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Use of Religious Observance as a Meaningful Occupation in Occupational Therapy

Abstract

Background: Research shows that religious and spiritual beliefs influence a person's health and quality of life. Studies have found that religious people are healthier and require less access to health services, and that clients want to have their religious and spiritual needs addressed as a part of their plan of care.

Method: This study used a descriptive survey design to explore the attitudes and behaviors of occupational therapists concerning religious observance in clinical practice. The survey yielded 181 responses from a random sampling from members of the American Occupational Therapy Association.

Results: The study found that while the majority of the respondents felt that religious observance was an important occupation, most rarely or never addressed religious observance in clinical practice due to reasons such as the work context and the sensitivity of the topic.

Conclusion: The findings suggest that education programs should better prepare graduates to view religious observance through the lens of task analysis rather than as a discussion of religion and spirituality. Furthermore, the findings suggest a potential unmet need that should be explored through further research.

Keywords

Religion, religious observance, spirituality, occupational therapy

Credentials Display and Country

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Religious and spiritual beliefs shape people's lives in myriad ways. Research shows that people's religious views impact their voting practices, charitable contributions, environmental regulation perceptions, and lifestyle choices (Pew Research Center, 2014).

Religious and spiritual activities and expression also shape a person's roles, routines, and habits (Humbert, 2016). According to the *2014 U.S. Religious Landscape Study*, conducted by Pew Research Center, 55% of the survey respondents indicated that they pray daily. Approximately 36% of those surveyed indicated that they attend a religious service at least once a week. Twenty-four percent stated that they attend prayer groups at least once a week, and at least 35% of the respondents indicated that they read religious texts at least once a week (Pew Research Center, 2014).

Religious and spiritual beliefs influence a person's health and quality of life. Some clinical studies have found that religious people are healthier and require less access to health services (Koenig, 2000; Koenig, McCullough, & Larson, 2001). It has been reported that religious people have better mental health and a better ability to adapt to stress (Koenig, 2000), and various studies have noted religious people have lower levels of depression and depressive symptoms (Baker & Cruickshank, 2009; Dein, 2006; Koenig & Larson, 2001; Moreira-Almeida & Koenig, 2006). Other reported benefits associated with religious beliefs and practices include lower suicide rates and less substance abuse as well as greater well-being, hope, optimism, purpose, life meaning, marital satisfaction, and social support (Koenig, 2004).

The literature also revealed that clients want to have their religious and spiritual needs addressed (Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999). King, Dimmers, Langer, and Murphy (2013) found that clients do not want their spiritual and religious concerns addressed in isolation from the other dimensions of care. Underwood and Teresi (2002) reported that most patients at end of life had many spiritual needs, and another study found that these patients had higher quality of life scores when these needs were addressed (Kang et al., 2012). Patients also felt that physicians should consider their spiritual needs and reported appreciating when physicians inquired into their religious beliefs (Ehman et al., 1999; Maugans & Wadland, 1991).

The second edition of the *Occupational Therapy Practice Framework: Domain and Process* (OTPF) introduced religious observance as an instrumental activity of daily living (IADL) (American Occupational Therapy Association [AOTA], 2008). Religious observance was not defined beyond "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent" (p. 631). The third edition of the OTPF expanded the occupation to include spiritual activities and expression as an IADL (AOTA, 2014). The additional definition, "engaging in activities that allow a sense of connectedness to something larger than oneself or that are especially meaningful" (p. S20) was provided. The inclusion of this occupation in the framework suggests that addressing a client's religious and spiritual needs falls in the scope of occupational therapy. Yet, there are no specifics regarding the capacity with which practitioners should do this. How are therapists interpreting their role in facilitating this occupation? An important tenet of occupational therapy is the role of occupation as an end and as a means (AOTA, 2014). Are therapists designing interventions that incorporate religious and spiritual activities into occupational therapy sessions, or are therapists viewing their role as supporting indirect participation in religious observation through activities of daily living (e.g., dressing, showering/bathing, functional mobility) and other IADLs (e.g., driving and community mobility)?

The topic of spirituality is not unfamiliar to occupational therapists. Occupational therapy has long promoted the prescription of therapeutic occupations that addressed the client's body, mind, and spirit (Quiroga, 1995). Numerous models used by occupational therapists to guide assessment and intervention consider the whole person, which includes the physical, social, psychological, and spiritual needs of the client (Christiansen & Baum, 1997; Stein & Cutler, 1998, Yerxa, 1998). The use of meaningful occupation as the primary modality of care requires occupational therapists to understand the personal values, interests, and needs of their clients (Morris, 2013). Client-centered treatment emphasizes the importance of meaningful occupation in practice. Spiritual needs are often met when the client is able to connect to something larger than himself or herself through meaningful occupation. While spirituality may encompass religious beliefs and activities, spirituality does not require a belief in God or a supernatural being (Collins, 1998; Johnston & Mayers, 2005); spirituality has been defined as "the search for meaning and purpose in life" (Johnston & Mayers, 2005, p. 386).

