2004

Spirituality and occupational therapy

Rebecca Susanne Wurm
Ithaca College

SPIRITUALITY AND OCCUPATIONAL THERAPY

A Masters Thesis presented to the Faculty of the
Graduate Program in Occupational Therapy
Ithaca College

In partial fulfillment of the requirements for the degree
Master of Science

---

by

Rebecca Susanne Wurm

May, 2004

Ithaca College

School of Health Sciences and Human Performance

Ithaca, New York

CERTIFICATE OF APPROVAL

This is to certify that the Thesis of

Rebecca Wurm

Submitted in partial fulfillment of the requirements for the degree of Master of Science in the Department of Occupational Therapy, School of Health Sciences and Human Performance at Ithaca College has been approved.

Thesis Advisor: [redacted]

Committee Members: [redacted]

Candidate: [redacted]

Chair, Graduate Program in Occupational Therapy: [redacted]

Dean of Graduate Studies: [redacted]

Date: July 7, 2004

Abstract

The topic of spirituality is a controversial issue for the occupational therapy (OT) community, as well as for healthcare in general. Spirituality is at the core of the Canadian OT model of practice, and the concept was added to the American OT practice framework in 2002. Key elements that factor into spirituality as an appropriate aspect of OT are how the concept is defined, how it is related to religion, and the relationship between spirituality, occupation, and disability. Many articles in the OT literature have attempted to clarify these issues; however, there is still much disagreement between the OT community in the United States and in Canada. A few research studies have attempted to gage the current attitudes and practices of occupational therapists (OTs) regarding spirituality. However, none of the OT literature has explored the difference and/or similarities between how OTs from Canada and the United States are perceiving and using spirituality as part of their OT practice. The purpose of this study was to gain further understanding about Canadian and American OTs knowledge, understanding and interventions related to spirituality.

The results of this study indicate that the knowledge and the way in which OTs value spirituality as a part of their practice is changing. The results also indicate that there is still confusion and uncertainty that is preventing therapists from addressing spirituality as much as they feel is appropriate. Many significant differences were found between the ways American and Canadian OTs are valuing and addressing spirituality. Many of these results are consistent with previous literature on the topic; however, other results indicate important new developments that will be valuable in increasing clarity of a controversial topic.

Acknowledgements

I would like to acknowledge "the ladies", Sue and Marilyn,

for endless hours of t dotting and i crossing!

and

My incredible parents,

for giving me a roof over my head, hot cups of tea, and never ending support.

You can finally ask me... is it done yet Bec?

Dedication

This thesis is dedicated with heartfelt gratitude to Nathan Tarter,

who has been by my side, challenging and comforting me,

with a perfect balance of patience, respect, and love.

Table of Contents

List of Tables

List of Figures

Chapter I: Introduction

> "Spirit is acknowledged as the impetus and motivation to discover purpose and meaning in life. Given that a core feature of OT is to facilitate therapeutic activities that are meaningful to the client, then the client's spirituality, as a source of inspiration, plays an influential role in directing what purposeful activities are identified as meaningful" (Engquist, D.E., Short-DeGraaf, M., Gliner, J. & Oltjenbruns, K., 1997, p.174).

Background

The topic of spirituality is a controversial issue for the occupational therapy (OT) profession, as well as for healthcare in general. Striving to achieve credible and practical methods for fitting clients' spirituality into our scientifically based healthcare system is a challenge that generates much discussion.

The first challenge often encountered by healthcare professionals when discussing the topic is how to define spirituality for appropriate use in a healthcare setting. This has been a focus of the majority of the OT literature thus far, however, there is still no definition that is both widely recognized by therapists and promoted for use by the national associations. Part of the challenge that occurs when attempting to define spirituality is that the concept is often closely associated with religion. Religion is often a very important aspect of peoples' lives; however, it is not a part of everyone's life. Much of the literature views religion as a way in which people may choose to express their spirituality; whereas spirituality is often viewed as something that all people experience throughout their lives.

Spirituality has been mentioned in the literature throughout the history of OT practice in both Canada and the United States of America (USA), but has been more prevalent in the Canadian journals. The Canadian Association of Occupational Therapists (CAOT) incorporated spirituality into their practice framework more than 20 years ago (CAOT, 1997). Comparatively, the American Occupational Therapy Association (AOTA) added spirituality to their practice framework in December of 2002 (AOTA, 2002). Neither the American nor Canadian OT authors have examined the differences or similarities between the two countries related to the incorporation of spirituality into OT theory and practice.

To successfully relate spirituality to OT it is important to link two aspects of OT to spirituality: occupation (the core of the profession) and disability (the experience of most OT clients). Some studies have focused on the way in which spirituality is often expressed through clients' daily occupations, (Christiansen, 1997; Howard, B.S., & Howard, H.R., 1997; McColl, M.A., 2000; Peloquin, 1997; Unruh, 1997; Unruh, 2000) however, only a few OT studies have attempted to link disability and spirituality (Boswell, B., Knight, S., Hamer, M. & McChesney, J., 2001; McColl et al., 2000a; McColl et al., 2000b; Urbanowski, R. & Vargo, J., 1994). These relationships need to be further examined and clearly illustrated so that both the OT and healthcare communities understand why spirituality is an important aspect of OT.

Currently, there are no widely accepted assessment tools, guidelines or treatment techniques proven effective for use by occupational therapists (OTs) that incorporate spirituality. A few studies have identified specific barriers that therapists perceive are preventing them from addressing spirituality (Collins, J.S., Paul, S., West-Frasier, J,

2001; Engquist et al., 1997; McColl, 2000). Barriers to inclusion of spirituality is also a very important topic to examine for it brings to light the specific problems, such as lack of experience and training, which can potentially be eradicated with problem solving by the OT profession.

Several articles published in both the USA and Canada have examined OTs' understanding of spirituality and how they are including it in their practice (Collins et al, 2001; Engquist et al., 1997; Rose, A., 1999; Taylor, E., Mitchell, J.E., Kenan, S. & Tacker, R., 2000). Therapists' uncertainty and confusion that have been apparent in these articles illustrate that therapists would benefit from clearly stated guidelines for including spirituality in OT practice.

Problem Statement

While spirituality has been incorporated in both the American and Canadian OT practice frameworks, the literature has demonstrated a mixed reaction from therapists about the appropriateness of incorporating spirituality in OT practice. There is very little research about the techniques therapists use to incorporate spirituality into practice, particularly in the USA. Furthermore, no studies to date have compared the way in which American and Canadian OTs perceive and use spirituality as a part of their OT intervention.

Rationale

It is an important time to be addressing the topic of spirituality in OT. The AOTA's recent inclusion of spirituality into the practice framework provides opportunities for further discussion and reflection to take place between Canadian and American therapists regarding the controversial topic of spirituality and OT. Comparing

and contrasting how the two countries incorporate spirituality could help to ensure that the best quality of care is taking place, and that therapists feel confident with the role spirituality has in their practice. The consequences of not addressing this issue could be significant. Without established guidelines, accepted definitions, and open discussion, it is likely that therapists will be addressing spirituality in a variety of ways, and inconsistencies may or may not adversely affect the OT profession.

The issue of spirituality and OT has great importance to our society as well. The American Association of People with Disabilities report that over 56 million Americans are living with a disability (2004). Spiritual aspects have been increasingly associated with disability, and it is very important that people with disabilities are receiving the best quality of care possible. If an OT can lessen the challenge of coping with a disability by helping clients express themselves spiritually through meaningful occupations, then the clients' rehabilitation process will improve. OTs have a unique opportunity to be leaders by setting an example of successfully integrating spirituality into a healthcare profession.

Purpose

The purpose of this study was to identify how OTs are choosing to define spirituality, as well as the overall perceptions they have on how it relates to OT. This study aimed to identify the treatment techniques that OTs are using to address spirituality, and which treatment techniques the therapists felt are more or less appropriate. The study also investigated the differences and similarities between the ways Canadian and American OTs understand, value, and address spirituality.

Chapter II: Literature Review

Introduction

Spirituality and the way it relates to occupational therapy (OT) has become a very popular theme in the OT literature in the last decade or so. Both the Canadian (Vol. 64, 1997) and American (Vol. 51, 1997) OT journals have had entire issues dedicated to the topic. The purpose of this literature review is to organize the current information into categories, therefore making it easier to compare and contrast the current information. The first and very significant aspect of this project is to define spirituality.

Defining Spirituality

The word spirituality represents a very complex and abstract concept that has been defined in a wide variety of ways. Hammell (2001) noted that although dictionaries list several meanings of the word, many of which contradict one another, this should not stop OTs from attempting to define it more resolutely. Urbanowski and Vargo (1994) argued that the reason it is difficult to incorporate spirituality into OT is because there are no empirical studies in the OT literature demonstrating that spirituality is truly an existing phenomenon of every individual, and because no definition can be operationalized. It is difficult to operationalize a definition of spirituality because the concept has different meanings to people and can be expressed in many different manners. Taylor et al. (2000) described the lack of a clear definition of spirituality as one of the three reasons why the concept of spirituality has thus far been widely neglected in American OT. The lack of a clear definition of spirituality could stand alone as a definitive reason for the need for further research to be conducted on the topic. In the pages that follow, the researcher will

present a summary of the current definitions outlined in the literature and the arguments that support or question that perspective.

Urbanowski & Vargo (1994) defined spirituality as "the experience of meaning in everyday life activities" (p. 89). The authors emphasized the importance of using the words meaning *in* [italics added] and not the words meaning *of* [italics added] daily life activities. The authors suggested that people are much more likely to reflect on what a specific component of their day means to them, rather than what all of life means. Urbanowski & Vargo (1994) further argued that if the OT profession adopts this approach to defining spirituality it would naturally befall OTs to assist clients in reformulating their spirituality by reconstructing their daily lives. However, this definition excludes some important components of spirituality, such as whether or not it is something everyone experiences, and how it is typically expressed.

Egan & DeLaat developed a definition in 1997 that was a synthesis of a few of the definitions proposed by OTs, and is more comprehensive:

> Spirituality relates to our thoughts, feelings and actions concerning the meaning we make of our daily lives. That meaning is thought to be derived from relationships with ourselves, other people, other creatures, the earth, and for those who choose, a relationship with a Higher being (p.116).

This definition is both secular and all-encompassing. It utilizes vocabulary that includes OT concepts, such as meaning and relationships, but does not exclude other professions or groups of people from being able to relate to the definition. However, not all people feel that this definition is appropriate for OT. Hammell (2001), a Canadian OT, countered

that this type of definition is problematic to the profession because believing in a higher power is not a universal phenomenon and because OTs do not have the education or authorization to be addressing such issues.

Hammell (2001) also proposed that the incorporation of a view of spirituality within OT practice that pertains to supernatural forces (even if they are of a secular nature), suggests that the profession considers this to be a widespread reality for most people, as well as being a superior view. However, it is important to note that the definition written by Egan & DeLaat (1997) does specify that having a relationship with a Higher being is just one way in which people can choose to relate and express their own spirituality. This identifies it as not a universal truth, but rather one that is common.

Hammell (2001) proposed that a client-centered practice would never contend that there is a preferred or privileged experience that should be named spirituality, and therefore OTs should exclude use of the word spirituality. She suggested the word *intrinsicality* [italics added] as an alternative for OTs. Hammell (2001) also suggested an alternate definition of spiritual "...as being of the nature of relating to the mind, spirit, and higher faculties and of the experience of meaning in our lives" (p. 73). This definition addresses the unique experience of being human and speaks to the meaning by which humans live their lives (Hammell, 2001).

Many definitions suggest that spirituality can be the source of our will or self-determination (AOTA, 2002; CAOT, 1997; Engquist et al., 1997; Gutterman, L., 1990; McColl, 2000). This is also evident in the CAOT's 1997 definition of spirituality as "a pervasive life-force, manifestation of a higher self, source of will and self-determination, and a sense of meaning, purpose and connectedness that people experience in the context

of their own environment" (p. 182). The AOTA (2002) recently defined spirituality as "the fundamental orientation of a person's life; that which inspires and motivates that individual" (p. 623). Engquist et al. (1997) acknowledged spirituality as the impetus and motivation to discover purpose and meaning in life. Urbanowski & Vargo (1994) disagreed with definitions similar to the ones listed above by saying that to imply that spirituality is a force that moves someone to do something or be something will add more ambiguity, and the concept will be confused with volition or will.

In addition to the themes of motivation and will, it can be said that there are three other themes present throughout the literature for defining spirituality. One theme represents definitions of a secular, global nature that include both conventional and alternative methods of expressing spirituality. Another theme represented in definitions focuses on expression of spirituality through religious means. The last theme found was one including meaning and/or connectedness that people feel during everyday lives. A few definitions focus on only one of these themes; however, most of the definitions incorporate a combination of the themes.

It is clear that there is a good deal of disagreement among both Canadian and American OT scholars as to how spirituality should be defined for use in OT. Defining a concept that cannot necessarily be seen or measured is always going to provide for ambiguity and confusion. Although OTs are disagreeing on many different aspects of the concept of spirituality, the relationship between spirituality and religion seems to be the most controversial issue.

Differences Between Spirituality and Religion

In almost every article written specifically on the topic of spirituality in the OT literature, the difference between religion and spirituality is a main issue addressed. First, it is very important to define the concept of religion before being able to examine how the concept relates to spirituality. The following paragraph includes some common definitions of religion found in the OT literature.

Christiansen (1997) defined religion as "the organized tradition of rules and orthodoxy that attempt to serve the needs of their followers" (p.170). Fitzgerald (1997) defined religion as the "social structures that we have created to fulfill our spiritual quest" (p. 407). Hill et al.'s (1998) definition of religion was especially noteworthy because the definition was created by a panel of diverse professionals and therefore could be considered to reflect a holistic view. This panel (Hill et al., 1998) defined religion as "the search for identity, belonging, and meaning through participation with an identifiable group of people that is organized around a spiritual goal" (p.20). All of these definitions portrayed religion as something distinctly different from spirituality, however, both the Fitzgerald (1997) and Hill et al. (1998) definitions used the word spiritual in the definition, implying a close relationship.

The relationship between religion and spirituality was best expressed by Collins, Paul & West-Frasier (2001) when the authors suggested that religion is a means by which spirituality can be expressed, and as one way in which a person may attempt to enhance his or her spirituality. Collins et al. (2001) acknowledged that while not every person is religious, spirituality is considered to be a characteristic of all people. Spirituality as a universal phenomenon was an assumption that seemed to be underlying much of the

literature. Universality was an important difference between religion and spirituality, because very little of the literature assumed that religion is a phenomenon that all humans experience. Another important difference to note is that people who do not hold religious beliefs may consider themselves to be spiritual people. These points are central to the discussion of how spirituality and religion relate to OT practice.

Egan & DeLaat (1994) outlines religion as having obvious benefits and harms. They describe it as having the potential to promote the expression of an individual's spirituality by advancing the individual's connection with self, others and a transcendental power. Alternately, they see religion as having the potential to block the expression of spirituality by cutting off an individual's self-awareness and connection with others. The authors believe that it would be virtually impossible to categorize religious beliefs as positive or negative, mainly due to the very personal nature of most people's belief systems. However, they also feel it is important to recognize that spirituality and religious expression can be at odds (Egan & DeLaat, 1994)

Not all of the authors writing on spirituality and OT feel that the concepts of spirituality and religion should be completely separated. In Howard and Howard's (1997) article, the authors suggested that trying to address spirituality outside of the context of religion would create an artificial divide between the two concepts. Unruh, Versnel, and Kerr (2002), described some persons who feel that the trend to separate the concepts of spirituality and religion is erroneous and question whether a secular definition of spirituality can still be meaningful. Hill et al. (1998) argued that the tension between religiosity and spirituality was based on a division of institutional and individual viewpoints. The way in which therapists understand spirituality as it is related to religion

becomes a significant issue when religion is incorporated into OT practice by therapists who deem this appropriate because they view religion as a part of spirituality.

It is in Taylor et al.'s (2000) survey that the most detrimental effects of therapists inappropriately utilizing religion and spirituality in practice becomes apparent. One of the therapists surveyed wrote "I disagree OTs should discuss spirituality with their clients unless they are of Christian faith. There are too many religions out there and they mess up people's minds. Jesus is the only True God" (p. 425). This is a very troublesome response because as Unruh et al. (2002) described, discussions about spirituality can be harmful to clients or therapists if the conversation causes a person to have to guard or affirm a particular faith or religious viewpoint. Often times clients are at a point in their life when they are feeling emotionally vulnerable. Having an OT pass judgment on a client's beliefs will not help that client feel more confident and self-assured. Unruh et al. (2002) suggested that discussing the religious elements of spirituality tends to cause discomfort when looked at in context to OT.

While therapists may support a clients' occupational performance in both spiritual and religious areas of the clients' life, they should not utilize their own religious perspective as the basis by which to do so within the therapeutic context. This idea was supported by Taylor et al., (2000):

> Although religious therapists may be more willing to address the spiritual needs of their clients than therapists who do not consider themselves religious, they must be able to do so in a manner that shows respect and tolerance for beliefs and practices that are different from their own (p. 425).

This statement acknowledges that religion can be a positive aspect and one that needs to be cautiously integrated when addressing spirituality within the therapeutic context.

The Development of Spirituality and Occupational Therapy

Since the beginning of OT, several people have suggested that there is a need to address spirituality in practice. According to Taylor et al. (2000), as early as 1920, OT philosophers viewed the person in a holistic manner, and recognized that addressing an illness or disability required addressing all the components of the individual. With this philosophy at the root of the profession, it is not surprising that OT strives to be a holistic profession, addressing any and all aspects of a person's life that are meaningful to that individual. This holistic practice of OT varies from country to country. Various social and political factors in two western countries that are neighbors, and on the surface may appear similar, have resulted in very different "stories" of how spirituality was incorporated.

Literature on the topic of spirituality from both Canada and the United States indicate that OT in Canada and the USA has similarities as well as distinct differences. The CAOT (1997) insists that "the importance of spirituality has always been highlighted in Canadian OT views of persons" (p.42) and this can account for the fact that Canadians have published the majority of the literature on the topic. It is important to note, however, that although Canada has recognized spirituality as an important aspect of human beings, this does not necessarily mean that therapists nation-wide are completely comfortable with or in agreement that it is being addressed in the most appropriate manner.

Initially in 1991, the CAOT had defined the person as comprised of four performance components: physical, socio-cultural, mental, and spiritual. Egan &

DeLaat (1997) suggested that an individuals' occupations were based on how the four components interacted in the environment. Then in 1997, the CAOT developed the current definition of spirituality. The CAOT (1997) further defined spirit as "our truest self, and as something we express in all of our actions" (p. 43) and described spirituality as an expression of volition and, "...a guide for expressing choice" (p. 43).

The change made by the CAOT (1997) modified spirituality from being one of four components thought to influence occupation, to being a major aspect of all human experience. Most importantly, the change placed spirituality at the core of the model. Several authors have felt this definition to be inadequate and/or a source of confusion, and have challenged the CAOT to re-examine the position of spirituality in the Model of Occupational Performance (Hammell, 2001; McColl, 2000; Unruh et al., 2002; Urbanowski & Vargo, 1994). Unruh et al. (2002) argued that if spirituality is the core of the model, then the primary concern for therapists is that of spirituality and not of occupation. They also argued that occupational identity rather than spirituality should have the central position in the Canadian model (Unruh et al, 2002).

Although spirituality has been acknowledged since the beginning of the American OT profession, the history of incorporating spirituality into OT practice and literature started later, and has much less volume than the Canadians. In March of 1997, a special issue of the American Journal of Occupational Therapy was published focusing specifically on issues of spirituality and OT (Peloquin & Christiansen, Eds.). Prominent OT scholars, dedicated researchers, and many other professionals worked hard to bring the issue of spirituality into the forefront of the OT community.

In the special spirituality issue of AJOT in 1997, Christiansen discussed a new surge of interest in the purpose and meaning of occupation, but noted an overall avoidance of reference to spirituality by American authors. An example of this is the fact that in American OT textbook indexes, spirituality is still largely unlisted (Christiansen, 1997). One solution Christiansen proposed was to place spirituality in the practice framework. In this way, spirituality would acknowledge a person's sense of self and his or her beliefs about power, control, and meaning in life, and the impact this has on occupational performance and participation.

Christiansen (1997) discussed the phenomenon of 'underground practice' in relationship to the context of spirituality. The therapists' expert understanding of the illness experience provides an ability to lead clients to a deeper understanding of themselves and their experiences through either words or actions. Therapists value this work; however, they fully realize it does not fall under the category of 'reimbursable'. Therefore this underground practice often gives therapists a great deal of internal conflict with their own values and ethics, and external conflict with the dominant medical culture held by so many in America (Christiansen, 1997). Major changes have taken place in the United States health care system in the last decade such as changes in Medicaid, changes in reimbursable services, and changes from fee-for-service systems to health management organizations. It is not surprising that therapists are struggling with ways in which to intervene in a holistic manner while simultaneously being reimbursed for services. Overall, Christiansen (1997) strongly asserted the need for the issue of spirituality to be addressed in a more open manner in the American OT community.

The other articles published in the 1997 spirituality issue of AJOT focused on a variety of issues relating to spirituality. Peloquin (1997) wrote the introduction to the special issue portraying her enthusiasm for the topic of spirituality and OT by describing in detail how important the spiritual perspective of occupation is to the profession. Spencer, Davidson, and White (1997) wrote an article with the purpose of examining the different aspects of hope that clients experience, and how OTs can help foster hope in their clients. Low (1997) wrote an article discussing the relationship between pain management and religious orientation. Many other articles from the special issue on spirituality will be mentioned throughout this chapter. With the range of articles and enthusiasm concerning the topic of spirituality that was apparent in the special issue of AJOT, it is surprising that very few articles about spirituality have been published in AJOT since 1997.

In the 2002 December issue of AJOT, the new practice framework was published, and for the first time in the United States the AOTA recognized spirituality as being a context for human beings' occupational performance. In the framework, the AOTA (2002) outlined the spiritual context as one of seven "interrelated conditions within and surrounding the client that influence performance" (p. 41). When giving further examples of what spirituality means, the practice framework offered, "essence of the person, greater or higher purpose, meaning, substance" (p. 41).

