Debility, whether caused by disease, trauma, or the aging process, whether temporary or permanent, challenges our doing and our being. It affects not only body and mind, but spirit too. It is a holistic experience. Occupational therapy has been a holistic discipline since its inception (Bing, 1997). Occupational therapy practitioners confront the debility of their clients with the belief that doing, alone, is not sufficient. Doing must be purposeful and have meaning, thereby engaging the mind and spirit: the whole person. Are doing and being dimensions of holism? I suggest the affirmative, that both the client’s doing and being must be engaged to ameliorate the debility. In this article, I shall illustrate this issue, drawing from my experiences as an occupational therapist and as a patient.

One Tuesday afternoon in October 1994, I received the results of a routine colonoscopy, which revealed that I had colon cancer. This is the disease that killed my sister untimely early at age 53; it is also the disease my mother still survives 49 years since her diagnosis. After my diagnosis, there ensued surgery, the discovery of metastases, a week of intensive chemotherapy, complications, more surgery, a year of chemotherapy, and 6 months of recovery from the physical ravages of that therapy. Throughout that time, I experienced varying degrees of debility. Sometimes my doing was reduced to the bare essentials; even talking was a huge effort that sapped my energy. The drastic reduction in doing gave me plenty of time for being. In fact, it seemed that healing required long periods of inertia during which I was fully aware of myself at that moment and of each moment that passed by. As an inveterate doer, this was strange territory for me.

Doing, Being, and Debility

The relationship among doing, being, and debility is delicate and complex. Frequently, our doing expresses who we are, or it may be a vehicle that we use to explore our being to understand ourselves better. It seems that health requires balance and harmony between doing and being. If we overdo, ignoring our body’s protests (fatigue, irritability) and forge ahead with doing, it is likely that debility will ensue. Ultimately, overdoing undermines our health, leaving us vulnerable to ubiquitous infections, and we succumb. It is likely that we have all had this experience at some time in our lives. Fortunately, the resulting illness—such as a severe cold or a bout of influenza—is usually brief, and we recover reasonably quickly.

It is possible that lack of harmony between who we are and what we do will precipitate a more serious illness. Mrs. S. thought so. Mrs. S. was in her 50s and was referred to me for scleroderma, which she had had for 2 years. By the time we met, the disease was in remission as a result of a fairly aggressive pharmacological regimen. Her hands were severely contracted, and she was dependent for the simplest activities of daily living (ADL). The goal of the referral was ADL independence. Mrs. S. confirmed this goal at our initial meeting. At this point, she was preoccupied by her inability to do the most fundamental things. As we addressed her personal care problems with changes in approach and some adaptive equipment, she realized that some of her problems with doing would be resolved. When she returned for her second visit, her entire focus had switched from her functional problems to her hands. “What can you do for my hands?” she wanted to know. Her hands were related to much more than ADL function. Mrs. S. was a lovely looking woman who took pride in her appearance. Her misshapen hands were an insult to her aesthetic sense. In addition, she had always earned her living by writing, an occupation made almost impossible by her disease. Her hands were indeed a place where her doing and being had coalesced.

As her story unfolded, I came to know that Mrs. S. was something of a perfectionist who had been living with her husband in an apartment in a city, though she was someone who loved the outdoors and the country. She had had a very high-pressure job, working for a large company writing reports on a variety of subjects that did not interest her in the slightest. She made very good money at the job. Mrs. S. was a poet. She had had a couple of volumes published, and her main interest was to write and publish more. However, writing poetry is not very lucrative, so she believed that she had to work at her uninteresting job to

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help support their lifestyle in the city. In short, she felt trapped. Her doing and being were totally out of accord. Finally, she became very ill with scleroderma, an autoimmune disease.