The review of the literature determined that while therapists acknowledge that spirituality should be addressed in occupational therapy practice (Engquist, Short-DeGraff, Glimmer, & Oltjenbruns, 1997; Farrar, 2001; Johnston & Mayers, 2005; Smith & Suto, 2012), it is not easily defined (Bursell & Mayers, 2010; Hammell, 2001; Morris, 2013), it encompasses many dimensions (Unruh, Versnel, & Kerr, 2002), it is difficult to assess due to the lack of standardized assessment tools related to spirituality (Engquist et al., 1997; Johnston & Mayers, 2005), it is difficult to address in clinical practice (Collins, 1998) due to the emphasis and regulations imposed by the medical model (Fleming & Mattingly as cited in Morris, 2013), and it is not formally taught or emphasized in educational curricula, thus leaving many practitioners with little preparation to address the spiritual needs of clients (Collins, Paul, & West-Frasier, 2002; Enquist et al., 1997; Johnston & Mayers, 2005; Morris, 2013; Smith & Suto, 2012).

While there are multiple sources indicating that religion and spirituality are important to clients and can improve health outcomes and quality of life, the occupational therapy literature offers little evidence of the use or inclusion of religious observance as a therapeutic occupation in clinical practice.

Farrar (2001) surveyed Canadian and U.S. occupational therapists asking them whether they assess the religious affiliation of their clients and whether they use information about spirituality and religious practices to develop meaningful treatment plans. Farrar found that while 88.1% of the respondents believed that occupational therapists should address spirituality, only 35.3% of the respondents address religion. When asked why they do not address spirituality or religion, the respondents most frequently responded that it was not relevant to the setting. The second most frequent response was that they lacked the training to address a client's religious life (Farrar, 2001).

Smith and Suto (2012) interviewed nine individuals with schizophrenia about the value of religion and spiritual practices. Occupational therapists working in mental health face the additional challenges of addressing religious observance and spirituality in practice because many delusions experienced by psychiatric clients relate to religious pre-occupation, or the therapist may fear that talking about such emotionally laden topics such as religion or spirituality may exacerbate symptoms. The results of their study indicated that religion and spirituality can play a role in helping clients cope with their illness and serve as a source of empowerment and agency. They stated that occupational therapists "with their focus on occupation, have the potential for the most direct access to conversations with their clients about their engagement in RS (religious and/or spiritual) practices" (Smith & Suto, 2012, p. 83).

Smith and Suto (2012) examined both religious observance and spirituality; however, this article will focus on the occupation of religious observance. Our decision was based on the fact that therapists' views concerning spirituality have been explored, but the profession's views regarding the place of religious observance remains unknown in the literature.

Through this study, we hoped to gain insight into the current view on the use of religious observance in occupational therapy practice. We sought to answer three questions: Is religious observance a meaningful occupation addressed in occupational therapy practice? How are therapists addressing religious observance? If therapists are not addressing this occupation, why not?

Method

Study Design

The study used a survey design to explore the attitudes that occupational therapists have about religious observance as an IADL and the way those attitudes influenced practice (Portney & Watkins, 2009). An online survey was chosen due to its perceived strength in obtaining candid answers from a large sample.

Participants

Contact information for 1,000 random occupational therapists practicing in the US was purchased from the AOTA member services. This service provided a convenience sample of therapists with an AOTA membership, who we believed were more likely to have knowledge of the OTPF and thus be aware of the profession's efforts to include religious observance in its scope of practice. We decided to exclude certified occupational therapy assistants because they do not independently assess patients or develop treatment plans. After obtaining approval from the Human Subjects Committee, letters requesting participation were mailed to the individuals provided by AOTA. The letter contained a description of the study's purpose, contact information for the primary investigator, a web-based survey URL address, and a unique password. Informed consent information was explained and consent was sought on the first page of the digital survey.

Instrument

The survey aimed to explore attitudes and behaviors regarding religion and spirituality. Eleven content questions and six demographic questions were developed to ascertain the attitudes occupational therapists had about these topics as well as the behaviors that resulted from these attitudes. Survey length was considered to balance the obtainment of valuable data while encouraging participation and avoiding test fatigue. Due to the lack of research into the subject of religious observance in occupational therapy practice, a review of the literature and the survey by Engquist et al. (1997) was considered to determine barriers to addressing spirituality that might also apply to addressing religious observance. The respondents were asked to use the following definitions to operationally explain religion. This definition was taken directly from the OTPF2 (the study used the term religious observance as it was conducted in 2013 and the OTPF3 was not yet adopted). Religion is "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent" (AOTA, 2008, p. 631).