Several articles have been published in Canadian journals that detail specific occupations that promote spirituality, places where OTs work where spirituality is a main focus of therapy, and how to better educate and include spirituality in the OT process (Algado, Gregori, & Egan, 1997; Egan & DeLaat, 1994; Egan & DeLaat, 1997;

Hammell, 2001; Kirsch, 1996; Kirsch, Dawson, Antolikova, & Reynolds, 2001; McColl, 2000; Simo-Algado, Mehta, Kronenberg, Cockburn, & Kirsch, 2002; Townsend, 1997; Unruh, 1997; Unruh, 2000; Unruh et al., 2002; Urbanowski & Vargo, 1994; Vrkljan, & Miller-Polgar, 2001). Comparatively, American journals have published only a few articles that begin to acknowledge spirituality as having a role in OT, or that determine the attitudes and perceptions of therapists regarding spirituality (Christiansen, 1997; Collins et al., 2001; Engquist et al., 1997; Howard & Howard, 1997; Peloquin, 1997 & Taylor et al., 2001). It is evident that Canadian OTs have had a great deal more time than American OTs to acclimate to the idea of spirituality as being an implicit aspect of OT practice (Egan & DeLaat, 1997).

Spirituality and Occupation

Peloquin (1997) promoted the idea that it is through meaningful occupation that spirituality can be appropriately addressed in OT. When occupation is seen as the making of lives and worlds, rather than simply doing or performing, it is a deeper and more spiritual perspective, and one for which OTs should strive. Peloquin (1997) stated that it is through the acts that make up the basis of our profession that we can begin to comprehend the relationship between spirituality and occupation.

> To see such radical making in the acts that we commonly name *doing* purposeful activities, *performing* life roles and tasks, *adapting* to the environment, *adjusting* to disability, and *achieving* skills or mastery, is to discern the spiritual depth of occupation (p.167).

Comprehending how human beings experience spirituality through occupation is a challenging task. Unruh (1997) discussed that OTs may need to expand upon the ways

in which they perceive occupation in order to successfully relate it to clients' spirituality. It is obvious that addressing spirituality as a client's occupation is more complex and ambiguous than addressing an occupation such as reading or bathing.

According to Moyers (1999), "the goal of occupational therapy is to increase the individual's ability to independently perform or control the performance of meaningful occupations and fulfillment of roles" (p. 64). Most of the OT definitions of spirituality include reference to "meaning" as a major component of a person's spirituality, implying that any activity that promotes "meaning" for a person has the potential to be an expression of his or her spirituality. Gaining function through meaningful occupation is the goal OTs strive to help their clients achieve. Therefore, it can be reasoned that OTs should strive to identify the occupations that are most meaningful to the client, thereby providing the client an opportunity for spiritual expression.

Collins et al. (2001) suggested that when OTs address the quality of the client's experiences, they are addressing spirituality, because quality of life affects spiritual well-being. Unruh (1997) clearly demonstrated how meaningful occupation can lead to an expression and/or enhancement of spirituality. As an example, she suggested that the reflection that occurs when one is gardening illustrates the need or drive for a spiritual life, and demonstrates a powerful relationship between spirituality and occupation. She quoted a woman battling with cancer who stated, "As I have gardened, feeling myself in some deep dialogue with an unseen and silent partner, I have come to know true inner peace" (Unruh, 1997, p. 157).

Christiansen (1997) proposed recognizing that meaning derived from occupation often has spiritual dimensions that will aid OTs in identifying spirituality as an aspect of

OT. Christiansen (1997) suggested that a failure to recognize that clients' are influenced by spiritual dimensions is a poor reflection of holistic practice. He also suggested that OTs would lose important opportunities for comprehending the depth of occupation, and would be deprived of experiences that could potentially augment their own spiritual development.

Christiansen (1997) described several activities that are opportunities for spiritual expression such as reading, art and letter writing. Fitzgerald (1997) described the roots of spirituality as being very simple, which therefore leads to many opportunities for spiritual expression in the most ordinary circumstances. Christiansen (1997) suggested that any occupation can be spiritual if attention is given to its context. Using these criteria, it can be said that therapists could be indirectly addressing spirituality with clients while directly addressing other meaningful occupations of the client.

It has been consistently argued in the literature that spirituality is most often expressed through one's occupation and occupational roles. Thus, it can be said that addressing spirituality through meaningful occupations is clearly within the domain of OT (Collins, 2001). This is a very important link to legitimizing spirituality as an integral aspect of OT. The other connection that is important to make is the dynamic relationship between spirituality and disability.

Spirituality and Disability

It is apparent from the literature available on spirituality in relation to OT, and to healthcare in general, that spirituality is perceived as an important aspect of the recovery and rehabilitation process for many individuals experiencing illness or disability. However, there are a very limited number of OT researchers who have assessed how

clients with disabilities experience changes in their spirituality. McColl was the lead researcher for two of three studies reported in the literature that address the topic of spirituality and disability.

McColl et al. (2000a) stated that some professionals view spirituality as a sequential characteristic that humans develop over the lifespan. Spiritual development is often viewed as not being inevitable, but dependent on certain challenges from the environment that provide the context for development. Disability is seen as one common challenge that provides a developmental context.

McColl (2000) wrote in detail about the relationship between disability and spirituality, and gave several reasons why disability often incites spiritual issues. The author proposed that asking the question 'why me, why now?' is usually going to occur when a persons' illness or injury results in disability; it is at this time that the implications of the disability and the elusiveness of those implications may cause people to seek meaning in spiritual terms. Often, disability will prompt a person's search for spiritual meaning because the disability has brought them close to death and/or closer to the idea of their own mortality. Disability may prevent people from expressing spirituality in the way they had prior to the disability, which may then cause them to find expression by other means or to reevaluate the value they had placed on these activities. The final reason McColl suggested is that with the onset of disability a person may need to develop new spiritual beliefs to make sense of the chaos they are experiencing (McColl, 2000).

McColl (2000) conducted 16 interviews of men and women who had become recently disabled, linked the results with other OT literature, and outlined the ways in which people tend to experience spirituality when faced with a disability. The author

suggested that some people would experience "disability as a reminder of humanity" (p.224). People are reminded of their vulnerability, and often begin to acknowledge that they are not immortal. Other people experience "disability as a mission" (p.224). They experience a change in the purpose of their lives, even if the reason for that change is unknown to them at first. McColl (2000) also described people who experience "disability as a punishment" (p.224). These people feel they were morally judged and given a disability, most likely by a higher being or power. Feelings of guilt and confusion will often accompany this interpretation. The last way in which McColl (2000) suggests people experience disability is "...as a warning" (p.224). In this case, people feel that they have been given a second chance to correct past wrongs and may have feelings of gratitude and sorrow as well.

In a qualitative research study done by Boswell et al., (2001) six women were interviewed in detail on the experience of having a disability and the effect this had in terms of their spirituality. The women were all classified as having a severe disability, however, no other variables were controlled. Although the women came from different backgrounds, religious upbringings, and social classes, these women all had similar thoughts about their experiences with spirituality and disability. The women in the study consistently described disability and spirituality as core dimensions of their lives that were evolving, interactive and interdependent (Boswell et al., 2001). The relationship between the two dimensions was seen as reciprocal, in that the women's disability had shaped the development and expression of their spirituality; and their spiritual beliefs had also shaped perceptions of their disability. There were some common characteristics of the relationship such as a period of questioning or openness to alternative understandings

that led to changes or refinements in their perceptions of themselves, the world, and their disability.

Urbanowski & Vargo (1994) depicted the experience of disability as having many spiritual implications not only for the person with the disability, but also for the people who were a part of that person's environment. The authors note that experiencing a crisis, such as the onset of disability, affects one's perception of one's ability to function in the future, which then causes the very meaning of daily activities to come into question. The crisis will ultimately lead to a re-evaluation of spirituality, as the meaning of all daily tasks is examined (Urbanowski & Vargo, 1994).

The research studies have clearly identified a relationship between spirituality and occupation, as well as between spirituality and disability. These two relationships are significant when looked at in the context of a practicing OT. The challenge lies in how OTs are supposed to apply this knowledge of spirituality, occupation, and disability to their everyday practice whether it be intervention with a terminally ill AIDS patient, or a construction worker with a tendon injury.

Occupational Therapy Intervention and Assessment of Spirituality

Gutterman (1990), McColl (2000), and Collins et al. (2001) described spirituality as an important aspect of treatment but not one that is necessarily addressed directly. In McColl's survey (2000), she asked therapists how they assess spirituality in practice. Although many therapists reported feelings of discomfort over their role in spirituality, some therapists reported that they directly approach the topic. Some examples of how therapists were addressing spirituality were by asking clients about their source of strength, or about their sense of control. McColl (2000) also found that therapists often

reported addressing spirituality in an indirect manner initially. One example of an indirect technique was simply creating a therapeutic environment conducive to spiritual discussions by building good rapport and trust with the client. It was also reported that clients often spoke about ways in which their faith or beliefs have been challenged, or ways in which they were no longer able to express their spirituality as they once did without requiring any cues from the therapist (McColl, 2000).

The CAOT (1991) described spirituality as one of the fundamental elements of intervention. They stated, "...the therapist must come to understand and accept what is at the center of the client's being (spirit) in order to develop a therapeutic relationship, examine motivation and finally engage the client in therapeutic activity" (CAOT, 1991, p.58). Further guidelines given by the CAOT (1991) suggested that OTs should give clients the opportunities to consider themes such as suffering, guilt, joy, forgiveness, loneliness, and inner peace in the course of an intervention.

Gutterman (1990) described the connection between spirituality and OT as occurring only when we define spirit as the life force within us that tells us who we really are. Gutterman depicted OTs as being able to stimulate or inspire the client towards self-actualization and insight by supporting the performance of meaningful activities and fulfillment of roles. Urbanowski & Vargo (1994) describe spirituality as providing "a link between the therapist's values as they relate to service, and the client's values as they pertain to meaning ascribed to routine daily activities" (p.89). Although many of these articles portray spirituality as a valid and worthwhile part of OT, there are not many guidelines specifically outlining how to assess and address a client's spirituality.

Urbanowski & Vargo (1994) claimed that the intent of assessment in relation to spirituality is to enter the client's reality. The authors described this type of assessment as helping to facilitate the therapeutic relationship based on trust and empathy. The authors outlined guidelines for assessing spirituality by using open-ended questions to:

1. Identify the meaning of the client's future in light of current experience
2. Identify the meaning of future activities of the client's significant others based on the current experience of the client
3. Identify the meaning of the client's perception of the arrangement of daily life activities (p. 91).

The assessment of spirituality should be an on-going process according to Urbanowski & Vargo (1994), and this process should be characterized by a meaning-centered approach. This will allow the client's perspective and spirituality to be considered in the rehabilitation process.

Based on her research and review of other available literature, McColl (2000) outlined the likely interventions that occur in OT that could address a client's spiritual needs. The first activity described is that of using narratives within therapy. Several authors (Collins et al., 2001; Egan & DeLaat, 1997; Howard & Howard, 1997; Kirsch, 1996 & McColl, 2000) agree that through the use of narratives, clients are likely to be able to connect their past or present with the future, feel at the center of the therapy process, and have a better sense of their voice, power and control (McColl, 2000).

Ritual is the second activity that the author discussed in terms of spiritual meaning (McColl, 2000). McColl (2000) defined ritual as "...a process that transforms an everyday activity into an activity with special meaning" (p. 225). Activities that promote

an appreciation of nature are also said to invoke spirit, however, just being outside may not invoke spirit. Therefore, this activity may require the therapist's facilitation to set up an occupation incorporating nature that is likely to be meaningful to the client. Creativity and the idea of "doing" is a very common experience often used in OT to promote spirituality. The last activity said to promote spirituality is the balance of work and play activities. Through this balance it is hypothesized that some people may have a restoration of dignity or an opportunity for meaningful contribution (2000).

Egan & DeLaat (1994) used the term 'spiritual crisis' and outlined it as occurring when a person is seeking a "meaningful interpretation of the chaos that exists" (p. 98). This term was used to describe a phenomenon similar to what OTs may be addressing with their clients. Some of the steps that Egan & DeLaat (1994) outlined for therapists to use to assist a client in a spiritual crisis are as follows: "Normalization of the crisis, affirmation of the individual's strengths, recognition of and respect for the individual's subjective experiences, balancing of these experiences with the outer world, and conveyance of hope and acceptance" (p.98). These steps are a good general outline for guiding therapists in the process of incorporating and addressing spirituality within the OT plan of care. Developing a formal guideline for therapists may be of great assistance for therapists who continue to feel hesitant to address spirituality.

Taylor et al. (2000) identified fifteen techniques for addressing spirituality in OT intervention. These techniques were collected from a review of the literature as well as discussion among the four authors. The treatment techniques are as follows:

- Pray for a client.
- Use spiritual language or concepts with a client

- Discuss with clients ways that their religious views are helpful.
- Recommend participation in a spiritual group or activity.
- Encourage clients to consider the spiritual meaning and purpose of their current life situation.
- Use "healing touch" with clients.
- Help clients reflect on their beliefs about what happens after death.
- Pray with a client.
- Encourage clients to write in a spiritual journal.
- Recommend spiritual readings to your clients.
- Meditate with a client.
- Recommend religious readings to your clients.
- Participate in clients' spiritual ritual(s) during therapy.
- Participate in clients' religious ritual(s) during therapy.
- Help clients develop spiritual rituals during therapy (Taylor et al., 2000, p.425).

These are just a few examples of occupations that therapists may be able to incorporate into therapy that could potentially address the client's spiritual needs. Taylor et al. reported therapists being less likely to address spirituality with clients through the use of occupations that directly address the topic. For example, the most direct techniques Taylor et al. (2000) included in their survey were participating in clients' religious and spiritual rituals during therapy. Both of these treatment techniques were ranked very low with only 7% of respondents reporting use of them. The treatment techniques that were used the most were those that were more indirect such as recommending participation in

spiritual groups, discussing spiritual topics or ideas, and finding ways that encouraged the clients to make use of their spirituality (Taylor et al., 2000).

Collins et al. (2001) also studied how therapists addressed spirituality. Eight topics were selected and respondents were asked to choose how often they discussed each topic with clients. Therapists reported discussing the meaning or purpose of illness most with clients and reported rarely or never addressing the role of God in illness (Collins et al., 2001). This suggests that therapists feel more comfortable addressing spirituality through occupations that are more secular and holistic than ones in which religious concepts and ideas are directly involved.

Therapists' Understanding and Inclusion of Spirituality into Occupational Therapy

A few professionals in the field of OT have performed research studies attempting to gauge both American and Canadian OTs current understanding of how spirituality relates to their OT practice and how they address it in practice. As reported in three different surveys (Engquist et al., 1997, Rose, 1999, Taylor et al., 2000), a majority of OTs agreed that spirituality is an important part of life and the rehabilitation process. However, most of those surveyed were either in disagreement or were undecided as to whether it falls under the domain of OT. In contrast, Kirsch et al. (2001) surveyed Canadian OT programs and found that 93% of the OT students surveyed felt that addressing spirituality was within the scope of the OT practice. This contrast could signify that the younger generation of OTs beginning to practice may feel more strongly about OT intervention including the dimension of spirituality, or that the realities of practice are not as clear when a student is in academia. This finding could also signify that professors are more likely to teach about issues regarding spirituality since it is in

both the Canadian and American practice frameworks. However, there are still matters needing clarification since only 32% of these same students felt they definitely understood the role of spirituality in relation to OT (Kirsch et al., 2001).

A study done by Udell & Chandler (2000), published in the British Journal of Occupational Therapy, took a phenomenological approach to examining how three different therapists dealt with and felt about addressing spirituality in practice. These therapists all held and practiced Christian beliefs, and it was obvious from the study that despite the fact that the author proposed a secular definition of spirituality, on several occasions the therapists referred to religion when talking about a client's spirituality. This unintentionally demonstrated how the two words, representing different concepts, are often used interchangeably. The authors are also practicing Christians, and in the interviews they addressed issues such as finding passages of the Bible, access to church, and praying (Udell & Chandler, 2000, p. 491). These occupations may be universal concerns for Christians and therefore were appropriate occupations to address; however, they are not necessarily central to everyone's spirituality and the results of this study cannot be generalized to all individuals or faith beliefs. This article does support the trend that therapists who identify themselves as spiritual people are more likely to address spirituality with their clients (Taylor et al., 2000).

Taylor et al. (2000) surveyed 296 members of the AOTA to better understand the attitudes of OTs in relation to spirituality. One conclusion was that the therapists who regard themselves as being religious had a more positive attitude overall about addressing spirituality in practice. Unlike the previous study that provided no definitions (Engquist et al. 1997), a major point of Taylor et al.'s study (2000) was to examine how therapists'

perceptions would become altered when given the choice of two definitions of spirituality. An interesting point is that when asked to choose between two definitions of spirituality, those therapists that were religious did not necessarily choose the religious definition, but the non-religious therapists consistently chose the global definition. Taylor et al. (2000) also found that "...participants who chose the global definition of spirituality had a significantly higher level of education and more years of experience..." (p.425) thus illustrating another factor involved in the issue of spirituality and religion in relation to OT.

In the 1997 study done by Engquist et al., 500 American OTs were surveyed regarding their beliefs and practices concerning spirituality and OT. Engquist et al. (1997) reported that although 89% agreed that spirituality was an important part of their daily job responsibilities, a large number of the respondents disagreed or were unsure that spirituality is within the scope of OT practice. Rose (1999) surveyed 60 therapists, all of whom worked in palliative care, and the results were significantly different with 55% of therapists agreeing that addressing spirituality is within the scope of OT. The difference in results between these two studies suggests that a view of spirituality as a part of OT could be related to the great variety of practice areas in the field of OT. The needs of clients in various settings could affect therapists' perceptions and be one reason the area tends to be controversial and unclear.

It is important to note that in many of the studies reviewed, the therapists often felt that referring to other professionals, such as chaplains, was appropriate when spiritual issues arose that exceeded a therapist's area of practice (Engquist et al., 1997, Rose, 1999, Collins et al., 2001). In both Engquist et al.'s study (1997) and Rose's study

(1999), respondents were asked to identify the most appropriate professional to address a client's spirituality. In both these studies, many other professionals were listed as more appropriate than the OT for this type of intervention. If a resource such as a chaplain were available at the therapists' workplace, the respondents seemed to agree that the OT should seek out this professional for consultation and collaboration in order to develop the most appropriate plan of action for addressing a client's spiritual needs (Engquist et al., 1997; Rose, 1999).

The most recent research study done on the topic of spirituality and OT was by Collins et al. in 2001. The results found by these authors indicated that the beliefs and behaviors of therapists regarding spirituality may be shifting (Collins et al., 2001). Most of the respondents continued to agree that spirituality was an important aspect of healthcare; and there was an increase in the number of therapists who reported integrating spirituality into treatment. The authors reported that there still seems to be a good amount of controversy surrounding the issue (Collins et al., 2001). Barriers that prevent therapists from addressing spirituality are a significant source of the controversy.

Perceived Barriers of Addressing Spirituality in Occupational Therapy

Collins et al. (2001) surveyed 112 OTs about the perceived barriers of addressing spirituality in practice. Although the survey given to therapists only included a secular definition of spirituality, many therapists' comments reflected the barriers of addressing religious issues in practice, not matters solely related to spirituality. This illustrates that the confusion between religion and spirituality may in itself be a barrier to therapists deeming it as appropriate to address spirituality. A similar barrier (Collins, 2001) was the

concern that a therapist may project his or her own beliefs onto clients (44.6% of therapists agreed, and 42.9% disagreed).

Collins et al. (2001) concluded that an overall lack of education or experience in taking a spiritual history was the barrier the respondents perceived as most significant to preventing them from addressing spirituality. This supported conclusions drawn by Engquist et al.'s study in 1997. Interestingly enough, although a large percent (55.7%) reported dissatisfaction with knowledge in this area, only 36% of therapists surveyed reported wanting more education in that area (Collins et al., 2001).

There were two additional reasons reported by Collins et al. (2001) that may account for a lack of incorporation of spirituality in OT practice: some therapists may not see themselves as the appropriate person to address these needs, and some therapists do not see the relevance of spirituality to their practice. This last point is especially significant due to the highly variant nature of the care OTs are giving. It is not surprising that some therapists may feel that spirituality really is not warranted in their practice. It appears that if a therapist were treating a client for an acute syndrome, issues regarding that client's spirituality would be less likely to affect his or her recovery than if the client was coping with terminal cancer. This point was also brought up by a respondent in the study done by Engquist et al. (1997): "Different settings require a greater or lesser emphasis on spirituality...my current one requires little...prior setting [rehabilitation hospitals, oncology, brain injury wards] required much more" (p. 178).

Engquist et al. (1997), whose respondents were all American, concluded that policy issues were one reason why respondents expressed concern about including spirituality into therapy. This is an interesting point and highlights the fact that in the

literature thus far, policy problems have been identified as being a barrier only in the American health care system.

The literature has demonstrated that an overall lack of education and training on how to address and incorporate spirituality is viewed as one of the most significant barriers confronting therapists. In McColl's 2000 Muriel Driver Lecture, she highlights this barrier in reference to spirituality's position in the Canadian Model:

> While we accept that we need theory from other disciplines to understand three of the components of human beings, for the one component that we have elevated to the central position of our guiding model, we have only our own upbringing and personal study to guide our professional role (p.227).

This point expertly demonstrated how differently therapists are educated and trained in the component of spirituality as compared to the other components of human beings. This lack of training specific to inclusion of spirituality in OT practice is of primary concern as the profession strives to broaden its view of the person.

