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**A QUALITATIVE STUDY EXPLORING HOW
OCCUPATIONAL THERAPISTS EMBED SPIRITUALITY
INTO THEIR PRACTICE**

JANICE ELIZABETH JONES

**A thesis submitted to the University of Huddersfield in partial fulfilment of the
requirements for the degree of Doctor of Philosophy**

The University of Huddersfield

JANUARY 2016

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Abstract

Introduction

Spirituality is a concept central to healthcare practice, and in particular to occupational therapy. As a profession, influenced from early Judeo-Christian religious beginnings, occupational therapy has retained yet translated this as a commitment to holistic, person-centred practice. Occupational therapy holds the uniqueness of the individual, and meaningful and purposeful expressions of health and well-being through occupation, as central to professional practice. Set in the context of 21st century healthcare, this thesis explored how occupational therapists (n=4) working in the English National Health Service (NHS) embedded spirituality into daily practice.

Methods

Two studies were undertaken, first a structured literature review and concept analysis, applying the method outlined by Walker & Avant (2011), to conceptualise spirituality as described in occupational therapy practice. Second, a qualitative study was undertaken, underpinned by an ethnographic approach, using participant-as-observer observation and follow up interviews to explore how occupational therapists embedded spirituality into everyday practice. Framework approach was used to guide analysis and interpret the large volume of unstructured textual data.

Findings

Despite the difficulties defining spirituality occupational therapists appeared able to apply the underpinning core values and philosophy of the profession and embed spirituality in their practice. Practitioners found it more meaningful to describe spirituality in terms of how they applied the concept in, and through, practice by comprehending the values, needs and concerns of the individual as opposed to a consistent definition. Occupational therapists engaged with spirituality by concerning themselves with supporting patients experiencing vulnerability due to disruption in their health and well-being. This support was achieved by the occupational therapist uncovering the individual needs of the patient and through delivering person-centred care by explicitly addressing spirituality. The scope to embed spirituality was on occasion limited by organisational and contextual factors that restricted the potential to practice fully. Achieving organisational targets by adopting time constrained interventions was perceived as having a particularly limiting impact on embedding spirituality in practice.

Conclusion

The Embedding Spirituality into Occupational Therapy (ESpiOT) model which emerged from the findings of this study is offered as a tool to guide practice, education and research into how spirituality is, and could be, embedded into occupational therapy practice.

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List of abbreviations

AOTA (American Occupational Therapy Association)

CAQDAS (Computer assisted methods of qualitative data analysis)

CAOT (Canadian Association of Occupational Therapists)

CMOP-E (Canadian Model of Occupational Performance and Engagement)

COT (College of Occupational Therapists)

DH (Department of Health)

ESpiOT (Embedding Spirituality into Occupational Therapy model)

HPC (Health Professions Council)

HCPC (Health and Care Professions Council)

IRAS (Integrated Research Application System)

LREC (Local Research Ethics Committee)

MOHO (Model of Human Occupation)

NCHSPCS (National Council for Hospice and Specialist Palliative Care Services)

NHS (National Health Service)

NIHCE (National Institute for Health and Clinical Excellence)

NRES (National Research Ethics Service)

PSI (Psycho Spiritual Integration)

RCN (Royal College of Nursing)

SSIG (Spirituality Special Interest Group)

SREP (School of Human and Health Sciences Ethic Panel)

SRV (Social Role Valorisation)

SWBS (Spiritual Well-being Scale)

UK (United Kingdom)

WFOT (World Federation of Occupational Therapists)

WHO (World Health Organisation)

WHOQOL SRPB (The World Health Organisation Quality of Life Spirituality, Religion and Personal Beliefs group)

Chapter One

Background and context

1. Introduction

This PhD thesis focussed on how occupational therapists embed spirituality into everyday clinical practice. This chapter begins by outlining my personal interest in spirituality and occupational therapy practice, embedding my journey which underpins this study at the outset of this thesis. The chapter continues with an exploration of the evolution of the concept of spirituality in healthcare practice. More specifically, the rich historical traditions, socio-political and philosophical influences of occupational therapy practice will be drawn. Definitions of occupational therapy and occupational will be offered to provide conceptual clarity. Definitions of spirituality for occupational therapy practice based on the current evidence are only briefly considered; as these are explored in depth in Chapter Two, a concept analysis of the meaning of spirituality in occupation therapy practice. A range of occupational therapy models and their underpinning key theories were evaluated in relation to how spirituality was addressed and applied to occupational therapy practice: The Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007) (refer to page 58), Model of Human Occupation (Kielhofner, 2009) (refer to page 61) and the Kawa Model (Iwama, 2006) (refer to page 63) are outlined in this first chapter. In addition to these models, the Psychospiritual Integration Frame of Reference for occupational therapy (Kang,2003) was used to scaffold the concept analysis findings and illuminate how the existing literature informs occupational therapy practice (refer to pages 56, 68-71). My personal perspectives that underpinned the motivation for undertaking this work will be offered. Finally, the chapter concludes with an overview of the thesis chapters.

1.1 Personal interest in the study of spirituality and occupational therapy practice

I approached this study from a personal expression and experience of spirituality in the Christian faith tradition, more recently lived out as a companion member of the Northumbria

Community. The Northumbria Community is a dispersed Christian community, drawing inspiration and rule of life from the Celtic saints and the locality of Northumberland centred on the Holy Island on Lindisfarne. This influences the lens through which I view spirituality, but for me spirituality is not exclusively a religious construct in practice. As an occupational therapist, of 35 years' experience, I have considered my practice to be holistic; considering the body, mind and spirit interaction to be essential to person-centred care. I have been committed to person-centred collaboration in a variety of physical disability and health contexts, helping people achieve their goals and desired outcomes. I qualified as an occupational therapist in 1980 and entered the profession at the height of its paradigm crisis and reductionist practice. It was the era of the professional holding the power of knowledge and knowing what was best for patients. Patients were engaged in therapeutic interventions for the objective value of the exercise as opposed to whether it was meaningful for them. This was the height of the era of functionalism where activities of daily living and home visits to provide equipment were seen as our expertise. I left occupational therapy during the mid-1980's for ten years and during some of this period lived in Nigeria with my family. This period of time living in West Africa was formative in embedding a cultural competence that I have drawn on many times in my subsequent return to occupational therapy practice. Amongst the cultural experiences of living alongside my Nigerian neighbours, I was struck by how they experienced the relationship between health and an individual's spirituality. I returned to the profession in the mid 1990's at the advent of the contemporary paradigm and the renewal of commitment to occupation-focused practice, the reason I had entered the profession in the first place.

My interest in spirituality developed much later in my career, in the new millennium, when I was challenged to embed spirituality in my practice following a peer review of assessments in a hospice. The standard occupational therapy assessment did not specifically address spiritual needs. Yet, working in a hospice, these were particularly relevant as end of life existential issues and anxieties challenged patients' own sense of meaning and values. From

the occupational therapy point of view, this provided the ideal opportunity to reflect on practice that engaged a person with occupations that embedded the spiritual constructs of meaning and purpose. Teaching the management of breathlessness techniques to individuals who wanted to perform prayers and other significant meaningful occupations were examples of what could be done.

Entering higher education provided two further strands to explore spirituality from the perspective of pre-registration occupational therapy students, and considering the wider issues of spirituality in healthcare education. First, in the education of occupational therapy students, teaching spirituality and occupation and engaging students in the subject that was often conflated with religion was challenging (Kirsh, Dawson, Antolikova & Reynolds, 2001). This led to a master's research study exploring the experience of undergraduate occupational therapy students developing the concept of spirituality in clinical practice (Jones, 2008). A key finding of this study was that students found they had positive experiences of relating the theory of spirituality to practice and this was reinforced by academic work to apply models to case studies. They expressed a number of opportunities for addressing spirituality while on their practice placements, some examples requiring them to consider their cultural competency. However, they were concerned that they might not be able to practice holistically when they were qualified practitioners owing to time pressures they observed their occupational therapy practice educators managing.

This master's research study was the inspiration to progress further and research what spirituality looked like in occupational therapy practice from a practitioner's perspective. My ideas were reinforced by a comment from an occupational therapist working in an Accident and Emergency department, following the presentation of the study at the College of Occupational Therapists Annual Conference (Jones, 2009). The delegate suggested that the presentation of findings had reassured and inspired her that her practice in a very fast paced; medically led service was embracing the concepts of spirituality. This inspired me to explore

occupational therapy practice in areas of practice where embedding spirituality would be considered challenging.

The impetus to explore spirituality further and what it means to occupational therapists was further inspired when I came across the doctoral work of Linda Finlay at the beginning of my doctoral studies. Linda's doctoral thesis, entitled *The Life World of the Occupational Therapist: meaning and motive in an uncertain world* (Finlay, 1998), illuminates the concept of holism and how in the late 1990's it was translated into occupational therapy practice. Her study employed participant observation and interviewing to gather data from occupational therapists in a phenomenological study. My study builds on Finlay's (1998) research. Her findings suggest that occupational therapists value holism but are uncertain how to translate it to practice. A tension existed between therapists' aims to practice holistically and service demands. This, she argued, demanded a more reductionist approach be employed (Finlay 2001). The theme of holism was considered broadly and not in its component parts of mind, body and *spirit*. The absence of directly considering the *spirit* lead me to consider the comparison between my own experiences of occupational therapy practice, my students and the findings of Finlay's study and how spirituality needed to be explored in more depth.

Second, a group of likeminded lecturers and associates formed the Spirituality Special Interest group in the School of Human and Health Sciences at the University. A mixed methods research study was carried out by the group to identify the healthcare teaching staff's understanding of spirituality and how it influenced their teaching (Prentis, Rogers, Wattis, Jones & Stephenson, 2014). The study demonstrated that, whereas spirituality was considered relevant to the participants' disciplines, it was only integrated into the curricula by a minority of them.

The significant issues from my personal experience of embedding spirituality in occupational therapy practice are as follows:

- How occupational therapists practicing in the 21st century embed spirituality in their day to day practice;
- What occupational therapy practice looks like with spirituality embedded and the impact on students' education;
- How spirituality is enacted in the curriculum of healthcare professions to prepare them for 21st century practice.

These experiences from practice and education have influenced the development of this thesis which aims to address one of these questions: how occupational therapists embed spirituality in their everyday practice? This research question and the aim and objectives of the study reported in this thesis are positioned at the end of this chapter in section 1.7, page 65.

1.2 Evolution of the concept of spirituality

The concept of spirituality has been debated in recent years from a range of perspectives including political, business, education, art, music and health and social care. The word spirituality is nebulous and often lacking clarity in its application. Rooted in the Latin and Greek words, *spiritualis* and *pneuma* – both of which relate to breathing - the term spirituality conveys images of life, and is often used to describe the unique spirit of an individual, their life force, the essence and energy of their being (Clarke, 2013). Originally exclusive to religious contexts and theology, spirituality conveyed the values and meanings of a person's worldview and inner strength to achieve their personal potential. From a theological perspective, the contemporary use of the word spirituality and its detachment from religious roots and traditions has led to difficulties defining spirituality (Sheldrake, 2013). Recent applications of the term spirituality to health and social care have included a heightened focus on individualism, enacted through subjective expressions of internal resources that emphasise the uniqueness of the individual and their experiences (Clarke, 2013). It has been suggested that the increased interest, and seeking spiritual dimensions in people's lives, is a way of finding meaning, purpose and answers in the face of global issues of instability and as a response to a perceived existential

threat (Clarke, 2013). This thesis was undertaken in the context of national and international events influencing society between 2010 and 2015, a period of economic instability following a global economic and political crisis, ongoing conflict and acts of terrorism, and significant natural world disasters such as earthquakes and tsunamis.

1.2.1 The importance of worldviews and spirituality

The concept of worldview is important for defining spirituality as it describes a culturally determined set of assumptions that influence society which are prevalent at a particular time in history (Martsof & Mickley, 1998). Worldview has been defined as, "...underlying assumptions about life and reality that encompasses ethics, values, beliefs, faith, spirituality and motivation," (Wolters, 1989, p.16). In relation to spirituality, and in particular religion, world views shape our understanding of reality and understanding of God (Borg, 2003). Over time, expressions of spirituality have been influenced by a range of worldviews, which have informed thinking and understanding of the world. In western culture, three worldviews, that span the early seventeenth century to present day and have been influential in shaping society can be characterised as: Enlightenment, Modernist and Post-Modernist. These worldviews provided context for the historical development of the concept of spirituality.

Prior to the Enlightenment, in the dominant western worldview, religion was pivotal to an individual and their communities' experiences of life together. Greater significance was placed on the spiritual dimension of illness with institutionalised healthcare provided by religious communities of monks and nuns (Wilcock & Hocking, 2015). The Enlightenment also referred to as the Age of Reason, in the seventeenth and eighteenth centuries, replaced the spiritual view of health with a more scientific paradigm. The sociological background of this era was framed by a move away from an agricultural way of life, dependent on the land and home industries, to one of industrial development and scientific advancement. In the background, religious conflict following the turbulence of the Reformation abounded (Skinner, 1978). Philosophers of the time advocated that scientific rationalism would replace religion as the

source of all knowledge; with the scientific and religious worlds in opposition (Creek, 1997; Wilcock, 2000). This opposition posed a challenge to previous intrinsic links between a person's health, and their spiritual and religious worlds.

Through society's understanding of science, from the late nineteenth century up until the late twentieth century, Modernism pervaded and included the rapid growth of urbanisation. The impact of the First World War on society was devastating as the deaths and casualties were phenomenal in comparison to previous combats (Gregory, 2008). The return of severely injured and disabled soldiers to the United Kingdom (UK) heightened the need for occupational therapists to provide rehabilitation programmes. At this time 'occupation for reconstruction' emerged based on the founding principles of science informing reconstructive interventions (Gutman, 1995; Schemm, 1994). Scientific interventions applied to rehabilitation were founded on the principles of the movement analysis of machines in order to rehabilitate the war disabled back to work (Wilcock, 2002). This reductionist scientific approach, and alignment with the medical model, adopted by the occupational therapists was popular with the government and a necessity post war. However, challenged the underlying professional principles of meaningful occupation to improve an individual's functional capacity (Gutman, 1995; Friedland, 1997).

During the Modernist period there was an optimism that science would solve the world's problems and, at least for some, a belief that rational thinking removed the need for spirituality or religious belief (Weinblatt & Avrech-Bar, 2001). The dominance of gaining scientific knowledge was prevalent in many health professions, including occupational therapy. The occupational therapy profession adopted a reductionist approach to practice in order to align the profession with medicine and gain recognition for the value of occupational therapy interventions in an era of the scientific developments dominating healthcare (Friedland, 1997; Wilcock, 2002). During the mid-20th century, a drift away from, and subsequent loss of connection to, the spiritual dimensions of care was influenced by the dominant biomedical model (Engel, 1977; Christiansen & Haertal, 2014). This model was underpinned by scientific

disciplines including pathology and pathophysiology not necessarily taking into account the complexity of human experiences. This reductionist approach, to healthcare focussed on physical illness rather than a holistic approach incorporating physical, mental, social and spiritual well-being.