Content questions included both Likert-type attitudinal questions and multiple choice questions. Attitudinal questions required the participants to rate their level of agreement using a 5-point Likert-type scale to statements such as "Occupational therapy practitioners are qualified to address a client's ability to participate in religious observance." Multiple choice questions were developed to estimate the

frequency (e.g., *never, rarely, sometimes, often, always*) with which occupational therapists assess a client's ability to participate in religious observance or the extent to which they create a list of interventions and barriers. In addition to forced response items, many questions included an "other" option that allowed the respondents to describe the ways in which religious observance was addressed during therapy. Research design questions and survey content were reviewed by faculty members of the university's occupational therapy program for face validity. A copy of the full survey is included in the Appendix.

Analyses

Descriptive statistics were run on all survey questions. Cross tabulations were used to determine whether practice setting, years of experience, gender, or geographic region influenced the respondents' attitudes and behaviors. The respondents were asked to rate their level of agreement to several Likert-type questions concerning religion, spirituality, and occupational therapy. For each statement, the mean level of agreement and the percentage of affirmative responses were calculated using SPSS 21.0. A point value was assigned to the responses (*strongly agree* = 5, *agree* = 4, *neutral* = 3, *disagree* = 2, *strongly disagree* = 1) to calculate the mean. The percentage of affirmative responses were calculated by combining the responses listed as *strongly agree* and *agree*.

Qualitative analyses determined whether there were themes that emerged from the optional write-in responses. Each researcher reviewed the qualitative data separately and created categorical codes. We then collaborated to compile the list of categorical codes after the first review and then individually recoded the data using the newly generated list of codes. We continued to discuss any differences that occurred in individual coding until we reached consensus. Themes were then created from the list of codes and reported based on the frequency of times the themes arose during analysis (Corbin & Strauss, 2008). The qualitative data that was gathered was done in such a way that the most credible way to obtain trustworthiness occurred as a part of the analysis of the data. The strategies used included peer examination, triangulation of raters, and auditing of data analysis (Krefting, 1991). The implementation of the abovementioned strategies ensured that the qualitative analysis process had higher credibility, transferability, and confirmability (Krefting, 1991).

Results

Of the 1,000 surveys distributed, 181 were completed (response rate = 18.2%). The majority of the respondents were female (92%), between 30 to 59 years of age (74.5%), and had obtained a master's degree in occupational therapy (48.3%). Approximately half (48.9%) had been practicing for 15+ years. The highest number of responses came from occupational therapists located in the North Central (26%) and North East (21%) regions of the US. The largest portion of the respondents worked in the school system (24%), followed by outpatient rehabilitation (19%), and acute care hospitals (16%). The majority of the respondents (87%) did not work in an agency run by a religious organization.

Approximately 76.8% of the respondents affirmed the statement "It is important to address a client's ability to participate in religious observance in occupational therapy practice" ($M = 3.96$, $SD = .85$). Yet only 69.9% of the respondents agreed with the statement "Occupational therapy practitioners are qualified to address a client's ability to participate in religious observance" ($M = 3.69$, $SD = .94$).

Research Question 1

The first research question addressed in this survey was: Is religious observance a meaningful occupation addressed in occupational therapy practice? For the purpose of this study, this was broken down into two behaviors: (a) assessing a client's ability to participate in religious observance and (b)

intervening by addressing religious observance in a client's plan of care. Table 1 summarizes the findings regarding how frequently the respondents assessed a client's ability to participate in religious observance and how often they included interventions for religious observance in their plans of care. More than 25% of the respondents indicated that they never assess a client's ability to participate in religious observance. Approximately 29% never wrote interventions related to religious observance in their plans of care.

Table 1

Frequencies Reported by the Respondents Assessing and Addressing Religious in Practice

Frequency	% of Respondents Assessing a Client's Ability to Participate in Religious Observance	% of Respondents Addressing a Client's Ability to Participate in Religious Observance in the POC
Never	25.96	28.7
Rarely	27.9	33.7
Sometimes	26.0	24.9
Often	15.5	11.1
Always	5.0	2.0

The respondents who indicated that they *rarely*, *sometimes*, *often*, or *always* addressed a client's ability to participate in religious observance were asked why they did. The two most frequent responses selected by the respondents were "My clients have identified it as a meaningful occupation and treatment priority" (87.1%) and "It is an important component of health and well-being" (66.7%). Table 2 provides a summary of frequencies of responses to all of the reasons offered.

