A Journey To See the Whole of Things

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“To dare is to lose one’s footing momentarily. To not dare is to lose oneself.”

—Søren Kierkegaard

This story is about my ongoing personal and professional journey to see the whole of things. Were I to pick the single most powerful catalyst of this journey, it would be my immersions in unfamiliar cultures where at first I felt I did not belong. In both my personal and professional life, such immersions have transformed me. For instance, I moved as a child from a homogenous southern community to an ethnically and culturally diverse area of the northeast and came to see that past rules no longer applied. In moments of discomfort, new lenses have been offered to me that progressively expanded my ability to see, understand, and care more deeply about people. Differing cultures have broadened my view of what constitutes a good life, while sharpening my understanding of shared human needs for love, belonging, and purpose. Indeed, lessons about culture and human nature have been more consequential to my growth as an occupational therapist than my mastery of any particular clinical or administrative professional skill.

Mentorship has also been an essential element of my journey toward seeing the whole of things. I name here only a few of the many people who kindly offered a wider lens when my scope was too narrow. I call them all mentors, although they came in many forms: my parents, colleagues, clients, employees, teachers, friends, family, students and, even, adversaries. In diverse ways, these teachers broadened and deepened my appreciation for people, the profession, and the richness of what we call occupation.

Becoming an Occupational Therapist

Entering the Culture of Occupational Therapy

It is difficult to measure the influences that led me to become an occupational therapist. On the personal side, my father’s life insurance money was burning a hole in my pocket and my heart. He was a first-generation immigrant, so furthering my education with that money would honor his dreams and support my emerging interests. Professionally, I was inspired by an occupational therapist, Sharon Anderson, who was a fountain of practical yet elegant answers to the challenges of children in my special education class. Sharon could see these children as whole persons with pasts, presents, and futures through the eyes of their parents, their teachers and, remarkably, the children themselves. I wanted to see this bigger picture too, a picture I also hoped would help me better know myself.

My enthusiasm for occupational therapy grew in force during my days as a graduate student at the University of North Carolina at Chapel Hill (UNC-Chapel Hill) in the early 1980s. I loved expressions like “balance of activity” and “purposeful activity” that functioned as powerful entry points into occupational therapy’s culture at the time. I came to see that occupational concepts like these had as much to do with my own life and well-being as they did with my future clients. I also discovered that I loved learning about theories and conceptual models that helped me understand humans as occupational beings. For my
Level II fieldwork student presentation at Harmanville Rehabilitation Center outside of Pittsburgh, Pennsylvania, I applied the Model of Human Occupation (Kielhofner, 1983) to a man with a head injury. The model helped me to appreciate this man as a whole, and to see his problems as neither a hopeless tangle to be straightened out nor a broken machine to be fixed. The model offered a way to explain his particular occupational performance issues and opportunities with much greater accuracy than had I merely attended to his neurological or sensorimotor problems. I was learning to think like an occupational therapist! Graduate school, including fieldwork, forced me to enter uncomfortably challenging situations in which old rules and ways of thinking no longer applied.

**Multiple Cultures and Mentors in a First Practice Setting**

There was not a health professional in my family tree. Yet my first position as an occupational therapist was at Duke University Medical Center. Within a week I was in a white coat carrying a beeper, schedule book, and stack of consult slips for people sicker than I had ever imagined. I remained at Duke for 11 years, progressing from a staff occupational therapist to a senior occupational therapist, and then finally to clinical director of occupational therapy. Over the course of those years, I faced challenges of representing occupational therapy within a medical culture. I grew into these roles because of our profession's ever inspiring culture of truly helping its young and also thanks to the kindness of patients who, despite their dire circumstances, still saw me as a person.