A reductionist approach to healthcare continued to dominate health professional practice over the mid and later part of the 20th century influencing the development of occupational therapy (Mayers, 2000). Practising in a reductionist, task-orientated, target driven environment was contrary to occupational therapy core philosophies and ethical values espoused in meaningful and purposeful occupations as the therapeutic medium to achieve health and well-being (Hocking, 2008). However, the modernist period was formative in the development of treatments, and influential in establishing the need for healthcare interventions and practice to be based on the best possible evidence. Advances in occupational therapy practice during this period had a positive impact on the development of specialisms in the profession (Wilcock, 2002). An influential occupational therapist, Mary Reilly, led the resurgence of the occupational therapy profession to re-establish its roots to embedding meaningful and purposeful occupation in practice (Reilly, 1922). Famously she re-acclaimed and framed the importance of the links between health and occupation within occupational therapy practice, "*Man, through the use of his hands as they are energised by mind and will, can influence the state of his own health*" (Reilly, 1922, p.2). Reilly's work emerged at a time when there was a shifting of the context of holistic occupational therapy practice to the reliance on underpinning biomedical practices. Her philosophy of occupational behaviour, espousing a holistic view of individuals and their daily occupation, and the subsequent occupational behaviour frame of reference was seminal in the development of The Model of Human Occupation. The Model of Human Occupation was one of the first occupation focused models of occupational therapy practice (Kielhofner, 1980). Additionally, during this period influential occupational therapy academics and theorists were becoming dissatisfied with the reductionist view of occupational therapy practice. A return to the core values of the profession was being advocated, and change in

occupational therapy theory initiated through the development of occupational therapy models (Kielhofner & Nicol, 1989; Hubbard, 1991). These models of practice re-focused the profession back on the core values and philosophies of holistic, patient-centred practice, embedding occupation for the advancement of an individual's health (Kielhofner, 2008; Duncan, 2011).

Post-modernism, emerging in a period dating from the late 20th century, presented a radical change in thinking with a freedom from being bound to the aspiration of needing to know all the answers (Weinblatt & Avrech-Bar, 2001). There was the recognition that a reductionist approach to health, although useful in some situations, was not the only framework for practicing healthcare. Although knowledge and progress was made in terms of health improvements, an inability to find causes and cures for all diseases, address world poverty and prevent wars did not emerge from the enlightenment or modernist worldviews. Consequently, post-modernism, as modern scientific knowledge could not be relied on, was an approach which challenged the ideas of objectivity and the basic tenet that there is no ultimate truth. During the post-modern period, there has been a renewed interest in spirituality, both in healthcare and other areas of life. It has been argued that a post-modern worldview enables the approach of occupational therapy to be best understood (Creek, 1997). Practitioners focused on the individual's experience of the meaning of their illness or disability, and how they can effect change within their lives rather than understanding or curing the presenting condition (Creek, 1997; Weinblatt & Avrech-Bar, 2001).

As a result of the post-modern influences on western societies, there appears to have been a shift away from a 'reductionist model' of healthcare. This paradigm shift meant a change from an emphasis on diseases and treatments, and the concomitant passivity of the patient, to a model of service and care delivery based on patient-centeredness. These ideals of patient-centred care are enshrined in the National Health Service (NHS) Constitution (Department of Health (DH), 2013) and the policy document: Treating patients and service users with respect, dignity and compassion (DH, 2013). Central to patient-centred models of care are the values

placed on the individual's aspirations and experiences, along with their cultural, religious and spiritual beliefs which are central rather than peripheral to care delivery (WHO, 2002; Thew, Edwards, Baptiste and Molineux, 2011). The World Health Organisation (WHO) (1998) asserted that health was dependent on the value placed on each individual, recognising their needs to find meaning, purpose and belonging in their spiritual search.

In addition to the range of political and ethical drivers influencing UK healthcare, resulting in a renewed focus on person-centred care delivery, a series of high profile investigations, such as Francis (2013) and Keogh (2013) reports, have exposed failing healthcare in England. The outcome of investigations has been to highlight the importance of holistic person-centred care, which meets the patients' cultural, religious and spiritual beliefs and needs (Health and Social Care Act, 2012). These investigations and resulting policy has provided an opportunity for occupational therapists to influence healthcare practice by promoting their practice underpinned by the core values and philosophy of the uniqueness of the individual. Embedding respect, dignity and compassion into care and providing holistic care have been identified as essential to person-centred care (Francis, 2013).

1.3 Spirituality in the context of healthcare

Spirituality has universal applicability, albeit in different guises, because of a human need to search for meaning and purpose (Thoresen, 1999). Individuals faced with ill health, disability or disruption to their lives often search for a sense of meaning and purpose to explain or interpret their circumstances (Clarke, 2013). Addressing spirituality when caring for patients is challenging for all health professionals, despite considerable effort there is still no agreed definition and a paucity of guidelines for practice (Sawatzky, 2005). The tensions in reaching coherent and meaningful definitions for spirituality are also compounded by the context of 21st century healthcare practice. Practitioners are faced with balancing policy which supports person-centred holistic care and healthcare service demands within finite budgets. In healthcare practice, the dimensions of spirituality are broadly associated with terms such as

connection and transcendence, with or without a belief in God or higher being, and purpose and meaning. Spirituality in healthcare practice is commonly defined as helping a person to find hope, meaning and purpose in their situation (Clarke, 2013). Contrary to popular belief, spirituality in healthcare practice does not translate solely to religious meanings and expressions. Embedding the concept of spirituality into healthcare facilitates individuals in exploring how they draw on spiritual resources, with or without a belief in God or a higher being, to improve health and well-being in the face of adversity (Clarke, 2013; Johnston & Mayers, 2005).

Renewed interest in spirituality has gained momentum with a number of professions including medicine, nursing, social work and occupational therapy. For example, in nursing spirituality is considered integral to the beliefs, values and the caring process (McSherry, Cash & Ross, 2004). This renewed interest is attributed to post-modern ideals placing less emphasis on science to provide overarching answers to all healthcare issues (Puchalski, 2001; Ellis & Narayanasamy, 2009). Despite a range of definitions relating to spirituality, applying them to healthcare practice remains challenging because they are not always meaningful for healthcare professionals and do not always meet patients' needs and expectations (Unruh, Versnel and Kerr, 2002; McSherry et al., 2004; Johnston & Mayers, 2005; Gordon, Kelly, and Mitchell, 2011). The following section explores definitions of spirituality from a range of health disciplines in order to highlight the challenges healthcare professionals experience in embedding spirituality into everyday practice because of a lack of a clear definition commensurate with the philosophical underpinning of their professional practice.

1.3.1 Defining spirituality for healthcare

Spirituality remains poorly defined within healthcare with definitions lacking clarity and little consensus between professions. Despite a range of definitions of spirituality offered for healthcare practice, there are concerns about defining a concept so individual and deeply personal which is influenced by an individual's beliefs, culture and worldview (Tanyi, 2002;

McSherry & Cash, 2004; Swinton, 2011). Furthermore, there are tensions when applying definitions to practice from professional groups, with different underpinning philosophies and professional agendas (Clarke, 2013). A number of definitions commonly found in the literature will be offered to highlight the challenges in defining spirituality, and their usefulness for application to occupational therapy practice, will be briefly considered. The concept analysis presented in Chapter Two considers definitions of spirituality in relation to occupational therapy in more detail.

Definitions commonly depict the tensions between a religious or sacred expression of spirituality and the concerns for an inclusive expression of spirituality which encompasses a belief in God or other force sometimes expressed as the *“ultimate”* (Hodge, 2001, p 204) or *“higher being”* (Johnston & Mayers, 2005, p 386). The following definition mirrors these tensions by differentiating the individual’s experience as a religious or non-religious expression of spirituality. These expressions of spirituality support an individual’s expression of meaning and purpose leading to achieving life goals. *“Spirituality is defined as a relationship with God or whatever is held the ultimate that fosters a sense of meaning, purpose and mission in life”*, (Hodge, 2001, p. 204). In contrast to Hodge’s (2001) definition suggesting spirituality is a personal relationship espoused in a belief system, Murray & Zenter’s (1989) definition reflects the perspective that spirituality is an important construct, whether it is embedded in a belief system or not.

A quality that goes beyond religious affiliation that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death

(Murray & Zenter, 1989, p.259)

Positioning spirituality as an experience with or without religious beliefs is reflected in many definitions where a personal spirituality is offered, and referred to as in the following definition as, *“the essential life force, [that] undergirds, motivates and vitalises human existence”* (Swinton, 2001, p.14). Embedded in this definition are ideas that spirituality is present in

everyone and intrinsic to who they are and their existence. This view is supported by research concluding that spirituality is an intrinsic human experience, with the potential to possess a conscious or unconscious appreciation of spirituality (McSherry, 2006). The relationship between spirituality and religion is debated in the literature without consensus, and therefore lacking in congruent guidance for application to practice. However, the literature from a North American viewpoint presents a stance which appears much more comfortable with articulating spirituality as a religious expression that can have a positive impact on the health and wellbeing of individuals (Pargament, 1999; Koenig, 2013). The development of measurements such as the Religious Coping Scale (Pargament, Koenig and Perez, 2000) attempted to make spirituality more tangible, rather than remaining a nebulous concept, and therefore measurable. A measurable dimension enables the impact of spirituality on health and wellbeing to be evaluated. Ultimately the issues currently facing healthcare practice in the UK are how to embed spirituality into the ideals of compassionate (de Zulueta, 2013), person-centred care (Papadopoulos & Ali, 2015) for patients whether their guiding principles are based on religion, a higher being or no beliefs pertaining to religion/higher being (de Zulueta, 2013; Papadopoulos & Ali, 2015).

In contrast to the definitions that consider the experience of spirituality intrinsically linked to religious or other worldly experiences, spirituality has been defined as a dimension promoting an individual motivation and guiding forces which expresses the uniqueness of our humanity (Piedmont, 2005). For example, a definition, drawn from the nursing profession related spirituality to searching for inner fulfilment that is unique to each individual:

The inner, intangible dimension that motivates us to be connected with others and our surroundings...the guiding force behind our uniqueness (that) acts as an inner source of power and energy which makes us "tick over" as a person.

(Ellis & Narayanasamy, 2009, p.887)

The uniquely personal motivational guiding forces, mentioned in the above definition, are commonly understood central constructs or domains of spirituality: meaning and purpose.

Meaning and purpose are prevalent in many definitions of spirituality for healthcare practice across a wide range of professional groups. The following definition is offered by the Royal College of Psychiatrists: *“In healthcare, spirituality is identified with experiencing a deep-seated sense of meaning and purpose in life, together with a sense of belonging. It is about acceptance, integration and wholeness.”* (The Royal College of Psychiatrists, 2014, p.1). This definition articulates the depth to which meaningful and purposeful experiences are linked to a sense of belonging. In contrast to this definition, the following definition develops the sense of meaning and purpose in relation to life, and a sense of belonging that explains the individual’s need to articulate experiences that are meaningful through their spiritual understanding.

While the human spirit may be deeply mysterious, pointing as it does towards aspects of reality that are deep, unfathomable and transcendent, spirituality is a human activity that attempts to express these profound experiences in inner longing in terms that are meaningful for the individual.

(Swinton, 2001, p 21)

The spiritual constructs espousing the individual’s search for meaning and purpose in their lives and achieving fulfilment is a common application of the more intangible elements of spirituality. These constructs of meaning and purpose can be found in definitions across health professions. Meaning and purpose are among the listed outcomes of spirituality for an individual facing adversity in the Murray and Zenter (1989) definition. These personal constructs of meaning and purpose which encompass fulfilment and connecting experiences reflect and individual’s need for connection with people or places in a meaningful or spiritually significant way.

The following extensive definition combines insights found in many of the definitions in healthcare literature. The definition was generated from a concept analysis, and is included in this discussion of definitions because it is commonly used in the literature for the development of our understanding of spirituality. However, the author suggests caution in attempting to

reach a conclusive definition due to the subjective and personal nature of spirituality (Tanyi, 2002).

Spirituality is a personal search for meaning and purpose in life, which may or may not be related to religion. It entails connection to self-chosen and or religious beliefs, values and practices that give meaning to life, thereby inspiring and motivating individuals to achieve optimal being. This connection brings faith, hope, peace and empowerment. The results are joy, forgiveness of oneself and others, awareness and acceptance of hardship and mortality, a heightened sense of physical and emotional well-being and the ability to transcend beyond the infirmities of existence.

(Tanyi, 2002, p.506)

The complexity of the definition above, although included many attributes associated with spirituality; has been criticised for its lack of operational utility for practitioners who are already struggling with such a nebulous concept (Clarke, 2009). Tanyi's (2002) and Murray and Zentner's (1989) definitions, were used to frame spirituality in a research study that generated the widely referenced Principles Components Model for Advancing Spirituality (McSherry, 2006). This model will be discussed in the following section that focuses on operationalizing spirituality within healthcare. The notion that we all create our own definition of spirituality is explored by the spiritual taxonomy of McSherry & Cash (2004); which concluded that the abundance of definitions, all implying different meaning, is dependent on the individual's interpretation, culture and world view. In summary, a broad definition of spirituality may lack significance for the individual and health professional and supports the notion of describing spirituality for an individual's personal context.

1.3.2 Operationalizing spirituality for healthcare

So far this chapter has offered a range of the definitions of spirituality and its attributes that are largely considered intangible. The widely acknowledged limitations of these definitions, for all healthcare practitioners, are related to operationalizing spirituality in practice. The skills necessary for spirituality to be embedded in practice are suggested in the following definitions:

“Spiritual or compassionate care involves serving the whole person – the physical, emotional, social, and spiritual. Such service is inherently a spiritual activity” (Puchalski, 2001, p.352).

Puchalski (2001) expands this definition by outlining compassionate care:

Practicing compassionate presence—i.e., being fully present and attentive to patients and being supportive to them in all of their suffering: physical, emotional, and spiritual:

- *Listening to patients' fears, hopes, pain, and dreams;*
- *Obtaining a spiritual history;*
- *Being attentive to all dimensions of patients and their families: body, mind, and spirit;*
- *Incorporating spiritual practices as appropriate;*
- *Involving chaplains as members of the interdisciplinary healthcare team.*

(Puchalski, 2001, p.355)

The above definition operationalizes spirituality with a framework of compassionate care, providing the professional with guidance as to how spirituality can be incorporated into care. For example, by listening to what is important to the individual patient, and assessing spiritual needs which can be incorporated into meaningful spiritual practices, and referring to professionals with specialist knowledge and expertise as necessary. Applying this framework of compassionate care to practice would require health professionals to understand the attributes of '*spiritual practices*' and their meaning to the individual patient.

Operationalizing spirituality in terms of what drives and motivates the individual to find meaning and purpose has been suggested as an application to healthcare practice (Coyle, 2002). Applying the constructs of meaning and purpose to all aspects and experiences of life, especially in times of crisis and need, strengthens the operationalizing of spirituality in practice. Spirituality has been applied in both practice and research to religion and religious practice as they are easier to define and measure operationally for example:

- Attendance at church services or religious worship;
- Benefits of belonging to a religious group;
- Many studies focus on health outcomes for patients with religious beliefs.

(Koenig, 2000 and 2001)

The World Health Organisation Quality of Life Spirituality, Religion and Personal Beliefs group (WHOQOL SRPB, 2006) developed the eight facets that distinguished spiritual from

psychosocial: connectedness to a spiritual being or force; meaning of life; awe; wholeness and integration; spiritual strength; inner peace/serenity/harmony; hope and optimism; faith. The limitation of these eight facets is that, while they emulate the constructs articulated in the earlier definitions, they do not provide the healthcare practitioner with the practical detail of how to incorporate spirituality into everyday practice.

The *'Principle Components Model for Advancing Spirituality'* in health was developed from a qualitative grounded theory study which included health professionals from occupational therapy, physiotherapy, nursing, social work, chaplaincy, patients and wider public (McSherry, 2006). By exploring the factors inhibiting or advancing spirituality in healthcare, the study aimed to appreciate a deeper understanding of these factors. From the findings a model for practice emerged that progressed beyond the theoretical bounds of spirituality. This model considered the shape of spiritual care in practice and how spiritual practice could be achieved by taking into consideration the multiplicity of factors involved from individual healthcare professionals, patients and the organisational constraints. The model presents six components of spiritual care (Table 1).