Table 2

Reasons Cited for Addressing Religious Observance by the Respondents Addressing it in Practice

Reason	%
My clients have identified it as a meaningful occupation and treatment priority	87.1
It is an important component of health and well-being	66.7
My personal religious beliefs/values have led me to think this is an import aspect of knowing a client	36.4
It is an included occupation in the AOTA Occupational Therapy Practice Framework document	23.5
It was emphasized in my occupational therapy education/training	13.6

Note. The respondents were allowed to choose all of the reasons that applied.

Cross tabulations were run to determine whether there were variations among levels of agreement to the attitudinal statements based on demographic variables, such as geographic region, years of practice, or gender. The data yielded no significant difference for any demographic variable.

Analysis of the qualitative data revealed two themes that influenced whether religious observance was assessed and addressed in occupational therapy practice: the client receiving services and the context in which occupational therapy services took place.

The client receiving services. Clients, not therapists, were the primary catalyst for bringing religious observance into the occupational therapy session through three mechanisms: initiating discussion about it, identifying it as a meaningful and important occupation, or identifying it as a goal for therapy. As one respondent explained:

I rarely broach the subject of religion or spirituality with patients. However, I have no issue addressing it if a patient brings it up. I often discuss it with patients because it is an important part of my patients' lives.

Another respondent noted:

If a client identifies spirituality or religious observance as a priority in his or her life, then I will take the time to follow up and address their concerns, but I usually do not directly ask about these topics in my evaluation or treatment sessions.

Another respondent expressed a similar sentiment: "if a client identifies participation in religious observance as a priority and a goal, then I address it as I would any other goal. It depends on the client and their [sic] goals."

The context in which occupational therapy services took place. The context in which the respondents practiced contributed to whether the respondents addressed religious observation in practice. The contexts seen as providing more support for addressing religious observance included evaluations that posed questions related to religious observance in the evaluation process or recognition of its use in the healing process for some clients. One respondent mentioned that "our facility encourages us to help the patient use their [sic] faith as part of their healing process if that is what they believe." Another explained that addressing religious observance was expected "[since addressing the patient's ability to participate in religious observance was] required as part of the evaluation process at my place of employment."

Research Question 2

The second research question asked: How are therapists addressing religious observance? The respondents were given a list of interventions to select. The most frequently chosen options were indirect methods, including "discussing the supportive role religion and the religious community can play in the client's life" (51.9%) and "discussing the benefits of religious observance toward health and well-being" (37.7%). Direct methods of addressing a client's ability to participate in religious observance included "helping the client contact a religious leader" (24%), "praying with the client" (20.3%), "simulating religious rituals or practicing components of such in the therapeutic sessions" (19%), "visiting the hospital chapel with the client" (14.3%), and "singing religious songs with the client" (8.3%).

The respondents were encouraged to write in other examples of interventions. Three themes emerged from the qualitative analysis of the data: assessment of religious activities or rituals, direct interventions, and indirect interventions.

Assessment of participation in religious activities or rituals. One respondent explained that assessment involved "identifying barriers that keep a client from being able to participate in religious observations (e.g., driving and mobility safety, activity tolerance, etc.)." Assessment also took place by "asking the client directly what tasks are involved in participating in stated religion so I can better assess their ability to participate." Another respondent stated, "[I ask] clients to describe and/or demonstrate the religious rituals that are important to them."

Direct interventions. While direct interventions were not the most common method identified in the sample, some of the respondents elected to elaborate on their role in facilitating this occupation. One respondent stated:

I had a patient who went to daily mass before his stroke. He had stopped because he was so afraid he would drop the Eucharist because his hand did not work as well as before. We practiced the action, then did a community reentry session to daily mass. That was quite a beautiful event.

Another respondent reported having “attended church with client[s] and family to assist parents in adapting the environment.” Another form of direct intervention used by a respondent was illustrated in this comment: “through community mobility training: taking people to their place of worship.”

Indirect interventions. Indirect intervention was the most frequently used method. Indirect interventions involved addressing the necessary activities or performance skills required for participation in religious observance rather than participation in the occupation itself. For one of the respondents, this started by “discussing with the client what specific skills they feel that they need to participate,” while another respondent explained more specifically that “to me, religious observance is more about performing the actions of your particular religion-whether it be kneeling, praying, etc. These are aspects I feel comfortable addressing.” Another respondent stated that intervention sometimes involved “identifying resources to help them attend religious observances.” One of the respondents reported indirect intervention by “working on a client’s ability to demonstrate strength/endurance to be able to participate in religious observance.” This view was echoed by another respondent, who stated that “only when my client expresses a desire to address the matter, I will address it. Intervention will always be in the form of addressing physical dysfunction to enhance participation in religious observance.”

