Olthius (1989) believed that all knowl-
knowledge has such a personal, implicit element and that persons hold an inner set of assumptions referred to as a “framework of commitment” (Polanyi, 1962, p. 59). Scientific values and scientific inquiry are preceded, guided, and given meaning by the scientist’s personal-cultural framework of commitment (i.e., his or her conception about the nature of things and corresponding views of reality). Therefore, an affirmation about the scientist’s view of reality exists anterior to, and gives shape to, the premise selected for investigation.

The important influence of this personal component of knowledge on practice has been demonstrated in natural science (Polanyi, 1958; VanLeeuwen, 1982), in medicine and economics (Starr, 1982), and in psychology and other human sciences (Van Belle, 1980; Vander Goot, 1987; VanLeeuwen, 1982). Each of these authors agreed that thought and action in their particular disciplines emerge from certain pretheoretical commitments about the nature of reality and the nature of human systems.

Method

Respondent

Because of the exploratory nature of this study, a single-case design was chosen to explore the research questions. The therapist was selected on the basis of her cultural background, her ability to articulate underlying philosophical assumptions, and her view of the scope of occupational therapy practice.

Data Collection

Three semistructured interviews were used to explore the respondent’s personal commitments with regard to what constitutes her reality. For the initial interview, general topics were formulated from Reed’s (1984) summary of assumptions underlying the theory and practice of occupational therapy (e.g., beliefs about human nature, occupation, health and illness, service delivery, the unique characteristics of occupational therapy).

After analysis of the first interview, questions for the second interview focused on topics that were emerging from the data. Apparent relationships between the respondent’s assumptions and her clinical practice were reviewed and examined further with her. The third interview provided in-depth discussion and clarification of the emanating components that appeared to anchor her clinical reasoning process.

In addition, the respondent was asked to select a treatment session for videotaping. The respondent determined which patient to approach, the location, the treatment modalities, and the duration of the treatment session. The videotaped session was supplemented with observation of three additional treatment sessions involving different patients. Field notes from these observations were meshed with the interview and video data.

Data Analysis

After each interview, the audiotapes were transcribed and coded (Lincoln & Guba, 1985) by the researcher. The data were grouped into categories after each transcription or collection of field notes. The categories were named and organized for causal analysis (Miles & Huberman, 1984) and were clarified or negated in subsequent interviews with the respondent. Causal analysis provided a method to describe in certain philosophical contexts what occurred in treatment and to disclose why treatment was carried out in a particular way. All data were marked for easy auditing of source (interview or observation) and date collected.

Member checking (Lincoln & Guba, 1985) was completed with the respondent (i.e., the complete text was submitted to the respondent to validate the conclusions). Because English is the respondent’s second language, direct quotes were corrected by the researcher for grammar and syntax. The respondent reviewed these corrections and agreed that no data had been altered in meaning as a result.

The research design established for this project has been identified as having potential for provoking reflection on the underlying value systems, beliefs, and assumptions that influence one’s practice (Fondiller, Rosage, & Neuhaus, 1990; Mattingly, 1991a, 1991b). Case studies are appropriate when a researcher seeks to create a detailed examination of a unique phenomenon (Carlson & Clark, 1991; Guba & Lincoln, 1989; Yin, 1984). They are effective when describing new phenomena and when discovering new variables within known phenomena. The rich details elicited through case study can lead to new hypotheses that will need to be verified through multiple research methodologies (Meyers, 1989a, 1989b).

Results

Overall, the respondent described complex underlying tenets for the occupational therapy intervention she provides. The visible, observable aspects of her practice include selecting and implementing various treatment techniques, selecting and explaining certain theory preferences, and developing therapist–patient relationships. However, the data strongly suggest that these day-to-day aspects of her practice are deeply rooted in her worldview, which, in turn, is deeply rooted in her sociocultural experiences (see Figure 1). For example, observation data revealed that the respondent often implemented traditional biomechanical treatment techniques. Through the interview data, however, it became apparent that her reasoning for using these treatment tools rested in many
The findings also suggest an interactive relationship among these four categories. For example, the respondent's beliefs about life, death, and eternity influence her beliefs about what it means to be human, while at the same time, her beliefs about what it means to be human influence her beliefs about life, death, and eternity.

Finally, the four categories are interdependent on a given sociocultural milieu. This suggests that the tenets of each category are directly related to the respondent's experiences. Therefore, a change in the sociocultural context can result in changes in any other components of the model.