Table 1: The Principle Components Model for Advancing Spirituality (McSherry, 2006)

Individuality	The individual experience of spirituality is shaped by, “culture, socialisation, life experience, religious beliefs and institutions.” p.910
Inclusivity	Refers to adhering to the perceptions and insights of all involved in the delivery of healthcare and a reflection of the wider community. This component suggests the competencies of the healthcare professional to address spirituality in their care.
Integrated	Caution against fragmentation, avoiding just another box to tick on the assessment form
Inter/intra disciplinary	This is central to the delivery of spiritual care. Patients advocate “spirituality is everyone’s business” p.913. Therefore good teamwork is needed.
Innate	Spirituality is innate within individuals, central to a person’s being. Words to describe spirituality such as ‘sparkle’, ‘essence’, inner’ and ‘makes you, you’ have been used. p.914
Institution	Spirituality is a powerful resource at times of illness and hospitalisation; opportunities to address spiritual needs enhance an individual’s sense of well-being. This may be dependent on the setting, for example resources in a hospice take into consideration the achievement of this goal.

The components of the model were identified as crucial elements in the advancement of spirituality in practice. This model appears to integrate the process of spiritual care as a central rather than an adjunct to care delivery. The model offers a framework for the integrated delivery of spiritual care which, if implemented into practice, has the potential to meet the individual's spiritual needs. The model is applicable to all areas of healthcare practice, focusing on the individual's intrinsic experience of spirituality rather than profession or practitioner specific needs. However, if the components are only partially addressed by healthcare or education, interventions are likely to fail to meet an individual's spiritual needs (McSherry, 2006).

The strengths of the *'Principle Components Model for Advancing Spirituality'* are that it was generated from interprofessional research and that patient and public viewpoints were sought and included in the development of the model. Including user and carers, is a unique feature of the model and addresses criticisms of many of the definitions of spirituality in that they have not been informed by the recipients of healthcare. A unique feature of the model is its multi-disciplinary application: the components are relevant to all professional groups and can be embedded at a service level as well as informing individuals in the development of their practice. To date there is limited evidence of the impact or effectiveness of the model in practice. Despite the models and frameworks offered in this section, there is little evidence to suggest spirituality has been effectively operationalized in practice by any healthcare professions. The purpose of this thesis was to explore how spirituality was embedded in the practice of occupational therapists; therefore, The Principle Components Model for Advancing Spirituality provides a useful framework for interprofessional practice. However, the framework is not explicit in outlining the specific components of spirituality that may assist occupational therapists practice in a way that addresses patient's spiritual needs.

In summary, there are some common themes across definitions offered, for example spirituality is relevant whether an individual has a religious connection with God or higher being, and that for some individuals the outworking of their religious practices provides them with a sense of well-being. Conversely, some definitions build on the existential experience of spirituality, which for many individuals can be a source of meaning and purpose. The quest for a coherent definition of spirituality remains a challenge for all healthcare professional groups. In general, the definitions offered in this chapter have been created in isolation from healthcare practice, without input from patients. Whilst there remains no clarity on a definition of spirituality, it is widely acknowledged in the definitions that addressing the spiritual dimensions in healthcare practice is integral to patients' well-being. In support of this assertion, Koenig suggests that, *"neglecting the spiritual dimension is just like ignoring a patient's social environment or psychological state, and results in failure to treat the whole person"* (Koenig, 2002, p.6).

1.3.3 Defining spirituality for occupational therapy practice

So far definitions of spirituality from a wide perspective of healthcare practice have been discussed, which will now be compared to definitions of spirituality for occupational therapy practice. Definitions of spirituality for occupational therapy practice have centred on engaging individuals in occupations and therapy which enhance meaning and purpose. Addressing spirituality through occupational therapy interventions means addressing these areas with the aim of improving the individual's wellbeing (Unruh et al., 2002). As with the other health professional definitions of spirituality presented earlier in this chapter, occupational therapists have also struggled with the complexity, challenges and tensions when trying to define spirituality. The issues of definition are similar across all professional groups resulting in, often unanswered questions such as:

- *Can individuals experience spirituality with or without a deity?*
- *Is spirituality a personal philosophy enabling an individual to interpret their life circumstances, or a concept that can meaningfully be defined?*

In practice, the focus of occupational therapy is the provision of experiences through occupation that promote meaning and purpose in life, and facilitate connections with people and places that provide an individual with a sense of personal well-being (Taylor, Mitchell, Kenan, and Tacker, 2000; Hammell, 2001; Canadian Association of Occupational Therapists (CAOT), 2002; Johnston & Mayers 2005). Essentially, the suggestion is that as occupational therapists focus on the core constructs of the profession and embed occupation into their practice, spirituality will be addressed as the integral elements of 'authentic' occupational therapy practice (Yerxa, 1967; Molke, 2011).

An appraisal of the literature and definitions relating to spirituality across health professional groups by Unruh and colleagues (2002) found that definitions of spirituality derived from a wide range of philosophical backgrounds. They asserted, from an analysis of the common themes found in the definitions of spirituality that they fall into two distinct categories: the sacred and the secular. The sacred definitions focus on an individual's relationship with God or a higher being. They embrace the idea of a power beyond an individual's own strength or capacity to control. In contrast to these ideals the secular definitions consider the themes of transcendence and connectedness that is a life force *within* a person. The themes of meaning and purpose in life are common in the secular definitions found in their analysis. The findings of Unruh's analysis demonstrate the issues but do not offer conceptual clarity or guidance that is helpful for occupational therapy practice.

The College of Occupational Therapists (COT) endorsed the following working definition of spirituality in order to address the perceived confusion in applying spirituality to practice. This definition is broad in application and embraces an idealistic position:

Spirituality can be defined as the search for meaning and purpose in life, which may or may not relate to a belief in God or some form of higher power. For those with no conception of supernatural belief, spirituality may relate to the notion of a motivating force, which involves an integration of the dimensions of mind, body and spirit. This personal belief or faith also shapes an individual's perspective on the world and is expressed in the way that he or she lives life. Therefore, spirituality is expressed

though connectedness to God, a higher being; and /or by one's relationships with self, others or nature.

(Johnston & Mayers 2005, p.386)

This idealistic stance, while referring to some of the core attributes of spirituality contextualised to occupational therapy, fails to offer guidance on how to practice in terms of addressing the spiritual needs of clients. Furthermore, the relationship between spirituality and meaningful occupation in practice is not fully articulated in this definition. Occupational therapists continue to report that the lack of a clear definition or guidelines for practice impacts on their ability to address spirituality (Bursell & Mayers, 2010).

In summary, defining spirituality for occupational therapy practice shares the tensions found with other healthcare professions. The definitions offered in the literature for occupational therapists to operationalize in their practice consider the following common elements with other healthcare professions:

- Spirituality with or without a belief in God or higher being;
- Present in every human being;
- Provides guiding life forces, motivation and inner resources to cope with adversity;
- Meaning and purpose;
- Connection to other people, community and nature.

In occupational therapy, attempts to develop theories about spirituality from these definitions have led to the development of a conceptual framework to guide practice (Kang, 2003). This conceptual framework is explored and applied in Chapter Two (Concept Analysis), and the domains outlined in Kang's framework were used to explain the findings of the concept analysis that are represented in Figure 7, page 87 in a Conceptual Framework for Spiritually Competent Occupational Therapy practice. The application of Kang's conceptual framework to the findings of the Concept Analysis are found in Table 5, page 82 and Table 6, page 84. However, spirituality is still considered to be a nebulous concept that is difficult to translate into practice and occupational therapists report being unsure how to embed the concept in day to day practice (Taylor et al., 2000; Belcham, 2004).

1.3.4 Limitations of definitions

Two issues make defining the concept of spirituality difficult. The first is the perceived need for a working definition; and the second the paucity of research underpinning the development of theoretical definitions, including the voice of those receiving the care from the health professionals. This has been highlighted by occupational therapists who advocate a working definition relevant to healthcare practitioners should emerge from research that considers the breadth of the individual's spiritual experiences (Collins, 2006), and mirrors Tanyi's 2002 critique of her own definition of spirituality. Additional limitations are found in our understanding of how to construct a definition congruent to theory, which can be operationalized in practice and has currency with the individuals who are receiving the care from health professionals.

Spirituality is contextual, influenced by a person's worldview, personal experiences and the socio-political context they live in. Therefore, some argue that owing to the subjective, individual nature of a person's spiritual experience it is not possible to develop a unified definition of spirituality for use across all professions and cultures (Martsof & Mickley, 1998; Swinton, 2001). Therefore, definitions need to be dynamic and constructed for the context where they will be applied. Definitions do give some insight into what might constitute spirituality. However, the major issue of the theory to practice divide is evident here. The key to defining spirituality is to understand what spirituality means for the individual receiving the care. Collaboration with patients and service users to develop a contextual definition has been advocated (McSherry et al., 2004; Gordon et al., 2011). There has been an over emphasis on producing a definition for spirituality and less consideration for making it useful for practice. Clarke (2013) suggests that rather than define spirituality it would be more congruent for practitioners to describe what spirituality looks like both to the practitioner and to the patient and carer. Narayanasamy (2001) suggests that individuals' perceptions of spirituality are so diverse it is unrealistic and idealistic to seek to provide one definition.

In order to develop some conceptual clarity, attempts have been made to describe rather than define spirituality. The following have been suggested as perceptions of what spirituality 'does' in an attempt to provide conceptual clarity.

- Manifestation of love;
- Search for hope, meaning and purpose;
- Religion and God;
- Excludes God and religion

(Swinton, 2001, p.13-16)

These attributes challenge the quest for a definition and are aimed at developing a better understanding of what spirituality '*looks like*' in practice. The issue of defining spirituality for occupational therapy is developed further in Chapter 2 (Concept Analysis), where the problems of locating spirituality for occupational therapists in a theoretic definition are challenged in an attempt to offer a more coherent exploration of the meaning of spirituality in the context of practice. Approaching spirituality from the perspective of viewing what is missing or absent in order to better understand, "*what it means to treat people as human beings*" is useful and will be revisited in Chapter 2 (p 85) Swinton (2011). The missing link is the attribute of spirituality which supports an individual's spiritual well-being and connections with people or places of meaning and spiritual significance. There has been a notable lack of involvement of patients and carers in the constructing of definitions for operationalizing spirituality, and this rightly calls into question the validity of the definitions offered. Spirituality is essentially about the individual's search for meaning in their life and experiences, therefore omitting the patient's perspective results in fragmented approaches (McSherry, 2012).

In summary, no single understanding of spirituality was identified from the definitions offered, and caution should prevail when including or excluding religious and cultural expressions of spirituality. The recognition of the spiritual needs of patients is an integral part of healthcare practice, including the examples presented from nursing, medicine and social work. Defining

spirituality remains contentious and problematic; looking into how spirituality is acted out in practice provides an alternative and perhaps more coherent route to incorporating spirituality in healthcare practice. The overriding concern is that our understanding of spirituality should be congruent with the individual patient's experience, worldview and culture (Ellis & Narayanasamy 2009). An individual's spirituality should be considered an integral part of healthcare. The concept analysis presented in Chapter Two of this thesis considers spirituality more specifically in relation to occupational therapy practice. It develops a description for spiritually competent practice rather than trying to find a "perfect" definition.

1.3.5 Well-being and spiritual well-being

The terms well-being and spiritual well-being as an outcome of addressing spirituality through the caring process, mobilising a person's inner resources to cope with adversity, have been used in the preceding sections. Well-being is defined as "*the state of being comfortable, healthy or happy*" (Oxford Online Dictionary, 2015). Although the term well-being is commonly used in relation to outcomes of healthcare, a definition supporting what well-being means is lacking in current policy advocating the well-being agenda, notably the most recent Care Act (The Care Act, 2015). Literature from psychology supporting the practical application of well-being to affect positive change in individuals' outlines the following principles (Ryan & Deci, 2001). Ryan and Deci (2001) suggested that the experience of subjective well-being had been considered from (short-term) *hedonic* and (sustained) *eudaimonic* perspectives. The hedonic approach considers happiness from the perspective of immediate experience of pleasure and the avoidance of pain. The eudaimonic approach considers meaning in relation to how a person is fully functioning. These two paradigms of well-being present definition of the causes and outcomes of well-being. The hedonic paradigm focuses on the subjective experience of well-being, and the eudaimonic on sustained psychological well-being. These two paradigms illuminate the challenges in defining well-being in practice and exploring how this can explain an individual's experience. An individual's experience of well-being includes elements of both paradigms to achieve a multidimensional state of well-being. This exploration of well-being

illuminates the following consideration of the elements involved in articulating spiritual well-being.

The issue of spirituality being conflated with religion is evident in the definitions, and a concern to ensure that application to people with or without a belief in God is embraced. In fact the definitions of spirituality can be said to fall between the acceptances that individual's spiritual experience is with or without a religious connotation. The search or yearning for finding a sense of personal fulfilment in meaning, purpose and connections that promote a sense of well-being, sometimes also defined as spiritual well-being. Spiritual well-being is considered as a multidimensional personal resource that helps a person to achieve well-being, and a factor in achieving quality of life that can be measurable against the "Spiritual Well-being Scale (SWBS)". The Spiritual Well-being Factors are two scales validated as psychometrically sound in the measurement of spiritual well-being in patients with cancer or other chronic debilitating illnesses (Peterman, Fitchett, Brady, Hernandez & Cella, 2002).

Further studies support the significant relationship between spiritual well-being and quality of life as a measurable aspect in patients with cancer and life limiting conditions by using the SWBS (Brady, Peterman, Fitchett, Mo & Cello, 1999; Whitford, Olver, Peterson, 2008) Furthermore, in end of life care where medical science can offer no further answers, Reed and Rousseau (2007) assert that their respondents found that their spiritual resources provided a resource for well-being. This generated a process called "*Transcending Life-Limiting Illness Framework*" (Reed & Rousseau, 2007, p.88). The process describes how an individual manages the realities of healthcare decisions relating to their present experience or future as their end of life approaches. The outcome of achieving spiritual well-being has been suggested as the individual's ability to appreciate life (eudemonia) in addition to managing distressing symptoms such as pain (hedonic well-being) (Brady et al., 1999, Whitford et al., 2008). These aspects of achieving quality of life through spiritual well-being resonate with the most inspirational application of meaning from Viktor Frankl's (2004) three sources of meaning in life. Frankl, a survivor of a Nazi concentration camp, suggested ultimate meaning in life came

from three sources; love, work and suffering. Love and connection with others supported a positive outlook in the face of extreme adversity. Work or achievement promoted a sense of satisfaction and value in an otherwise aimless existence. Finally, the most challenging was suffering which Frankl articulated as the simple act of survival and finding meaning in places where external forces could not reach him.

Spiritual well-being is articulated in occupational therapy practice as the search for meaning and purpose. Wilcock and Hocking (2015) suggest that this is achieved by balancing the demands of occupations and the spiritual experiences inherent in them, whether they are chosen or obligatory. This will be enhanced if the occupations enable a person to experience a *“higher order of meaning”* (p. 201). An earlier consideration of spiritual well-being was suggested by CAOT (1991), as a force that *“permeates”* life, giving it meaning. Therefore, spiritual well-being can be defined as a dynamic interaction between the existential experience of meaning in an individual’s life and their opportunity for expression of meaning in their lives through occupation. For instance, the incorporation of the constructs of the hedonic and eudaimonic paradigms along with the individuals’ experiences of happiness, pleasure and meaning leads to spiritual well-being and an individual’s experience of quality of life.

1.4 Historical development of occupational therapy and the influence of spirituality

This section will discuss the religious, social and political influences on the development of occupational therapy, highlighting how spirituality has influenced the development of the profession and shaped practice.