Research Question 3

The third research question asked: Why are therapists not addressing a client’s ability to participate in religious observance? Table 3 provides a summary of the reasons reported by the respondents who did not address a client’s ability to participate in religious observance. The most frequent reason (79.5%) for not addressing this area was that clients had not identified it as a priority. The second most frequently cited reason (29.5%) was that addressing religious observance did not align with the organizational culture of the respondent’s practice setting.

Table 3

Reasons Therapists Are Not Addressing a Client’s Ability to Participate in Religious Observance

Reason	No. responses (n = 132)	Percentage
Clients have not identified it as a priority	105	79.5
It does not align with the organizational culture	39	29.5
Standardized evaluation/treatment protocol does not include	21	15.9
Is not a reimbursable intervention	14	10.6
Therapist hasn’t been educated	13	9.8
Therapist is uncomfortable broaching with clients	9	6.8

Note. The respondents were allowed to choose all of the reasons that applied.

Analysis of the qualitative data revealed two themes: the context, including the treatment setting and sociopolitical factors, and the sensitive nature of the topic.

The context. Elucidation of the lack of alignment with the treatment setting's culture was provided by some of the respondents in regard to addressing religious observance. One respondent noted that "often I am in the school setting where there is a divide between church and state, where it is not my place to bring it up." This was echoed by another respondent who said "I primarily work in public schools. Unless a parent would request assistance ([and this] has not occurred in 13 years of practice), I don't feel it is appropriate in this setting."

The sociopolitical issues that can potentially arise in response to this issue were another area of concern. Another respondent stated,

[The] United States is a secular country and religion can be a sensitive topic to discuss in OT practice. I also work with a diverse group of people who all come from different religious backgrounds. I hesitate talking to them about religion because I somehow believe that today's religions are often associated with politics or political figures and things may get controversial.

The sensitive nature of the topic. Discomfort with the topic of religious observance on the part of the respondent was the least frequently cited reason for not addressing religious observance. However, the qualitative data revealed that some of the respondents held concern about broaching the topic. As one respondent mentioned, "I don't want to offend anyone; I let them bring it up." Another discussed the potential divide between the therapist's and the client's beliefs, mentioning that "[it] may be a sensitive topic or their beliefs may not align with my own, in which [case] I would have a difficult time fully supporting them in participating in their beliefs."

Discussion

The results of this study are similar to other research on spirituality and religion in occupational therapy practice. Most of the respondents (77%) felt that religious observance is an important occupation to address in practice when it is meaningful to the client. The respondents recognized religion's role in health promotion and well-being, which is a finding that has been supported by studies in and outside of the occupational therapy literature (Engquist et al., 1997; Farrar, 2001; Howard & Howard, 1997; Johnston & Mayers, 2005; McClain, Rosenfeld, & Breitbart, 2003; Peralta-Catipon & Hwang, 2011).

While the respondents acknowledged the importance of religious observance, the results of this study do not support the application of this belief in clinical practice. Over half of the respondents (53.9%) never or rarely asked questions about it and, unsurprisingly, this resulted in religious observance being never or rarely addressed in the client's plan of care. The finding is slightly higher than the findings of Farrar (2001). She reported that religious affiliation was not assessed by about half (46.1%) of the U.S. respondents in her study.

One hypothesis, generated prior to the start of the study, was that the inclusion of religious observance in the OTPF may have resulted in reconsideration of this occupation in a therapist's personal practice, resulting in an increased number of therapists addressing religious observance as an occupation in practice. This hypothesis was not supported by the evidence. The study found that most of the respondents (58%) indicated that they did not use the OTPF2 as a guide for assessment and intervention.

The reason for this disparity between attitudes/beliefs and behavior was not clear from the data. Analysis of setting, gender, and education level found no statistical differences that accounted for why religious observance was not addressed. The only evident explanation is that most of the respondents

feel discussion of religious observance is something that should be the client's responsibility to initiate. Without the client's expressed interest in addressing religious observation, the respondents appeared unwilling to initiate such dialogue. This finding is similar to Engquist et al. (1997) who found that 67% of surveyed therapists were willing to address spirituality, but only when it was mentioned by the client. Farrar (2001) reported that 22.4% of the U.S. practitioners in her study only assessed religious affiliation when the client mentioned the topic. Furthermore, Farrar reported that 23.5% of the U.S. respondents indicated they had no right to ask questions about the client's spirituality or religion. In a country that values the separation between church and state, it is perhaps not surprising that therapists do not bring up such potentially sensitive topics. However, the findings indicate that therapists do not feel uncomfortable bringing up the subject. Only 6.8% of the respondents cited this as a reason for not addressing religious observance with a client.