Summary

The research on issues of spirituality and OT has become increasingly available only in the last decade or so. A majority of this research has been done in Canada, which is not surprising since the Canadian model of practice includes spirituality as one of the central aspects of a person. From this review of the literature, it is apparent that in terms of spirituality and its relation to OT, there are some issues we know a great deal about, and some issues that continue to elude us. We are aware that spirituality has a deeply rooted history in relation to health and wellness, and more specifically, in relation to OT. There is a good deal of congruence and consistency evident throughout the literature in

Canada, America, and Great Britain. Throughout the literature, however, research has shown that there is some ambiguity about whether or not OTs feel this is part of their domain of practice. Defining spirituality has been a major source of disagreement for leading researchers in the field, especially when one attempts to distinguish the concept from that of religion (Hammell, 2001; McColl, 2000; Unruh et al., 2002; Urbanowski & Vargo, 1994). Most of the researchers agree that in terms of OT, spirituality needs to be defined and thought of as a secular entity that may or may not be expressed individually within the context of religious beliefs.

The OT community cannot ignore that important barriers to incorporating spirituality into OT have been identified. It is clear that the uncertainty and ambiguity that therapists' feel related to the role of spiritual issues within the context of OT will continue to be a major issue unless it is addressed by the profession. While there is attention being paid to this issue by the professional associations, further research to identify therapists' current levels of confidence and understanding is warranted to form a basis for identifying strategies to address the problem. The following chapter will detail the methodology that went into completing this study.

Chapter III: Methodology

Introduction

This chapter will outline the detailed measures that were taken to complete this research study. The researcher will explain the type of research performed, the participants involved, the concepts being researched as well as the overall data analysis procedure.

This study utilized survey research, which is a descriptive study of populations and a useful method for learning the current status of a population (Munro, 2001). A self-administered survey was used to identify therapists' knowledge and values about integrating spirituality into OT treatment. The study addressed the following three research questions:

1. What are occupational therapists' level of knowledge and values related to spirituality in the context of OT?
2. How are OT's addressing spirituality in everyday practice?
3. What are the differences between the ways in which Canadian and American therapists are addressing spirituality?

Participants

Five hundred randomly selected mailing labels were purchased from the American Occupational Therapy Association (AOTA), and two hundred and fifty randomized mailing labels were purchased from the Canadian Association of Occupational Therapists (CAOT). Due to the fact that there are a smaller number of Canadian OTs compared to the numbers of American therapists, this ratio of 2:1 was chosen to be representative of the ratio of Canadian and American therapists. The AOTA

database divides therapists according to the settings in which they work, e.g. mental health or inpatient. Practice areas were chosen from the AOTA's list to correspond as closely as possible to areas that were primarily focused on treatment with adults. The selection criteria for the CAOT list included an option to choose therapists that only work with populations of ages 18 and older rather than by practice area; therefore, this was the inclusion criteria for the Canadian therapists. The completed surveys were only included in data analysis if the respondents indicated they were a practicing OT and if 75% or more of the survey was completed.

Operationalization of Concepts

There are several concepts embedded in the research questions designed by the researcher that required operationalization. The first research question, "What are occupational therapists' level of knowledge and values related to spirituality in the context of OT?", was operationalized as follows: The term, 'occupational therapist', signifies an American or Canadian registered by the national OT association to practice OT, whose name and address were provided to the researcher from the purchased address lists from the Canadian or American OT association. Based on Bloom's taxonomy (Gronlund, 1978) the term, 'knowledge', was defined as the ability to define, describe, identify, and select concepts related to spirituality. Therapists' knowledge of concepts related to spirituality was measured in section II of the survey. 'Value' was defined as the ability to believe, influence, prefer, pursue, seek and value concepts related to spirituality (Gronlund, 1978). Therapists' value of concepts related to spirituality were measured by questions 1-8, 15 and 18 in section III, and by questions 1-13 in section V of the survey. The term 'spirituality' was defined as a broad concept that incorporates meaning that is

experienced on a daily basis from a persons' occupations and/or various relationships. One's spirituality, and the beliefs that develop from it, can be expressed in a variety of manners, and it can, but does not have to, include a persons' religious views. The term, 'within the context of OT', was defined in two ways. The first definition of context of OT was related to the practice (evaluation, treatment etc.) of an occupational therapist and was measured by questions 9-14 from section III of the survey. The second definition of context of OT was related to the education (academic or on-the-job training) of an occupational therapist and was measured by questions 16 and 17 from section III of the survey.

To operationalize the second research question, "How are OT's addressing spirituality in everyday practice?", the term 'addressing' refers to the treatment techniques therapists are using in everyday practice (section IVa & IVb). For this study, the term 'appropriate' was defined as being suitable for use by an OT in their everyday practice. The term 'everyday practice' was defined as the therapy that OTs are doing with clients in their job setting.

The third research question, "What are the differences between the ways in which Canadian and American therapists are addressing spirituality?", requires operationalization of the terms 'Canadian' and 'American'. Canadian and American was defined as the nationality of the respondents, which was determined by their address provided to the researcher by the American and Canadian OT associations.

Measurement Instruments

The survey used for this study was developed from previously used surveys, with additional questions designed by the researcher and her committee. The studies used to develop the survey are as follows:

- A survey designed by Engquist et al. (1997) regarding therapists' opinions about spirituality and therapy, the appropriateness of initiating discussion about spirituality with clients, and who should be responsible for addressing spiritual needs. The survey was adapted from a survey by Knox (1990), which was part of an unpublished master's thesis designed to assess beliefs and opinions of OTs practicing in the state of Colorado. Engquist et al's study recommended inclusion of a definition of spirituality on the survey to possibly aid in response rate.
- Andrew Rose (1999) used a modified version of the survey developed by Engquist et al. (1997) to survey 60 OTs working in palliative care in Britain. Rose (1999) added a section in which the respondents were asked to indicate their agreement with opinion statements by using a visual analog scale.
- A researcher-developed survey by Taylor et al. (2000) was based on discussion among the authors as well as an extensive review of pertinent health care and OT literature. Participants were first asked to choose between two definitions of spirituality; one being a global definition, and the other being a religious definition. Using the definition they chose, participants were asked to answer 15 questions regarding their opinions about spirituality and OT practice. The next section of this survey consisted of 19 yes or no

questions assessing what techniques therapists had used to address spirituality and whether they deemed the given technique as appropriate. Another section asked participants questions regarding their personal religious and/or spiritual background as well as education levels.

- Collins et al. (2001) adapted a survey from the "Physicians' Spiritual Assessment Survey" developed by Ellis, Vinson, and Ewigman (1999). Changes were made to this survey so it better reflected OT practice and a definition of spirituality was added. The survey designed by Collins et al. (2001) included sections on demographics, beliefs about spirituality and health/OT, spiritual topics frequently discussed with clients, the perceived barriers to addressing spirituality, referrals to other professionals regarding spirituality, and a comment section.

The researcher combined aspects of the four surveys based on the recommendations of the authors in hopes of developing a more comprehensive survey. The survey questions specifications can be seen in Table 1.

Pilot surveys were given to 12 faculty members at the researchers' educational institution to increase the face validity of the survey. Faculty members were provided with a survey and instruction sheet, which asked them to include comments wherever they deemed necessary on issues such as layout, time it took to complete the survey, grammar and content. The researcher and thesis committee reviewed feedback and small grammar and format changes were made. Addressing any further reliability was beyond the scope of this master's level study. The final copy of the instrument and the letter sent to the therapists is in Appendix A.

Procedure

After the survey instrument was reviewed and accepted by the Human Subject Review Committee, the multi-step process of administering the surveys was begun. The surveys sent to both the American and Canadian therapists were coded with numbers on the outside of the return envelope to match the randomized address lists. This was used to ensure that when a therapist completed and sent back a survey she or he would not be sent a reminder letter or second survey. A research assistant crossed off the names of the respondents and recoded the surveys as they were returned so that the researcher could refer to comment numbers while maintaining the respondents' anonymity. Once the data collection period was over, the address lists were destroyed.

A survey packet consisting of the cover letter, the 2-page survey, and a stamped pre-addressed envelope was mailed to 500 American OTs and 250 Canadian OTs. Two weeks after the initial mailing, a reminder letter was sent to all the participants who had not yet responded. Another two weeks after the reminder letter was sent, a second survey packet was sent to the remainder of the participants who had not responded. The second survey packet included a revised cover letter, the two page survey and a return stamped pre-addressed envelope for the Americans and no envelope for the Canadians due to financial costs. This change was the only difference between the procedure of mailing for the Canadian and American therapists.

Design for Analyzing and Interpreting Data

The software program used for data analysis was the Statistical Package for the Social Sciences for Windows, Version 11.0. For the purpose of this study, any statistical data with a p value of less than or equal to .05 was considered significant. For this study,

the strength of correlation coefficients was measured as follows: a coefficient of .00-.25 signifies little if any strength, .26-.49 signifies low strength, .50-.69 signifies moderate strength, .70-.89 signifies high strength and .90-1.00 signifies very high strength (Munro, 2001).

To answer the first research question, "What are OTs level of knowledge and values related to spirituality in the context of OT?", the researcher used frequency tables (count and percent) depicting how the respondents chose to rank the definitions of spirituality. Frequency tables were also constructed for all 18 questions of section III of the survey, which measured therapists' understanding and value of spirituality.

To get an accurate depiction of therapists' knowledge and values related to spirituality, the researcher coded the Likert scale so that the six choices (strongly disagree, disagree, somewhat disagree, somewhat agree, agree, and strongly agree) corresponded to numbers (1-6) to be used for various computing purposes. Five categories were constructed by grouping questions that revolved around common themes. The categories and their respective questions are as follows;

- Therapists' value of their own spirituality
  - I consider myself to be a spiritual person
  - My spirituality is an essential part of my life.
  - My spirituality assists me in performing my daily job responsibilities.
- Therapists' value of the human experience of spirituality
  - Spirituality is a fundamental aspect of being human
  - I believe that spiritual well-being is an important component of good health

- Illness, disability, and crisis affect the spiritual lives of clients'
- A client's spirituality may influence his or her recovery.

- Spirituality as appropriate within the context of occupational therapy practice
  - Addressing spirituality issues is within the scope of the occupational therapy profession
  - Gathering spiritual information about a client should be a part of an occupational therapy assessment
  - Good occupational therapy practice must address the spiritual needs of a client
  - Therapists should try to incorporate activities that allow clients to express spiritual needs and concerns into their programs
  - It is appropriate for an occupational therapist to raise the topic of spirituality with a client
- Spirituality as appropriate within the context of occupational therapy education
  - Occupational therapy education should prepare therapists to address the spiritual needs of their clients
  - I want more academic and/or on-the-job training about how I can better assist as an occupational therapist with clients' spiritual needs
- Therapists' education of how to address clients' spiritual needs
  - My academic training has not prepared me to deal with clients' spiritual needs

- My on-the-job training has not prepared me to deal with clients' spiritual needs

Two of the statements in section III did not fit into a category and were left as their own category. Those statements are as follows:

- Therapists' value of their own religiosity
  - I consider myself to be a religious person
- Spirituality as appropriate within the context of OT only if initiated by client
  - Occupational therapists should address spirituality only if the client expresses interest first

The 18 questions in section III pertained to one of seven categories; the researcher was able to calculate an overall score for each of the categories for each of the respondents. The score for each category was calculated by summing the individual questions making up the categories, and then dividing that sum by the number of questions in the category. A Cronbach Alpha test was done on the five categories made up of more than one statement to check the internal consistency reliability of the groupings. With 0.8 indicating the desired result for reliability (Munro, 2001), the researcher arranged the categories to establish the strongest internal consistency reliability for each grouping. If a category had a Cronbach Alpha score of less than 0.8, that category was not included in further statistical analyses. Descriptive statistics (mean and standard deviation) were computed on the five categories, and a Pearson's Product Moment Correlation was used to determine the relationship between the respondents' reported years in practice and each of the categories. The two statements regarding therapists reported experience in

reported experience in academic and on-the-job training were also correlated to years in practice to compare to the results of previous studies.

A one-way ANOVA analysis was used to assess the relationship between therapists' reported area of practice and each of the seven categories. To further assess any significant relationships found in the ANOVA, a Tukey HSD post-hoc test was used. A one-way ANOVA analysis also was used to assess the relationship between therapists' education levels and each of the seven categories. To further assess any significant relationships found in the ANOVA, a Tukey HSD post-hoc test was used. To compare the ANOVA results of the seven categories, each individual question from section III was compared to the therapists' reported area of practice and education levels using a one-way ANOVA. To further answer research question one, frequency tables (n and %) were made for section V to gain insight to the barriers the respondents perceived as interfering or preventing them from addressing spirituality.

To answer the second research question, "How are OTs addressing spirituality in everyday practice?", three steps were taken to analyze the data. Frequency tables were used to assess which treatment techniques therapists felt were appropriate for OT intervention (section IVa), and which treatment techniques OTs were actually using (section IVb). A Wilcoxon Sign Rank test was used to compare the differences between how respondents rated each of the 16 treatment interventions as being appropriate for OT and the frequency each of the respondents reported using the treatment interventions. Bar graphs were used to visually portray the differences between the two populations.

To answer the third research question, "What are the differences between the ways in which Canadian and American therapists are addressing spirituality?", the

following steps were taken. Independent sample T-tests were used to compare the two populations' age in years and their years in practice. A non-parametric Mann Whitney U Test was used to identify differences between the Canadians and Americans for the nominal data of the demographics section I, which included gender, practice area, education level, practice location and client population ages. A Mann Whitney U test was also used to identify differences for section II of ranking definitions, and for all of section IVb. Bar graphs were used to give a visual representation of the significant differences between the two populations. For all of sections III, IVa, and V, an independent samples test was used to compare the responses of the American therapists to those of Canadian therapists, as the data was ratio data.

Assumptions

This study was being conducted under several assumptions. The researcher assumed that she would be able to design the survey in a way that would not reflect obvious personal beliefs or opinions held by the researcher herself, and would therefore not be biased in any way. Another assumption was that the participants of this study would answer the questions honestly and without regard for any notions of desirability. When designing the survey, it was also assumed that the questions on the survey measured what they were intended to measure. By including a section on the perceived barriers to addressing spirituality, the researcher assumed that there are barriers to addressing spirituality based on previous literature.

Delimitations & Limitations

Survey research has limitations that are unavoidable. Because the respondent is answering the survey in private, there is always the chance that the questions or

some flaws in designing the survey, such as the wording of questions, which were also limitations to the study. One logistical limitation that occurred was that the researcher decided to not purchase the postage necessary to include a return envelope for the second survey packet sent to the Canadians. This likely influenced the number of Canadian therapists who responded when the second survey was sent out.

A delimitation of this study was that when choosing the participants from the two country's OT association's, the researcher chose to survey only therapists who were listed with their association as working with populations 18 and above because addressing spirituality in pediatric OT is not very well researched. Another delimitation is that survey research is less conclusive than observational research because the researcher has to trust the respondents' answers rather than one's own clinical judgment and observations.

Chapter IV: Results

Introduction

The previous chapter described the methodology of the research study and the procedure used to answer the research questions. This chapter will describe the results of the research study. The demographics of the participants will be presented first, followed by the results of the three research questions.

Participants

Of the 750 therapists who were mailed a survey, a total of 444 surveys were returned for a return rate of 58% overall. Eight surveys could not be included in the analysis because they did not meet the inclusion criteria resulting in a valid return rate of 58% (436 surveys). Both the Canadian and American therapists returned 58% of the surveys mailed. Of the 436 therapists that participated in this study, 87.2% were female and 12.4 % were male, which is a typical representation of the gender distribution of practicing OTs. The average age of the respondents was 40 years old, and the age range fell between 23 years and 81 years of age. The number of years in practice varied from less than 1 year to 56 years. The average number of years in practice was 13.4 (SD= 10.024). The majority of the respondents (64.9%) reported practicing in an urban location, 22.9% reported practicing in a town location, and 11.5% practice in a rural location. A small number of the respondents (.7%) reported practicing in a combination of practice locations.

The education levels of the participants varied and many respondents had degrees in disciplines other than OT. The majority (77.5%) had a Bachelor's degree in OT. Of the therapists surveyed, 20.4% of the respondents had a Master's degree in OT, and .7% had

achieved a Doctoral degree in OT. In addition, 8.9% of the participants had been certified in a specialty area, and 10.3% had a Master's degree in another field. A small number of respondents (1.8%), reported having a Doctoral degree in another field, and 14% of the respondents noted that they had another degree as well.

The survey asked the respondents to check the age group of the population with whom they worked most frequently. However, 18.5% of the respondents checked more than one age group or wrote on the survey that they mostly treat a population younger than 18 years of age. Of the remaining therapists surveyed, 5.3% worked with 18-30 year olds, 28.5% worked with 31-55 year olds, and 17.1% worked with the population between the ages of 56-70. The remaining respondents (30.6%) reported working with the 71+ population.

The practice areas of the 436 respondents were very diverse, and 11.9% reported working in a combination of areas. Of the therapists surveyed, 3.7% worked in an academic setting, 8.9% worked in home health, 10.1% worked in a nursing home, and 10.3% worked in a mental health setting. Of the remaining therapists, 11.7% worked in a community-based care setting, 14.4% in an inpatient setting and 15.6% worked in an outpatient setting. There were no respondents that reported working in hospice care. Some respondents (13.1%) reported working in a practice area other than the areas listed above.

Between the American and Canadian therapists, the two statistically significantly different demographics were gender, ($t(360.938) = 2.060$, $p = .040$, American percentage= 84.8% female, Canadian percentage= 91.8% female), and age in years ($t(365.349) = 3.814$, $p = .000$, American mean= 41.63, Canadian mean= 37.84). The two populations

showed no statistically significant differences between their years in practice, (t (11.797)= -.173, p= .863), their practice area (U= -.937, p= .349), their practice location (U= -1.312, p= .190), nor for the ages of the client populations with whom they work, (U= -1.116, p= .264). The results of the two populations' education levels were unable to be used for comparison in a statistical analysis because the educational requirements for practicing OT in Canada and the US are different enough that many options were not chosen at all by Canadians.

Research Question One: Knowledge and Values of Spirituality

The results of the first research question, "What are OT's level of knowledge and values related to spirituality in the context of OT?", will first be addressed by examining the way in which respondents ranked the definitions listed on the survey. The definitions were ranked in the following order from most appropriate to least appropriate:

1. Egan & DeLaat global definition
2. AOTA definition
3. CAOT definition
4. Religious definition

The frequency table on the definition rankings can be seen in Table 2.

Frequency tables were made for all of the 18 questions in section III regarding therapists' knowledge and values on issues of spirituality. Overall, statements that questioned therapists' value of their own spirituality were consistent with one another; 83.5% agreed or strongly agreed that they consider themselves to be a spiritual person and 75.5% agreed or strongly agreed that spirituality is an essential part of their lives. Therapists' value of their own religiosity was somewhat less than their value of their

spirituality, with 53.6% agreeing or strongly agreeing that they consider themselves to be religious.

The majority of therapists (83.9%) agreed or agreed strongly that illness, disability and crisis affect the spiritual lives of clients', and 88.7% agreed or agreed strongly that a client's spirituality may influence his or her recovery.

Just over half of the respondents, (51.7%) agreed or strongly agreed that addressing spirituality is within the scope of OT and 38.3% agreed or strongly agreed that good OT practice must address the spiritual needs of a client.

There were mixed results for the statements determining therapists' feelings of preparedness for addressing spirituality from their academic and on-the-job training; 39.9% strongly disagreed or disagreed and 10.4% strongly agreed or agreed that they did not feel prepared by academic training; 27.3% strongly disagreed or disagreed and 26.3% strongly agreed or agreed that they did not feel prepared by on-the-job training. More specifics of these results can be seen in Table 3.

Table 4 represents the results from the Cronbach Alpha test. Only two of the five categories, made up of more than one statement, had a coefficient above 0.8; 'therapists' value of their own spirituality' had a coefficient of .907, and 'spirituality as appropriate within the context of OT' had a coefficient of .917. Therefore, the three other categories that had a Cronbach Alpha score of less than 0.8 were not used in any further statistical analyses. The two single statement categories of 'therapists' value of their own religiosity', and 'spirituality as appropriate in the context of OT only if client initiates', were used in the statistical analyses.

The descriptive statistics for the two multiple statement categories that were derived from questions in section III are as follows: therapists' value of their own spirituality had a mean of 5.02, (SD= .91798, n= 432), and 'spirituality as appropriate within the context of OT practice' had a mean of 4.278, (SD= .97689, n= 430). The descriptive statistics of the two single statement categories from section III are as follows: 'therapists' value of their own religiosity' had a mean of 4.11, (SD= 1.433, n= 436) and 'spirituality as appropriate within the context of OT only if initiated by client' had a mean of p= 3.95, (SD= 1.311, n=434). These four categories will be referred to as the comparative categories hereafter in this paper.

While it was hoped that further statistical analysis of the data related to educational level could be carried out, limitations of the survey question related to educational level did not allow for this to occur.

There were no statistically significant relationships found between the respondents' years in practice and the comparative categories (two multiple statement and two single statement) used in the Pearson correlation test. The category of 'therapists' value of their own spirituality' and their years in practice had a very little strength relationship with a correlation coefficient of .094, p= .053, n= 424. The remaining results of the Pearson Product Moment Correlation can be seen in Table 5.

The statement, 'My academic training has not prepared me to deal with clients' spiritual needs' was correlated to respondents reported years of practice and yielded a statistically significant inverse relationship of low strength with a correlation coefficient of -.288, p=.000, n= 426. There was no statistically significant relationship between

respondents reported years in practice and the statement 'My on-the-job training has prepared me to deal with clients' spiritual needs'.

There were two statistically significant relationships found between therapists' practice areas and the four comparative categories. The category of 'spirituality as appropriate within the context of OT practice' and the category of 'spirituality as appropriate within the context of OT only if initiated by client' were both statistically significant. All of the ANOVA results can be seen in Table 6. The Tukey B Post-Hoc test indicated that the only practice areas that were statistically significantly different from one another (in the category of 'spirituality as appropriate within the context of OT practice') were the mental health and the inpatient setting, ($p = .026$, inpatient mean= 3.9968, $n = 63$; mental health mean= 4.6222, $n = 45$). Under the category of 'spirituality as appropriate within the context of OT only if initiated by client', there were three statistically significantly different practice areas; the first was between the practice areas of mental health and nursing home, ($p = .002$, mental health mean= 3.24, $n = 45$; nursing home mean= 4.35, $n = 43$); the second was between mental health and the outpatient setting, ($p = .003$, outpatient mean= 4.21, $n = 68$); the last statistically significantly different relationship was between the mental health setting and the option with which therapists reported working in a combination of practice areas, ($p = .002$, combination mean= 4.28, $n = 53$).