1.4.1 Underpinning philosophies of occupational therapy

The core philosophical underpinning of occupational therapy is that physical, mental and spiritual dimensions are part of the whole human being; consequently, occupational therapy practice should incorporate all of these dimensions in order to embed person-centred occupational therapy practice (Hagedorn, 1995; Taylor et al, 2000; Belcham, 2004; Townsend & Polatajko, 2013). Hence the dimension of spirituality is at the core of the philosophical

framework of holistic person-centred occupational therapy practice. The most influential early founder of the philosophy of occupational therapy is attributed to psychiatrist Adolf Meyer. Meyer approached the treatment of mental illness from the perspectives of psychobiology theory, which espoused a holistic approach that recognised an individual's need for a structured range of activities. A balance of work and rest was advocated as essential to achieve wellbeing (Turner, 2002; Christiansen & Haertal, 2014). Meyer advocated for occupational therapy, his seminal publication, *The Philosophy of Occupational Therapy* (Meyer, 1922), promoted the belief that through occupational therapy patients recognised their daily habits and were able to regain a sense of wellbeing. He postulated that a lack of occupation or engagement in activity during convalescence was morally wrong, causing disorientation and further debilitation. His philosophy for occupational therapy espoused engagement in occupations (work, play, rest and sleep) to motivate patients, enhance their self-confidence and make a positive impact on their mental health. Thus occupation became recognised as linked to positive health (Meyer, 1922).

Historically occupational therapy has a strong underpinning philosophical background in the Judeo-Christian traditions. For example, the early founders of the profession engaged in altruistic endeavours to improve the treatment experiences of people with mental health problems (LeVesconte, 1935; Wilcock, 2000). Early associations between the Moral Treatment Movement, advocated by the Tukes at the Retreat in York, and occupational therapy have been made; connections were made with the use of occupation and habit training programmes and were considered as early '*occupational therapeutic*' practices promoting health and well-being, dating back to the 18th century (Peloquin, 1989; Wilcock, 2001). More recent attempts to define the role of the occupational therapist have shifted the focus of practice to embracing social change and the impact of change on individuals, groups and populations (Kronenberg, 2005; Thew et al, 2011). The importance of the spiritual dimension of occupational therapy, and how spirituality is enacted in day to day interactions with individuals, needs to be articulated if spirituality is to be embedded and evident in practice.

Embedding spirituality in practice has its roots in religious and philosophical movements linking purposeful occupation with spiritual well-being. Occupational therapy practice traditionally operates within a holistic framework, where illness and wellness are viewed in the context of an individual's social and physical environment (Hubbard, 1991; Schkade & Schultz, 1992; McColl, 1994). However, the profession has also been shaped by contemporaneous social and political influences. Early occupational therapy interventions focussed on the humanistic concern for individual well-being and their capacity to use their own efforts to change themselves affecting their own responsibility for their circumstances (Barnitt & Mayers, 1993; Paterson, 1997). There have been ongoing debates about the founding principles of the profession. Notably it has been argued that applying humanist principles to occupational therapy practice are in conflict with behavioural, developmental and psychodynamic approaches to occupational therapy practice (Barnitt & Mayers, 1993). These later approaches have limitations in their application to contemporary practice as they advocate a power relationship between therapist and patient which conflicts with the humanistic principles of client autonomy and involvement in care decisions (Barnitt & Mayers, 1993). The contemporary paradigm focuses on promoting the individual's unique experience of health-promoting occupation and occupational justice and seeks to promote access to participation in meaningful occupations for all in society. In recent years debates about the philosophy of occupational therapy have been devoid of including the humanist approach (Townsend & Wilcock, 2004; Kielhofner, 2009; Molineux & Baptiste, 2011).

Duncan (2011) has offered an outline of the profession's principal concerns. These relate to the unique experiences of individuals as they participate in occupations, leading to a meaningful life and influencing their health and well-being at individual, group or population levels. This summary of the philosophical underpinning offers a coherent standpoint from which to explore practice from a variety of spiritual perspectives. Although healthcare was dominated by a reductionist biomedical model (Turner, 2002), a shift to a holistic patient-centred paradigm has occurred (Kielhofner, 2009). Subsequently, occupational therapists

worldwide have reconnected with their roots, embracing the value of occupation as meaningful, purposeful and influencing health and well-being (Reilly, 1962; Richards, 1998, Yerxa, 1990). The discipline of Occupational Science developed in response to a need for occupational therapists to better understand and articulate the core construct of occupation, and its relationship to health and well-being (Yerxa, 1990; Clarke, Parham, Carlson, Frank, Johnson, Pierce, Wolfe & Zemke, 1991). The purpose of Occupational Science as an academic discipline is to promote, through research, an understanding of the personal and meaningful nature of occupation, how individuals shape their existence and reconstruct the meaning in their lives following an adverse situation causing disruption to their daily life. The occupation an individual engages in defines the essence of who they are and how they express meanings that are social, symbolic or spiritual in nature (Yerxa, 1987; Zemke & Clarke, 1996; World Federation of Occupational Therapists (WFOT), 2012; Wilcock & Hocking, 2015).

The main purpose of occupational therapy is to enable participation and engagement in occupations to assist people to achieve health and well-being. This engagement and participation in occupations helps provide meaning and purpose in a person's life. Meaning and purpose are also central to definitions of spirituality. The profession's values are based on a philosophy embracing the uniqueness of a person's experience and holistic patient-centred care (Law, Baptiste, McColl, Opzoomer, Polatajko & Pollock, 1990; Duncan, 2011). Models of practice, for example the Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007) and The Kawa Model (Iwama, 2006), promote this philosophy incorporating physical, psychosocial and spiritual dimensions (Iwama, 2006; Townsend & Polatajko, 2007).

The rich tradition of occupational therapy in espousing meaningful and purposeful occupation which promotes health and well-being is a common thread throughout the profession's history (Meyer, 1922; Reilly, 1962; Yerxa, Clark, Frank, Jackson, Parham & Pierce, 1989; Peloquin, 1991; Kielhofner, 1992; Hagedorn, 1995; Trombly, 1995; Nelson, 1997; Hinjosa & Kramer,

1997; Hammell, 2004). More recently the challenges of interpreting meaningful and purposeful occupation in traditional ways have led to a consideration of the issues in a multi-cultural society with diverse socio-political and economic contexts. For instance, assumptions relating to client-centeredness with diverse patient groups need to inform the theory of occupational therapy, and ultimately how the uniqueness of individuals with vastly differing worldviews can be encapsulated in a philosophy largely developed from western ideologies (Hammell, 2009). It is this diverse context that the study reported in this thesis seeks to address and influence.

Links between the value of occupation and the presence of spirituality in shaping the development of the profession over the last two hundred years are presented in the following table. Table 2 below presents the social, political and professional influences shaping occupational therapy from the 18th century in order to understand how embedding the dimension of spirituality is essential for the delivery of holistic person-centred practice. The following two sections, 1.3.2 Socio political influences and 1.3.3 Professional influences and paradigms, illuminate the table further. These two sections discuss the influences on the profession and how spirituality has been embedded throughout the development from 18th century to the present day.

Table 2: Influences of spirituality on occupational therapy (Religious and spiritual influences shaded in grey)

Century	18th	19 th	20th							21 st
Year			1914-18	1939-45	1948	1960's	1970's	1980's	1990's	2000-2014
Social & political influences of occupational therapy	Industrial Revolution 1760 -1870 Transition to new manufacturing processes from manual to machine Workhouses treated poor		World War 1 Suffrage movement; women's education & professions (Wilcock, 2002) Protestant work ethic (Weber et al., 2002)	World War 2	Launch of the NHS		Divide health & social services; increased care delivered in the community (Wilcock, 2002)	Increase in technology; social, economic, political change; work related stress (Boyt Schell et al, 2013)	Increased global links =travel, technology, refugees (Wilcock, 2002)	New millennium; global economic crisis; war & conflicts; environmental disasters (Boyt Schell et al, 2013) Modernising Health & Social Care(2000, 2012)
		Romantic Movement, Arts and Crafts Movement John Ruskin (1819 – 1900) William Morris (1834 - 1896)								
Professional influence and paradigms			1900 -1940's Paradigm of occupation Occupation for reconstruction, 1930's-60's productive roles and purpose for living (Wilcock, 2001) Meyer's The Philosophy of Occupational Therapy (Meyer, 1922)			1960's – 1970's Biomedical Paradigm Occupational therapy focussed on functional activities, independence and activities of daily living (Wilcock, 2002)		Shift away from the biomedical paradigm from 1980's Influence of occupational science on the profession through research and practice (Yerxa, 1980) Re birth of occupation (Duncan, 2011)		
		Moral & Humane Treatment of People with Mental Health Problems William (1732 – 1822) / Samuel Tuke (1784-1857) Labour not occupation (Paterson, 1997)	Development of a model for vocational rehabilitation in USA & Canada Thomas Kidner (1866-1932)	OT practice located in institutions & departments. Dominance of biomedical model of care. Disease orientated practice (Wilcock, 2002).	Mary Reilly (USA) (1916-2011) - catalyst for re-emergence of holism & spirituality (Reilly, 1962)	Decade of self-doubt. Reductionist model of care (Wilcock, 2002)	Development of models of practice e.g. for example Model of Human Occupation (Kielhofner, 1980)	Development of Canadian model of Occupational Performance; spirituality central domain (CAOT, 1997)	Definition spirituality in OT (Johnston & Mayers, 2005) Publications about spirituality increased.	
		Occupational Therapy in England Elizabeth Casson (1881- 1954), founder of the first OT Training School in England in 1930.								
		Settlement house movement Occupation for social health and well-being Octavia Hill (1838-1912)(Wilcock, 2001)							Canadian definition of spirituality (CAOT, 1991)	Development of the Kawa model (Iwama, 2006)

1.4.2 Socio-political influences

As outlined, occupational therapy has its origins in religious movements and a strong association with spiritual dimensions, whilst practice has been shaped by contemporaneous social and political influences (Duncan, 2011). In England, the social and political influences on the emergence of occupational therapy were the Moral Treatment (Peloquin, 1989), Arts and Crafts and Settlement movements (Levine, 1987; Drake, 1992; Schemm, 1994) (Table 2). The industrial revolution changed social structures and environments as individuals moved from rural to urban living. Transition from manual labour to machine production changed traditional perspectives of occupations (Peloquin, 1989). Hard work, an outward manifestation of the Christian faith, pervaded the early twentieth century (Weber, Baehr & Wells, 2002). This Protestant Work Ethic, the term coined by Weber, valued employment as providing sustenance, a meaningful and purposeful role within society, and influenced beliefs that occupation had a spiritual dimension, thus linking occupation to holism (Duncan, 2011). The ideology that purposeful activity also improved an individual's moral character was a feature of early occupational therapy post World War 1 (Gutman, 1995).

These early influences on the development of the philosophy of the profession placed the value of the individual and the art of doing in high esteem. However, the emphasis on the perfection of the product as espoused by the Arts and Crafts movement, in particular the ideals of John Ruskin and his opposition to mechanisation of production, could be considered to be detrimental to the creative work in occupational therapy practice. The perfection of the finished product pervaded practice into the reductionist period. Craft work was seen as a medium for therapy, but not always providing a meaningful outcome for the individual whose therapeutic engagement was determined by the product as opposed to the intrinsic personal meaning (Levine, 1987; Schemm, 1994). This position persisted but was challenged by consequences of two world wars and the implications of the disabilities resulting from injuries. Occupational therapists developed functional and rehabilitation skills, essential in managing war injuries, and measureable occupational therapy outcomes resulted.

Embedding a scientific approach to care aligned to the biomedical model could have contributed to occupational therapy becoming distanced from its religious and spiritual beginnings (Hocking, 2008). This extended alliance to the biomedical paradigm, arguably left a profession entrenched in practices divorced from its historical roots (Wilcock, 2001). It did, however, progress occupational therapy into the realm of physical disability albeit without a transferable application of the early philosophy. The emphasis placed on the finished product from the Arts and Crafts movement influence, and the functional outcomes, were paramount regardless of the meaning to the person (Turner, 2002).

The systemisation of healthcare introduced with the NHS in the UK in 1948 impacted on the development of occupational therapy (Paterson, 1998). Occupational therapists worked in hospitals, primarily occupying long stay patients with diversional activities. This was the period of large healthcare institutions later criticised for 'stripping' individuals of their roles and contact with the outside world. Social Role Valorisation (SRV) advanced the human rights and living conditions of individuals already, or at risk of becoming devalued by society, such as marginalised groups, in particular individuals with a Learning Disability (Wolfensberger, 2000). Platts (1993) challenged SRV as an inadequate structure to apply to occupational therapy practice. However, suggested that, when used in collaboration with the Model of Human Occupation (MOHO) (Kielhofner, 1980; 2008; 2009), SRV provided a sound underpinning philosophy for occupational therapy practice. SRV is concerned with the uniqueness of individuals and their value in society, and supports the earlier practice of the Moral Treatment Movement (Peloquin, 1989), which had a profound influence on the development of occupational therapy.

During the 1970s occupational therapy developed rapidly, focussing on functional activities, independence and activities of daily living. This rapid transformation coincided with a perceived loss of professional focus and reductionist practice as the relationship between meaningful and purposeful occupation and its valuable health promoting benefits diminished (Wilcock, 2002). The modernisation of healthcare and the specific contribution occupational

therapists make to the health and well-being of the population has been recognised (Health and Social Care Act, 2012). This coincided with a renewed confidence in the paradigm of occupation stemming from a growing evidence-base in occupational science. The end of the 20th century witnessed unprecedented technological advances and global mobility, impacting on the delivery of occupational therapy with a greater need to understand other worldviews (Wilcock, 2002). The challenge for the NHS in England is to respond to global changes, increased consumerism, choice and individualised person-centred care while delivering safe, sustainable and efficient, cost effective services (Equity and Excellence, Liberating the NHS, 2010). This heightens the tension, with time pressures and target driven services limiting holistic practice, including embedding spiritual care into practice.

1.4.3 Professional influences and paradigms

Three paradigms have influenced occupational therapy practice since its inception in the early 1900's: the paradigm of occupation, mechanistic paradigm and contemporary paradigm (Kielhofner, 2009). These paradigms have been highlighted in Table 2 to illuminate the timeline of the influences on professional practice. The paradigm of occupation (1900's – 1940's) arose out of the founding views and values of the profession that occupation was essential to an individual's life and health. The links between the mind and body were acknowledged during this period, using the core construct of occupation to embed health promoting occupation focussed occupational therapy interventions. Prior to that, during the nineteenth century, the Moral Treatment movement advocated work and practising religious beliefs as a humane treatment for people with mental illness, and is often perceived as being closely associated with current occupational therapy practice (Peloquin, 1989).

Similarly, the profession's early founders such as Thomas Kidner (1866-1932) and Octavia Hill (1838-1912) were influenced by the Arts and Crafts movement, largely through the inspiration of John Ruskin (Levine, 1987; Friedland, 2007). Kidner and Hill embodied a connection with the spiritual experience of art as a transforming medium, through the

perfection of skills required to master arts and crafts (Hocking, 2008). These early founders of the profession connected personal religious beliefs with their endeavours to improve the health and well-being of their communities. For example, Kidner, from England, practiced primarily in North America and developed the vocational rehabilitation model for injured service men, founded on his religious convictions to create a '*Kingdom of God on Earth*' (Friedland, 2007, p.298). Hill, a radical social reformer of the late 19th century, founded the Settlement movement, which provided meaningful and purposeful occupations for '*Settlement*' residents. Hill, a committed Christian, has been widely recognised as the '*grandmother*' of occupational therapy and worked closely with Elizabeth Casson (1881-1954), who founded the first occupational therapy training school in England in 1930 (Wilcock, 2002).