Sociocultural Influences on the Respondent’s Professional Choices

The respondent is a citizen of Bombay, India. She worked with multiple diagnostic and age groups in Bombay for 15 years before coming to the United States in 1992. She is the first of her family members to travel to this country to work. Opportunities in occupational therapy, financial obligations to her family, and a sense of adventure all contributed to the respondent’s decision to practice in the United States.

The respondent discussed in depth how the Hindu culture and belief system influences societal structure, family roles, and education in India. For example, reincarnation is the basis for understanding why one is born into a particular family or into a particular socioeconomic group. One may receive certain parents, receive a certain status, or have access to varying opportunities on the basis of good or bad karmas, or work, done in a prior life. The respondent’s family members believed that she had been someone great in her past life. Her parents were able to make that determination through comparing her personality, actions, and accomplishments with other children, including their own children. The respondent was always the child who did well and received high merits. Families in India often target the high-achieving child for higher education and success.

According to the respondent, education in India includes learning Hinduism from a very early age, which influences all aspects of one’s life, including career choice. For example, the respondent grew up with a sibling who had polio. She discussed the impact this had on her professional choice: When she was younger, the respondent would take her sister to therapy, and as she watched the physical therapist, she “had the impression that I must do [physical therapy] because therapy made a lot of difference in my sister’s life.” In the respondent’s culture, “impressions” are related to the Hindu belief system. These intuitions indicated that she had been associated with the unique treatment interventions emerge.

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Figure 1. The relationship between worldview and clinical practice.
medical professions in her past life and that she must pursue her interest in the medical field.

The process by which the respondent decided that she was meant to study occupational therapy is another example of how professional choice is rooted in the belief system of her culture. The respondent reported that she was working on a chemistry experiment when she was called to interview for admission to the occupational therapy program. This opportunity surprised her because she was awaiting a call to interview for physical therapy school. She left the lab in the middle of her experiment and went to the interview, feeling that she "must go there." Although she did not know much about occupational therapy, she was "drawn" to that interview and to the profession. The respondent had an intuitive understanding that occupational therapy would suit her interests in psychology, art, and science. She also realized that occupational therapy "was destined" for her and that inside herself she had the drive or desire to be admitted to that school. Her education at the medical college began that day, and she never returned for her things left in the locker at the chemistry lab. In this study, these cultural and educational factors were established as the soil out of which has grown the respondent's experience and perspective on the world.

Basis for Faith

This category is defined as one's "beginning that has no beginning" or one's "final reality" (Sire, 1990, p. 35). The respondent articulated her belief that ultimately "God is everywhere in the form of energies." This power permeates the universe, yet it is available within each person. Therefore, life's quest for each person is to unite with the cosmic power by becoming aware of the god within. If, through control of the senses and exclusive concentration of the mind, one can reach this place of unity with the supreme power, then a person "can be free from anxiety and worry, will become a balanced person, be filled with positive vibrations, and be able to fight any stresses." If someone is unable to achieve oneness with the supreme cosmic energy in this lifetime, one's soul continues to be reborn until it reaches ultimate peace in that eternal union.

The beliefs categorized as the respondent's basis for faith serve as the lens for her vantage point on clinical practice. The themes that developed later as key pieces of her clinical reasoning can be traced to the starting points she described as ultimate reality. The respondent believes that awareness promotes realizing the self, and once you understand yourself, you will know all the world. At that point, you can easily understand all events, you will be a balanced person, you will be the person who will not get affected by so many sorrows...you are reaching to the desire to meet God or just unite with the supreme soul.

Therefore, the respondent attempts to promote self-awareness in her patients through pointing out their skills and their improvements and encouraging them to try new things and to use concentration while engaged in tasks. Her belief in the soul's quest for union with the divine through concentration, peace, good deeds, and struggling against suffering will become clearer as other components of her worldview are considered.

Life, Death, and Eternity

The respondent defined life as an "embodied soul on an immortal journey." She believes that if on that journey one's soul does good deeds, it returns in the next birth as "a good person with few sorrows and few worries." However, if in the previous life the soul was hurtful to others, it must undergo suffering in the current life. The respondent reported that the quest of the soul throughout lifetimes is to advance itself to a progressively better status toward union with God. To accomplish this, the soul must do good deeds and liberate itself from material connections, desires, attachments, and worries or sorrows. The respondent believes that through such a liberation, the soul will achieve a state of peace and fulfill its journey.