The final results needed to answer research question one pertain to the perceived barriers of addressing spirituality in OT practice (section V). The barriers that therapists reported were preventing them from addressing spirituality the most were barriers that had to do with issues of limited time in therapy (60.7% agreed or strongly agreed that this

was a barrier). The other barrier pertaining to limited time was limited length of treatment to develop rapport necessary to address spirituality effectively, and 39.4% of respondents agreed or agreed strongly that this was a barrier.

Other barriers that were commonly reported as important were having a lack of experience and/or training in assessing the spiritual issues of clients (39.1% agreed or strongly agreed that this was a barrier), and uncertainty about how to manage spiritual issues raised by clients (28.6% of respondents agreed or strongly agreed that this was a barrier). However, it is important to note that a similar number of respondents (26.2%), disagreed or disagreed strongly with the barrier of uncertainty about how to manage spiritual issues. Issues of uncertainty pertaining to whether or not it is appropriate to address spirituality with clients were seen as less important barriers, 17.2% agreed or strongly agreed that addressing spirituality is not appropriate to the OT's role, and 17.9% agreed or strongly agreed that clients' do not want to share their spiritual concerns with their OT. The specific results of the perceived barriers (section V) can be seen in Table 7.

Research Question Two: Addressing Spirituality

To answer the second research question, "How are therapists addressing spirituality in everyday practice?", frequency tables were made for section IVa which represented which treatment techniques were deemed appropriate, and section IVb of the survey, which represented how often respondents reported using these treatment techniques. The four treatment techniques that therapists agreed were most appropriate for use in OT are as follows: 45.9% of respondents agreed or strongly agreed that 'recommend participation in a spiritual group or activity' was appropriate; 42.5% of respondents agreed or strongly agreed that 'discuss with clients ways that their religious beliefs are

helpful' was appropriate; 41.5% of respondents agreed or strongly agreed that 'encourage clients to consider the spiritual meaning and purpose of their current life situation' was appropriate; and 39.0% of respondents agreed or strongly agreed that 'help clients explore the spiritual meaning of occupations' was appropriate. There were two treatment techniques that more than half of the respondents disagreed or strongly disagreed were appropriate for use in OT: 'recommend religious readings to your clients', 54.3% disagreed or strongly disagreed; and 'participate in clients' religious rituals during therapy', 53.2% disagreed or strongly disagreed. Further specific results from section IVa can be seen in Table 8.

There were four treatment techniques that more than 80% reported never using: 80.1% for 'help clients develop spiritual rituals during therapy', 80.2% for 'participate in clients' spiritual rituals during therapy', 81.4% for participate in clients' religious rituals during therapy', and 81.5% for 'recommend religious readings to your clients'. Small percentages of respondents consistently reported using the treatment techniques frequently or always. The most often used techniques were 'pray for a client' (14% chose frequently and 1.9% chose always), 'discuss with client ways that their religious beliefs are helpful'(12.7% chose frequently and .7% chose always), and 'use spiritual language and concepts with clients' (11.6% chose frequently and 1.2% chose always). Further specific results for section IVb can be seen in Table 9.

When comparing utilization and appropriateness of the 16 treatment techniques, the Wilcoxon sign rank test was statistically significant with a p value of .000 for each technique. The therapists consistently ranked techniques as being appropriate much more

than they reported using any of the techniques. The specific results of the Wilcoxon sign rank test can be seen in Table 10.

Research Question Three: Differences Between Canadian and American Respondents

The results of the third research question, what are the differences between the ways in which Canadian and American therapists are addressing spirituality, are presented in the following paragraphs. All of the data answered from research questions one and two are re-analyzed in the third research question looking specifically at the statistically significant differences between the American and Canadian respondents.

Knowledge and values of spirituality.

There were very few statistically significant differences between the Canadian and American respondents' knowledge and values regarding spirituality. The two populations ranked two of the four definitions statistically significantly differently. The AOTA definition ranking was statistically significantly different, (U= -3.324, p= .001), as was the religious definition, (U= -5.164, p= .000). There were no statistically significantly different ways in which the two populations ranked the CAOT definition, (U= -1.053, p= .292), nor the Egan & DeLaat definition, (U= -.266, p= .790). The distribution of how the two populations ranked the definitions can be seen in Figures 1 thru 4.

Out of the eighteen statements analyzed in section III, seven were statistically significantly different between the two populations. Differences for the one stand alone statement, 'I consider myself to be a religious person' were significantly statistically different (t (434) = 3.595, p= .000, American mean= 4.28, Canadian mean= 3.77).

Three of the statements pertained to being academically prepared to address spirituality. There were statistically significant differences in how American and Canadian therapists valued the following: 'OT education should prepare therapists to address the spiritual needs of their clients' ($t(364.135) = -2.645$, $p = .009$, American mean= 4.46, Canadian mean= 4.74); 'My academic training has prepared me to deal with clients' spiritual needs' ($t(336.318) = -2.111$, $p = .036$, American mean= 2.85, Canadian mean= 3.10); 'I want more academic and/or on-the-job training about how I can better assist as an OT with clients' spiritual needs' ($t(339.820) = -2.277$, $p = .023$, American mean= 3.64, Canadian mean= 3.93).

Another area that was statistically significantly different between the Canadians and the Americans were three statements that pertained to spirituality being within the scope of OT: 'It is appropriate for an OT to raise the topic of spirituality with a client' ($t(434) = -2.555$, $p = .011$, American mean= 4.17, Canadian mean= 4.47); 'Gathering spiritual information about a client should be a part of an OT assessment' ($t(431) = -2.152$, $p = .032$, American mean= 4.00, Canadian mean= 4.26); and 'OTs should address spirituality only if the client expresses interest first' ($t(272.910) = 2.687$, $p = .008$, American mean= 4.07, Canadian mean= 3.71).

Eleven of the statements regarding how therapists conceptualize spirituality did not have statistically significant differences between American and Canadian therapists. Those results can be seen in Table 11.

Barriers.

When the researcher compared how the two populations of respondents perceived the barriers of addressing spirituality, a statistically significant difference was found in

only 2 of the 13 barriers. One barrier that was statistically significantly different was the belief that addressing spirituality is not appropriate to the OT's role, (t (422)= 2.296, p= .022, American mean= 3.30, Canadian mean= 2.98). The other barrier where a statistically significant difference was found was the lack of financial reimbursement for addressing spiritual needs of clients, (t (333.432)= 7.859, p= .000, American mean= 3.57, Canadian mean= 2.37). The majority of the barriers compared between the two populations were not statistically significantly different. Those results can be seen in Table 12.

Appropriateness of treatment techniques.

The perceived appropriateness of the following treatment techniques were statistically significantly different between the American and Canadian respondents: pray for clients (t (329.347)= 4.886, p= .000, American mean= 3.58, Canadian mean= 2.80); discuss with clients ways that their religious beliefs are helpful (t (421) = 2.216, p=. 027, American mean= 4.26, Canadian mean= 3.99); pray with clients (t (315.178)= 4.122, p= .000, American mean= 3.10, Canadian mean= 2.53); recommend religious readings to your clients (t (310.039)= 4.723, p= .000, American mean= 2.76, Canadian mean= 2.14); participate in clients' religious ritual(s) during therapy (t (310.881)= 2.591, p= .010, American mean= 2.69, Canadian mean= 2.35); use "healing touch" with clients, (t (406)= 4.795, p= .000, American mean= 3.64, Canadian mean= 2.87); help clients reflect on their beliefs about what happens after death, (t (415)= 2.590, p= .010, American mean= 3.74, Canadian mean= 3.37) and explore spiritual meaning of occupations with clients, (t (418)= -2.991, p= .003, American mean= 3.88, Canadian mean= 4.30). There were eight treatment techniques that were not ranked statistically significantly different when the

two populations were asked if the therapists felt the techniques were appropriate for use in OT practice. Those statistical results can be seen in Table 13.

Utilization of treatment techniques.

Another area in which there were also statistically significant differences was the frequency with which the Canadians and Americans reported using the treatment techniques as can be seen from figures 5-12. The reported use of the following treatment techniques were all statistically significantly different between the American and Canadian respondents: pray for clients (U= -4.538, p= .000); use "healing touch" with clients (U= -4.650, p= .000); help clients reflect on their beliefs about what happens after death (U= -3.364, p= .001); pray with clients (U= -3.924, p= .000); meditate with clients (U= -2.124, p= .034); recommend religious readings to your clients (U= -2.740, p= .006); participate in clients' religious ritual(s) during therapy (U= -2.432, p= .015), and explore spiritual meaning of occupations with clients (U= -4.218, p= .000). The treatment techniques that did not have statistically significant differences between the two populations can be seen in Table 14.

Chapter V: Discussion

Introduction

This chapter will focus on discussing the meaning of the study results. The results will be compared to previous research to identify continuing themes, new trends and significant points. A significant point to highlight is that the 58% response rate is high for survey research, which usually results in a response rate of less than 50% (Judd, Smith and Kidder, 1991). The respondents seemed to be very enthusiastic about the topic, which was demonstrated by the 49% of respondents who wrote comments in the optional comment section. Many of these comments were often lengthy paragraphs voicing strong opinions, experiences, and overall enthusiasm regarding the topic of spirituality in the context of OT. This point is a significant one, for it supports the need for more research and discussion on this topic.

Research Question One: Knowledge and Values of Spirituality

The results from research question one illustrate Canadian and American OT's knowledge and values related to spirituality in the context of OT. Overall, the results from this research question demonstrated several consistencies with previous literature along with some new trends, and an increase in knowledge and enthusiasm regarding the topic of spirituality in OT. The specifics are addressed in the next three sections.

Knowledge of definitions.

The first purpose of this study was to determine how therapists understand and value spirituality when addressing it in practice. It is apparent from comparing the results of this study to the current OT literature that the way therapists are choosing to define spirituality is changing and becoming more unified. The results in the current study are

considerably different from previous results. Just under half (48.1%) of the respondents ranked the global (Egan & DeLaat) definition as the most appropriate definition, and over half of the respondents (56.8%) ranked the religious definition as the least appropriate. Taylor et al. (2000) also had respondents choose their preferred definition for spirituality, and both the religious and global definition were included in that study as well. In Taylor et al.'s study, 67% chose the religious definition, 25% chose the global definition and 8% wrote in their own definition (2000). A 23.1% increase of therapists choosing the global definition is significant; however, it is also important to note the large decrease (47.3%) from Taylor et al.'s study in 2000 to the current study, in therapists perceiving the religious definition to be appropriate for use in OT. This change demonstrates the growing awareness by practicing OTs for a need to separate religion and spirituality, which has been a common theme of the recent OT literature related to spirituality. Another possible explanation for the change in therapists' definition choice is that the current study offered four definitions, whereas Taylor et al's study (2000) offered only the religious and global definition. With two more definitions to choose from, it was likely that respondents' rankings of definitions would be different.

Although the survey did not focus heavily on the issue, many respondents chose to comment on the issue of religion and spirituality. The comments were quite diverse throughout both American and Canadian populations. Most of the comments were similar to the one made by an American therapist:

> I believe that discussion of spirituality & its benefits in recovery are a positive part of therapy. However, it is important to always be respectful of religious differences & NEVER imply that your beliefs are correct, right, better, or superior

> to your clients' beliefs. Generally, discussion of God or religion is inappropriate, unless brought up first by the client (A018).

Another American respondent demonstrated a very different viewpoint regarding the role of religion that was only shared by a small number of other respondents:

> 'Spiritual' is so vague that it can encourage participation in pagan non-Christian beliefs and practices that I believe lead people into error and spiritual danger. Participation in traditional Christian prayer and reading content such as the Psalms can be encouraging to the patient and strengthen his connection to God's healing power- this is what is appropriate (A132).

It is clear from reading these two different approaches, among the many others, that spirituality in relation to religion is an issue of great importance that continues to demand attention from the OT community. This study reinforces the need to distinguish between the two concepts of spirituality and religion to ensure that therapists are addressing issues that are within the legal and ethical scope of OT practice.

The definitions provided by the AOTA and the CAOT did not have results that were as conclusive as the other two definitions. The ranking of the AOTA definition was spread out evenly in all four categories from most appropriate to least appropriate. The ranking of the CAOT definition was most heavily concentrated in the two sections of second and third most appropriate. These indistinct results are also important, for it implies that neither of these definitions is providing therapists with an adequate working definition of spirituality for use in their OT practice. Furthermore, there are definitions that therapists feel are more appropriate. There are no previous studies for comparison

because the two OT association definitions had not been included in any other research studies at the time this study was done.

Values regarding spirituality.

The three questions regarding therapists' values of themselves as spiritual people were all answered with strong consistency, and with a high mean (5.02, equivalent to 'agree'), which represents the strength of therapists' values of their own spirituality. These results are consistent with the three studies that asked identical or similar questions, (Engquist et al., 1997; Rose, 1999; Taylor et al., 2000). This signifies that the majority of OTs considered, and still consider, spirituality to be a significant aspect of their lives, and related to their role as a therapist.

Therapists' values of their own religiosity were not as high as their value of spirituality with 43.6% of respondents agreeing or strongly agreeing with being a religious person. The only study that addressed respondents' religiosity was by Taylor et al. (2000), in which 64% considered themselves religious. In this study, it is important to note that 40% more therapists agreed or agreed strongly with considering themselves a spiritual person rather than a religious person, which demonstrates that a person can perceive himself or herself to be spiritual but not express that spirituality using religious means.

An interesting theme that was evident in comments written by respondents is that a therapists' own sense of spirituality often influences whether he or she feels comfortable addressing spirituality with clients. One American therapist commented, "I am an atheist in the religious sense, but believe strongly in a spiritual orientation in life. Others, including clients, find this difficult to reconcile and is a barrier in these pursuits

with clients (A 230)." A Canadian respondent commented, "I think a therapist's comfort level with their own spirituality and discussing others' spirituality is a definite factor (C119)." An American commented, "I find it much easier to communicate with my residents who share the same belief system, probably because I have a better idea of what is involved... I think I would need to learn more about the other faiths before I felt comfortable enough to address (them) more fully in therapy (A053)." Another therapist wrote a comment that reflected a small percentage of the respondents' comments, "I am a person who believes what the Bible says and I have a personal relationship with Jesus Christ. My job as an OT is one of my ministries and I believe that I can lead or direct my patients to God thru Jesus... (C156)." These comments all contribute to a similar theme of how religion is an important aspect of this topic, while at the same time are very different depictions of how therapists perceive their religiosity to be influencing their ability to relate on a spiritual level with clients.

A majority of respondents (85.7%) agreed or strongly agreed that spiritual well-being is an important component of good health. These results are similar to previous results found by Engquist et al. (84%) in 1997, and Rose (88%) in 1999, and are slightly lower than results found by Collins et al. (96%) in 2001. Therapists agreed with similar statements with consistency; 88.7% agreed or strongly agreed that a client's spirituality may influence his or her recovery and 83.9% agreed or strongly agreed that illness, disability and crisis affect the spiritual lives of clients. These numbers represent the majority of respondents, thus making it very clear that therapists have some strong values about how spirituality is related to human experiences such as well-being, disability and the rehabilitation process. In general, it can be said that therapists were more sure of how

important spirituality is to human experiences related to rehabilitation and less sure whether spirituality should be included in OT assessment and treatment.

Just over half (51.7%) of the respondents from the current study agreed or strongly agreed that addressing spirituality is within the scope of the OT profession. This is a large increase compared to the 37.7% of respondents from Engquist et al.'s study (1997) and to the 33% from Rose's study in 1999. It is also an increase from Collin et al.'s study in 2001, when just under half (45.5%) agreed or strongly agreed that addressing spirituality is within the scope of OT. In addition, another third of the respondents from this study reported that they agreed somewhat with the statement, yet only 12% of respondents disagreed somewhat, disagreed, or strongly disagreed that addressing spirituality is within the scope of OT. A continuing trend shows that as spirituality becomes a more overt topic both in OT and in healthcare in general, more therapists believe that addressing it is within their scope of practice.

When questions addressed specifics on how therapists feel spirituality should be addressed, the results were less conclusive. The two statements (questions 13 and 14 from section III) regarding specifics of addressing spirituality shown in Figure 13 are asking the same question, but the questions are framed in different manners. One states it is appropriate for OTs to raise the topic of spirituality with a client, and the other states it is appropriate for OTs to address the topic of spirituality only if the client raises the topic first. One would assume that the results to these statements would be different as well. However, the results were very similar. Thus, it was apparent that there was some underlying confusion occurring for these two statements to have such similar results. It is possible that the respondents were confused because the questions were worded similarly.

It is also possible that these results further demonstrate that bringing up the topic of spirituality may be dependent on the client and practice setting as was made evident previously by the ANOVA results demonstrating statistically significant differences between respondents working in a mental health practice setting versus a nursing home or inpatient setting. These ambiguous results warrant further discussion and research on the topic of spirituality within the scope of OT practice.

Many therapists commented on the appropriateness of bringing up the topic of spirituality with clients versus addressing it only if the client expresses an interest. One American therapist wrote, "When clients bring up the topic, it is wonderful to include spirituality. However I do not want to offend others or do not feel comfortable bringing it up in the right way (#026)."

An important aspect the survey covered, and one that has been a focus of a few articles in recent years, is that of educating OT students on the topic of spirituality. A large percentage of respondents disagreed that their training had not prepared them, or in other words, they felt prepared to address clients' spiritual needs from their academic training. In both Engquist et al.'s study (1997) and Rose's study (1999), the majority of respondents (82% and 74% respectively) agreed that spirituality was not covered in their OT education. In Taylor et al.'s study in 2000, 84% of respondents demonstrated similar views disagreeing that spirituality was covered in their academic education. It is possible that because spirituality is becoming a more common aspect of OT, younger therapists have begun to receive academic training on the topic. However, when the statement was correlated to the respondents' years in practice, the statistically significant relationship indicated that the more experienced therapists were feeling more prepared by their

academic training. These results are inconsistent with the previous studies. The researcher acknowledges that the wording of these questions (#16 and #17 from section III) is confusing, because by choosing 'strongly disagree' that their training had not prepared them, the respondent is essentially saying it did prepare them. It is unknown if the wording of the questions was misleading or if therapists are indeed feeling more prepared by their academic and on-the job training than in all previous studies. Due to this inconsistency, it is recommended that these results be interpreted cautiously.

As seen in Figure 14, more therapists have reported receiving academic than on-the-job training on how to address client's spiritual concerns. Although therapists did not feel as prepared by their on-the-job training, the results for preparation by their on-the-job training were more evenly spread among the possible agreement options. In contrast, the results from Engquist et al.'s (1997) and Rose's (1999) studies indicated that respondents reported feeling more prepared to address spirituality by their on-the-job training than by their academic. It is important to note that all of the respondents in Rose's (1999) study worked in hospice care, which could signify that the OTs are receiving more on-the-job training because the therapists have to address spirituality much more frequently than in other typical OT settings. Overall, it can be said that the results from the current study are inconsistent with the results from these two previous studies (Engquist et al., 1997; Rose, 1999). However, it is important to add that a large percentage of therapists reported not having received any type of training on the topic. It is likely that in the United States, therapists' exposure to spirituality will increase, both on the job and in the classroom, due to the addition of spirituality as a construct in the practice framework in 2002.

When asked if OT education should prepare therapists to address spirituality, a majority of the respondents in the current study (59.4%) agreed or strongly agreed that it should. In Taylor et al.'s study (2000) 54% agreed, 27% were neutral and 19% disagreed with the same statement. The consistency of results from the current and previous study is noteworthy, and clearly indicates that therapists have been, and continue to recognize the need for spirituality to be an aspect of OT education.

However, as seen in Figure 15, there is an interesting twist to this topic that makes the therapists' responses about OT education less conclusive. Despite the majority of respondents agreeing that spirituality should be a part of formal OT education, only 30.7% agreed or strongly agreed that they want more academic and/or on-the-job training on the topic. These results seem to be contradictory, and there are a few reasons that could potentially explain the difference. It is possible that the therapists feel that it is important for the next generation of OT students to be educated on issues of spirituality, but that it is too late or perhaps unnecessary for the therapists who have already been practicing to receive continuing education on the topic.

In Rose's 1999 study in which only therapists working in palliative care were surveyed, 64% of respondents indicated interest in receiving continuing education on issues of spirituality. This is almost double the number from the current study, which may indicate that therapists feel receiving continuing education on how to deal with clients' spirituality is dependent on the OT's practice area. However, in the current study there were no statistically significant results from the ANOVA test comparing practice area to statements regarding education. Many therapists wrote comments that alluded to the idea

that the rationale for addressing spirituality is dependent on the therapists' practice area. One American therapist wrote a comment that was similar to many other comments:

> I feel that addressing spirituality is more appropriate in some settings than in others, or with some diagnosis more than others. For instance, with someone with a spinal cord injury, I can see addressing that part of his or her life versus someone you are treating to increase range of motion secondary to a wrist fracture. Of course, there are exceptions to all areas, but I feel that spirituality is more appropriately addressed with those individuals who have, and are experiencing major life altering events (A006).

Similar reasoning could also explain why about one third of the respondents indicated they did not want more academic and/or on-the-job training on the topic. It can be assumed that practice areas such as hospice, inpatient and outpatient traumatic brain injury/spinal cord injury rehab units, and mental health are areas where it is more likely that patients are experiencing life-altering disabilities. Further, it is likely that therapists who are not working in these types of practice areas are not interested in receiving continuing education on spirituality simply because it does not pertain to the interventions with which they are dealing on a daily basis.

Barriers.

The results from the current study suggest new findings regarding the barriers therapists perceive as preventing them from addressing spirituality. The two barriers from the current study that had the most consensus are concerned with having a limited amount of time. More than half (60.7%) of the respondents in the current study agreed or strongly agreed that having limited time for therapy overall was a barrier, whereas in Collin et

al.'s (2001) study, 41.9% of respondents identified that this was a major barrier. The other barrier most respondents agreed with was having a limited length of treatment to develop the rapport necessary to address spirituality effectively. These two barriers suggest that the time demands made on therapists in today's fast-paced, productivity-focused healthcare system contribute to their inability to consistently address spirituality in their practice.