The mechanistic paradigm (1960's – 1970's), was in harmony with the modernist worldview and the necessity of the profession to align to the medical profession's claimed objectivity. There was a distinct focus during this period on a biomedical approach to healthcare and measuring practice in terms of patient (health) outcomes. During this period the profession lost sight of its roots in the value of meaningful occupation as health promoting. This paradigm was in fact short lived as it was superseded by the following contemporary paradigm which has had a more profound impact on the development of the profession and the evidence-base to support embedding spirituality in practice (Kielhofner, 2009; Duncan, 2011)

Despite early connections, during the biomedical dominance of healthcare in the mid-20th century, there has been a paucity of reference to spirituality in occupational therapy literature. This could be attributed to a belief that occupational therapy interventions, reducing the impact of illness or injury, were the rightful focus of practice. This period of reductionism created internal professional conflicts as promoting health and well-being was an entrenched professional value associated with holistic, patient-centred care (Wilcock, 2002). The contemporary paradigm (1980's onwards) heralded the return to the founding principles and values of occupation focussed practice. This paradigm period has seen the advent of the

discipline of occupational science that helps the profession to understand the complexity of occupation in new ways.

The developments linked to occupational science legitimised occupational therapists in developing practice in new ways not restricted to the biomedical model of care delivery and challenged western ideologies of professional practice (Yerxa, Clark, Frank, Jackson, Parham, Pierce, Stein & Zemke, 1989). Whilst retaining the benefits of the objective developments during the mechanistic paradigm, occupational therapists were equipped to re-establish occupation and its valuable impact on health and well-being, providing objective measurements where appropriate. This return to the profession's historical roots saw the first occupational therapy conceptual models for practice emerging. These models placed spirituality as a central construct of the person (Law et al., 1990). More recently, the Japanese Kawa "river" model integrated the explanatory metaphor of a river. The application of the river metaphor postulated that a person's life course required therapeutic interventions based on life events and an appreciation of the individual's worldview. This links to the individual's worldview was particularly relevant as the therapist engaged individuals from differing cultural backgrounds in unfamiliar environments (Turpin & Iwama, 2011; Paxson, Winston, Tobey, Johnston & Iwama, 2012). Conceptual models and their support in practice of spirituality are discussed further in a later section of this introduction. The need to define spirituality as a construct of occupational therapy re-emerged in the 1990's as an attempt to reconnect with the profession's roots in meaningful and purposeful occupation for health and well-being (CAOT, 1997).

The activists, who shaped occupational therapy in the early 20th century, predominately engaged in altruistic endeavours for the common good, as an expression of their Christian faith. The holistic philosophy is central to occupational therapists providing comprehensive care to individuals and, by embedding the spiritual component of holism, can enhance an individual's health and well-being (Christiansen, 1997; Hume, 1999; Roberts, 1999). The re-awakening of the core value of occupation provided opportunities for reclaiming the

transforming experiences of occupation, as embedded in the Arts and Crafts and Moral Treatment movements (Hocking, 2008). The role occupational therapists perform in seeking to aid individuals in identifying meaning in their lives has been articulated in a study comparing the role of the occupational therapist with pastoral care workers in a hospital environment (Beagan & Kumas-Tan, 2005). As the profession re-connects with its origins in meaningful and purposeful occupation for health and well-being, it is time for occupational therapists to develop confidence about embedding spirituality in practice. Over the past fifteen years, a number of small scale UK research studies have demonstrated that occupational therapists do consider addressing an individual's spiritual needs to be part of their role (Rose, 1999; Hoyland & Mayers, 2005). The link between spirituality and an individual's unique experience of meaning, expressed through occupation, has health promoting qualities (Udell & Chandler, 2000; Wilding, May, & Muir-Cochrane, 2005). However, the challenge for occupational therapy practice is promoting the tangible benefits of embedding spirituality into therapeutic interventions in a context still driven by outcomes measured in relatively simplistic terms.

Despite current global economic challenges and healthcare reconfigurations, there appears to be a professional drive not to return to a reductionist model of care delivery. Occupational therapists continue to develop their practice, and take stock of investigations highlighting the need for all health professionals to treat patients with respect and dignity (Francis, 2013). Occupational therapists also have a legal and moral obligation to adhere to their Code of Ethics and Professional Conduct, requiring them to have a working appreciation of an individual's culture and beliefs, highlighting the need for occupational therapists to practice with spiritual competence (COT, 2010). The challenges for occupational therapist to embed spirituality into their practice are as follows:

- Translating the rich professional heritage of spirituality into practice;
- Developing a sound evidence-base relating to the value of spiritual dimensions in enhancing care;

- Ensuring occupational therapists have the necessary skills and confidence to practice within a spiritual framework. Embedding spirituality into the pre-registration curricula and opportunities for post registration continuing professional development.

1.5 Defining occupational therapy

Occupational therapy is characterised by a broad knowledge base and wide clinical application. Definitions are wide-ranging and fraught with misconceptions (Duncan, 2011). Occupational therapists engage with people in the context of everyday experience of life, which can lead to the profession being misconceived and not always recognised for the complexity of interventions or roles therapists undertake (Creek, 1997). The World Federation of Occupational Therapists (WFOT) published the following working definition of occupational therapy:

Occupational therapy is a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do so, or by modifying the occupation or the environment to better support their occupational engagement. Occupational therapists believe that participation can be supported or restricted by the physical, affective or cognitive abilities of the individual, the characteristics of the occupation, or the physical, social, cultural, attitudinal and legislative environments. Therefore, occupational therapy practice is focused on enabling individuals to change aspects of their person, the occupation, the environment, or some combination of these to enhance occupational participation.

(WFOT Statement of Occupational Therapy, 2010)

This definition highlights the client-centred nature of occupational therapy practice and its unique professional focus on occupation as health-promoting and impacting on a person's well-being through participation or engagement. The primary vehicle of intervention in occupational therapy practice is occupation.

1.5.1 Defining occupation

Occupation is the central tenet of occupational therapy practice. It defines the purpose and process of an occupational therapist's daily day to day involvement with people. There are a number of definitions of occupation; the purpose of this section is to illuminate a working definition that provides the context for this study. The following definition locates occupation as central to the professional practice of occupational therapists and identifies spirituality as a dimension of occupation and therefore part of the practice of occupational therapists:

Occupations is used to mean all the things people want, need, or have to do, whether physical, mental, social, sexual, political or spiritual in nature and is inclusive of sleep and rest. It refers to all aspects of actual human doing, being, becoming and belonging. The practical, everyday medium of self-expression or of making or experiencing meaning, occupation is the activist of human experience whether occupations are contemplative, reflective, and meditative or action based.

(Wilcock & Townsend, 2014, p.542)

This comprehensive definition situates occupation, in its broadest sense, as the vehicle to maintain or improve a person's health and well-being through active participation. The definition also includes spirituality as an aspect of "*human doing, being, becoming and belonging*".

1.5.2 Occupation and spirituality

The relationship between occupation and spirituality has been debated in the literature with some positive examples of how occupation is employed to support addressing spirituality through occupational therapy practice. Religious and cultural occupations which focus on sources of meaning for an individual were considered to positively address a person's spiritual needs in healthcare (Rosenfield, 2000). Embedding creative occupations into practice has been acknowledged as an opportunity for a person to participate in spiritually uplifting activities that positively impact on their health and well-being. Additionally, it has been suggested that if occupational therapists recognise an individual's need to be creative, and engaged in meaningful occupation, the therapeutic intervention can address a person's spiritual needs

(Howard & Howard, 1997; Billock, 2009). The use of opportunities to acknowledge cultural experiences espoused by festivals and celebrations has been considered as a mode of addressing spiritual needs of individuals (Luboshitzky & Gaber, 2001). They suggest that the transcendent nature of taking part in celebrations fulfils the spiritual need within the individual's socio-cultural environment. These examples highlight the opportunities that occupational therapists have in their practice to address spirituality through occupation with a diverse range of opportunities. The occupational therapist's ability to embed occupation that is meaningful and purposeful into their interventions with patients also has the potential to address their spiritual needs. A Canadian perspective of addressing patients' spiritual needs considers the appropriateness of prayer (Farah & McColl, 2008). They argue, from a review of literature, that prayer is appropriate within the scope of occupational therapy interventions. They advise using the following four questions in their decision making:

1. Is the client's problem spiritual in nature?
2. Is the therapist equipped to offer prayer?
3. Would the client be receptive to it?
4. Would the workplace support it?

Studies reporting spirituality from a UK perspective are more cautious surrounding the issue of prayer and fear of being accused of proselytising. There were examples of embedding the religious and cultural beliefs of patients into therapeutic interventions, for example access to places of worship and meeting cultural needs regarding food preparation (Udell & Chandler, 2000; Hoyland & Mayers, 2005). Kang (2003) argues that as Western Society has moved away from spiritual values the impact has resulted in social deconstruction. Kang's conceptual framework, applying Psychospiritual Integration (PSI) to occupational therapy practice, suggests that for some people all occupations are spiritual. Kang espouses the view that, despite external social influences suggesting otherwise, individuals do have the capacity to engage on a spiritual level with all occupations they need or choose to engage in.

1.5.3 Spirituality and occupational therapy models

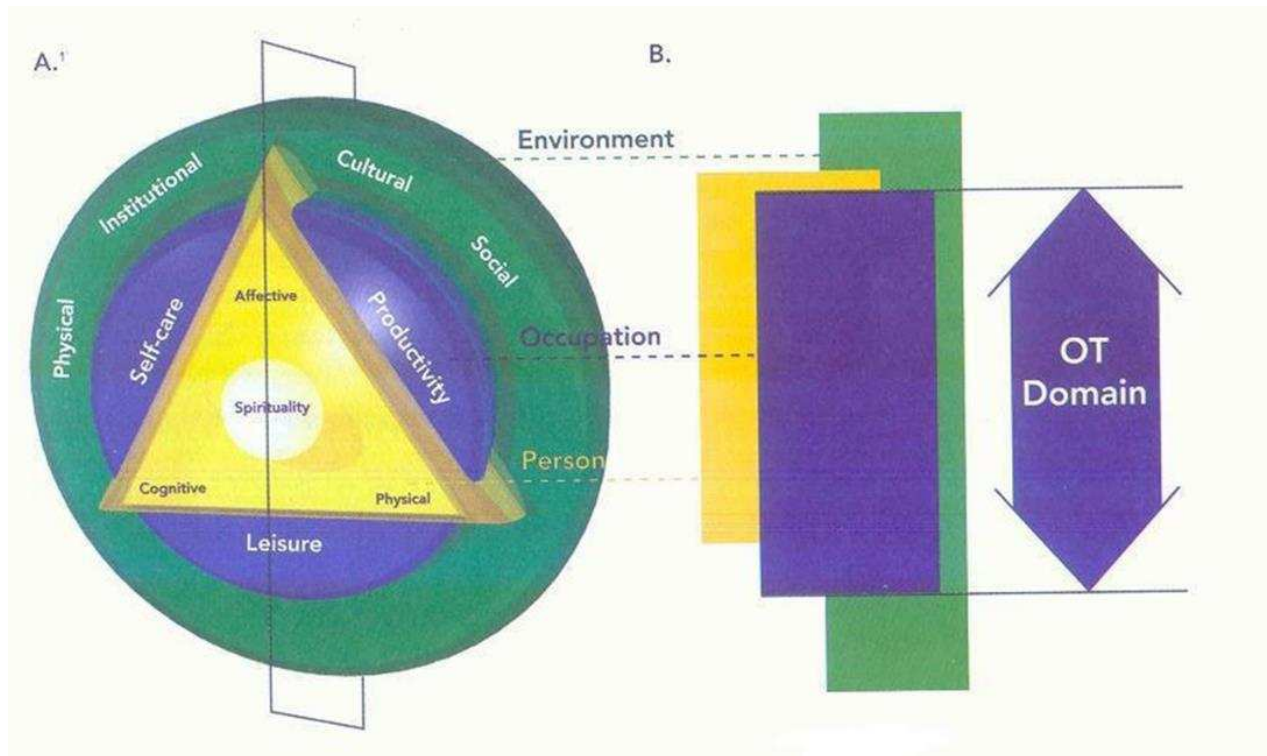
Occupational therapists' express difficulties in articulating how spirituality is embedded into their practice. The relationship between theory and practice was found to be problematic by occupational therapists and the need for more input at pre-registration level, including guidelines for practice were suggested (Belcham, 2004). This is somewhat surprising for a profession that holds holistic practice as one of its core philosophies. A number of models and theories have been developed to frame and underpin occupational therapy practice. Spirituality is identified explicitly in the Canadian Association of Occupational Therapy (CAOT) guidelines for practice and the Canadian Model of Occupational Performance – Engagement (CMOP-E) (Townsend & Polatajko, 2007). Other models, such as the Model of Human Occupation (MOHO) (Kielhofner, 2008) and the KAWA model (Iwama, 2006), place the person centrally but are less explicit about the location of the spiritual domain.

The Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007) is a bio psychosocial model developed by occupational therapy theorists in Canada over the past 35 years. The latest format of the model (Townsend & Polatajko, 2007) features the relationship between the person, who is represented centrally, defining the essence of the person as spirituality, the individual's performance and engagement (categorised as cognitive, affective and physical domains) through different areas of occupation and the environment.

Figure 1 shows the diagrammatic representation of The Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007).

Figure 1: The Canadian Model of Occupational Performance and Engagement

From Townsend, E. A., & Polatajko, H. J. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being and justice through occupation*. Ottawa: CAOT Publications ACE (p23).



The diagrammatic representation of CMOP-E is divided into two parts, A and B. Section A represents the diagram of CMOP-E and specifies the domain of concern represented by this model. Section B presents a transactional view of the model linking the person, occupation and environment in a three dimensional model.

The constructs of the model are listed below.

- Cognitive: how a person uses their capacity for thinking, understanding, solving problems and perceiving;
- Affective: the individual's experiences and feelings are captured in this performance component, and how they impact on their occupational performance;
- Physical: This is the performance component that examines the 'doing' of occupations, an individual's physical capacity to take part in occupations.

The areas of occupation are categorised as; self-care, productivity and leisure.

- Self-care: These are occupations an individual engages in to take care of themselves, for example washing, dressing and cooking;
- Productivity: This is not necessarily defined as work; it also applies to occupations a person does to contribute socially;
- Leisure: These are occupations a person carries out for pleasure and enjoyment.

The surrounding environment in which these occupations are carried out are categorised as physical, cultural, social and institutional environments. It is acknowledged that in practice the environment is dynamic and it is necessary to accommodate a number of changes as the elements above interact with it (Iwama & Turpin, 2011).

- Physical: this supports the exploration of the barriers and supports within a person's environment. It can include issues of accessibility as well as the proximity of other social structures such as family;
- Cultural: this element is dynamic and dependent on the individual's beliefs and values that will impact on how an intervention is structured to meet their specific cultural needs;
- Social: this is composed of the individual's social structure, friends, family, carers and the roles they adopt in different situations. An individual's impairment may limit their social environment and thus engagement in occupations;
- Institutional: this is the political, legal and economic environments that impact on an individual's capacity to engage in occupations.