When I was a staff occupational therapist, Marianne Chauvin, my supervisor, and Deborah Swinton, a COTA with whom I worked, instilled in me a solid foundation for client-centered practice. I learned volumes about adaptation and remediation, as well as about how to respect patients as whole persons within a medical culture. Later I was coached into the position as the occupational therapy clinical director by Ellen Scherling, who was leaving the position. My decision to move into management was also influenced by Barb Schell, the former director of occupational therapy at Harmanville Rehabilitation Center. When I was a fieldwork student, Barb had explained her administrative approach to me in a way that made management seem actually soulful. Until I found my feet as an administrator, I often called Cathy Nielson, my former professor. Cathy is the kind of person you want in the air traffic control room to calmly talk an amateur through a safe landing after the pilot has had a heart attack. Carolynn Baun generously shared her wisdom and helped me through some difficult transitions in the Division.

Across disciplines, I also developed strong ties to other managers in nursing, social work, among other departments, which resulted in another invaluable network of support and exposed me to diverse professional cultures. Many managers with whom I built relationships were women experiencing the so-called "glass ceiling." Their struggles for professional recognition and resources were, in essence, no different than mine.

I perhaps owe my greatest debt of gratitude to the patients with whom I worked. What a privilege to be alone with so many people who shared with me their joys, losses, sufferings, adaptations, and resilience. Some were poor tenant farmers who grew up under the indignities of segregation; others were privileged world travelers with hardships of other kinds. I listened, learned, and carried their stories in my head and heart. Meanwhile my hands made splints, carried equipment, and scribbled notes in voluminous medical charts. I felt a deep satisfaction whenever my hands, heart, and head converged and the therapy I provided helped someone to do something of great meaning. I am indebted to numerous patients who kept my feet on the ground and my focus on the present moment, even when I was distracted by the latest bad news from the budget office. I think of the violinist with a brain tumor who paused while struggling to grasp a spoon, saying, "It's really sad, isn't it?"

Although we are all thankful for advances in medicine, a dominant medical model culture can undermine what I believe to be great occupational therapy. My experience with the Rehab Stroke Group is an example of this struggle. The Stroke Group was led by occupational therapists that collaborated and bargained with other disciplines to ensure a regular 11 a.m. meeting time. The group consisted of planned community outings, cooking activities, educational sessions, and shared stories. Maybe more important, the group was fun. We tackled problems far beyond, “I want to move my arm and walk,” to dealing with how personal identities can be changed or maintained after a stroke. Conversations ranged from the best way to cook chicken to how growing up in poverty could prepare one to deal with adversity from disability. When the group was cohesive, it struck me as the ultimate therapeutic experience for people with lives turned upside down.

My first professional presentation was about the Stroke Group, given at the annual meeting of the North Carolina Occupational Therapy Association in 1988. After weeks of preparation, only a handful of people came to my presentation. Meanwhile, the conference sessions on physical handling techniques were packed. Consistent with the values conveyed in these attendance numbers, the Stroke Group was eventually abandoned to allow for more "mat time" for patients in rehabilitation. This occurred after inpatient lengths of stay had decreased, neurodevelopmental therapy (NDT) had become akin to scripture among practitioners, and individualized goals were trumped by a standard national outcome measure for rehabilitation. I, too, became NDT certified, gave and heard talks on the subject, and once even attended a workshop by Berta and Karl Bobath, the originators of NDT.

Although I still use some of the old and newer NDT principles with older adults, they are a small part of my current practice. For the most part, these types of techniques now seem like a distraction from using the treatment power of occupation to more efficiently reach the client’s goals. My mentors in this transformation were, once again, my occupational therapy clients. One revelation occurred with a highly educated man with severe...
hemiparesis who I saw for outpatient therapy. This gentleman would come into the clinic, lay his arm on the table, and expect me to go about fixing it. A therapist at another facility, who called herself an “NDT-OT,” had instilled in him the belief that he should not use his arm in daily activities until therapists got it moving better: a conviction that hindered his recovery and return to a meaningful life. Moonlighting in home health threw another wrench into my overriding concern with precise handling techniques. These experiences opened a window onto the complexities of people’s real-life occupational challenges that no handling techniques, however skillful, could overcome.