According to the respondent, the quality of deeds or the degree of liberation achieved will not be the only measures, however, for the soul's next status. How the soul manages suffering will also determine the destiny of its next generation. Suffering is often the tool by which the soul "strengthens itself for the next life." If one fights suffering with mental strength, one will inherit a good next life on the way to that eventual union with God. In the respondent's belief, the reason for this promotion is because wrestling against and resisting stress through mental strength is the means by which one redeems past actions and comes to realize one's divinity. It follows that if mental strength and positive thinking are to be achieved, weakness, fear, and ignorance must be abolished. It is essential that a person overcomes these hindrances to strength in order to "face suffering, to know peace, and to reach divinity."

As a result of these beliefs, one underlying goal of the therapeutic approaches the respondent implements is to assist patients in developing mental strength and to help them fight the illness: "If someone has experienced physical illness or injury and is fighting that situation with mental strength, if he or she has accepted the situation, and developed a calmness about it, then [he or she] will not suffer in the next birth." The respondent believes that through promoting the patient's awareness of his or her internal strength to fight suffering, the therapist is caught.
up in a higher cause of assisting fellow souls in their journey toward peace and oneness with God.

Nature of Humans

What the respondent believes about the cosmos (i.e., what constitutes ultimate reality, what is characteristic of life, death, and eternity) shapes her beliefs about what constitutes being human. She clearly stated her belief that every person is divine and is charged to ultimately become aware of his or her own divinity. This awareness can occur through rigorous discipline to reach beyond the material life and into a sphere where cosmic, universal power is recognized as internal, personal power. In this divine quest, human beings may tap this energy for strength, peace, balance, and protection from and resistance to stresses or sufferings.

Humans as a sum of their evolutionary history. The respondent stated that a person is a product of a long evolutionary history and that each step of that evolution is carried within the subconscious and can be brought to conscious control through strict training. For example:

Once a pattern is made in our evolutionary history, it is there forever but may need to be brought back under conscious control; for example, once humans could shake the skin like the cow—this submerged pattern can be brought back from the vast ocean of action.

Because of this underlying belief, the respondent views her treatment as a means to promote awareness of remote patterns. How she approached self-feeding is a good example. From her perspective, all movement patterns are ingrained. From previous lives, a person has inherited functional abilities, such as hand-to-mouth patterns. These abilities are laid down from the past and are not destroyed by cerebrovascular accident or other treatment diagnoses. The injured patient simply experiences a gap between those inborn patterns and his or her current skills and can no longer access them. The respondent stated that it is her role to “remind the person [that] he or she can do it. They lose that connection, and I will connect that link between what is lost and what one is. . . . I make the patient more aware of that.” Therefore, one goal of occupational therapy from this view on the world is to increase awareness and to re-born forgotten patterns.

In implementing the treatment plan to improve self-feeding, the respondent will not use the feeding task itself to revive that dormant skill because the ability to feed oneself is ingrained. The patients are simply no longer “aware” of their potential. Therefore, she uses a biomechanics practice model both to increase the patient’s awareness of ingrained patterns and to reestablish the resultant external movement. To accomplish this, the respondent uses “therapeutic media,” such as cones, pulleys, and so forth, set up to imitate movement patterns required for self-feeding. After the patient is aware and movement patterns are being regained, the respondent reasoned that the patient will automatically apply it to the feeding task because in the context of “seeing the meal and feeling the hunger, the patient will start using the hand.” When a patient receives biomechanical training, the respondent believes that the patient will again realize that there is a conditioned feeding pattern from somewhere in the past.

Throughout the clinical observations, it appeared that the respondent’s treatment focus was primarily on sensorimotor component areas and not connected to activities of daily living. Only when she explicated her belief about how humans are born with the skills of entire lifetimes could one understand the reasoning behind her interventions. The respondent agreed that her clinical intervention is directly rooted in this personal-cultural belief about what makes a person.

Humans as mind-body-soul oneness. Another component in the respondent’s beliefs about what it means to be human is that a person is a unity among mind, body, and soul:

I see their mind, I see their physical needs, I see their mental needs, their psychological needs, their spiritual needs, and their emotional needs. Everyone has this mind, body, and soul. When I work with a patient, I work on the three levels. I believe my therapy should approach the mind, reach to the soul, and then the physical will not be a problem.

There is an inextricable unity among the three areas. There is also a hierarchy of access. That is, for there to be physical changes, there must be 100% concentration of mind, and the soul must be aware or conscious of what is happening. Awareness and insight occur at the soul level. When the mind is free from distraction and the soul has awareness of what is occurring, the body can be empowered to overcome injury.