Ensuring spirituality was at the centre of the CMOP-E has been challenging. The first, challenge related to the word spirituality and its lack of agreed definition for occupational therapists (Hammell, 2001). Hammell argued that without a congruent definition of spirituality, that placed it central in the Canadian model, led to misunderstandings between patients and occupational therapists. She proposed that intrinsicality would express more coherently how spirituality articulated an individual's unique "*personal philosophy of meaning with which we interpret our lives*" (p.186). The second challenge emerged from Unruh et al's (2002) seminal publication, who argued that placing spirituality at the centre of the model devalued the

profession's primary concern of occupation. Unruh et al (2002) proposed that "*occupational identity*" was more closely related to how the individual constructed personal meaning. Both these challenges remain unresolved. Despite challenges regarding the positioning of spirituality, the model continues to place spirituality at the centre defining it as the "*very essence of who we are as human beings*" (Townsend & Polatajko, 2013, p69). The model articulates the importance of meaningful occupation and spirituality as the driving force motivating an individual to seek meaning and happiness through occupations or '*doing*'. The CMOP-E supports and guides the occupational therapist in considering the spiritual dimensions of an individual's life as central to their interventions. It places spirituality described as the "*essence*" of the individual central, and therefore guiding the person-centred application of all components of the model. This supports the occupational therapist's core philosophy of the person being central to practice. Additionally, the emphasis placed on engagement allows the occupational therapist to think not only of active involvement in occupations, but also to consider occupations that are deeply meaningful for an individual but which they can no longer take an active part in.

The Model of Human Occupation (MOHO) (Kielhofner, 1980, 2008, 2009) has been acknowledged by occupational therapy practice since the early 1980's as one of the most widely used occupation-focussed models. The model's value in practice has been highlighted as follows:

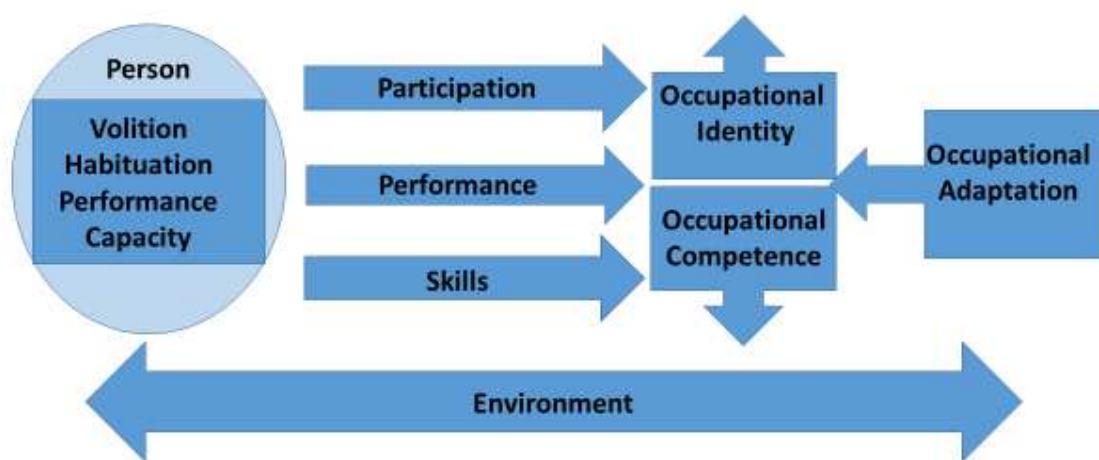
- *Supports occupation-focussed practice;*
- *Helps prioritise clients' needs;*
- *Provides a holistic view of clients;*
- *Offers a client-centred approach.*

(Kielhofner, 2008, p.1)

The model seeks to explore and categorise the key components of occupation, namely, "*the environmental impact, volition, habituation, performance capacity, participation, performance, skills, occupational identity and occupational competence*" (Kielhofner, 2008, p.145). The

model uses these components to explain how an individual engages in occupation within their environment and how the process leads to occupational adaptation. Figure 2 represents the constructs of the Model of Human Occupation in an adapted diagram (Kielhofner, 2008, pp 108,148)

Figure 2: Model of Human Occupation



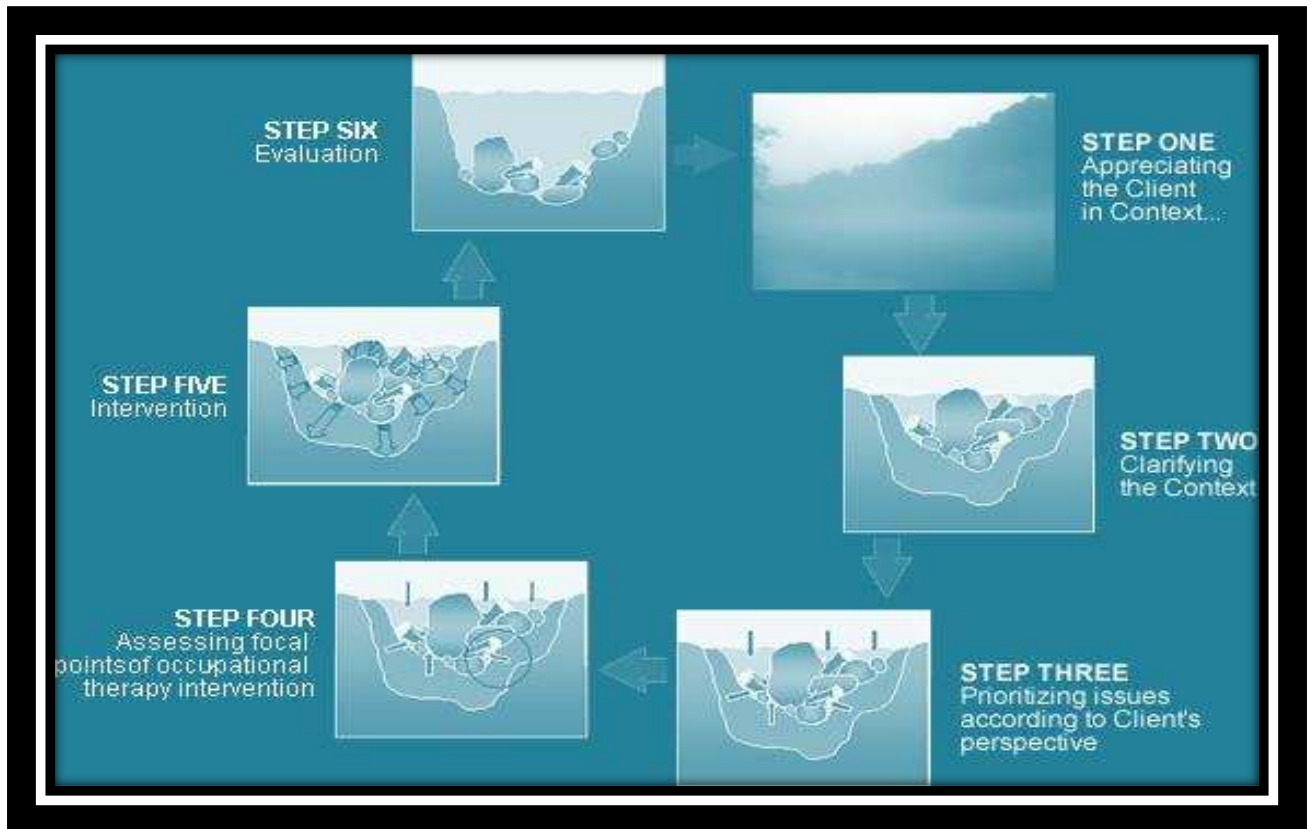
It is the internal construct of volition that is of interest in considering how this model supports operationalizing spirituality in practice. The model is described as applying holistic principles to ascertaining the view of clients. However, the spiritual aspect of holism is not articulated. The body and the mind are considered to be integral to how an individual functions. However, there is no explanation of the spiritual component integral to holism.

The model does not explicitly address spirituality, however the individual subsystem of volition where religious, spiritual, values and beliefs can be acknowledged does provide the opportunity for spirituality to be considered (Kang, 2003; Belcham, 2004). Volition is defined as, *“Pattern of thoughts and feelings about one-self as an actor in one’s world which occur as one anticipates, chooses, experiences and interprets what one does,”* (Kielhofner, 2008, p.

47). Volition is applied to the MOHO as an individual's motivation for engaging in occupations that are meaningful, valued, shaped by culture and part of their unique personal history. This application of volition highlights the uniqueness of the individual, their worldview and personal capacities that shape what are meaningful in their lives. It also provides the occupational therapist with the potential theoretical background to address what has been defined as spirituality, in terms of an individual's unique expression of meaning and purpose through occupation.

The most recent occupational therapy model is the Kawa model. This model has been acclaimed for its cultural relevance being constructed from Japanese and Asian ideals, as opposed to the Western values espoused by the majority of other models of practice. The model challenges the western existentialist perspective of the individual with the Asian collectivist worldview. From the collectivist perspective, the individual is seen in harmony with the people and the context in which they live. The occupational therapist is charged with understanding how a person belongs within their context or environment before they can progress to engage in meaningful occupations. The existentialist view focuses on the individualistic demonstration of the person and their context (Iwama, 2006). Figure 3 shows how the Kawa model is represented diagrammatically and applied to occupational therapy practice. The Kawa model doesn't espouse spiritual constructs in its application to practice, however it does focus on the individual and their unique worldview from a non-western perspective. Globally populations accessing health and social care are from a range of cultures, and these challenge the application of models to practice without considering their applicability to the individual's cultural background and worldview.

Figure 3: The Kawa Model, Application to Practice (kawamodel.com, n.d.)



The lack of clarity about how to embed spirituality in practice, and the lack of professional guidelines on this topic are consistent themes in occupational therapy literature (Udell & Chandler, 2000; Belcham, 2004; Johnston & Mayers, 2005). The suggestion that an increased application of models, such as the three addressed above, would improve holistic practice (including attention to spirituality) remains a tension for occupational therapists in practice. Despite how well established the models are in occupational therapy education their reported application in practice remains patchy (Parker & Sykes, 2006). Developing an understanding of *how* these models could support embedding spirituality in practice could be more productive, as all three models provide opportunities to address spirituality whether explicit or not.

1.6 Chapter summary and thesis overview

The purpose of this chapter was to explore spirituality, the relationship with early occupation therapy practice and the wider healthcare context. This chapter has discussed the tensions of defining spirituality in the wider health and social care sector, confirming that the quest for a firm definition that embraces all professions is possibly futile. A better way forward may be exploring what spirituality *looks like* in practice including from the patient's point of view. The background issues relating to the study of spirituality and occupational therapy practice. It has considered how the occupational therapy profession has developed with spirituality being a strong influence in its founders' worldviews. The underpinning philosophy and how this has developed through the changing paradigms to a rebirth of the profession's original values and beliefs has been explored. Finally, by outlining how the renewed interest in the place of spirituality as a core domain for professional practice impacts on occupational therapy practice. The key issues for occupational therapy practice relating to spirituality are:

- Lack of a widely acceptable, operational definition of spirituality;
- Occupational therapists are unsure how spirituality translates into practice but feel it is an important dimension of practice;
- The need for a model or framework with guidelines to support practice.

Finally, my personal interest and motivation for carrying out this study as an occupational therapist and academic have been presented, and how this has shaped this thesis will be revisited in Chapter Seven.

This thesis is concerned with how occupational therapists embed spirituality into their day-to-day clinical practice; therefore, definitions of occupational therapy and occupation have been offered to illuminate the professional background. The Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007) is offered as an introduction to how spirituality can be operationalized in practice. This is further explored in Chapter Two, concept analysis of spirituality and occupational therapy practice. In Chapter Three, methodological approaches are considered and the rationale is presented for choosing

qualitative methods, in particular an ethnographic approach using participant observation and semi-structured interviews. The study methods are outlined in Chapter Four. Chapter Five presents the study findings and the themes developed from the data. The themes are discussed further in Chapter Six and a conceptual framework supporting embedding spirituality in occupational therapy practice is presented. The quality measures applied to this study are presented in Chapter Seven, the strengths and limitations of the study are articulated along with a reflexive and reflective account of the study and thesis. Finally, in Chapter Eight conclusions are drawn and implications for practice, research, education and development of policy are offered.

1.7 Research question, aim and objectives

The study reported in this thesis was based on a desire to understand how spirituality was embedded within occupational therapy practice, and ultimately whether practice supported meeting patients' spiritual needs. The initial research question was framed as:

“How do occupational therapists embed spirituality in their day to day practice?”

This study aimed to explore how occupational therapists embed spirituality in their day to day practice.

The specific objectives were to:

1. Investigate therapeutic interventions that occupational therapists considered to be a dimension of spiritual care;
2. Observe how opportunities to address dimensions of spirituality were identified and incorporated in occupational therapy practice;
3. Explore the facilitators and obstructions to embedding dimensions of the spiritual aspects of care within occupational therapy practice.

Chapter Two

Concept Analysis

2. Introduction

This chapter presents a concept analysis of how spirituality has been understood and applied in occupational therapy practice, expanding on the issues introduced in Chapter One. The empirical referents of addressing spiritual as a means of guiding practice, and the antecedents and attributes underpinning spirituality as a dimension of occupational therapy practice are outlined. Based on the findings of the concept analysis a framework for occupational therapy practice was developed as a practical guide for occupational therapists to incorporate spirituality in their practice. Consideration was given as to the best place to position the concept analysis within this thesis, as it was an integral part of the study. The purpose of the concept analysis was to explore what was already known about how spirituality was embedded into occupational therapy practice in order to develop an empirical study which complemented previous research. Therefore, the concept analysis is positioned before the empirical study presented in Chapters Three, Four and Five. The concept analysis explored the existing evidence base, providing the rationale to undertake the study reported in this thesis, which adds to the body of evidence. In addition, by reviewing the established research, a method of data collection was chosen that had not previously been used in the exploration of spirituality and occupational therapy practice, yet offered the opportunity to observe practice. In addition, undertaking the concept analysis enabled the ongoing challenges of integrating spirituality in occupational therapy practice to be identified, which helped identify gaps in research and frame the empirical study undertaken as part of this thesis.

2.1 Concept analysis: the rationale

Chapter One, highlighted that spirituality is a key domain of occupational therapy practice and, for some individuals and communities, all occupations are viewed as spiritual (Kang, 2003, Johnston & Mayers, 2005). However, occupational therapists find conceptualising spirituality and its meaning for both themselves and their patients challenging (Belcham, 2004). In addition, embedding spirituality in practice has been hindered by the absence of practical guidance (Udell & Chandler, 2000; Belcham, 2004; Bursell & Mayers, 2010). However, research has explored occupational therapists' perceptions and experiences of addressing spirituality in practice, and the skills and attributes occupational therapists require for meeting patients' spiritual needs (Unruh et al., 2002; Morris 2013). Developing effective therapeutic relationships was identified as being central to occupational therapy practice, and included facilitating interactions that recognise and address the individual's spiritual needs (Udell & Chandler, 2000). Effectively addressing a person's spirituality can be influenced by the occupational therapists' attitudes to, and values placed on, incorporating spirituality in practice (Taylor et al., 2000). The adoption of a non-judgemental approach and sensitivity to a person's beliefs, values and connecting experiences is essential to developing a therapeutic relationship. Providing spiritual care requires the occupational therapist to have an understanding of their own spirituality in order to support others and maintain professional boundaries.

The literature relating to spirituality and occupational therapy examines the construct of spirituality from two distinct positions: a theoretical and an idealistic stance. The theoretical stance is underpinned by philosophical theories such as that of existentialism. Whereas the idealistic stance seeks to define what would be ideal, without reference to how spirituality is embodied in practice. Both positions have been criticised for lacking real world applicability. From the theoretical point of view, spirituality has been described in existential terms such as finding meaning and purpose; a source of connectedness or interconnectedness with oneself, other people and the universe; a universal phenomenon located within all people primarily

coming in focus during times of crisis (Unruh et al., 2002; Clarke, 2013). These descriptions highlight the relationship between culture, religion and spirituality. The relationship between spirituality and religion can be a source of controversy. Some authors emphasise the close link of spirituality to religion (Koenig, King and Carson, 2012). Others assert spirituality is an all-embracing experience irrespective of religious affiliation or beliefs (Johnston & Mayers 2005). Additionally, the American Occupational Therapy Association (AOTA) includes spirituality as a personal factor when engaging a person in meaningful occupation (AOTA, 2013).