In Collin et al.'s (2001) study, just over half of the respondents (55.7%) identified lack of experience or education as the major barrier to addressing spirituality. In the current study, the number dropped to 39.1% of respondents who agreed or strongly agreed with the same statement. This result indicates that therapists feel their lack of education is less of a barrier than was previously reported. These results are consistent with the results from questions 16 and 17 (seen in table 14) that asked therapists to agree or disagree with the statements of not being prepared by their academic and/or on-the-job training to address spiritual needs.

Another difference between the two studies was that in the current study, 28.6% agreed that they felt uncertainty about how to handle spiritual issues raised by clients, whereas in Collins et al.'s study (2001), 46.5% of respondents perceived this as an important barrier. The last noteworthy change from Collin et al.'s study is that 44.6% of respondents agreed that having concern of projecting their own beliefs onto a client was a main barrier, whereas 29.6% in the current study agreed with the same statement. Both of the barriers discussed in this paragraph are concepts that demonstrate uncertainty about addressing spirituality, and both barriers have become of less concern for therapists since Collin et al.'s study in 2001.

Collin et al.'s (2001) study included similar questions and had inconclusive results since the range of responses were very spread out throughout the agreement options. The authors ascribed this result to "therapists' personal feelings about the area of spirituality and the differences in their work areas" (Collins et al., 2001, p.87). It appears that for this specific section on barriers to addressing spirituality, the current study found results that are more conclusive.

Overall, this study suggests that therapists' feelings of uncertainty, confusion and/or lack of training on issues of spirituality that were once major barriers are now decreasing. It can be hoped that, with the continuing attention the issue is demanding from the OT community, these types of barriers will only continue to decrease as time goes on. If this indeed continues to happen, then more time can be spent focusing on how to provide enough time for therapists and patients to develop relationships that allow for addressing spirituality in a realistic and appropriate manner.

Research Question Two: Addressing Spirituality

The second purpose of this study was to learn how therapists are addressing spirituality in their OT practice. The other study that examined this question was by Taylor et al. in 2000. All of the same treatment techniques explored in this study were also used in the previous study excluding one; 'Explore spiritual meaning of occupations with clients" is a treatment technique that was added by the researcher and her committee, because none of the other techniques were focusing on or including the concept of occupation. The current study examined the question differently by first asking the respondents to choose their level of agreement with the specific treatment

technique as being appropriate for use in OT, and then asking them to rate how often they use the technique in their practice.

Appropriateness of treatment techniques.

Overall, the results seemed to be somewhat mixed regarding how respondents felt about treatment techniques being appropriate for use in OT. One trend or pattern that was identified is that the respondents seemed more likely to disagree with the appropriateness of a treatment technique if it was more direct or involving. The treatment techniques that used words like 'participate' and 'recommend', and the other more direct techniques were generally found to be less appropriate by the respondents. This result is logical when one considers that some therapists do not feel prepared to address spirituality, and not all respondents are convinced spirituality should be addressed by OTs.

The treatment techniques therapists considered appropriate were more indirect and abstract techniques involving contemplating and discussing, rather than doing. This result is consistent with the finding that therapists feel a lack of time to be a significant barrier. Using one of the techniques listed above, like discussing ways in which clients' religious beliefs are helpful, could be more easily incorporated into a treatment plan while simultaneously doing other interventions as compared to participating in a client's religious or spiritual rituals. Many of the techniques felt to be more appropriate by respondents were also techniques that were more client-driven in nature. The overall outcome from this section is that the majority of respondents agreed in some form that most of the treatment techniques were appropriate for use in OT. These findings suggest that therapists have some developed ideas about what are appropriate and inappropriate techniques for addressing spirituality.

Utilization of treatment techniques.

To further answer research question two, the frequency that therapists reported actually utilizing these treatment techniques will now be discussed. The surprising result of this section of the survey is that most therapists are rarely using any of the treatment techniques identified to address spirituality. The fact that such a majority of the respondents reported never addressing spirituality using the treatment techniques on the survey suggests that therapists perceive limits as to how therapists should be addressing spirituality in practice and that they do not feel trained and prepared to do so. It was made evident that therapists feel that many of the treatment techniques are in fact appropriate to OT, and that therapists are conceptualizing spirituality in a very positive manner related to their OT practice. One could hypothesize that if the majority of therapists feel that a technique is appropriate, a good number of those therapists would also report using the treatment technique in practice. However, it is likely that many therapists do not yet feel comfortable addressing spirituality through these means. It is also possible that therapists are using different techniques to address spirituality than the suggested techniques listed on the survey, or that they do not feel they have the time, experience, or training to do so in their OT practice.

Research Question Three: Differences Between Canadian and American Respondents

The third purpose of this research study was to examine the differences between the ways in which American and Canadian OTs are conceptualizing and addressing spirituality in practice. No other previous research studies have compared these two populations concerning this topic; therefore, all of the following information is original and has no basis for comparison.

Demographics and knowledge of definitions.

The demographics of the two populations did not differ significantly except in gender and in age of the practicing therapists. The mean age of the Canadian therapists was 37.8, and the mean age of the American therapists were 41.6. This statistically significant difference could have implications; however, the age difference most likely did not affect the results of the two populations greatly. Given that most of the demographics were not statistically significantly different between the two groups, the other statistically significant differences in the study are not likely due to demographic differences. The similarity with which the two populations ranked the Egan & DeLaat definition is useful information, for it implies that both populations feel that it is the most appropriate definition for use in OT. The similarity of the two populations ranking the CAOT definition most commonly as the second or third most appropriate definition implies that there are positive aspects to the definition, but that there is a definition both populations feel is more appropriate. The way the Canadians and Americans ranked the religious definition was statistically significantly different (with the Americans feeling more positively), and this marks the beginning of a trend that strongly suggests that the two populations differ on issues pertaining to religion being involved in OT. The way in which the two populations ranked the AOTA definition was statistically significantly different. An interesting result is that the Canadians consistently ranked it as more appropriate than did the Americans. When explaining this result it is important to remember that the definition had just been proposed by the AOTA when these surveys were being completed by the therapists, and that it is likely that all four definitions were being read by the respondents for the first time. It is possible that the language of the

definition proposed by AOTA (2002) is more culturally suitable to the Canadians than it is to the Americans.

Values regarding spirituality.

The statistically significant differences between the populations became much more apparent when the therapists were questioned regarding their beliefs and personal opinions regarding spirituality and other relevant issues. Of the seven statements that were statistically significantly different between the two populations, five of them are statements that reflect an opinion of spirituality as a valid aspect of OT, and the other two are more personal experience statements. With all five statements that reflect the opinion that spirituality is within the scope of OT, the Canadian population consistently agreed more that spirituality should be a part of OT. This result is to be expected when one considers that Canadians have been incorporating spirituality into their practice framework for decades, whereas Americans have only recently added the term to their practice framework.

Due to Canada's longer history of inclusion of spirituality, it is understandable that the Canadians reported feeling more prepared by their academic training. An unexpected addition to this result was the statistically significant difference regarding the statement of wanting more training for addressing spiritual issues. Although the Canadians feel more prepared to address spirituality, they desire training on the subject more than the Americans. One possible explanation for this is that the Canadians have been more exposed to the issues and realize the potential benefits for clients and their practice overall. The Americans may become more enthusiastic about the topic once they receive more education on how spirituality can be a positive aspect of OT. Another

important difference to highlight is how Americans consider themselves more religious than do the Canadians. This statistically significant difference seems to be a consistent difference when comparing how the two groups responded to the treatment techniques for addressing spirituality, which will be discussed in the next few pages.

Barriers.

The two groups of OTs responded similarly to the questions regarding perceived barriers to addressing spirituality. The Americans agreed more than the Canadians did with the barrier of 'belief that addressing spirituality is not appropriate to the OT's role'. This result is logical and consistent with the previous results that the American population surveyed is not as convinced as the Canadian population that spirituality should be an important aspect of OT. The other barrier that was identified as being statistically significantly different between the two populations was 'lack of financial reimbursement for addressing spiritual needs of clients'. Given the emphasis on financial reimbursement in the American health care setting, and the fact that Canada has socialized healthcare, it is not surprising that American therapists would be more likely to perceive reimbursement as a barrier. The remaining barriers were all ranked very similarly between the two populations of therapists, which implies that even though there are statistically significant differences in some areas, the two populations of therapists still have many of the same feelings and opinions of the positive and negative issues that come with addressing spirituality in OT.

Appropriateness of treatment techniques.

There were many statistically significant differences between how the American and Canadian therapists felt the treatment techniques were appropriate for use in OT. The

most significant finding from these results is that all five of the treatment techniques that imply a religious theme to them by either including the words 'religion' or 'pray' in the technique, were found to be statistically significantly different between the two populations; the American therapists found the techniques to be more appropriate for use in OT. This finding implies that overall the Canadians feel more strongly that addressing spirituality by using treatment techniques that have religious implications is inappropriate. It is important to remember that the current study has already demonstrated that the Canadians considered themselves less religious than did the American therapists. This could be one possible reason as to why the Canadians feel differently about using religious treatment techniques in practice. Another possibility is the fact that the Canadians have had much more time to analyze the ways in which addressing spirituality is acceptable within an OT practice.

There was only one treatment technique that the Canadians thought was more appropriate than the Americans did, and that was 'Explore spiritual meaning of occupations with clients', which is obviously a technique that is occupation based, and more secular than the other treatment techniques that were statistically significantly different. Again, it is important to note that with more experience and training, the Canadians may have more developed ideas as to what techniques are effective for addressing spirituality.

Utilization of treatment techniques.

The American and Canadian therapists also responded differently when they reported how often they used the specific treatment techniques for addressing spirituality. Six of the eight treatment techniques that were statistically significantly different in this

category were also statistically significantly different when the respondents ranked the treatment techniques as appropriate for use in OT. Therefore, similar reasoning can be used to explain the results. The Canadian and American therapists have had very different experiences and exposure to the idea of addressing spirituality in OT practice. The differences between the two populations' ideas pertaining to religion and spirituality likely influenced these results as well.

Conclusion

This research study has yielded many interesting results. With such a large amount of data, it was likely that there would be some new trends and contributions that could add to the previous research. It is possible that had this study focused on fewer areas of this topic, there would have been a greater amount of conclusive results. However, the three research questions were answered in detail, and because of the large amount of information, there are several recommendations to be made for how to continue research on the topic of spirituality.

Chapter VI: Conclusions & Recommendations for Further Research

Research Question One: Knowledge and Values of Spirituality

Throughout the process of this research study, the relationship between the concepts of spirituality and religion was a significant issue when addressing therapists' knowledge and values regarding spirituality. It was apparent that while some therapists were still equating the terms as interchangeable, many therapists have become aware that the two concepts can be viewed as distinct from one another. This point was made clear when the majority of respondents deemed the religious definition as least appropriate, and the global definition as most appropriate for use in occupational therapy. These results suggest that therapists may be understanding spirituality to be more holistic and more related to occupation than other definitions were portraying.

Further conclusions regarding therapists' knowledge and values of spirituality were that the majority of therapists felt that spirituality was an important aspect of their lives, as well as an important aspect of the human experience and rehabilitation process overall. Many therapists felt that spirituality was within the scope of occupational therapy; however many were unclear about their specific roles in including it in the therapy process. This is to be expected considering that many therapists did not feel prepared by their training to address spirituality, and that most therapists are not currently addressing spirituality in practice. Therapists consistently reported that spirituality should be included in academic education for future students, however, only a small portion of the respondents reported wanting further education, while many more were unsure as to whether this would benefit them.

The barriers that were identified as most significant were those pertaining to lack of time and not to discomfort with the topic. The results pertaining to the barriers that respondents reported as being important were conclusive, and offer the potential for specific problem solving to occur by the occupational therapy community to help therapists feel that they have the time and are prepared to address spirituality in practice.

Overall, when comparing the current results to previous studies, it appears that therapists' knowledge and understanding of spirituality have become more succinct; however, a few issues are still causing confusion and disagreement for therapists. Further research on how therapists are understanding spirituality is definitely warranted. Potential research will continue to outline whether ideas are changing as the issue receives more attention from the profession and occupational therapy community.

Research Question Two: Addressing spirituality

The results of research question two were less conclusive than the results of research question one. However, this is logical because it signifies that therapists' ideas about spirituality are more developed than their knowledge of how to actually incorporate and address it in practice. Overall, therapists felt that treatment techniques that were more indirect were more appropriate and those that were more direct were viewed as less appropriate.

One of the most important results of this study is that despite all the ways in which respondents indicated that spirituality is a positive aspect of therapy, very few therapists are addressing it using the treatment techniques given in the survey. This clearly indicates that therapists need more education on appropriate ways of addressing

spirituality in their occupational therapy practices. This also is an area where further research on other ways in which therapists are addressing spirituality would be useful.

Research Question Three: Differences between Canadian and American Respondents

The results of research question three also had some conclusive results, and can potentially offer a great deal of helpful information to both American and Canadian occupational therapists. Overall, the Canadian and American respondents differed significantly in a few important ways. Religion was consistently a major theme of the significant differences. The Canadian respondents rated themselves as being less religious, and ranked the religious definition and all the treatment techniques pertaining to religion as being less appropriate than the Americans. Another significant difference was that the Canadians agreed more that spirituality should be a part of occupational therapy than did the Americans. The two populations ranked the way barriers affect their ability to address spirituality very similarly. Canadians had some clear ideas that perhaps reflected that they have had much more time to determine how to incorporate spirituality into their occupational therapy profession. However, the Canadian respondents demonstrated that there are still issues that provide for confusion and disagreement among the therapists. American and Canadian therapists have a unique opportunity to offer important advice to one another, possibly helping both communities to incorporate spirituality in a way that is clear and beneficial to both clients and therapists alike.

Recommendations for Future Research

This study has offered many results and conclusions, yet it has raised just as many questions that will need to be researched in order to fully understand the issue of spirituality in the occupational therapy profession. Many respondents wrote comments

that outlined specific guidelines for referral of clients needing spiritual guidance to other professionals. This is logical considering that there are other professionals trained to address clients' spiritual issues. However, it is very possible that clients in need of a spiritual guide would also benefit from spirituality being incorporated into their OT treatment through means of occupation. A few therapists even commented on how helpful it was for them to be able to meet with that spirituality guide to discuss ways in which to help the client. This issue was not addressed in this study and requires further research.

Another important issue needing clarification is the role that spirituality should play when occupational therapists are treating pediatric clients. Although the researcher chose only to survey therapists who primarily treat adults; there were still many therapists who also treated children and these therapists had a great deal to say. Many reported addressing spirituality with their client's parents or not at all because the child was too young. There are no guidelines from either association on how to address spirituality in the pediatric setting; therefore, any kind of research on this topic would be beneficial.

It was clear to the researcher that therapists are incredibly enthusiastic about this topic, even if they feel spirituality has no place in an occupational therapy treatment session. Therapists have strong opinions and it is the researchers' belief that although the survey research was helpful, qualitative interviews may be the most effective means of analyzing this topic and all its parts. More qualitative research on how clients experience spiritual needs in the face of disability or illness is also vital to placing spirituality firmly in the domain of occupational therapy.

Overall, the researcher was able to conclude that spirituality is an issue that is pertinent to occupational therapy research, and to the profession overall. This issue has the potential to cause many theoretical disagreements between therapists, as was seen by the manner in which some of the respondents voiced opposing viewpoints. However, it also has the potential to give emphasis to the unique ways in which occupational therapists can help clients foster, express, or recover their spirituality.

References

Algado, S.S., Gregori, J.M.G., & Egan, M. (1997). *Canadian Journal of Occupational Therapy,* 64, 138-145.

American Association of People with Disabilities. (2004). Retrieved February 20th, 2004, from www.aapd-dc.org/

American Occupational Therapy Association. (2002, December). *Occupational therapy practice framework: Domain and process.* American Journal of Occupational Therapy, 56, 609-639.

Boswell, B., Knight, S., Hamer, M. & McChesney, J. (2001). Disability and spirituality: a reciprocal relationship with implications for the rehabilitation process. *Journal of Rehabilitation*, 67, 67-70.

Canadian Association of Occupational Therapists (1991). Occupational therapy guidelines for client-centered practice. Ottawa, ON: CAOT Publications ACE.

Canadian Association of Occupational Therapists (1997). Enabling occupation: An occupational therapy perspective. Ottawa, ON: CAOT Publications ACE.

Christiansen, C. (1997). Acknowledging a spiritual dimension in occupational therapy practice. *American Journal of Occupational Therapy*, 51, 169-172.

Collins, J.S., Paul, S., West-Frasier, J. (2001). The utilization of spirituality in occupational therapy: beliefs, practices, and perceived barriers. *OT in Health Care*, 14 73-92.

Egan, M. & Delaat, M.D. (1994). Considering spirituality in occupational therapy practice. *Canadian Journal of Occupational Therapy,* 61, 95-101.

Egan, M. & Delaat, M.D. (1997). The implicit spirituality of occupational therapy practice. *Canadian Journal of Occupational Therapy*, 64, 115-121.

Engquist, D.E., Short-DeGraaf, M., Gliner, J. & Oltjenbruns, K. (1997). Occupational therapists' beliefs and practices with regard to spirituality and therapy. *The American Journal of Occupational Therapy*, 51, 173-180.

Fitzgerald, J. (1997). Reclaiming the whole: self, spirit and society. *Disability and Rehabilitation*, 19, 407-413.

Gronlund, Norman E. (1978). *Stating objectives for classroom instruction* (2nd ed.). New York, New York: Macmillan Publishing Co.

Gutterman, L. (1990). A day treatment program for persons with AIDS. *American Journal of Occupational Therapy*, 44, 7-11.

Hammell, K. W. (2001). Intrinsicality: Reconsidering spirituality, meanings, and mandates. *Canadian Journal of Occupational Therapy*, 68, 186-192.

Hill, P.C., Pargament, K.I., Swyers, J.P., Hill, R.L., McCollough, M.E., Hood, R.W., & Baumeister, R.E., (1998). Definitions of religion and spirituality. In D.B. Larson, J.P. Swyers & M.E. McCullough (Eds.) Scientific research on spirituality and health: A consensus report (pp. 14-30). Rockville, Maryland: National Institute for Healthcare Research.

Howard, B.S. & Howard, H.R. (1997). Occupation as spiritual activity. *American Journal of Occupational Therapy*, 51, 181-185.

Judd, C.M., Kidder, L.H., & Smith, E.R. (1991). *Research Methods in Social Relations* (6th ed.). Stamford, Connecticut: International Thomson Publishing.

Kirsch, B. (1996). A narrative approach to addressing spirituality in occupational therapy: Exploring personal meaning and purpose. *Canadian Journal of Occupational Therapy*, 63, 55-61.

Kirsch, B., Dawson, D., Antolikova, S. & Reynolds, L. (2001). Developing awareness of spirituality in occupational therapy students: Are our curricula up to the desk? *Occupational Therapy International*, 8, 119-126.

Low, J.F., (1997). Religious orientation and pain management. *American Journal of Occupational Therapy*, 51, 215-219.

McColl, M.A. (2000). Spirit, occupation and disability. *Canadian Journal of Occupational Therapy*, 67, 217-228.

McColl, M.A., Bickenbach, J., Johnston, J., Nishihama, S., Schumaker, M., Smith, K., Smith, M. & Yealland, B. (2000a). Changes in spiritual beliefs after traumatic disability. *Archives of Physical Medicine of Rehabilitation*, 81, 817-823.

McColl, M.A., Bickenbach, J., Johnston, J., Nishihama, S., Schumaker, M., Smith, K., Smith, M. & Yealland, B. (2000b). Spiritual issues associated with traumatic-onset disability. *Disability and Rehabilitation*, 22, 555-564.

Moyers, P. (1999). The Guide to Occupational Therapy Practice [Special Issue]. *American Journal of Occupational Therapy*, 53, 62-69.

Munro, Barbara Hazard. (2001). *Statistical methods for health care research* (4th ed.). Philadelphia, PA: Lippincott, Williams & Wilkins.

Peloquin, S.M. (1997). The spiritual depth of occupation: Making worlds and making lives. *American Journal of Occupational Therapy*, 51, 167-168.

Peloquin, S.M. & Christiansen, C. (Eds.). (1997). Special issue on occupation, spirituality, and life meaning. *American Journal of Occupational Therapy*, 51 (3).

Rose, A. (1999). Spirituality & palliative care: the attitudes of occupational therapy. *British Journal of Occupational Therapy*, 62, 307-312.

Simo-Algado, S., Mehta, N., Kronenberg, F., Cockburn, L. & Kirsch, B. (2002). Occupational therapy intervention with children survivors of war. *Canadian Journal of Occupational Therapy*, 69, 205-213.

Spencer, J., Davidson, H. & White, V. (1997). Helping clients develop hopes for the future. *American Journal of Occupational Therapy*, 51, 191-198.

Taylor, E., Mitchell, J.E., Kenan, S. & Tacker, R. (2000). Attitudes of occupational therapists toward spirituality in practice. *The American Journal of Occupational Therapy*, 54, 421-426.

Townsend, E. (1997). Inclusiveness: A community dimension of spirituality. *Canadian Journal of Occupational Therapy*, 64, 146-155.

Udell, L.S. & Chandler, C. (2000). The role of the occupational therapist in addressing spiritual needs of clients. *British Journal of Occupational Therapy*, 63, 10-14.

Unruh, A. (1997). Spirituality and occupation: garden musings and the Himalayan blue poppy. *Canadian Journal of Occupational Therapy*, 64, 156-162.

Unruh, A. (2000). The occupation of gardening in life-threatening illness: A qualitative pilot project. *Canadian Journal of Occupational Therapy*, 67, 70-77.

Unruh, A., Versnel, J. & Kerr, N. (2002). Spirituality unplugged: a review of commonalities and contentions and a resolution. *Canadian Journal of Occupational Therapy*, 69, 5-12.

Urbanowski, R. & Vargo, J. (1994). Spirituality, daily practice, and the occupational performance model. *Canadian Journal of Occupational Therapy*, 61, 88-95.