Still, there are some occupational therapists (38%) who are addressing religious observance in some capacity during practice. As one respondent stated, "it is the client's right to practice religion and it is part of my job to eliminate barriers to this." The most common method of intervention in this study was what researchers identified as indirect interventions. This finding was similar to Farrar (2001), who found that 75.8% of the U.S. respondents who did address religious observance focused on "extrinsic religious activities, such as functional ability to participate in worship, Bible study groups, prayer groups, religious holidays, referrals to clergy, and church accessibility issues" (p. 72).

Approximately 25% of the sample were practitioners working in school-based practice. Many of these respondents never or rarely assess or address religious observance in practice. This practice aligns with the literature. According to Clark and Chandler (2013), some occupational therapists are not allowed to address religious practice or procedure in this practice area because participation in religious services is not part of the typical day (public vs. private parochial).

Implications

The findings of this study suggest that the majority of occupational therapists do not currently view religious observance (later to be re-named and revised as religious and spiritual activities and expression) as a meaningful therapeutic occupation to be used in practice, regardless of its inclusion as an IADL in the OTPF. Furthermore, the findings may suggest that more occupational therapists are embracing the view that the purpose of addressing this occupation is to meet an end goal (maintaining the client's participation in this occupation) as opposed to using this occupation as a means, as suggested by Smith and Suto (2012)—using activities associated with religious observance and spirituality as therapeutic interventions to promote agency and empowerment. This indicates a potential need for further education and training to assist therapists in analyzing the occupational performance of religious observance in a procedural manner like any other occupation. While the OTPF has provided the profession with tacit encouragement to address the issue of religious observance with clients, this encouragement does not seem to be translating into practice.

When religious observance is not given equal consideration like any other facet of the client, the overall scope of therapy may be limited from its holistic potential. Even when clients do not specifically mention religious observance as a priority, it does not negate the need to raise questions about the importance this topic may have for individuals. The sensitivity surrounding it is broadly recognized in today's society, and clients may refrain from mentioning religious concerns for the same reason that therapists hesitate to raise the issue. Clients may not be aware of the full range of activities that fall in

the scope of occupational therapy, and they may not know they are able to identify religious observance as a priority for treatment.

As therapists, it is imperative to overcome the possible discomfort surrounding this subject so that clients may feel comfortable to voice all concerns they may have. Even though occupational therapists support the importance of religious observance and the place it has in the domain of occupational therapy, the lack of application into action indicates that therapists may benefit from further education about how to do so. This may involve being informed of expected behaviors for different religions to increase comfort and confidence in addressing the needs of a client's specific forms of worship.

Additional training for current practitioners and inclusion in the curriculum of entry-level education programs may help future therapists see that religious observance can be assessed and addressed in the same manner as many other areas of occupation. Therapists already address other "sensitive" topics, such as sexual activity, money management, and driving. The 2011 Accreditation Standards outline outcomes that students must "demonstrate knowledge and appreciation of the role sociocultural, socioeconomic, and diversity factors and lifestyle choices in contemporary society" (Accreditation Council of Occupational Therapy Education [ACOTE], 2013, Standard B.1.4., p. 19). Furthermore, Standard B.2.9 states that students must be prepared to "express support for the quality of life, well-being, and occupation of the individual, group, or population" (p. 20).

The qualitative data in the study suggests that those who are addressing religious observance in practice are doing so from a functional rather than philosophical approach. Using the lens of task analysis, a level of comfort with addressing religious observance may be fostered to allow this potential need to be met more frequently.

The profession would benefit from further research into this topic, such as analyzing a larger sample size to increase the likelihood that the sample accurately captures the reality of occupational therapy practice in the US and the world abroad. Contacting state occupational therapy associations or practitioners from Canada and the United Kingdom may also provide a means of reaching more respondents. Adding exclusion criteria for school-based therapists, who are unable to address the topics of religious observance and spirituality regardless of individual perceptions of their use in the therapy process, is suggested so that more meaningful data is obtained. This would allow for the collected data to better reflect the opinions and resulting behaviors occupational therapists have regarding these topics.

Limitations

A major limitation of the study was the measurement tool itself. In hindsight, it was difficult to determine whether the respondents were in fact asking the client about religious observance or not. Survey Question 3 asked the respondents to indicate whether they assessed a client's ability to participate in religious observance *never, rarely, sometimes, often, or always*. Many practitioners answered *never* as reported in the results, yet many then went on to answer Survey Question 6, which asked if they were not addressing religious observance in practice to indicate why. Some of these same respondents indicated that "clients have not identified it as a priority." The question's clarity was called into question. We did not capture the behavior of all of the respondents, since some of those responding *never* in fact never did ask, while others who had indicated *never* appeared to have asked their client if it was an important occupation/priority of the client. When the client answered 'no,' they did not go on to assess the ability of the client to participate in that occupation.