Spirituality is described as a central construct of occupational therapy practice yet, as highlighted in Chapter One, remains contentious and difficult to define (Unruh et al., 2002). Occupational therapy is a profession committed to a holistic approach that values the uniqueness of each person. The unique core constructs of occupational therapy professional practice explicitly articulate the spiritual dimension of practice, such as engaging the individual in meaningful and purposeful occupations that promote health, well-being, and enhance quality of life (Townsend, 2002). In part, difficulties in embedding spiritual assessment and care in occupational therapy practice result from a lack of conceptual clarity or guidance that is helpful for occupational therapy practice (Unruh et al., 2002).

There are two theoretical frameworks or models that explicitly support occupational therapists embedding spirituality in their practice. The Canadian Model of Occupational Performance – Engagement (CMOP-E) (Townsend & Polatajko, 2007) and the Psycho-Spiritual Integration (PSI) conceptual framework (Kang, 2003). CMOP-E has been explained in Chapter One (refer to Figure 1, page 58), as a model that locates the individual and their spirituality as central to all occupational therapy practice. The application of CMOP-E has been linked to enhancing client-centred practice as the individual constructs, with the occupational therapist, a representation of their worldview that interprets their expression of spirituality (Townsend & Polatajko, 2013).

An alternative theoretical approach Kang's (2003) Psycho-spiritual Integration (PSI) conceptual framework was developed from a comprehensive review of literature relating to spirituality. The PSI conceptual framework has been proposed as a means of embedding spirituality in occupational therapy practice (Kang 2003). The conceptual framework describes six dimensions of spirituality: becoming; meaning; being; centeredness; connectedness; and transcendence. Kang (2003) suggested that the absence of one or more of these dimensions leads to 'spiritual deprivation' and a subsequent loss of well-being. Figures 4 and 5 highlight the components and dynamics of Psychospiritual Integration, and how spirituality is represented in Psychospiritual Integration applied to the conceptual foundations of Kang's Psychospiritual integration frame of reference for occupational therapy (Kang, 2003, p97)

Figure 4: Psychospiritual Integration components and dynamics (p 97)

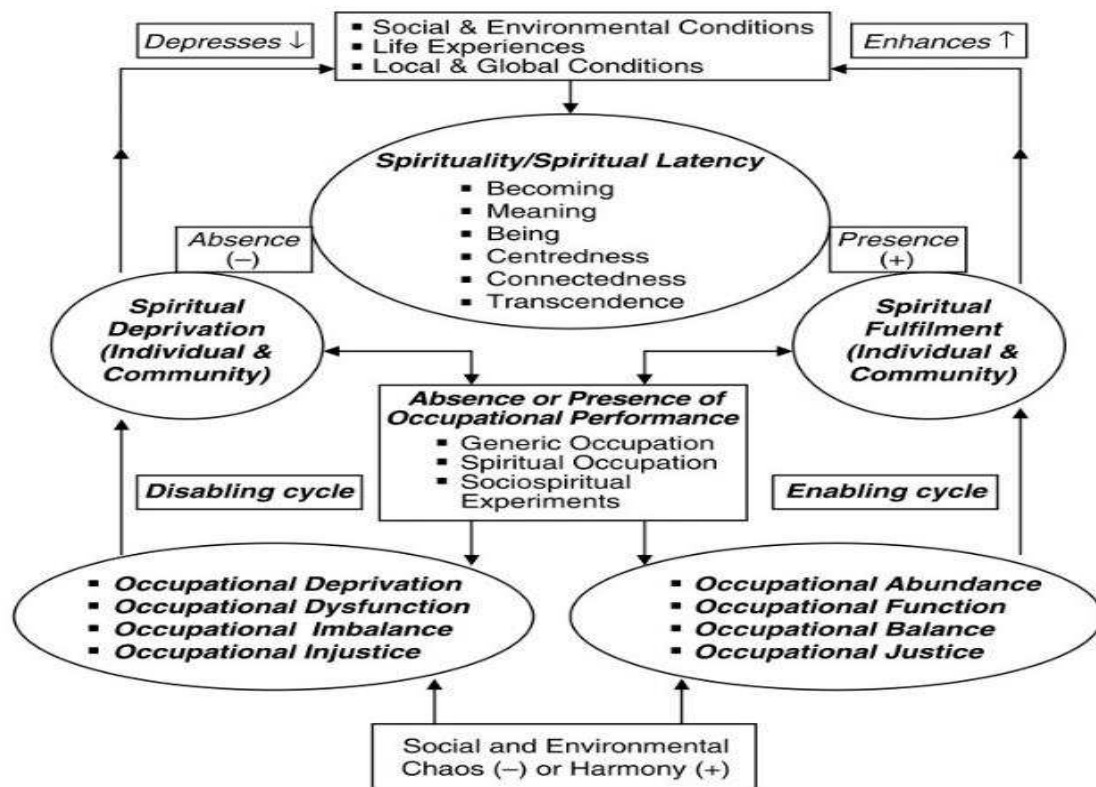
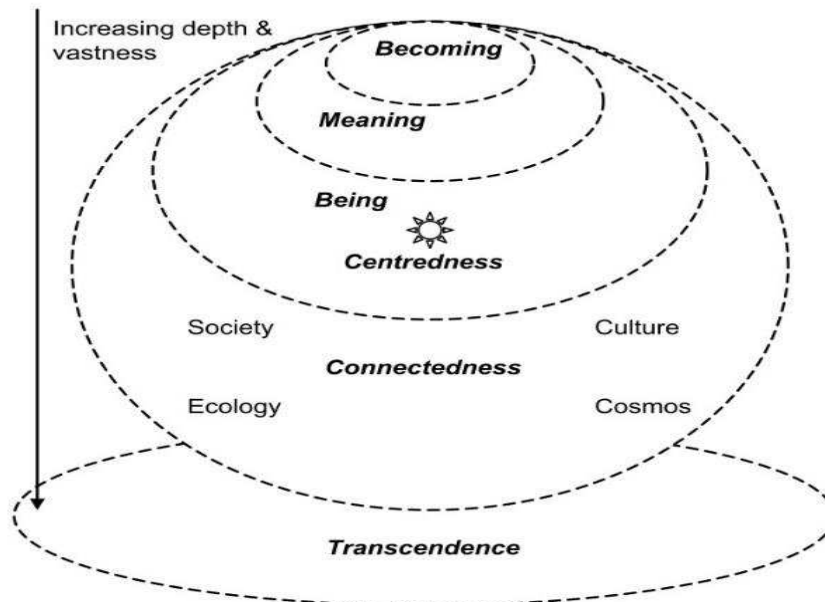


Figure 5: Diagrammatic representation of spirituality in Psychospiritual Integration

(p97)



Both diagrams (Figures 4 and 5 are from Kang, C. (2003). A Psychospiritual integration frame of reference for occupational therapy. Part 1: Conceptual foundations. *Australian Occupational Therapy Journal*, 50, 92-103.

Although the PSI framework anchors spirituality conceptually for occupational therapy, it does not operationalize it in the context of the occupational therapy encounter, and how spirituality impacts on engagement in occupation (Donica, 2008). Additionally, there does not appear to be any published evidence of the application or evaluation of the framework in occupational therapy practice. However, the framework does provide an effective template to assess the importance of spirituality and its impact on occupational performance. The framework remains incomplete, complex and requires further application to how occupational therapists effectively embed spirituality in their day-to-day practice.

The theoretical frameworks outlined have added to conceptual clarity in relation to providing occupational therapists with guidance on how to integrate spirituality in practice. The purpose of this concept analysis was to clarify the concept of spirituality, and how it has been articulated in studies that have investigated how occupational therapists address and embed spirituality in practice. Notwithstanding, the limitations of the theoretical frameworks outlined, the six dimensions of Kang's (2003) PSI framework illuminated further the dimensions of spirituality, outlined in Chapter One, in relation to occupational therapy practice and provided a structure to the analysis. However, Kang's (2003) paper did not meet the criteria to be included in the concept analysis.

The concept analysis aimed to identify the antecedents and attributes of spirituality as a dimension of occupational therapy practice. The specific objectives were to:

- Examine the literature relating to occupational therapy practice and spirituality;
- Critical analysis of the literature, extracting the constructs of spirituality and occupational therapy practice;
- Synthesis of the constructs of spirituality relating to occupational therapy practice;
- Develop a conceptual framework to guide occupational therapy practice.

2.2 Concept analysis method

Concept analysis is one of several methods used in concept development as a way of clarifying, describing, understanding and ultimately progressing complex concepts in healthcare. Strategies used to develop concepts differ in relation to the overall purpose of developing the concept, and how well concepts are established and used. Concept analysis is appropriate if the concepts are well established but lack clarity and remain nebulous and difficult to apply in practice. Whereas concept synthesis is appropriate for constructing a new concept if there is little existing knowledge, and concept derivation is the re-defining of a concept already in existence which has become outdated (Smith & McSherry, 2004; Walker & Avant, 2011). Concept analysis, as described by Walker and Avant (2011), was adopted

because, despite the many attempts to clarify its meaning, spirituality remains an ambiguous and nebulous concept, and remains challenging to embed in practice.

There are a range of approaches to undertaking a concept analysis, each with differing epistemological and ontological underpinnings. A critique of 13 frameworks for undertaking concept analysis suggested that the underpinning ontological perspectives and processes were not based on credible methodologies, particularly where frameworks have been adopted uncritically (Beckwith, Dickinson & Kendall, 2008). Two widely adopted models of concept analysis were considered: Rogers' (1991) evolutionary cycle which is a continuous cyclical process, developing and progressing as the context of the concept changes and evolves with use and time; and Hupcey and Penrod's (2005) principle-based model, that advocates cross disciplinary analysis to develop a comprehensive theoretical conceptualisation. Although both approaches could have been used, concept analysis, as described by Walker and Avant (2011), was adopted because it was more likely to meet the aim of the analysis which was to identify the antecedents and attributes of spirituality as a dimension of occupational therapy practice. Central to their approach is identifying the antecedents and attributes of the concept and providing example cases. In this concept analysis cases related to instances where spirituality was a dimension of occupational therapists' practice. The approach adopted had the strength of being based on both a critique of scientific literature (empirical referents) and everyday usage of instances and of recognising that concepts are context dependent (Risjord, 2009).

Walker and Avant's (2011) method has limitations and has been criticised for lacking rigour because of the subjectivity inherent in the interpretations of the concepts explored (Hupcey, Morse, Lenz & Cerdas Tasm, 1996; Hupcey & Penrod, 2005). Furthermore, adopting an essentially reductionist approach may fail to capture the effect of time and rapidity of changing contexts that inevitably influence conceptual understanding (Risjord, 2009). Despite these criticisms, Walker and Avant's (2011) eight stage process offered a clear and systematic method of enquiry. This facilitated the development of a meaningful description of spiritually

competent occupational therapy practice grounded in evidence. The method also facilitated the delineation of attributes that could be assimilated in a framework which could be used to explore and develop theory to aid research. The eight stages are presented in Table 3.

Table 3: Application of Walker and Avant's (2011) stages of concept analysis

Concept analysis stages	Application to Concept Analysis
1. Identify an ambiguous concept	Spirituality is an ambiguous concept and challenging to translate in practice
2. Determine the aims or purposes for analysis	This concept analysis aimed to explore the facets of spirituality in occupational therapy <i>practice</i> as reported in published research
3. Identify all the uses of the concept	A literature search was undertaken to identify research relating to spirituality and occupational therapy practice. Eight papers were selected to inform the concept analysis
4. Determine the defining attributes	The defining attributes of spirituality, as enacted in the occupational therapy therapeutic relationship, are underpinned by a holistic, person-centred approach to practice were mapped to Kang's (2003) Psychospiritual Integration framework
5. Construct a model case	A model case study was developed to highlight how the defining attributes identified in the studies reviewed could be expressed in practice
6. Construct borderline, related, contrary, invented and illegitimate cases	The model case was considered in relation to the barriers highlighted in the studies reviewed to illuminate situations where borderline, related, contrary, invented and illegitimate cases could occur in practice
7. Identify antecedents and consequences	Situations leading a person to require interventions by an occupational therapist are listed as antecedents; the outcomes of occupational therapist interventions are reported as consequences.
8. Define empirical referents	Empirical referents, demonstrating the existence of spirituality in occupational therapy practice, are outlined in the discussion of the concept synthesis findings

2.3 Inclusion/ exclusion criteria

Published studies were included in the concept analysis if they met the following criteria:

- Primary research published in the English language in peer reviewed journals from January 2000 to December 2013. This timeframe was used to capture the issues surrounding health policy and practice contemporary to occupational therapy and spirituality in an international arena;
- Empirical research focusing solely on the practice of occupational therapists addressing spirituality.

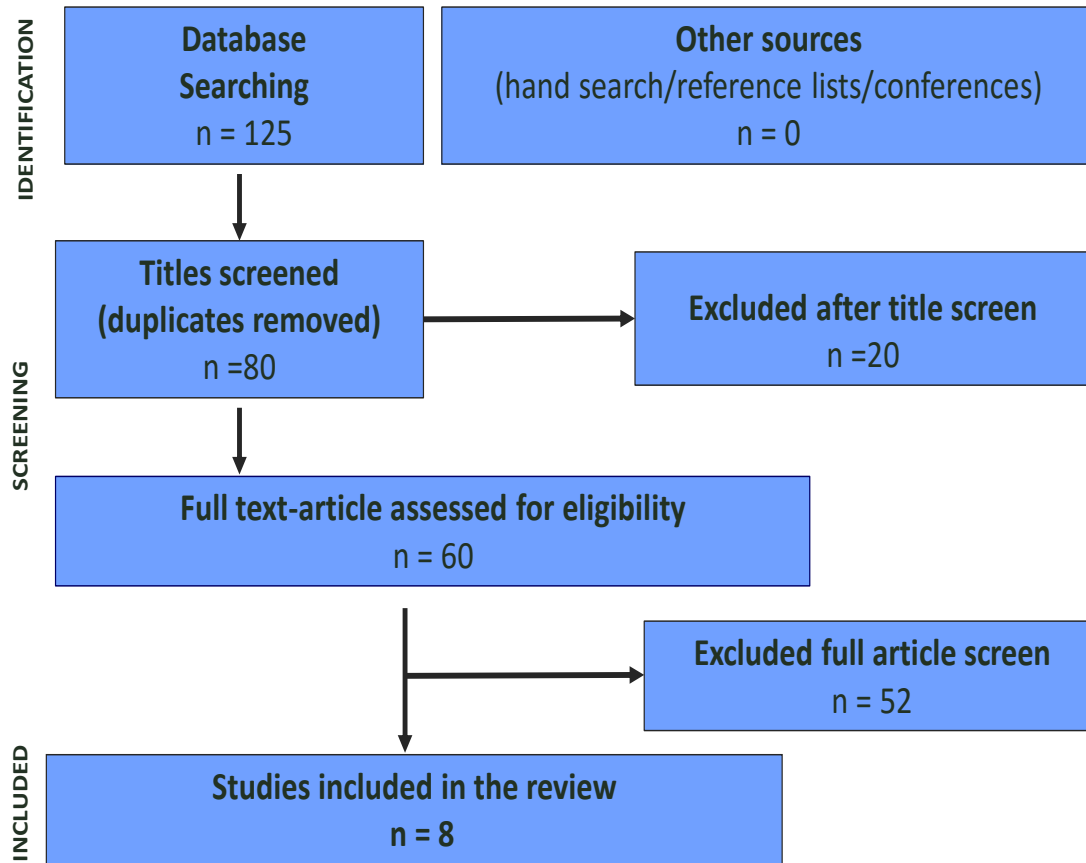
Exclusion criteria included:

- Articles published outside the timeframe stated above for inclusion;
- The focus was on embedding spirituality in occupational therapy education;
- Individual occupational therapist's perspectives of spirituality and opinion articles;
- Articles not concerned with occupational therapy practice; for example, nursing practice, psychology, complimentary medicine and applications of spirituality, religion, mental health and health outcomes.