Vrkljan, B., Miller-Polgar, J. (2001). Meaning of occupational engagement in life-threatening illness: A qualitative pilot project. *Canadian Journal of Occupational Therapy*, 68, 237-240.

Bibliography

Garrison, J.W. (2002). Habits as social tools in context. *Occupational Therapy Journal of Research*, 22, S11- S16.

Green, R.L., Benshoff, J.J. & Harris-Forbes, J.A. (2001). Spirituality in rehabilitation counselor education: A pilot survey. *Journal of Rehabilitation*, 67, 55-60.

Jamison, J.E. (1995). Spirituality and medical ethics. *The American Journal of Hospice & Palliative Care*, 12, 41-45.

Judd, C., Smith, E., & Kidder, L. (1991). Research Methods in Social Relations 6th Ed. Orlando, FL: Holt Rinehart and Winston.

Kroeker, P.T. (1997). Spirituality and occupational therapy in a secular culture. *Canadian Journal of Occupational Therapy*, 64, 122-126.

Musgrave, C. F., Easly A.C., Gregory J.A. (2002). Spirituality and health for women of color. *American Journal of Public Health*, 92, 557-560.

Nosek, Margaret A., Hughes, Rosemary B. (2001). Psychospiritual aspects of sense of self in women with physical disabilities. *Journal of Rehabilitation*, 67, 20-25.

Piedmont, R.L. (2001). Spiritual transcendence and the scientific study of rehabilitation. *Journal of Rehabilitation*, 67, 4-14.

Spaniol, L. (2002). Spirituality and Connectedness. *Psychiatric Rehabilitation Journal*, 25, 321-322.

Stein, F., Soderback, I. (2000). Editorial: What is the future of research in occupational therapy in the 21st century? *Occupational Therapy International*, 7, 213-217.

Trieschmann, B. (2001). Spirituality and energy medicine. *Journal of Rehabilitation*. 67, 26-32

Underwood-Gordon, L., Peters, D.J., Bijur, P. & Fuhrer, M. (1997). Roles of religiousness and spirituality in medical rehabilitation and the lives of person with disabilities. *American Journal of Physical Medicine and Rehabilitation*, 19, 617-623.

Appendix A

Cover Letter

Dear fellow occupational therapist,

My name is Rebecca Wurm and I am a graduate student in occupational therapy at Ithaca College in Ithaca, New York. I am very excited to be sending you this survey that I have developed for the purpose of completing my thesis entitled, "Aspects of Spirituality in Occupational Therapy". Many of you may be aware that this topic has been getting a lot of attention in the OT literature during the last decade. Much of the literature has concluded that the topic of spirituality and its place in the OT practice is one of controversy and confusion. It is my hope that this study will shed more light as to how you, a practicing occupational therapist from Canada or the United States, feel about these issues. You have been randomly selected to complete this survey because you are a member of either the American Occupational Therapy Association (AOTA) or the Canadian Association of Occupational Therapy (CAOT).

This survey will ask you questions on your thoughts and opinions on several different issues pertaining to spirituality and how it relates to OT. The survey should take approximately 15 minutes for you to fill out and return. A pre-paid return envelope has been included for your convenience. If at anytime a question from this survey causes you to feel at all uncomfortable, you have the choice as to whether or not you complete the question. You can be confident that your answers to this survey will remain confidential and anonymous throughout the data analysis, and will be destroyed at the end of the research study.

Your prompt completion and return of this survey is vitally important to my study. Sending the completed survey back will imply your informed consent to participate in this study. If at any time you wish to withdraw from this study, or if you have any questions, feel free to contact me at the information listed below. I will be very grateful if you take a small amount of time from your busy schedule to complete this survey adding any comments you feel are necessary.

Thank you very much for your time and energy,

Rebecca Wurm, OTS
Rwurm1@ithaca.edu
(607) 272-8573

Survey

I. Practice Settings/Demographics

1. Please check your gender:
   _____Male _____Female
2. Please indicate your age:_____
3. Please check the area of practice that best describes your job:
   _____Academics _____Community-Based Care
   _____Home health _____Hospice care
   _____Inpatient _____Mental Health
   _____Nursing Home _____Outpatient
   _____Private Practice
   _____Other (please specify)_____
4. Please check all that apply:
   _____Bachelor's degree in OT _____Master's degree in OT
   _____Certificate in OT _____Doctorate in OT
   _____Doctorate in other field
   _____Specialty certification (please specify)_____
   _____Other (please specify)_____
5. _____Years in Practice
6. _____Practice Location (population):
   _____Rural (less than 10,000)
   _____Medium-size town (10,000-50,000)
   _____City or metropolitan area (greater than 50,000
7. The majority of the people I treat are between this age:
   _____18-30 _____31-55
   _____56-70 _____71+

II. Definition of Spirituality

Rank the following definitions in order of appropriateness for use in occupational therapy with #1 being the most appropriate and #4 being the least appropriate.

_____"The fundamental orientation of a person's life; that which inspires and motivates that individual."

_____"A pervasive life force, manifestation of a higher self, source of will and self-determination, and a sense of meaning, purpose and connectedness that people experience in the context of their own environment"

_____"Spirituality relates to our thoughts, feelings and actions concerning the meaning we make of our daily lives. That meaning is thought to be derived from relationships with ourselves, other people, other creatures, and for those who choose, a relationship with a Higher being."

_____"Spirituality refers to having a personal relationship with God or other deities that inspires and gives meaning and purpose to life."

III. Please circle the one number in each row that most closely reflects your views:

	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
1. I consider myself to be a spiritual person.	1	2	3	4	5	6
2. I consider myself to be a religious person.	1	2	3	4	5	6
3. My spirituality is an essential part of my life.	1	2	3	4	5	6
4. My spirituality assists me in performing my daily job responsibilities.	1	2	3	4	5	6
5. Spirituality is a fundamental aspect of being human.	1	2	3	4	5	6
6. I believe that spiritual well-being is an important component of good health.	1	2	3	4	5	6
7. Illness, disability, and crisis affect the spiritual lives of clients'.	1	2	3	4	5	6
8. A client's spirituality may influence his or her recovery.	1	2	3	4	5	6
9. Addressing spirituality issues is within the scope of the occupational therapy profession.	1	2	3	4	5	6
10. Gathering spiritual information about a client should be a part of an occupational therapy assessment.	1	2	3	4	5	6
11. Good occupational therapy practice must address the spiritual needs of a client.	1	2	3	4	5	6
12. Therapists should try to incorporate activities that allow clients to express spiritual needs and concerns into their programs.	1	2	3	4	5	6
13. It is appropriate for an occupational therapist to raise the topic of spirituality with a client.	1	2	3	4	5	6
14. Occupational therapists should address spirituality only if the client expresses interest first.	1	2	3	4	5	6
15. Occupational therapy education should prepare therapists to address the spiritual needs of their clients.	1	2	3	4	5	6
16. My academic training has not prepared me to deal with clients' spiritual needs.	1	2	3	4	5	6
17. My on-the-job training has not prepared me to deal with clients' spiritual needs.	1	2	3	4	5	6
18. I want more academic and on-the-job training about how I can better assist as an occupational therapist with clients' spiritual needs.	1	2	3	4	5	6

IV. In the space provided, please check the treatment techniques you feel are **appropriate for occupational therapy practice** and which treatment methods you have used in the past.

Treatment technique	Treatment technique is appropriate for OT						I use this treatment technique in my OT practice				
	Strongly disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree	Never	Rarely	Sometimes	Frequently	Always
1. Pray for clients.											
2. Use spiritual language and concepts with clients.											
3. Discuss with clients ways that their religious beliefs are helpful.											
4. Recommend participation in a spiritual group or activity.											
5. Encourage clients to consider the spiritual meaning and purpose of their current life situation.											
6 Use "healing touch" with clients.											
7 Help clients reflect on their beliefs about what happens after death.											
8. Pray with clients.											
9. Encourage clients to write in a spiritual journal.											
10. Recommend spiritual readings to your clients.											
11. Meditate with clients.											
12. Recommend religious readings to your clients.											
13. Participate in clients' spiritual ritual(s) during therapy.											
14. Participate in clients' religious ritual(s) during therapy.											
15. Help clients develop spiritual rituals during therapy.											
16. Explore spiritual meaning of occupations with clients.											

V. To what extent do the following items act as barriers to addressing spiritual issues with your clients? Circle one number in each row.

	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
1. My own discomfort with the subject matter.	1	2	3	4	5	6
2. Belief that addressing spirituality is not appropriate to the occupational therapists' role.	1	2	3	4	5	6
3. Concern that I will project my own beliefs onto clients.	1	2	3	4	5	6
4. Lack of experience or training in assessing spiritual needs of clients'.	1	2	3	4	5	6
5. Uncertainty about how to manage spiritual issues raised by clients.	1	2	3	4	5	6
6. Limited time for therapy overall.	1	2	3	4	5	6
7. Belief that spiritual issues must take a lower priority than more acute issues.	1	2	3	4	5	6
8. Belief that clients' do not want to share their spiritual concerns with their occupational therapist.	1	2	3	4	5	6
9. Limited length of treatment to develop rapport necessary to address spirituality effectively.	1	2	3	4	5	6
10. Difficulty in using appropriately understood language in discussion of spiritual issues.	1	2	3	4	5	6
11. Negative attitudes of peers toward addressing my clients' spirituality.	1	2	3	4	5	6
12. Lack of financial reimbursement for addressing spiritual needs of clients'.	1	2	3	4	5	6
13. Fear of conflict between my beliefs and the beliefs of my clients'.	1	2	3	4	5	6

VI. In the space provided, please write any responses to this survey, as well as any additional information you feel was not asked, or you feel may be pertinent to this study.

Thank You Very Much!

Table 1

Survey Questions Specifications

Question No.	Rationale	Reference
Section II	Research has highlighted that defining the term spirituality is one of the major sources of confusion for therapists, requiring more conclusive research.	CAOT, 1991;Egan & DeLaat, 1997; Taylor, 2000; AOTA, 2002;
Section III No. 1, 2 &4	Statements pertaining to therapists' values of their own spirituality have been one of the most consistent and important factors in the recent research.	Engquist et al., 1997; Rose, 1999; Taylor et al., 2000; Collins et al., 2001
Section III No. 2	Recent research has studied therapists' value of their own religiosity only through how the respondents chose definitions from a survey. The researcher felt it was necessary to include a question directly about the value of the therapists' religiosity.	Taylor et al., 2000
Section III No. 5-8	Statements pertaining to therapists' value of the human experience of spirituality have been a very important factor in recent literature, linking spirituality with the experience of disability.	Engquist et al., 1997; Rose, 1999; Taylor et al., 2000; Collins et al., 2001

Table 1 continued...

Section III No. 9-13	Therapists' feeling that it is appropriate to address spirituality within the context of OT practice is a central issue that recent research has highlighted as being somewhat controversial when compared to the frequency that therapists are addressing spirituality.	Engquist et al., 1997; Rose, 1999; Taylor et al., 2000; Collins et al., 2001
Section III No. 14	The topic of whether OT's should raise the topic of spirituality with all clients, or only address it if the client raises it has been a controversial topic in recent literature.	Engquist et al., 1997; Rose, 1999; Taylor et al., 2000;
Section III No. 15 & 18	Research has demonstrated mixed results having to do with therapists' feelings regarding spirituality being an aspect of OT education, and therapists' feelings about getting further education on the topic.	Engquist et al., 1997; Rose, 1999; Taylor et al., 2000;
Section IVa No. 16	The researcher and her committee designed this treatment technique because none of the other techniques addressed the important concept of addressing spirituality through occupation.	
Section IVb No. 1-15	How often therapists are using treatment techniques to address spirituality is a vital aspect of recent research, demonstrating how therapists are putting all of the knowledge and values of the concept of spirituality into practice.	Taylor et al., 2000, Collins et al., 2001

Table 1 continued...

Section IVb No. 16	How often therapists are using treatment techniques to address spirituality is a vital aspect of recent research, demonstrating how therapists are putting all of the knowledge and values into practice.	Taylor et al., 2000, Collins et al., 2001
Section V No. 1-12	Research has shown that occupational therapists are not addressing spirituality with great frequency, and also that specific barriers may be the cause of this. The researcher altered some of the wordings of the barriers to make them more understandable.	Collins et al., 2001
Section V No. 13	The fear of conflicting beliefs between client and therapist was added as a barrier because the researcher and her committee felt that this was an important concept that had not been previously addressed.	
Section VI	The researcher wanted to provide a section for respondents to add any additional comments related to the survey.	

Table 2

Definition Ranking Frequency Table

Ranking	Egan & DeLaat		Religious	
	Frequency	Valid Percent	Frequency	Valid Percent
Most appropriate	202	48.1	81	19.7
2nd most appropriate	120	28.6	52	12.6
3rd most appropriate	82	19.5	45	10.9
Least appropriate	16	3.8	234	56.8
Total	420	100.0	412	100.0

Table 2 continued...

Ranking	AOTA		CAOT	
	Frequency	Valid Percent	Frequency	Valid Percent
Most appropriate	100	24.4	57	13.9
2nd most appropriate	100	24.4	134	32.7
3rd most appropriate	116	28.4	158	38.5
Least appropriate	93	22.7	60	14.6
Total	409	100.0	410	100.0

Table 3

Perceptions Regarding Spirituality

Statements regarding spirituality	Percentages of Respondents					
	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
1. I consider myself to be a spiritual person.	.7	.9	1.6	13.3	43.6	39.9
2. I consider myself to be a religious person.	5.7	12.4	8.3	30.0	25.9	17.7
3. My spirituality is an essential part of my life.	.7	1.6	3.2	19.0	35.8	39.7
4. My spirituality assists me in performing my daily job responsibilities.	1.2	3.9	5.3	22.7	35.2	31.7
5. Spirituality is a fundamental aspect of being human.	1.2	1.4	3.9	19.7	38.2	35.6

Table 3 continued...

Statements regarding spirituality	Percentages of Respondents					
	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
6. Spiritual well-being is an important component of good health.	.7	.9	1.6	11.1	40.1	45.6
7. Illness, disability, and crisis affect the spiritual lives of clients.	.5	1.8	1.6	12.2	40.6	43.3
8. A client's spirituality may influence his or her recovery.	0	.5	1.6	9.2	40.2	48.5
9. Addressing spirituality issues is within the scope of the OT profession.	2.8	3.2	6.0	36.3	35.6	16.1

Table 3 continued...

Statements regarding spirituality	Percentages of Respondents					
	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
10. Gathering spiritual information about a client should be part of an OT assessment.	5.1	3.9	14.5	40.6	25.6	10.2
11. Good OT practice must address the spiritual needs of a client.	2.1	8.1	13.1	38.5	25.6	12.7
12. Therapists should try to incorporate activities that allow clients to express spiritual needs and concerns into their programs.	.7	4.6	9.0	36.9	35.7	13.1

Table 3 continued...

Statements regarding spirituality	Percentages of Respondents					
	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
13. OTs should address spirituality only if the client expresses interest first.	2.1	14.5	20.7	23.7	27.2	11.8
14. OTs should address spirituality only if the client expresses interest first.	2.1	14.5	20.7	23.7	27.2	11.8
15. OT education should prepare them to address the spiritual needs of clients.	2.3	4.1	7.1	27.1	41.1	18.3

Table 3 continued...

Statements regarding spirituality	Percentages of Respondents					
	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
16. My academic training has not prepared me to deal with clients' spiritual needs.	12.9	27.0	26.0	23.7	9.0	1.4
17. My on-the-job training has not prepared me to deal with clients' spiritual needs.	9.7	17.6	17.6	28.9	22.4	3.9
18. I want more academic and on-the-job training about how I can better assist as an OT with clients' spiritual needs.	6.7	13.6	15.5	33.5	24.5	6.2

Table 4

Cronbach Alpha test for internal consistency reliability of categories.

Categories	Number of items	Cronbach's Alpha
Therapists' value of their own spirituality	3	.907
Therapists' value of human experience of spirituality	4	.743
Spirituality as appropriate in OT practice	5	.917
Spirituality as appropriate in OT education	2	.737
Therapists' education in addressing spirituality	2	.619

Table 5

Correlation Between Categories and Years in Practice

Categories	T	Sig. (2-tailed)	N
	Years in Practice		
Therapists' value of human experience of spirituality	-.026	.596	417
Therapists' value of their own religion	.048	.326	428
Spirituality as appropriate in OT practice	-.074	.128	422
Spirituality as appropriate only if client initiates	-.038	.433	426

Table 6

ANOVA comparison of therapists' practice areas and categories.

ANOVA						
Categories		SS	df	MS	F	Sig.
Therapists' value of their own spirituality	Between groups	5.727	8	.716	.847	.562
	Within groups	357.471	423	.845		
	Total	363.197	431			
Therapists' value of their own religiosity	Between groups	8.962	8	1.120	.541	.825
	Within groups	883.754	427	2.070		
	Total	892.716	435			
Spirituality as appropriate in OT practice	Between groups	19.994	8	2.499	2.702	.007
	Within groups	389.406	421	.925		
	Total	409.400	429			
Spirituality as appropriate only if client initiates	Between groups	49.411	8	6.176	3.780	.000
	Within groups	694.371	425	1.634		
	Total	743.781	433			

Table 7

Perceived Barriers of Addressing Spirituality in OT

Barriers	Items act as barriers to addressing spiritual issues with clients					
	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
1. My own discomfort with the subject matter.	13.6	27.2	18.1	27.2	11.0	2.8
2. Belief that addressing spirituality is not appropriate to the OTs role.	10.4	24.1	24.3	24.1	11.8	5.4
3. Concern that I will project my own beliefs onto clients.	7.5	20.6	11.7	30.6	21.0	8.6
4. Lack of experience or training in assessing spiritual needs.	6.1	15.2	11.2	28.3	27.2	11.9

Table 7 continued...

Barriers	Items act as barriers to addressing spiritual issues with clients					
	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
5. Belief that spiritual issues must take a lower priority than more acute issues.	8.2	23.0	18.3	27.2	16.9	6.6
6. Belief that clients' do not want to share their spiritual concerns with their OT.	6.3	22.1	19.6	34.0	15.6	2.3
7. Limited length of treatment to develop rapport necessary to address spirituality effectively.	4.4	15.4	13.3	27.3	27.3	12.1
8. Uncertainty about how to manage spiritual issues raised by clients.	6.1	20.1	13.3	31.9	22.0	6.6

Table 7 continued...

Barriers	Items act as barriers to addressing spiritual issues with clients					
	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
9. Lack of financial reimbursement for addressing spiritual needs of clients'.	19.3	25.9	12.5	14.4	16.5	11.5
10. Limited time for therapy overall.	3.5	9.8	7.5	18.5	32.0	28.7
11. Difficulty in using appropriately understood language in discussion of spiritual issues.	6.1	20.1	17.1	31.4	19.0	6.3
12. Negative attitudes of peers toward addressing my clients' spirituality.	14.4	30.5	24.3	18.4	10.4	1.9
13. Fear of conflict between my beliefs and the beliefs of my clients'.	13.1	23.5	17.2	20.0	17.2	8.9

Table 8

Treatment Techniques Appropriate for Use in OT

Treatment technique	Treatment technique is appropriate for OT					
	Strongly disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
1. Pray for a client.	19.3	20.0	10.8	20.0	19.3	10.6
2. Use spiritual language and concepts with a client.	4.0	11.0	10.5	41.2	28.1	5.2
3. Discuss with client ways that their religious beliefs are helpful.	4.0	6.6	9.9	36.9	33.3	9.2
4. Recommend participation in a spiritual group or activity.	2.6	4.8	12.4	34.4	36.6	9.3
5. Encourage clients to consider the spiritual meaning and purpose of their current life situation.	5.0	6.2	12.1	35.3	30.1	11.4

Table 8 continued...

Treatment technique	Treatment technique is appropriate for OT					
	Strongly disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
6. Use "healing touch" with clients.	17.4	16.2	13.0	25.5	20.3	7.6
7. Help clients reflect on their beliefs about what happens after death.	9.8	13.2	16.3	33.8	19.9	7.0
8. Pray with a client.	22.6	19.2	19.7	25.5	9.7	3.4
9. Encourage clients to write in a spiritual journal.	4.5	8.6	10.0	42.2	29.1	5.5
10. Recommend spiritual readings to your clients.	14.2	18.8	20.7	29.1	13.9	3.4
11. Meditate with clients.	16.9	19.3	18.1	25.4	16.9	3.4

Table 8 continued...

Treatment technique	Treatment technique is appropriate for OT					
	Strongly disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
12. Recommend religious readings to your clients.	28.1	26.2	17.8	19.0	7.5	1.4
13. Participate in clients' spiritual ritual(s) during therapy.	21.9	21.0	22.2	24.1	8.9	1.9
14. Participate in clients' religious ritual(s) during therapy.	27.8	25.4	18.4	20.3	6.5	1.7
15. Help clients develop spiritual rituals during therapy.	20.4	22.8	19.4	24.9	10.6	1.9
16. Help clients explore the spiritual meaning of occupations.	7.1	8.6	11.2	34.0	26.4	12.6

Table 9

Treatment Techniques Used in OT Practice

Treatment technique	I use this treatment technique in my OT practice				
	Never	Rarely	Sometimes	Frequently	Always
1. Pray for a client.	39.5	14.8	29.8	14.0	1.9
2. Use spiritual language and concepts with a client.	17.1	23.4	46.7	11.6	1.2
3. Discuss with client ways that their religious beliefs are helpful.	18.3	27.2	41.1	12.7	.7
4. Recommend participation in a spiritual group or activity.	23.2	23.2	42.4	10.7	.5
5. Encourage clients to consider the spiritual meaning and purpose of their current life situation.	24.0	30.3	33.5	9.2	2.9
6. Use "healing touch" with clients.	60.0	11.0	15.2	10.8	2.9
7. Help clients reflect on their beliefs about what happens after death.	48.3	28.8	18.8	3.9	.2
8. Pray with a client.	68.9	21.0	9.2	.7	.2

Table 9 continued...