Another limitation was the low response rate (18.2%). This could have resulted in a non-response bias where religious issues may have been addressed more or less frequently by the broader field of occupational therapists. The low response rate may have in part been due to the use of a cumbersome mixed-methods administration method that required researchers to contact the AOTA subscribers by mail through a physical mailing address to ask willing participants to complete the online survey. Streamlining the administration method to be entirely computer-based may have increased the number of responses. Another significant limitation was the inclusion of therapists working in a school setting. Due to the nature of a public-school practice setting, occupational therapists are not allowed to address religion, thereby skewing the results in an underrepresentation of therapists addressing the occupational performance problem. The survey did not attempt to measure the religiosity of the respondents, which also limits the generalizability of the findings. Finally, limiting inclusion to members of the AOTA could have led to increased familiarity regarding the inclusion of religious observance in the OTPF that non-member occupational therapists may not have.

Conclusion

The main aim of this study was to determine whether occupational therapists view and address religious observance as meaningful therapeutic occupations in clinical practice. The results suggest that while occupational therapists recognized the importance of addressing a client's ability to participate in religious observance, most of the time they rarely or never assessed or addressed this area in practice.

The most frequently cited reason for not addressing religious observance was that the client had not identified it as a priority for therapy. Unfortunately, we were unable to determine whether the clients were being asked about religious observance as an important occupation or whether the practitioners rely on the clients to initiate discussion about these occupations. The qualitative themes suggest that there is a hesitancy among the respondents to ask the client about religious observance and that therapists are waiting for the client to raise the topic.

Regardless, these findings support the need for further education and training to assist therapists in translating their understanding of the importance of religious observance into actual client care. Further research would help to explore the broader field's view and application of this topic and the possible methods for developing practice guidelines regarding participation in religious and spiritual activities and expression.

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Appendix

An Exploratory Study on The Use of Religious Observance as a Meaningful Occupation in Occupational Therapy

You are being asked to participate in a research study conducted by William Cercle, Sarah Gaudet, and Lauren Keele, master's students in occupational therapy at Idaho State University, Pocatello, Idaho. You have been asked to participate in this research because you are an occupational therapist who is currently working with clients, and we would like to know if you are addressing religious observance and/or spirituality with your clients. Your participation in this research project is voluntary. You should read the information below and ask questions about anything you do not understand before deciding whether or not to participate.

Purpose of the study

This study is focused on exploring whether occupational therapists are using religious observance and/or spirituality as a meaningful therapeutic occupation in their clinical practice. The results of this study may be used to direct future research regarding clinical reasoning and outcome studies of the efficacy of religious observance as a therapeutic occupation.

What will happen to me in this study?

If you decide to participate, you will complete a survey in an online (web-based) format. The survey will include questions or statements about how you use and implement activities related to religious observance and will take about 10 min to complete.

What are the possible risks and discomforts?

Potential risks and discomforts may include anxiety regarding answering questions about the choices you make as an occupational therapist and sitting for the time required to complete the survey.

What are the possible benefits of taking part in the study?

The primary benefit of taking part in this study is the knowledge that you have contributed to research in occupational therapy.

Are there any payments to me for taking part in this study?

There is no payment for participating in this study.

Will my information be kept private?

The information that you provide will be kept confidential. Only the principal investigators will have password protected access to this survey. Once the study has been completed, the information will be downloaded to a password protected file. Your answers will remain anonymous, as any personally identifiable information, such as your name or email address, will be separated from your responses on the survey and deleted.

What are my rights as a participant, and what will happen if I decide not to participate?

Your participation in this study is voluntary. Your decision whether or not to take part will not affect your current or future relationship with Idaho State University. You are not waiving any legal claims or rights. If you do decide to take part in this study, you are free to change your mind and stop taking the survey at any time.

Who do I contact if I have questions or concerns?

If you have any questions or concerns with this study, you may contact the investigators in the Department of Physical and Occupational Therapy at Idaho State University. Dr. Kelly Thompson, thomkel2@isu.edu, or 208.282.4097

By completing and submitting this survey you are: (a) acknowledging that you are an occupational therapist currently practicing in the United States; (b) providing your informed consent to participate in this research study.

If you would like to participate in this study please continue to the survey below.

1. Informed Consent: Please type in the unique password you were assigned; it can be found in the cover letter we mailed you.