This belief formed the backdrop to many treatment interventions that the respondent provided. It was also used as a screen for how she framed and evaluated clinical situations. For example, the respondent believes that she has dual roles when implementing treatment. First, she must address range of motion and strength in order to “meet the physician’s requirements.” Second, she must increase awareness of the soul and positive thinking within the mind.

In treating a geriatric patient for standing balance and trunk control, the respondent described her approach as follows: “Initially, the patient stated she was unable to stand, afraid to attempt getting up from her wheelchair, or to stand for more than a few seconds. The patient thought she was sick because she had fallen.” When the respondent asked the patient to transfer to another surface, the patient became very angry with her, but out of
anger, she transferred herself to the other chair. The respondent interpreted the problem at that point to be “her spirit is not under control; this behavior is interfering with her progress.” She proceeded to educate the patient by saying, “If you train your mind, if you calm down, if you go slowly, if you use high-level seats, you will be able to transfer safely.” In her own description of this intervention, the respondent stated that she made the patient more aware and showed the patient what her potential was: “I improved her awareness, and then she could do it.” The patient improved from maximum assistance with transfers to stand-by assistance with a walker. The respondent’s goals were to have the patient participating in functional mobility tasks independently and safely through increased hand function and decreased agitation. She believed that these goals were accomplished by making the patient more aware and “more positive.” In this case, the respondent defined the problem as that of the mind. She calmed the mind, made the soul aware, and the body improved.

In another description of her treatment approach with a patient who had rheumatoid arthritis, the respondent described a traditional joint stiffness, muscle strengthening, and mobility program. However, from her belief in a mind–body–soul unity, she added that “arthritis is not only a disease of the body. The disease process is hand-in-hand with one’s emotions, mind, environment, and even the weather.” Therefore, the respondent approached the treatment by “targeting the patient’s mind, promoting the patient’s inner strength, and encouraging a positive approach” to fight the disease. She explained to her patient that the disease is not going to go away; it is degenerative, and all medication is superficial—it can only reduce the symptoms temporarily. If you do not use your mental strength, and you are not going to fight for your own strength, it is going to damage your whole pattern. Worries will be able to affect the endocrinological balance, which will result in a decrease in joint lubrication and will increase arthritic symptoms. So try to develop your inner strength and fight the disease. Reduce the drugs and use your willpower.

Because of occupational therapy’s focus on the impact of occupation on the whole person, the respondent believes that the occupational therapist is the primary professional who can strengthen the mind and “pull the patient out of a stressful mind-set.”

In addition to an internal unity among mind, body, and soul, the respondent believes that there must also be a unity between what is going on in one’s mind and what one is engaged in externally. If one is engaged in a task, but one’s mind is distracted by other things, unity is disrupted. The mind must be made ready for the event or task and must “be in tune with” that external object or project.

As a result, the respondent often uses treatment tasks specifically to divert the patient from distractions of the mind and the internal world, from preoccupations, to focus on the external world. She asks her patients to concentrate on the task and to let go of what is worrying them. For example, grooming tasks are frequently used to help the patient with depression to refocus on the external world. Through conversation, the respondent also uses herself as a tool for reconnecting a patient to the external environment by saying, “Wash your face, clean up, and just be with me. You are smiling, and it is so pleasant to talk with you.”

The respondent’s belief that a person is a mind–body–soul unity also serves as a framework for her definition of health. She believes that in order to have health restored, one must first have the mind healthy because it is the gatekeeper of the body and soul:

[A healthy person is] that person who says I can face anything, I can be out from any stress, I have this ability, and positive thinking makes me healthy. If patients easily accept their situation; are happy, positive, and confident; and have peace of mind, then they have health. One must not let the mind get distracted or allow the mind to have negative thoughts. Instead, one must focus the mind, concentrate until there is internal calm and peace uniting mind, body, soul. The Hindu philosophy’s practice of yoga is an exercise to accomplish balance between the mind, body, and soul. This is believed to be the way one becomes the best human being possible.

Although the respondent uses biomechanical treatment techniques, she attempts to accomplish both a balance of mind and soul and improved hand function, functional mobility, or other neuromotor goals that are appropriate to each patient.