Treatment technique	I use this treatment technique in my OT practice				
	Never	Rarely	Sometimes	Frequently	Always
9. Encourage clients to write in a spiritual journal.	64.1	18.8	13.5	3.4	.2
10. Recommend spiritual readings to your clients.	67.7	19.5	10.8	1.9	0
11. Meditate with a client.	75.0	12.7	9.1	2.6	.5
12. Recommend religious readings to your clients.	81.5	13.0	5.3	.2	0
13. Participate in clients' spiritual ritual(s) during therapy.	80.2	13.8	5.3	.5	.2
14. Participate in clients' religious ritual(s) during therapy.	81.4	13.1	5.1	.2	.2

Table 9 continued...

Treatment technique	I use this treatment technique in my OT practice				
	Never	Rarely	Sometimes	Frequently	Always
15. Help clients develop spiritual rituals during therapy.	80.1	12.8	6.5	.5	0
16. Help clients explore the spiritual meaning of occupations.	43.0	24.0	22.6	7.5	2.9

Table 10

Comparison of appropriateness and utilization of treatment techniques

Treatment techniques	Z	p
1. Pray for a client.	-14.026	.000
2. Use spiritual language and concepts with a client.	-16.647	.000
3. Discuss with client ways that their religious beliefs are helpful.	-17.146	.000
4. Recommend participation in a spiritual group or activity.	-17.146	.000
5. Encourage clients to consider the spiritual meaning and purpose of their current life situation.	-16.963	.000
6. Use "healing touch" with clients.	-15.628	.000
7. Help clients reflect on their beliefs about what happens after death.	-16.293	.000
8. Pray with a client.	-15.231	.000
9. Encourage clients to write in a spiritual journal.	-17.190	.000
10. Recommend spiritual readings to your clients.	-16.014	.000
11. Meditate with a client.	-15.754	.000
12. Recommend religious readings to your clients.	-14.716	.000
13. Participate in clients' spiritual ritual(s) during therapy.	-15.418	.000
14. Participate in clients' religious ritual(s) during therapy.	-14.721	.000
15. Help clients develop spiritual rituals during therapy.	-15.538	.000
16. Help clients explore the spiritual meaning of occupations.	-16.818	.000

Table 11

Statements regarding spirituality that were insignificantly different between the two populations

Spirituality Statements	df	t	p	USA Mean	Canada Mean
1. I consider myself to be a spiritual person.	434	1.179	.239	5.21	5.11
3. My spirituality is an essential part of my life.	434	3.595	.702	5.08	5.04
4. My spirituality assists me in performing my daily job responsibilities.	430	.998	.319	4.86	4.74
5. Spirituality is a fundamental aspect of being human.	430	-.705	.481	4.97	5.04
6. I believe that spiritual well-being is an important component of good health.	432	.399	.690	5.27	5.23
7. Illness, disability, and crisis affect the spiritual lives of clients'.	432	-.367	.714	5.19	5.23
8. A client's spirituality may influence his or her recovery.	431	.348	.726	5.36	5.33
9. Addressing spirituality issues is within the scope of the occupational therapy profession.	433	-1.40	.162	4.42	4.58

Table 11 continued...

Spirituality Statements	df	t	p	USA Mean	Canada Mean
11. Good occupational therapy practice must address the spiritual needs of a client.	432	-.644	.520	4.13	4.21
12. Therapists should try to incorporate activities that allow clients to express spiritual needs and concerns into their programs.	432	.743	.458	4.44	4.37
17. My on-the-job training has not prepared me to deal with clients' spiritual needs.	326.482	.777	.438	3.52	3.42

Table 12

Perceived barriers that were insignificantly different between the two populations

Barriers	df	t	p	USA Mean	Canada Mean
1. My own discomfort with the subject matter.	424	-1.247	.213	2.98	3.15
3. Concern that I will project my own beliefs onto clients'.	426	.113	.910	3.64	3.62
4. Lack of experience or training in assessing spiritual needs of clients'.	425	-.419	.676	3.89	3.95
5. Uncertainty about how to manage spiritual issues raised by clients.	425	.287	.774	3.65	3.61
6. Limited time for therapy overall.	426	-1.549	.122	4.44	4.67
7. Belief that spiritual issues must take a lower priority than more acute issues.	425	-.152	.879	3.40	3.43
8. Belief that clients' do not want to share their spiritual concerns with their occupational therapist.	427	-.080	.937	3.37	3.38
9. Limited length of treatment to develop rapport necessary to address spirituality effectively.	426	-1.737	.083	3.86	4.10

Table 12 continued...

Barriers	df	t	p	USA Mean	Canada Mean
10. Difficulty in using appropriately understood language in discussion of spiritual issues.	425	-1.724	.085	3.48	3.72
11. Negative attitudes of peers toward addressing my clients' spirituality.	421	.821	.412	2.89	2.78
13. Fear of conflict between my beliefs and the beliefs of my clients'.	427	1.222	.222	3.38	3.19

Table 13

Appropriate treatment techniques that were insignificantly different between the two populations

Treatment Techniques	df	t	p	USA Mean	Canada Mean
2. Use spiritual language and concepts with a client.	418	.927	.354	3.98	3.87
4. Recommend participation in a spiritual group or activity.	419	.544	.586	4.28	4.21
5. Encourage clients to consider the spiritual meaning and purpose of their current life situation.	420	-.162	.872	4.13	4.15
9. Encourage clients to write in a spiritual journal.	417	.450	.653	4.11	4.01
10. Recommend spiritual readings to your clients.	414	1.362	.174	3.26	3.07
11. Meditate with a client.	412	1.326	.186	3.23	3.03
13. Participate in clients' spiritual ritual(s) during therapy.	413	.968	.333	2.87	2.74
15. Help clients develop spiritual rituals during therapy.	415	-.244	.807	2.87	2.91

Table 14

Utilization of treatment techniques that were insignificantly different between the two populations

Treatment Techniques	U	p
2. Use spiritual language and concepts with a client.	-.416	.677
3. Discuss with clients ways that their religious beliefs are helpful.	-.865	.387
4. Recommend participation in a spiritual group or activity.	-.280	.780
5. Encourage clients to consider the spiritual meaning and purpose of their current life situation.	-.640	.522
9. Encourage clients to write in a spiritual journal.	-1.743	.081
10. Recommend spiritual readings to your clients.	-.233	.816
13. Participate in clients' spiritual ritual(s) during therapy.	-1.777	.076
15. Help clients develop spiritual ritual(s) during therapy.	-.092	.927

Figure 1

Canadian and American ranking of AOTA definition

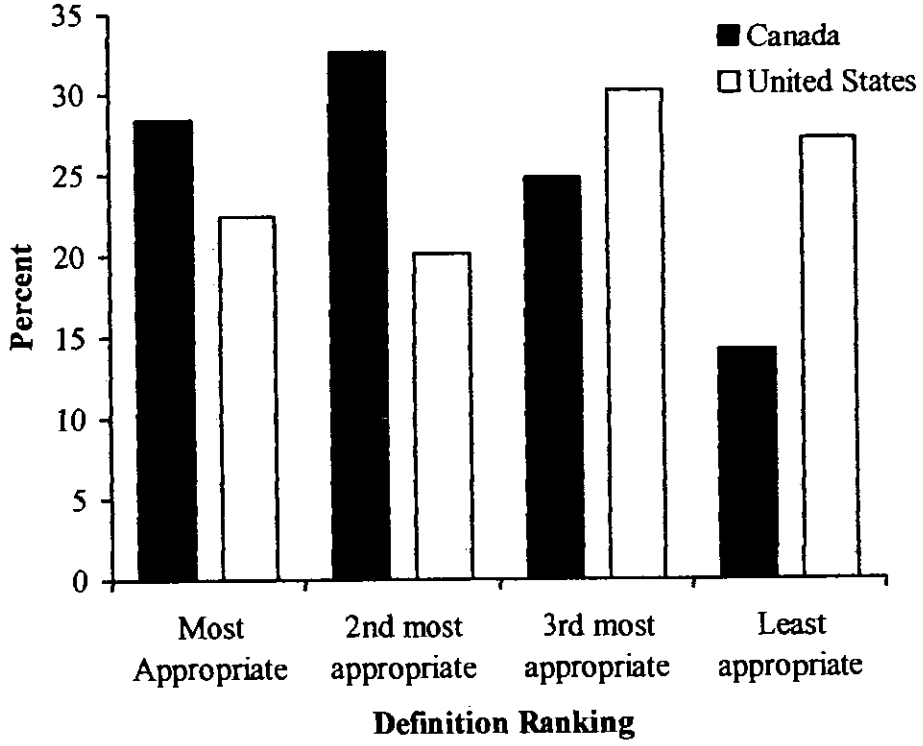

Figure 2

Canadian and American ranking of CAOT definition

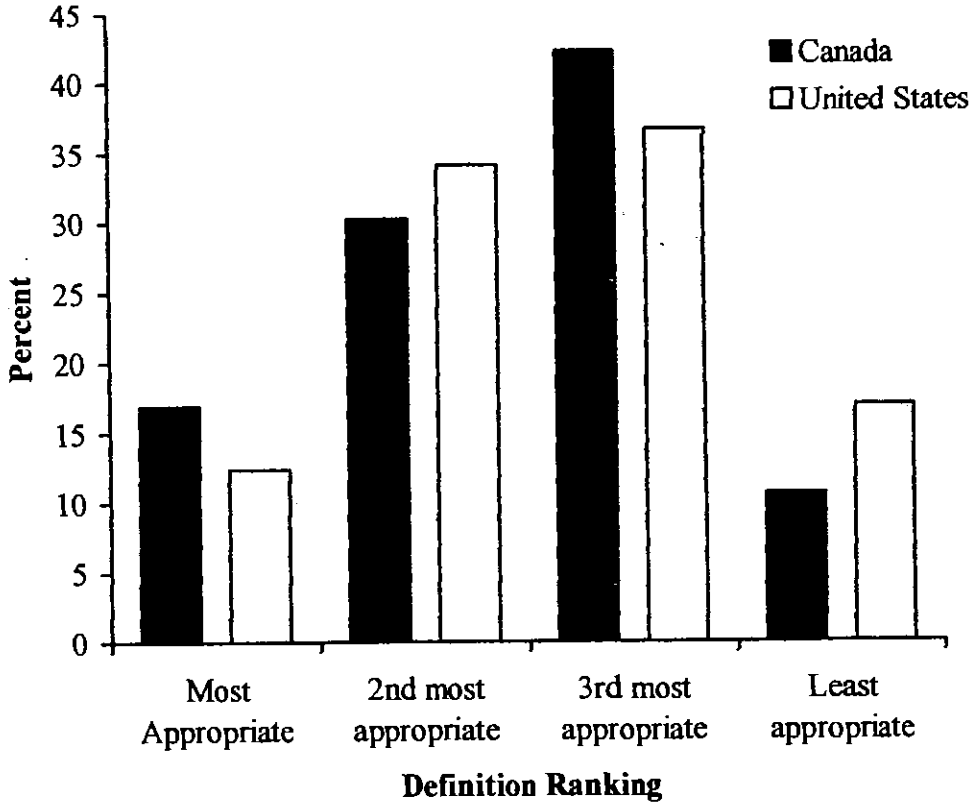

Figure 3

Canadian and American ranking of Egan & DeLaat definition

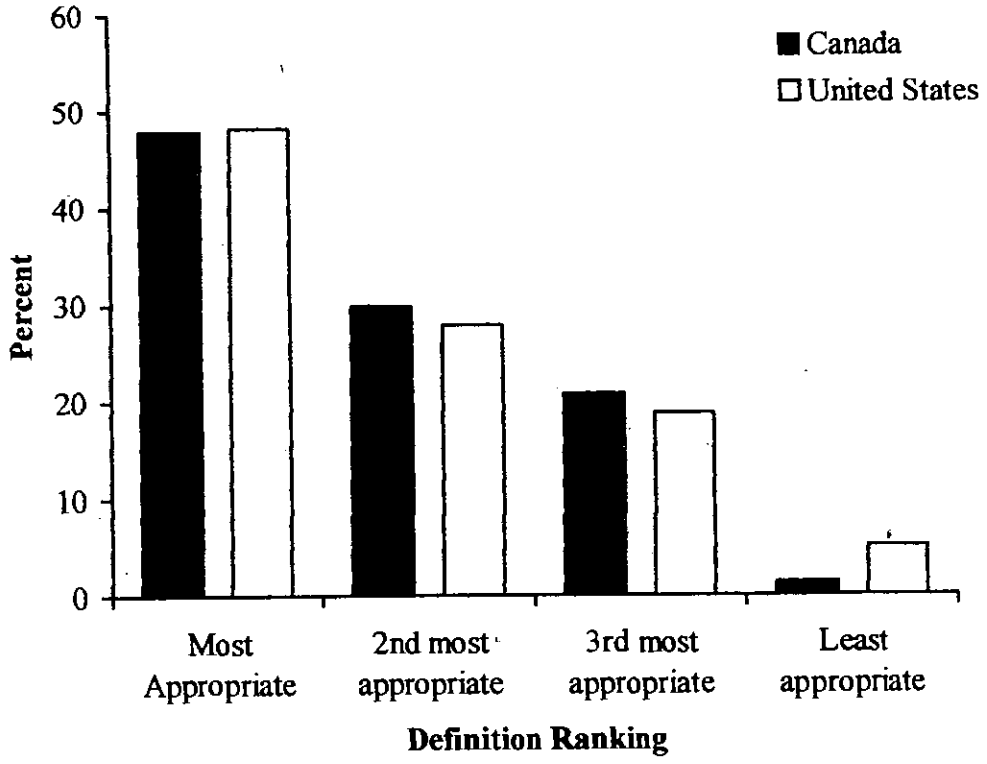

Figure 4

Canadian and American ranking of religious definition

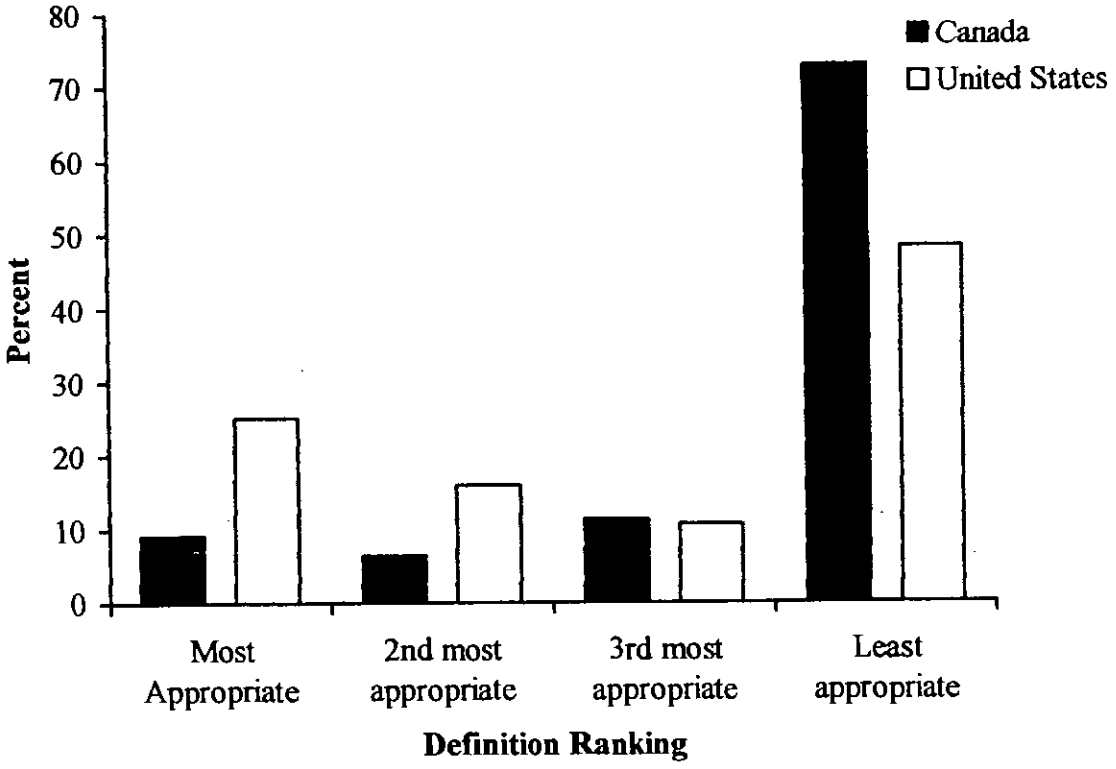

Figure 5

Canadian and American use of treatment technique: Pray for clients

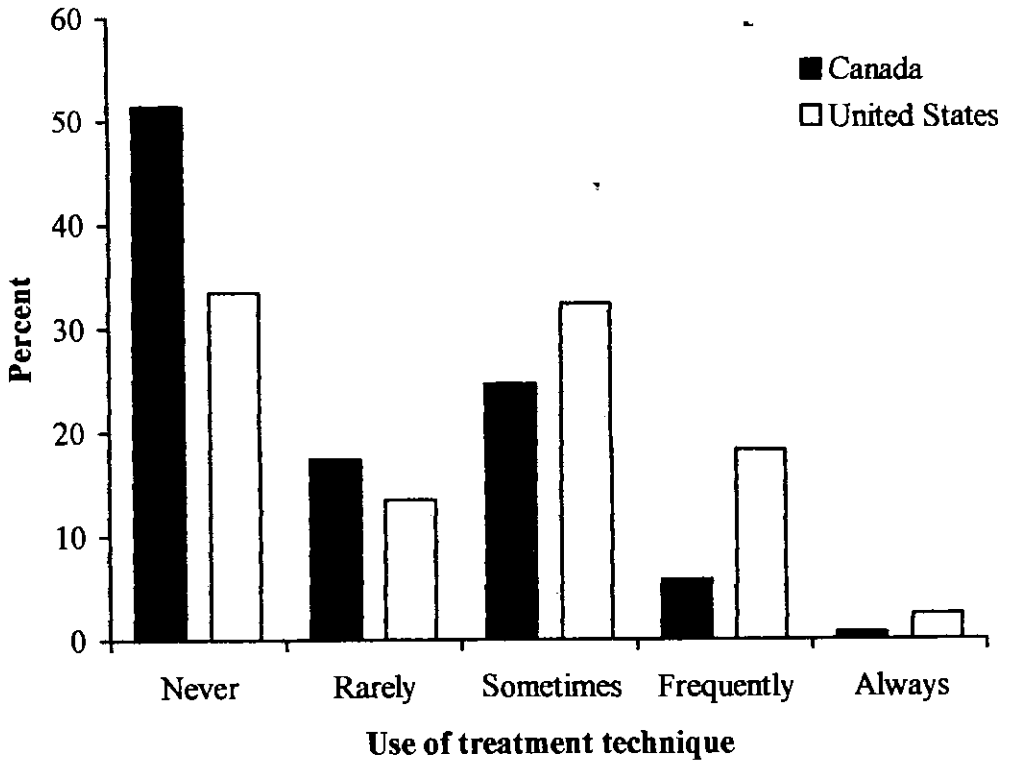

Figure 6

Canadian and American use of treatment technique: Use "healing touch" with clients

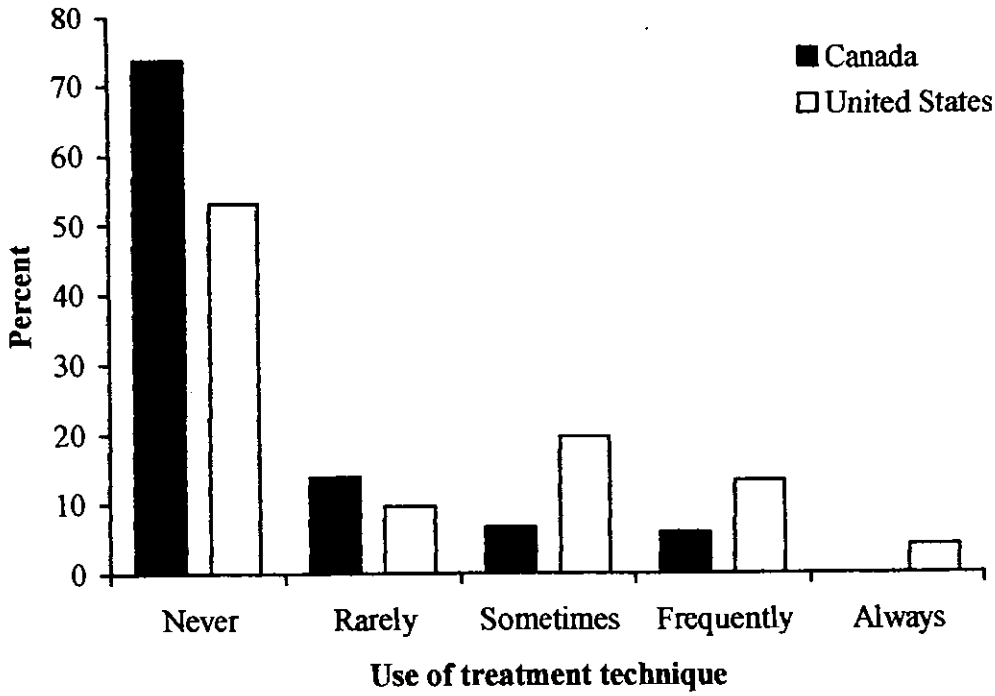

Figure 7

Canadian and American use of treatment technique: Help clients reflect on beliefs about what happens after death