By the time we met, she and her family had left the city and moved to a small community in the country. She no longer had her high-pressure job but was still doing some contract work for the company. She had time to write her poetry. She had time to reflect on what happened, and she was able to see the imbalance that had developed between her doing and being. One day she told me she thought that she had given herself the disease as the only legitimate way out of an intolerable situation. The disease had put a stop to her doing and given her a lot of time to think about her being. It also allowed her to seriously consider moving to the country. In her new life, she was working to establish a better balance between doing and being. It was not an easy task. Although this is undoubtedly an oversimplification of a very complicated case, it is not unreasonable to suppose that the intrapersonal stresses of her life before diagnosis contributed to her succumbing to the disease.

Conversely, sometimes doing facilitates being. After my diagnosis of cancer, I was very busy doing. I had to find a surgeon, learn about the disease and surgery, make an orderly retreat from my clinical practice, and organize the household in preparation for an expected 6 weeks of reduced capacity. All this doing was occasionally interspersed with quiet times of introspection during which I began to look at the emotional issues and faced the reality that I had been diagnosed with “the big C,” which seemed inconceivable and unreal. The necessary doing kept me calm and buffered my being while I confronted the diagnosis and mustered resources for what was to come.

*Vis Medicatrix Naturae*

The idea that body and mind are inseparable goes back much further than the origins of occupational therapy. The Greek physician Hippocrates recognized a natural healing force within people and referred to it as *vis medicatrix naturae,* “the healing power of nature,” which is surely the effect of mind and spirit working in concert with the body to promote healing. Our mind-set at the outset of debility can be helpful or harmful. Cousins (1979) recounted that, as a boy, when he was hospitalized for tuberculosis, he and his fellow patients fell into two groups: those who believed that they would get well and those who believed that they would die. He was in the former group and, with his fellow survivors, would recruit new patients into their group. He noted that, “I couldn’t help being impressed with the fact that the boys in my group had a far higher percentage of ‘discharged as cured’ outcomes than the kids in the other group” (p. 156). As holistic practitioners, we need to know how our patients view their debilities and predicaments so we can facilitate the natural healing process. We can find this out in a variety of ways, including listening to patients’ self-talk.

Mrs. P had kidney disease as a result of diabetes. She was on dialysis and had to have an arteriovenous shunt placed in her left arm for dialysis access. After the procedure, her left hand became edematous and stiff. She subsequently developed reflex sympathetic dystrophy (RSD) in her left upper extremity, and it was at this point that she was referred to me. She had been receiving therapy from another therapist at the time, and she told me at our first encounter that it wasn’t doing her any good. As we worked together over the next couple of sessions, I noticed that she repeatedly said that her hand would never get any better. I pointed this out to her and suggested that she was working against herself coming to therapy, carrying out her home program but telling herself that she would never get any better; her doing and being were out of alignment. I asked her whether she would try giving herself a new message, and she agreed. I asked her to tell herself that her hand could get better. We discussed the fact that this would not be easy, that she would have to be vigilant and catch herself whenever she was giving herself the negative message and change it to the more hopeful one. She agreed to try and, in fact, started showing progress thereafter.

By the time I had received my diagnosis of colon cancer, I had already seen my sister die of the disease, but I had also seen my mother survive. My case was similar to my mother’s in that we were both diagnosed early. It was easy for me to decide that I would survive just as my mother had. Thus, from the outset I expected a positive outcome and, although sometimes I felt very ill indeed, I never doubted that I would survive. Later, during chemotherapy, I became aware that my attitude toward chemotherapy was negative and probably unhelpful. I decided I needed to make a conscious effort to welcome the pharmaceutical into my body and give them the best chance to do maximum good. So I changed my self-talk from “Ugh, I have to have chemo today” to “Welcome chemo. I know that you (oral medication) will enhance my immune system and that you (intravenous medication) will fight all the mutating cells you encounter.” Whether this change made any medically discernible difference is unknown. However, my changed mindset gave me a sense of active involvement in a treatment that can be experienced passively and lead to feelings of victimization. The holistic therapist is aware of the patient’s mind-set toward self-talk about his or her debility and encourages the mobilization of personal resources to facilitate *vis medicatrix naturae,* the natural healing ability.