2. Please indicate your level of agreement to each of the statements below. We ask you to consider each statement using the definitions offered by the AOTA’s (2008) *Occupational Therapy Practice Framework: Domain and Process* document. Spirituality is defined as “the personal quest for understanding answers to ultimate questions about life, meaning, and about the relationship with the sacred or transcendent, which may lead to or arise from the development of religious rituals and the formation of community.” Religious observance entails participating in religion (“an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent”).

Strongly agree	Agree	Neutral/ No Opinion	Disagree	Strongly Disagree
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Religious observance and spirituality are concepts that can be used interchangeably.

It is important to address a client’s ability to participate in religious observance in occupational therapy practice.

It is important to address a client’s spirituality in occupational therapy practice.

Occupational therapy practitioners are qualified to address a client’s ability to participate in religious observance.

Occupational therapy practitioners are qualified to address a client’s spirituality.

3. Please select one response for each statement below.

Always	Often	Sometimes	Rarely	Never
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I assess a client’s ability to participate in religious observance.

I include interventions that target a client's ability to participate in religious observance in the client's plan of care.

I ask clients questions about their spirituality.

I include interventions that address spirituality in the client's plan of care.

4. If you do address a client's ability to participate in RELIGIOUS OBSERVANCE, why? Check all that apply. (If you responded *Never* to Question #2a, please skip to Question #5.)

It is an important component of health and well-being.

It is an included occupation in the AOTA Occupational Therapy Practice Framework document.

It was emphasized in my occupational therapy education/training.

My personal religious beliefs/values have led me to think this is an important aspect of knowing a client.

My clients have identified it as a meaningful occupation and treatment priority.

Other: (please specify)

5. How do you address a client's ability to participate in RELIGIOUS OBSERVANCE in your therapy sessions? (Check all that apply.)

Indirectly, by discussing the benefits of religious observance toward health and well-being.

Indirectly, by discussing the supportive role religion and the religious community can play in the client's life.

Directly, by helping the client contact a religious leader.

Directly, by simulating religious rituals or practicing components of such in therapeutic sessions.

Directly, by visiting the hospital chapel with the client.

Directly, by singing religious songs with the client.

Directly, by praying with the client.

Other: (please specify)

6. If you do not address a client's ability to participate in RELIGIOUS OBSERVANCE in your therapy practice, why not? Check all that apply.

Clients have not identified it as a priority.

It does not align with the organizational culture of my setting.

It is a topic that I find uncomfortable broaching with clients.

Clients are uncomfortable discussing this topic.

I haven't been educated in that area.

It is not a reimbursable intervention.

We use a standardized evaluation and treatment protocols that do not include religious observance.

7. If you address a client's SPIRITUALITY, why? Check all that apply. (If you selected the *Never* option for Question #2d, skip this question.)

It is an important component of health and well-being.

It is an included occupation in the AOTA Occupational Therapy Practice Framework document.

It was emphasized in my occupational therapy education/training.

My personal religious beliefs/values have led me to think this is an important aspect of knowing a client.

My clients have identified it as a meaningful occupation and treatment priority.

Other: (please specify)

8. If you do not address a client's SPIRITUALITY in your therapy practice, which option best describes the reason you do not address it: Check all that apply.

Clients have not identified it as a treatment priority.

It does not align with the organizational culture in my setting.

It is a topic that I find uncomfortable broaching with clients.

Client are uncomfortable discussing this topic.

I haven't been educated in this area.

It is not a reimbursable intervention.

We use standardized evaluation and treatment protocols that do not include spirituality.

Other: (please specify)

9. Do you assess a client's ability to participate in religious observance and their spirituality separately?

Yes

No

10. Do you use the AOTA's *Occupational Therapy Practice Framework: Domain and Process* document as a guide for assessment?

Yes

No

11. Please feel free to add any comments or information you would care to share on the subject of addressing spirituality or religious observance in occupational therapy practice that has not been covered in this survey.

12. Please indicate your gender:

Male

Female

13. Indicate your age group:

20-29

30-39

40-49

50-59

60 and older

14. How many years have you been working as an occupational therapist?

0-5

6-10

11-15

More than 15 years

15. What is the highest level of education you have completed?

Bachelor's degree in occupational therapy

Master's degree in occupational therapy

Master's degree in another field

Clinical doctorate in occupational therapy

Doctorate in another field

PhD in occupational therapy

16. What state do you practice in?

17. What setting do you primarily work in?

Acute hospital (not mental health)

Behavioral health/Mental health

Early Intervention

Home Health

Inpatient rehabilitation

Long term care facility

Outpatient rehabilitation

School system

Skilled nursing facility

Wellness program

Other (please specify):

18. Is your place of employment associated with a religious organization?

Yes

No

Thank you for participating in this survey!