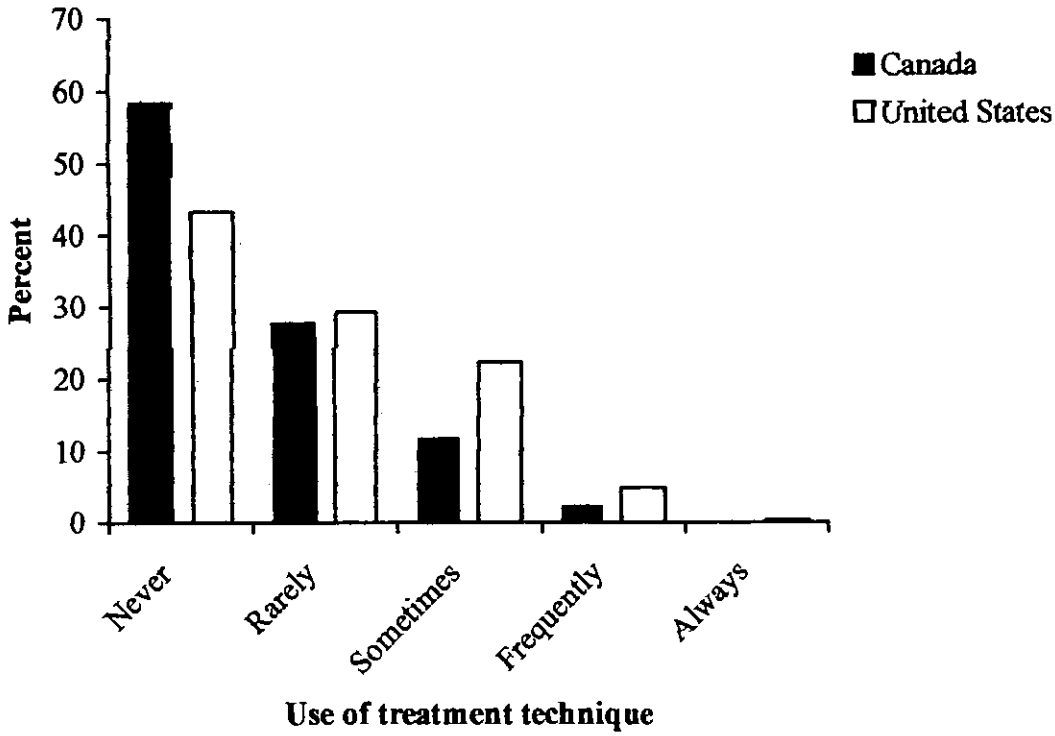

Figure 8

Canadian and American use of treatment technique: Pray with clients

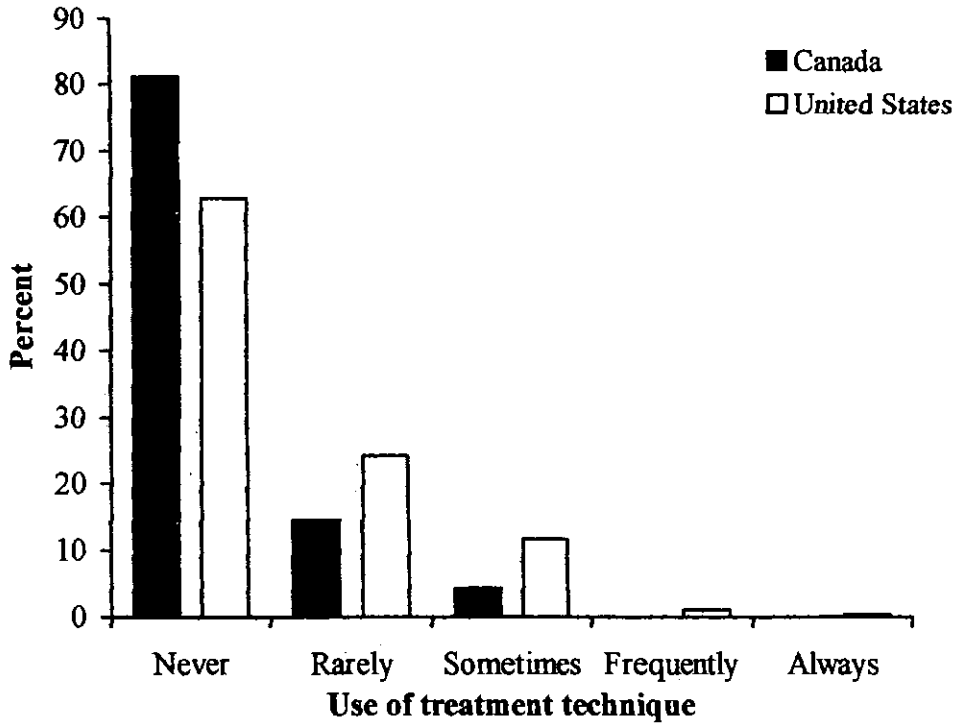

Figure 9

Canadian and American use of treatment technique: Meditate with clients

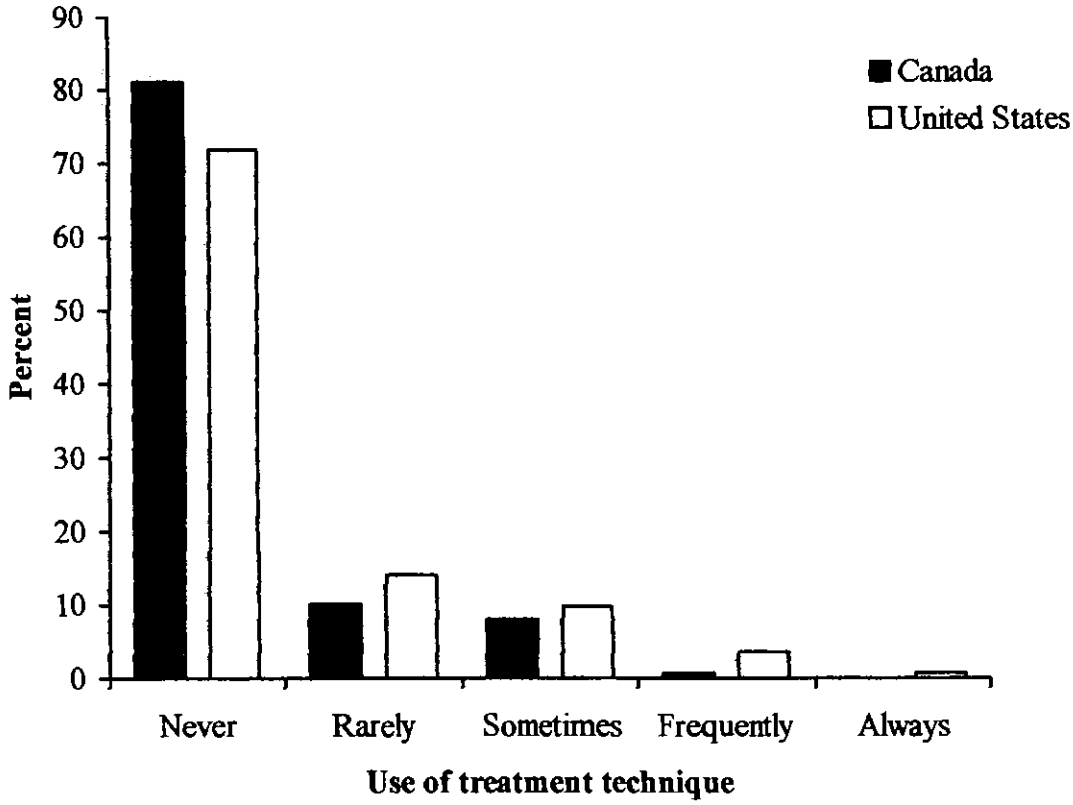

Figure 10

Canadian and American use of treatment technique: Recommend religious readings to clients

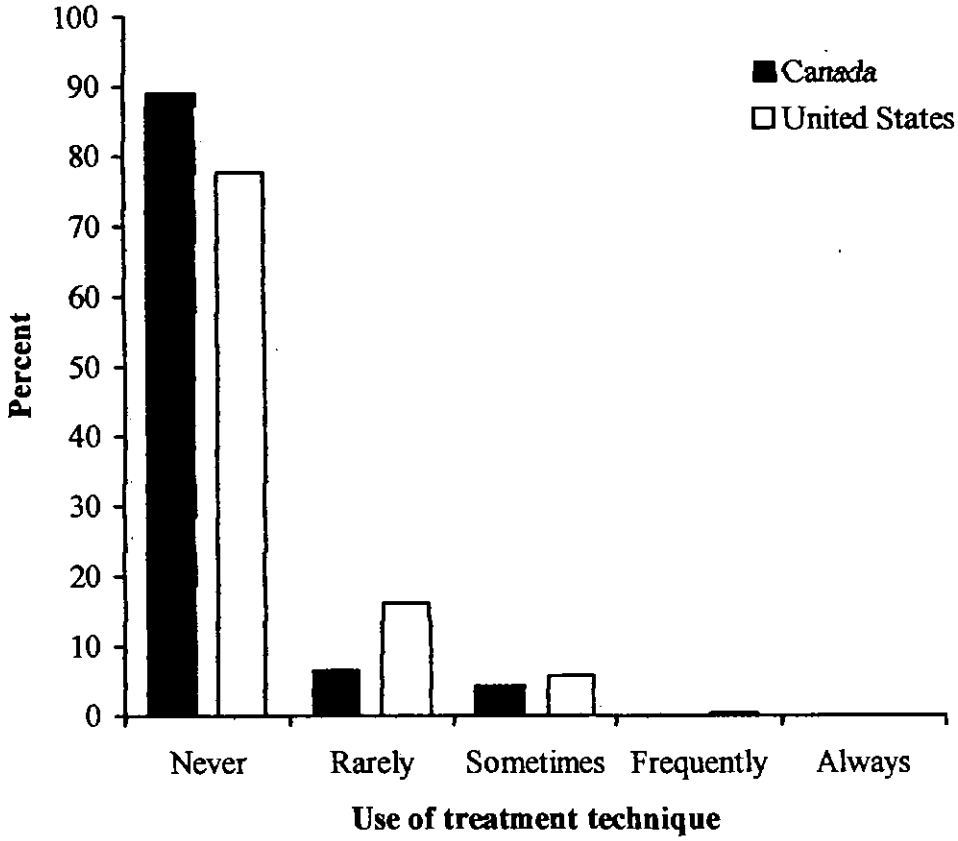

Figure 11

Canadian and American use of treatment technique: Participate in clients' religious rituals during therapy

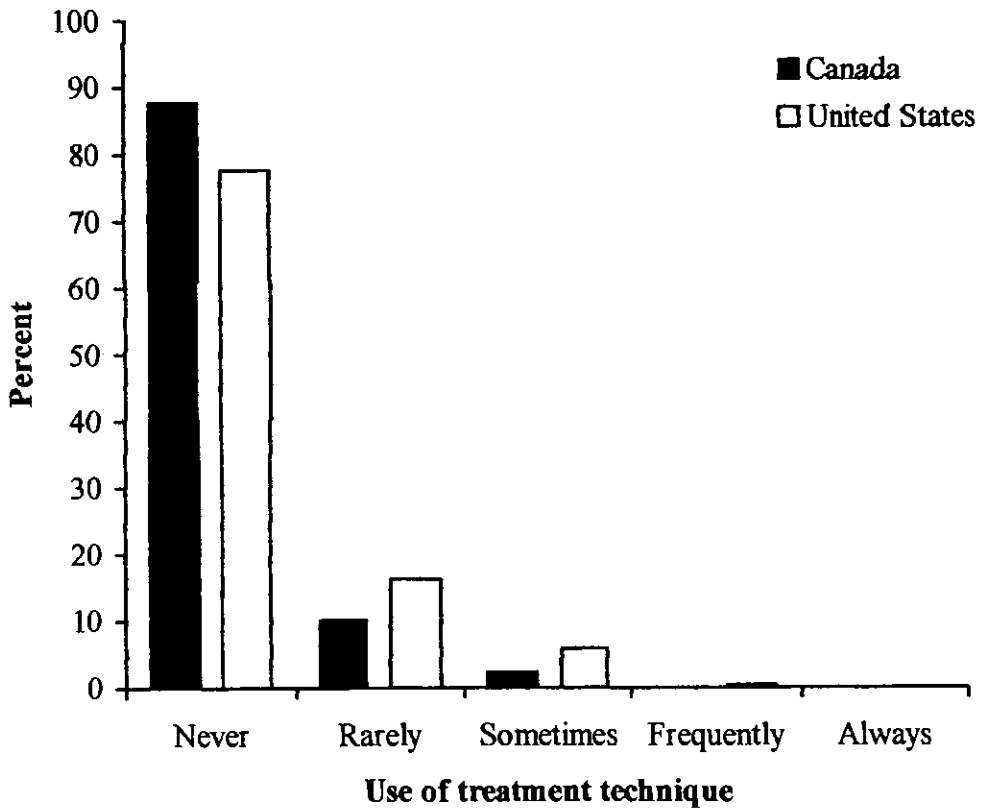

Figure 12

Canadian and American use of treatment technique: Explore spiritual meaning of occupations with clients

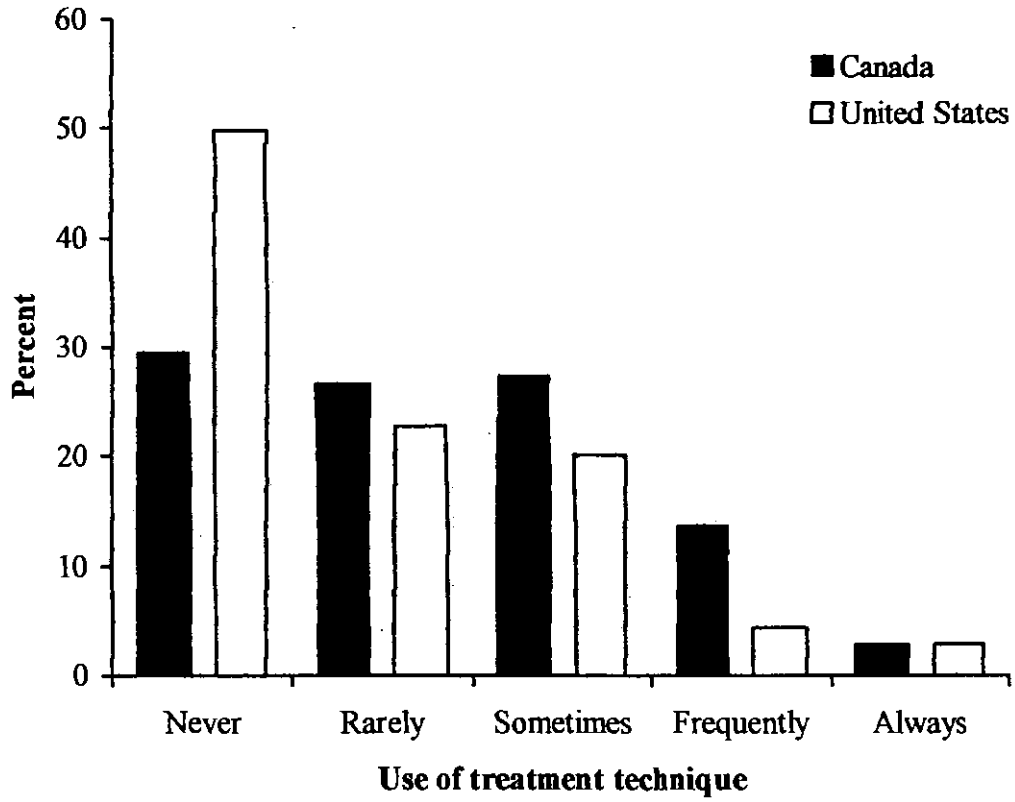

Figure 13

Appropriateness of bringing up topic of spirituality with clients

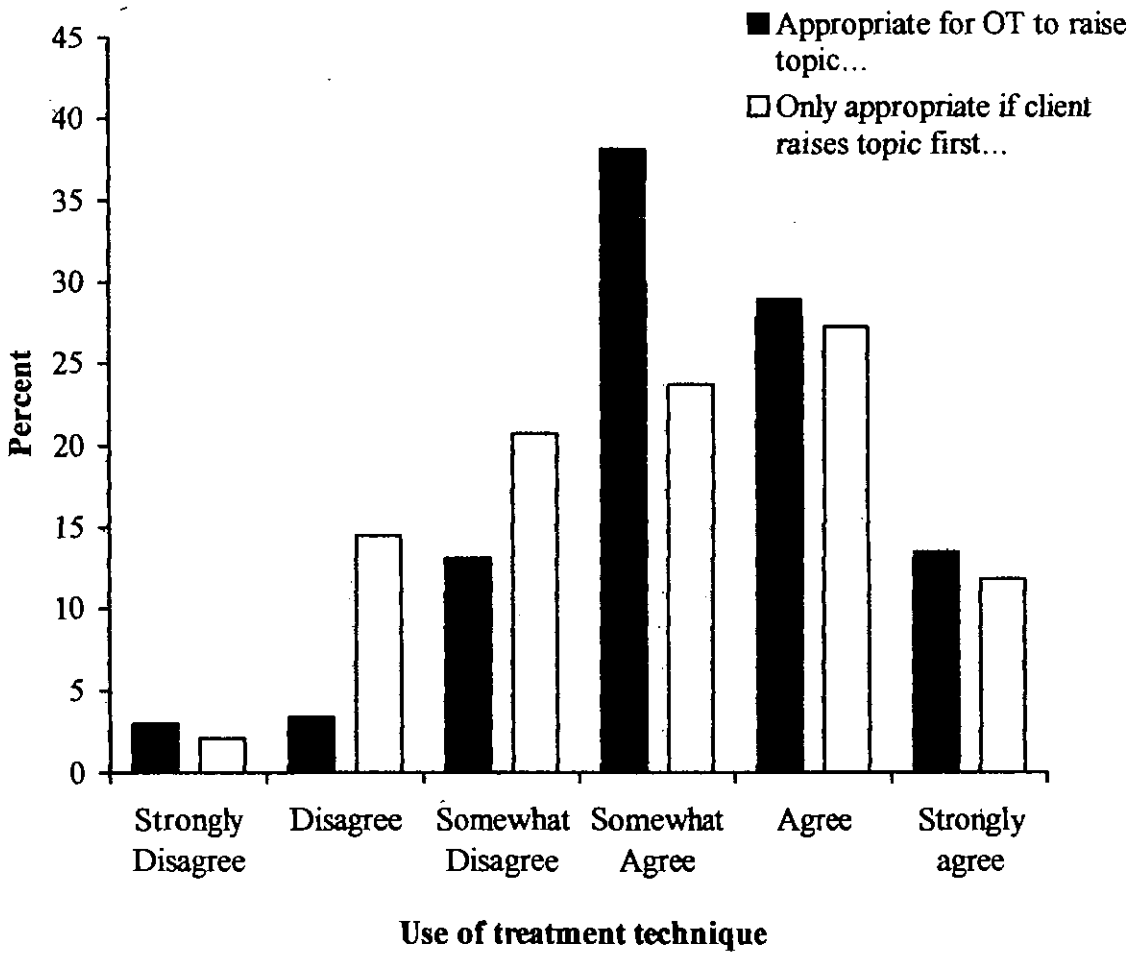

Figure 14

Therapists' sense of preparedness for addressing spirituality

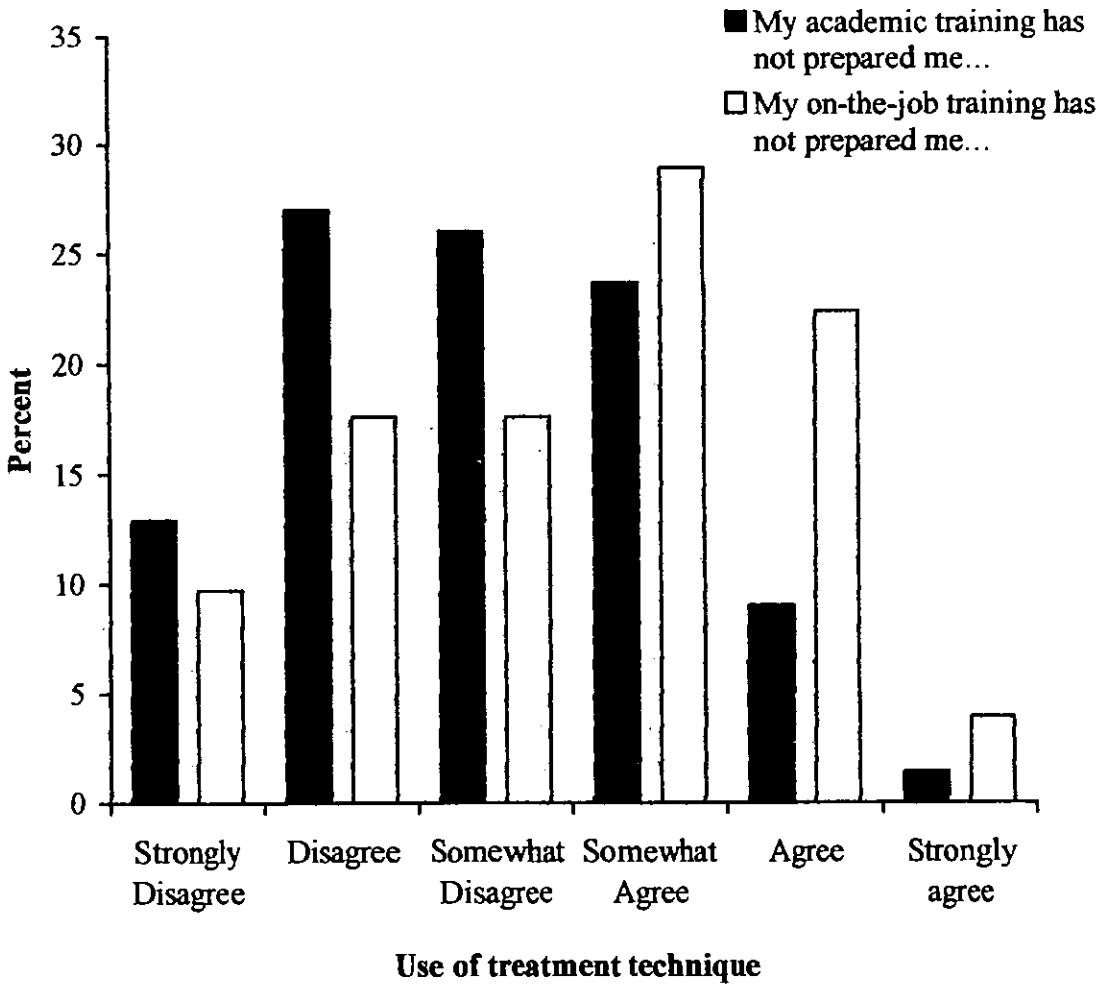

Figure 15

Appropriateness of spirituality in OT education