**Capitalizing on the Placebo Effect**

The importance of how we approach debility and its treatment is clearly illustrated in studies of the placebo effect. These studies reveal that the placebo effect is more than a simple belief that a certain pill or procedure will heal and are surely demonstrations of the connection between mind and body. Spino (1995) stated:

Placebos have no power on their own. They are merely symbols, a seal to the contract between patient and physician. Prescribing a placebo is no substitute for time, energy, or communication, but simply the promise of dedication. Giving a placebo is only the first step, a symbol of the physician’s hope to help. (p. 301)

He noted that words also can be placebos. Benson (1996) pointed out that the placebo effect embodies both belief and expectations on the part of the patient and the caregiver, as follows:

1. Belief and expectancy on the part of the patient

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Thus, not only must the holistic practitioner be cognizant of the patient’s doing and being, but the practitioner must bring both his or her own doing (therapeutic skills) and being (therapeutic use of self) to the therapy encounter. The occupational therapy practitioner must be a full participant in the therapeutic alliance. The holistic practitioner capitalizes the placebo effect by discussing treatment strategies with the patient, discussing the evidence of their efficacy, and explaining their expected outcomes.

I was fortunate that I found care providers in whom I could have great faith and all of whom seemed to be cognizant of *vis medicatrix naturae* and the placebo effect and who took time to engage me in my own care. At the outset, my primary care physician reminded me that I could enhance my natural healing ability. Before the initial surgery, he encouraged me to visualize myself as healthy and strong afterward and doing some physical activity I enjoyed, thereby programming an expectation of a positive outcome. My surgeon took time to explain the procedure to me and my husband and fully addressed all our questions. Immediately after the operation, pain, tension, and anxiety almost overwhelmed me. A wonderful friend came to the hospital every day and gave me a massage, which was immensely calming. The physicians and nursing staff were supportive and facilitative of this practice. Later, when metastases were discovered, my oncologist explained the treatment options open to me and discussed her rationale for the treatment regimen of choice. During chemotherapy, nausea became a difficult side effect and the anti-nausea medications were hard to tolerate. When I started to experience *anticipatory* nausea, I decided I had better do something! I sought instruction in self-hypnosis and after a few sessions was able to control the nausea most of the time. I used other techniques as well to enhance and support my natural healing power, to mobilize and align my body, mind, and spirit in the quest to overcome debility. I used imagery to guide and enhance chemotherapy and maintain my immune system, relaxation techniques to reduce stress, meditation to enhance my sense of being and deal with pain, and yoga to rebuild depleted physical strength. The holistic practitioner is willing to entertain such approaches and discuss them with patients when and to the extent they are appropriate.

Whereas holism is an old concept based on observation and experience, studies in psychoneuroimmunology not only support the connection among thoughts, emotions, belief, and body functions, but also demonstrate how the connections are made (Justice, 1987). As holistic practitioners, we can share some of this information with our patients. The knowledge that these relationships have been scientifically demonstrated may help some persons mobilize their own natural healing power.

**Meaning**

A key aspect of the connection between being and doing is meaning. As occupational therapy practitioners, we value meaningful activity. If our doing is meaningful, we are happier and healthier (Dossey, 1991). In the case of Mrs. S., described earlier, her work was not meaningful to her in any way except that it earned her a large salary. This alone did not provide enough meaning for her. She was a good and able writer, but she spent her days writing about things she was not interested in and indeed had little knowledge about. Without meaning, her being was deprived of nourishment, and eventually she succumbed to illness.

Ms. J. was an artist, farm manager, and shepherdess. She was referred to occupational therapy because of the pain and debility caused by osteoarthritis in her hands. As the sole caretaker of the sheep, medicating them routinely, paring their hooves, and assisting with lambing was hard on her hands. During our first session, we discussed all that she did, the disease itself, and things that she could do to protect her joints and ultimately her hand function. She had some choices about just what she could do on the farm and said that she did not have to keep the sheep, she could sell them. During our second session, Ms. J. told me of the changes she had made to her doing and that she had thought about giving up the sheep but decided not to, saying, “The sheep seem to be part of my spirit right now, I need to keep them.” She was making an informed decision and was willing to enlist help with the heavier aspects of their care. The sheep added meaning to her being, and she was willing to modify her doing to keep them.