Humans and their protective layers. After her discussion of human beings as an internal unity of mind, body, and soul in need of unity between the mind and external engagements, the respondent described another element of personhood. Each person has an external protective system that guards against life’s stresses. The respondent described this protective system as “auras,” or “layers,” or “coverings.” Only when these resistive layers are in place can a person be in tune with the external environment. She described a patient who comes for occupational therapy as having lost “the layers for the resistance to stress. The coping mechanism has gone away.” As a result of this starting assumption about being human, the respondent often uses a therapeutic use of self to restore layers that will resist stress by training the patient’s mind to become positive and self-confident. By providing positive feedback to patients about their performance of therapeutic tasks and by pointing out their improvements, the respondent believes that occupational therapists play an important role in helping patients develop enough resistive layers to fight the suffering they are encountering. Again, fighting suffering is essential to the soul’s journey to unite with God.

Relationship of humans to the world. The respondent
believes that as humans go about this rigorous discipline of restoring and maintaining their resistive layers, as they strive for unity between mind and occupation and among mind, body, and soul, the natural world will often deter them or lure them off course. She believes that the material world distracts from the internal journey toward one's divinity. Therefore, the relationship that humans have with the rest of the world is an adversarial one that must be transcended through strict discipline of the mind, body, and soul: “What is lasting is only God and peace. All one needs is peace. If you have money, you don’t have anything because God and peace are within you.” Hence, in practice, the respondent will often attempt to get her patients to “calm down” because she believes that peace is a prerequisite to fighting the suffering, which in turn is a prerequisite to advancing the soul toward its ultimate union with God.

**Basis for Knowledge**

The final category of the respondent's pretheoretical assumptions can be defined as how she perceives knowledge, or what she believes is the basis for why she knows what she knows. As discussed earlier, the respondent believes that destiny is the key determinant of both small and important life events. She explains that one way a person can know what destiny holds is through “the science of horoscopes and astrology.” Another way one knows what one should do or should not do, including the intervention between therapist and patient, is through “vibrations” that the person or situation, or even object, emit. The respondent discussed vibrations as a medium by which intuition is made known and that vibrations can be either positive or negative: “Certain vibrations will mix with specific other vibrations.” The positive pairing of vibrations is the basis for knowing what path one is meant to follow or what decision one should make.

In practice, the respondent repeatedly described her clinical reasoning process as “I see what is ahead,” “I see the next thing,” “I see behind the physical problem.” She described her basis for knowing as “intuitive power.” This intuitive power is often her process for knowing what is occurring in a treatment session. When dealing with a person as a mind-body-soul unity, intuitive knowledge is the means by which the respondent knows what is behind the physical problem or what in the mind is actually contributing to the physical problem. The respondent stated that through vibrations, she can read patients' stresses when she enters the room:

I can read their problem. There are problems in addition to their medical diagnosis or any associated complications—those things are affecting their body. But more than that are the things that are affecting their mind and their mental responses. I am not talking about their cognition, I am talking about their psychological reactions.

One way the respondent used intuitive knowledge through vibrations for clinical reasoning was in screening patients in a skilled nursing facility to determine the need for therapeutic intervention: “In screening certain patients, I will not feel comfortable as I am conducting the screen; in those cases, I don’t think they are good occupational therapy candidates.” On the other hand, the respondent believes that she, as an occupational therapist, is the only professional who can work with certain patients because she sees the issues behind the behaviors or the physical problems, addresses those in her treatment, and believes that she achieves treatment results other disciplines are unable to achieve. In the case of an agitated patient, other disciplines discharged the patient from treatment because she was “not motivated.” The respondent, however, “saw that she had many distractions of the mind because of her family and wanting to go home.” The respondent reported that in these cases, she will make use of [treatment activities] which the patient has not seen which will not make her defensive. I make use of the same goals in a different activity. For the first 2 or 3 days, I will observe her. Whatever I find her doing, I will just move with that and use that as my treatment. Then by the 3rd day, I will be able to get her to do many things.

The respondent believes that she uses her interaction with the patient to become “totally with them” and finds in her treatment that her total union with the patient enables the patient to do a requested task.

In another example, the respondent was asked to work with another therapist’s patient. The patient was reported to have only 30 seconds of postural control in unsupported sitting and was frequently refusing therapy. But the respondent was able to “sense the needs of the patient” and said, “Ok, today I will just be here with you while you work. Do whatever you need to do for your bath.” In her “totality of support,” she found the patient able to complete a 60-minute bath without postural support. The patient requested to be placed on the respondent’s caseload, saying, “I think you will do much better.” The respondent believes that her perspectives on the world make her treatment interventions “a different thing.”