One of the greatest lessons I take away from my years as a clinical director is this: Leaders are empowered by their staff. Since occupational therapy practitioners in most settings interact continuously with other professionals, both negative and positive experiences are going to be communicated organization-wide and either work to undermine or enhance the credibility of all occupational therapists, leaders and staff alike. While clinical director, I was able to attend management meetings with confidence and, therefore, power, because I had, for the most part, the support and trust of the occupational therapy staff. This was especially important given the political situation of the Occupational Therapy Division, which was established in 1980 as a small stepchild of the large well-known Physical Therapy Department. My boss was a former president of the American Physical Therapy Association and the consummate advocate for his profession. We shared a deep concern for patients’ well-being. Yet, we had ideological differences that caused me many sleepless nights. Because of the quality of the staff and services we delivered, occupational therapy was eventually incorporated in some form into most clinical service areas of the medical center and our numbers of practitioners grew, even in times of layoffs and budget cuts.

Reflecting today on those 11 years, I am enormously grateful for my rich network of occupational therapy colleagues, plus my interdisciplinary allies, who helped me land on solid ground over and again. I also now realize how my clinical experiences instilled a passionate commitment to work with older adults and their families. It seems, too, that my early love of studying theory had grown, and I found myself increasingly drawn to the literature on clinical reasoning and occupational science (e.g., Mattingly, 1991, Mattingly & Fleming, 1994; Wood, 1995; Yerxa et al., 1989). I also increasingly struggled to balance the inflexible hours demanded by my clinical director position with being the parent of a young daughter. And I tired of spending seemingly more hours each week discussing budgets in mind-numbing detail, down to the cost of pencils. Nevertheless, I cannot fully explain why I left a job that had become my love and my identity. Perhaps the whole of my life was coming into sharper focus, including my need to find new kinds of challenges. What I do know is that one day I found myself fishing through the trash to find a letter I had tossed asking me to apply for a faculty position at UNC-Chapel Hill.

The Cultures of Academia and Practice in Occupational Therapy

My transition to the culture of academia, and to the particular culture of the Occupational Therapy Program at UNC-Chapel Hill, was yet another lesson about how the old rules no longer apply. The expectations of faculty members took me months to name and years to understand. After about 7 years, I stopped showing up at the office by 8 a.m. wondering where everyone was. Except for class and meeting times, nobody cared where I was as long as I showed up by 3 p.m. Sometimes, nobody cared where I was as long as I showed up by 3 p.m. I imagined, and it has also been more difficult than I imagined. A tough challenge arose as my clinical “halo” began to wear off in the eyes of the students and I seemingly became something less than a real occupational therapist. Given my involvement in UNC-Chapel Hill’s Program on Aging interdisciplinary team, this development surprised me. Indeed, I have learned that academic survival requires that faculty members have a clear area of focus, and mine has been gerontology. Shortly after volunteering to accompany the Program on Aging team on consultations, I became its core team member in occupational therapy. This work has allowed me to practice with a fantastic team across multiple venues, including weekly geriatric clinics, rural outreach consultations, and interdisciplinary educational conferences (Coppola et al., 2002). Gerontology has led me to new mentors in occupational therapy, especially Corky Glantz who helped me see myself as a leader. Work with older adults is enormously satisfying, as it requires understanding of people’s lives as a whole, in the context of their families and communities. I am learning that the junction of mind and heart produces the energy and wisdom to make a real difference in the lives of others. Accordingly, I have come to address the challenges of teaching by sharing poignant stories from my past and current clinical practices that reveal how my mind and my heart struggle and converge as an occupational therapist.

I have also come to appreciate the power of stories as a fieldwork coordinator. This role requires me to look through multiple cultural lenses and straddle not only the academic and clinical cultures of my profession, but also the multiple cultures of recipients of occupational therapy services. Student stories about clinical encounters, particularly uncomfortable ones, are occasions to explore differing viewpoints of clients, family members, practitioners, administrators, and others in the communities from which the stories emerged. In
The heart, mind, and soul of occupational therapy come to us in many ways and by mentors of many forms. Our profession carries a gift of connection to others in our lives, past, present, and future. The blue bowl on my desk serves as a reminder of what I have received from others, the relationships I now enjoy, and the responsibility I have to continue the journey.

For Josie

References