As well as searching for meaning in our lives and our doing, we may also search for meaning in our debility (Dossey, 1991). This was certainly the case for me. As part of the quest, I read widely, and one of the most touching books I read was Reynolds Price’s (1995) autobiography, *A Whole New Life*. Although the details of our debilities were totally different, I found that he gave voice to many of my experiences, and I was deeply touched. In *Close to the Bone*, Shinoda Bolen (1996) likened life-threatening illness to a journey to the underworld. It seemed to be such an apt simile, and her book helped me view my debility from a different perspective. In addition to reading, I found meaning through psychotherapy; the loving support and care of my husband; family, friends, and colleagues, and my dreams.

**Dreams as Guides to Meaning**

Our dreams connect us with parts of our being that are not readily accessible to us during our waking hours. Dream information is frequently obscure and requires some effort to understand. Ms. B. was a radiology nurse who had injured her back while helping a patient off the X-ray table. After an extensive course of physical therapy, she was referred to occupational therapy for work conditioning. She still had a great deal of pain, which drastically reduced her capacity for doing. She had always been a great doer and was quite depressed by her debility. When she looked outside herself for pain relief and did not find it, we agreed that one goal of therapy would be to learn ways of reducing the pain. To do so, we incorporated relaxation training and imagery into her treatment program. One day she told me that she had dreamed about me helping her to handle the pain. She joked that we must be seeing too much of each other if I was appearing in her dreams. I invited her to look at the dream a little differently. I introduced her to the idea that everybody in the dream represents a part of the dreamer; thus, the therapist in her dream might actually represent the therapist part of her (Koch-Sheras, 1983). In discussing this idea, we focused
on her strength and fortitude and her goal of return to work. Through these discussions, she recognized that there was indeed a therapist part of her that could help her take charge of the pain.

Shortly after I finished my year of chemotherapy, I had the following dream:

The sky is very gray and overcast. I am walking with a soldier who is escorting me through fields of dead. All the dead are dressed in heavy, gray greatcoats; it is a uniform, they are soldiers too. I know that they are the enemy. I walk through two large fields of them. I am checking to be sure they are all dead, and they are.

The meaning became clear as I analyzed the dream using Koch-Sheras’ (1983) approach: The soldier part of me (the fighter) is showing me the dead soldiers part of me (the cancer cells). I am alive and able to verify that they are all dead. The battle is over. I found this dream immensely comforting and reassuring.

Epilogue

The preceding stories illustrate a variety of ways in which doing, being, and debility interact. Mrs. S’s debility was permanent, but through it she found the courage to change her doing—and, indeed, her whole situation—in quite radical ways. Mrs. P’s presenting debility, upper-extremity RSD, interfered with her doing and was a very clear reminder of her underlying, permanent debility, diabetic kidney failure. Her repeated statements that her hand would never improve seemed to reflect a sense of resigned acceptance about her situation. When she was able to separate her hand dysfunction from her underlying disease and believe that her hand could improve, she was able to make it so. Ms. J. was able to be clear about the importance of her sheep to her being and was open to learning new ways of doing that would permit her to keep them. Ms. B. found her dreams a way of connecting to her being so she could learn new ways of getting back to doing. My experience has given me a deeper appreciation of the holistic nature of debility, of the relationship among doing, being, and debility. It convinced me of the need for occupational therapy practitioners to be true to their roots and practice holistically. Doing and being are, undoubtedly, dimensions of holism.

Acknowledgments

I thank my husband, family, friends, and colleagues who took over my doing when necessary, supported my being, and facilitated my healing so lovingly. I also thank the myriad of health care professionals who ministered to my body, mind, and spirit throughout. This article is dedicated to the memory of my sister, Rachel Johnston Binions (1936–1989), and my father, William Scott Johnston (1907–1996).

References