Because of her belief system, much of the respondent’s intervention involves discussion with the patient to “make the patient understand life stresses, how to face them, and make the patient’s mind ready for that new life.” The occupational therapist “must give patients solutions to how they can fight the stresses and come out from [under] them.” This involves not only educating patients about the illness or injury and providing examples
of how they can function in light of the condition, but also encouraging patients by comparing their current performance on certain treatment activities, such as pulleys or cones, to previous performance. The respondent believes that in pointing out patients' improvement, they are able to see that "they are good, and they will do it."

Another reported goal of the respondent's therapeutic interactions with patients involves establishing "concentration power." A patient may not be aware of what is happening with an illness or injury; for example, a patient may not be aware of how impaired his or her hemiplegic arm is. The respondent believes that the occupational therapist must make patients aware by getting them to concentrate fully on the muscle needed to do the task: "When you make the patient aware, the patient will achieve the goal; it is easy when one places full concentration on that particular activity," and when someone is concentrating intensely, the therapist has "reached to the soul, and the body will follow."

Summary

A large portion of what the respondent provides to her patients is a therapeutic use of herself. On the basis of her worldview, she completely believes in the power of her own interactions to accomplish most of the facets that are critical to treatment (i.e., awareness, concentration; a positive mind; peace of mind; resistance to stresses; internal unity among mind, body, and soul; unity between internal environment and the external environment; a restoration of protective layers). One can conclude that much of what the respondent provides her patients is closely intertwined with, and influenced by, an out-of-site system of beliefs about the world and people in the world.

Discussion

Many studies conducted in clinical reasoning refer to an element of reasoning that is at work behind the scenes, that goes beyond a therapist's experience level, and that is unique to the individual therapist (Barris & Kielhofner, 1985; Gillette & Mattingly, 1987; Krefting, 1985; Mattingly, 1989, 1991a, 1991b; Parham, 1987; Reed, 1984; Rogers, 1983, 1986; Schell & Cervero, 1993). Some have considered this hidden element to be so tacit as to be mostly unminable for articulation (Schön, 1983). Mattingly (1989) referred to this unseen facet of reasoning as a therapist's personal values and beliefs.

This study described the underground component of reasoning; it delves one layer deeper than personal values and beliefs in order to obtain a glimpse of what comprises values and beliefs. This study offers a framework for clinical reasoning that emerges from four categories of one therapist's belief system.

This case suggests that clinical reasoning is grounded, in part, in a therapist's particular spin on the world, which includes his or her answers to the following questions: What is ultimate reality or what is the ultimate reason why things are the way they are? What is the purpose of life? What happens at death? What is a person? How do we know what we know? Each therapist will answer these questions differently, depending on his or her personal sociocultural background and life experiences. Additionally, the answers are fluid and may change over time as a result of new experiences, personal development, and professional growth.

Looking at clinical reasoning as having worldview roots not only provides for a further description of the reasoning process, but also has several implications for both the profession and the individual practitioner. Because occupational therapy in the United States is promoting increased diversity, this study provides a framework for understanding and supervising clinicians with varying backgrounds. It has potential to serve as a meeting ground, or bridge, between persons of different cultures. For example, in this case, I originally perceived the performance of this therapist to be reductionistic and biomechanical. But as I was able to understand how she defines the world, her treatment became more profound and illustrated a kind of holism that I desire for my own practice. As therapists are able to trade eyeglasses, there can be tremendous learning across borders.

The model presented in this article has potential in both teaching and developing clinical reasoning skills. If the concept of practice as stemming from a therapist's particular view of the world is supported by further research, then clinical reasoning courses may begin to help students and therapists to better understand their own working view of the world and how it affects their treatment approach.

In sum, this case has described a phenomenon that has been reported in the literature of other disciplines and is applicable to clinical reasoning in occupational therapy: A therapist holds certain pretheoretical commitments about the world that influences clinical delivery of services. The pretheoretical commitments this therapist holds could be categorized into her personal beliefs about reality, life and death, human nature, and knowledge. Likewise, her pretheoretical commitments related to these belief categories could be traced outwardly, and how her personal beliefs influenced her clinical reasoning could be described.

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Cordelia Myers Writer's Award

The American Occupational Therapy Association is pleased to announce that Sally McAlonan has been chosen as the recipient of the Cordelia Myers Writer's Award for the 1996 AJOT volume year. Her article, “Improving Sexual Rehabilitation Services: The Patient's Perspective,” published in the November/December issue, was considered by the AJOT Editorial Board members to be a strong piece of professional writing by a first-time contributor to AJOT during the 12-month period. The AJOT Editorial Board and staff members extend their congratulations to Sally McAlonan.