2.4 Concept analysis procedures

Studies were identified by searching the following health and social sciences data bases: Medline, PsychINFO, Web of Knowledge, Wiley Interscience, CINHALL and PUB MED, between 2000 and 2013. The following search terms were used for each data base: Spirit* AND spirituality AND occupation AND occupational therapy, the process and search results are presented in Figure 6.

Figure 6: Flow chart of study selection process



The total number of titles returned was 125; these were reduced to 80 once duplicates were removed. The abstracts of 80 articles were reviewed by myself to establish if the focus of the article related to spirituality and occupational therapy, of the papers 20 were excluded because on further examination they related to other areas of spirituality and were not concerned with occupational therapy; for example, nursing practice, psychology, complimentary medicine and applications of spirituality, religion, mental health and health outcomes. The full text of the remaining 60 articles were retrieved and assessed for eligibility for inclusion. Following detailed reading of retrieved articles, a further 52 were excluded because they did not meet the aims of the concept analysis or the inclusion criteria, resulting in eight articles being included in the concept analyses.

The synthesis of the 8 articles included involved two stages:

- Stage one involved critiquing each study, using the CASP tool, and extracting the key findings. These key findings are presented in Table 4 (page 76).
- Stage two involved mapping the key findings to the antecedents (or foundations), defining attributes (central components) and consequences related to embedding spirituality in occupational therapy practice (Finfgeld-Connett, 2007; Walker & Avant, 2011). The antecedents, defining attributes and consequences of addressing spirituality in occupational therapy are presented in Table 5 (page 82).

Central to Walker and Avant's (2011) method of concept analysis is the use of case examples as a way of constructing meaning and enhancing understanding of the concept being explored. The antecedents and attributes were brought together to develop a model case which was framed using the domains of spirituality outlined in the PSI (Kang, 2003), section 2.5.1. (page 83). The PSI framework was useful to provide a 'scaffolding' to illuminate the domains of spirituality for occupational therapy practice, but has limitations in that it has not been substantially evaluated in relation to its application in occupational therapy practice.

2.5 Findings

Three qualitative studies were included that elicited the perceptions and experiences of occupational therapists by semi structured interview methods and analysed data using variations on thematic analysis (Udell & Chandler, 2000; Beagan & Kumas-Tan, 2005; Hoyland & Mayers, 2005). One qualitative study used a phenomenological design for data collection and analysis (Egan & Swedersky, 2003). All four quantitative studies explored the significance of occupational therapists' experiences of spiritual care in practice and their attitudes to the phenomenon by means of questionnaires, with data analysed using both descriptive and inferential statistics (Taylor et al., 2000; Collins, Paul & West-Frasier, 2001; Farrar, 2001; Morris, 2013). A summary of the eight studies informing the concept analysis are presented in Table 4.

Table 4: Overview of studies informing the concept analysis

Author/s	Year	Study aim	Methods	Participant numbers	Key findings
Beagan and Kumas-Tan (Canada)	2005	Explored how occupational therapists describe addressing spiritual issues in their day-to-day work in comparison to pastoral care professionals.	Qualitative interview based study Data analysis was carried out by coding transcripts using AtlasTi software	Snowballing sampling of 20 occupational therapists, 21 pastoral care workers via newsletters and recruitment letters to local professional associations.	<ul style="list-style-type: none"> • Delivering effective occupational therapy requires commitment to holistic practice that respects client values, desires and dreams, and the individual meaning they attribute to occupations. • Meeting spiritual needs requires identifying meaning in a person's life • Client-occupational therapist relationship is central to addressing issues in day-to-day practice
Collins et al (USA)	2001	Investigate the beliefs, practices and perceived barriers to embedding spirituality in the assessment and treatment of patients in occupational therapy practice	Quantitative survey Questionnaire was an adaption of 'Physician Spiritual Assessment Survey' (Ellis et al, 1999) Data analysis used descriptive statistics and inferential Pearson Chi-square analysis	Random sample of 250 members of the American Occupational Therapy Association (AOTA), 112 participated	<ul style="list-style-type: none"> • No relationship between occupational therapy practice settings and embedding spirituality in practice was reported • Slight increase in the consideration of spirituality in practice compared with previous studies carried out • Barriers to embedding spiritual care in practice included lack of education in undertaking a spiritual history and the practicalities of incorporating spirituality in practice
Egan and Swedersky (Canada)	2003	Exploration of spirituality as experienced by occupational therapists in practice.	Qualitative study Semi-structured Interviews Analysis based on modified phenomenological approach according to Colaizzi (1978)	Purposive sample of 8 occupational therapists who considered spirituality in their practice	Four themes about embedding spirituality in practice emerged: <ul style="list-style-type: none"> • Addressing religious concerns • Addressing suffering • Acknowledging individual worth and uniqueness • Positive impact of occupational therapists in addressing spirituality with patients

Farrar (USA, Canada)	2001	To determine how occupational therapists addressed patients spiritual and religious needs in practice	Quantitative survey Researcher developed questionnaire Data analysis included descriptive statistics, primarily frequencies and qualitative content analysis to categorise codes and develop themes	Random sample of 410 occupational therapists, from North America identified from the Canadian Association of Occupational Therapists (CAOT) and AOTA membership. 38% responses rate	<ul style="list-style-type: none"> • Spirituality was identified as a key domain of occupational therapy practice • Examples relating to embedding spirituality in practice included; addressing diet, relaxation, therapeutic touch, self-esteem activities, locus of control, expression of feelings in a safe therapeutic environment
Hoyland and Mayers (UK)	2005	Explored how occupational therapists address spirituality as part of their domain of practice	Qualitative study Semi-structured Interviews Data analysis involved coded data and developing themes	Convenience sample of 6 occupational therapists from physical rehabilitation and mental health settings	<ul style="list-style-type: none"> • Occupational therapists consider spirituality as central to their domain of practice • Listening and delivering holistic care are ways of embedding spirituality in every day practice • Importance of therapeutic relationship is central to addressing spiritual issues in day to day practice
Morris (USA)	2013	Perceptions of including spirituality and spiritual care in occupational therapy practice	Quantitative study Questionnaire used the 'Spiritual Care Perspectives Scale' (Taylor et al 1994) Data analysis based on descriptive and inferential statistics to determine the significance and perceptions of spiritual care in practice	Self-selecting sample 310 occupational therapy practitioners and members of AOTA	<ul style="list-style-type: none"> • Occupational therapists consider lack of educational preparation hinders their ability to address spiritual aspects of care • Occupational therapists perceive they lack understanding of the individual constructs central to spirituality • Using a spirituality assessment tool was highlighted as a way to meet an individual's spiritual needs.

Taylor et al (USA)	2000	To determine the attitudes of occupational therapists about spirituality in relation to practice	Quantitative survey Researcher-developed attitude questionnaire Statistical analysis using descriptive and inferential statistical tests	Random sample of 396 occupational therapists, 210 participated	<ul style="list-style-type: none"> • Occupational therapist's attitudes about spirituality and occupational therapy practice were diverse: participants who considered themselves religious had more positive view about embedding spirituality in practice • Praying for client, using spiritual language, discussing client's religious beliefs were identified as ways of meeting spiritual needs
Udell and Chandler (UK)	2000	Understand the experience of occupational therapists addressing spiritual needs of patient	Qualitative study Semi-structured Interviews Data analysed using coding and interpretative analysis methods	Non-probability purposive sampling - 3 Christian occupational therapists	<ul style="list-style-type: none"> • The role of the occupational therapist included acknowledgement of spiritual need that impacted on function, respect for clients by incorporating choice, dignity and religious traditions in care • Therapeutic relationship was highlighted as central to providing spiritual dimension of care

In three of the studies, spirituality was identified as central to occupational therapy practice (Udell & Chandler, 2000; Farrar, 2001; Hoyland & Mayers, 2005). The findings suggested occupational therapists identified a relationship between addressing patients' spiritual and religious needs, which were implicitly linked to effective patient-professional engagement and developing effective therapeutic relationships (Farrar, 2001). Dimensions of meaning and purpose were highlighted as a vehicle for addressing spirituality through occupational therapy practice and interventions (Morris, 2013). However, a limited range of in depth assessment tools specifically for occupational therapists and outcome measures for spiritual domains of practice were perceived as a barrier to meeting an individual's spiritual needs.

The majority of the studies reviewed were undertaken in North America (Taylor et al., 2000; Collins et al., 2001; Farrar, 2001; Egan & Swedersky 2003; Beagan & Kumas-Tan 2005; Morris, 2013). These studies emphasised the importance of a person's religious beliefs in framing therapeutic interventions rather than the broader aspects of spirituality (Taylor et al., 2000). However, one Canadian qualitative study compared the role of occupational therapists and pastoral care professionals in addressing spirituality (Beagan & Kumas-Tan, 2005). Their findings supported the notion that addressing spirituality was part of the overarching philosophical framework of occupational therapy practice. Similarly, the UK studies adopting qualitative interview designs were more likely to identify the development of therapeutic relationships with people in order to address spirituality in practice (Udell & Chandler, 2000; Hoyland & Mayers, 2005).

The studies from both UK and North America found that occupational therapists were committed to providing person-centred interventions and recognised the importance of therapeutic relationships for addressing spiritual dimensions in practice. However, there was a lack of description of how to address patients' spiritual need in practice and a failure to offer guidance relating to integrating spirituality for occupational therapy practitioners (Hoyland & Mayers, 2005; Morris, 2013).

Spirituality was identified as the overarching philosophical framework, and central to occupational therapy practice (Udell & Chandler, 2000; Farrar, 2001; Beagan & Kumas-Tan, 2005; Hoyland & Mayers, 2005). The key findings within each study (Table 4, page 76) were analysed to identify the antecedents, defining attributes and consequences of addressing spiritual needs in occupational therapy practice. The antecedents related to the impact of a disruption to a person's health status in terms of loss of meaning and purpose, and a connection to life, reflected in Kang's (2003) PSI framework. The defining attributes of embedding spirituality in occupational therapy practice were the provision of a holistic, person-centred approach to occupational therapy practice, facilitated through effective therapeutic relationships and the support and restoration of the dimensions within the PSI framework.

Although the PSI framework (Kang, 2003) has provided a useful structure for examining spirituality in occupational therapy practice, the framework was not developed from empirical research; therefore, the article itself did not meet the criteria for inclusion in the concept analysis. Kang (2003) emphasises that to experience spiritual well-being all the domains need to be addressed. An omission in Kang's framework is the construct of suffering and how occupational therapists address this in their practice. As a construct of embedding spirituality in occupational therapy practice suffering was a notable omission and has been included in this concept analysis, and applied to the defining attributes. Suffering was an essential theme of occupational therapy practice in the study by Egan and Swedersky (2003). Suffering was described as assisting the individual to deal with feelings and distress caused by pain and loss in order to alleviate suffering. Additionally, addressing suffering, as a construct of spirituality, was considered essential to enable a person to employ coping strategies to deal with their distress and progress towards improved functioning. Therefore, the construct of suffering has been included in the defining attributes of embedding spirituality in occupational therapy practice (Table 5, page 82).

Table 5: Antecedents, defining attributes and consequences of spirituality in occupational therapy practice

Antecedents	Defining attributes	Consequences
<p>Disruption to a person's health status affecting their well-being and quality of life for example:</p> <ul style="list-style-type: none"> Acute illness Mental health problem Terminal diagnosis End of life Loss or grief 	<p>Addressing suffering related to the individual's circumstances; and the provision of a holistic, person-centred approach to occupational therapy practice; the therapeutic relationship facilitates addressing a patient's spiritual needs</p>	<p>Individuals' experience well-being through a sense of meaning and purpose in their life and spiritual order, and work towards the restoration of values and a belief system</p>
<p>Disruption may lead to:</p> <ul style="list-style-type: none"> • Loss of 'flow' in a person's occupations and life balance • Loss of 'meaning' and 'purpose', and 'significance' in life • Loss of purpose in life with the consequence of lowered self esteem • Lack of 'values' in life • Lack of connection within life • Lack of ability to transcend disruptions 	<p>Attributes of disruption reflected the dimensions of PSI framework (Kang 2003):</p> <ul style="list-style-type: none"> Becoming Meaning Being Centeredness Connectedness Transcendence 	<p>Recognition of inner resources assists coping with disruptive situations in a person's life, either temporary or permanent.</p> <p>Spiritual order exists when an individual can reconcile most or all PSI dimensions of spirituality (Kang, 2003)</p>

2.5.1 Concept analysis: model case study

Central to Walker and Avant's (2011) method is the use of case examples as a way of constructing meaning and understanding of the concept being explored. A model case has been constructed from my professional experience as an occupational therapist, to demonstrate how spirituality is aligned to occupational therapy practice and the defining attributes outlined in Table 5.

Jean was a 67-year-old woman who, following a stroke had right-sided weakness of her upper and lower limbs. She had short term memory problems which she had developed strategies to overcome. Following her husband's death six months prior to her stroke, Jean had sold her home and moved to a ground floor apartment with a small garden. Her interests included gardening, playing the piano, spending time with her family and being a member of the Women's Institute. Piano playing was a strategy she used to reduce her anxiety.

Jean was transferred from an acute hospital ward to an intermediate care residential setting for six weeks' rehabilitation. The focus of the rehabilitation was to improve her independence with activities of daily living and ultimately reduce her dependence on a care package when she was discharged home. She was anxious to return home as she described feeling hopeful and happy there. Jean's goals were identified in collaboration with the occupational therapist, are applied to the defining attributes and explained in Table 6.

Table 6: Defining attributes applied to the model case study

Address anxiety regarding discharge home – *suffering*;
Her goal to live independently at home without carers – *becoming*;
Returning to playing the piano and gardening with some adaptation necessary – *meaning*;
Achieve a sense of personal independence and satisfaction with life – *being*;
Re balance her life following her significant losses – *centeredness*;
Remain an active member of her family and community – *connectedness*;
Develop inner resilience to reach beyond her problems and develop strategies to cope with symptoms such as anxiety, for example by playing the piano – *transcendence*.

The shared goal setting and the development of strategies to enhance Jean's spiritual well-being facilitated this process. For example, Jean's aspiration to play the piano again, which provided her with a sense of achievement and reduced her stress helped to give new meaning and an experience of transcendence to her life. This could only be achieved by skilful help in setting intermediate goals to help her regain the motor and cognitive skills necessary to regain this ability. Once the motor and cognitive skills were regained this supported her inner resilience to cope with symptoms such as anxiety. Recognising suffering has been identified as a pre-requisite to responding to an individual's personal circumstances (Egan & Swedersky, 2003). Recognising Jean's loss of her husband, and the suffering involved in grieving, required consideration when identifying goals and appropriate interventions with Jean.

Creating '*borderline*', '*related*' and '*contrary*' cases to illuminate the application of the concept to a case study is advocated by Walker and Avant (2011) ensuring that the defining characteristics of the concept are fully explored. '*Borderline cases*' have some of the defining attributes but demonstrate inconsistency from the concept under consideration. A borderline case can illuminate the consistency of the model case or provide clarity about the defining attributes. An example of creating a borderline care applied to occupational therapy practice

could be seen in the following instance. The occupational therapist attempts to develop a therapeutic relationship, which is necessary to promote addressing aspects of holistic care including spirituality, and they are compromised by time pressures (Hoyland & Mayers, 2005). A “*related case*” where some of the defining attributes were present has been referred to as tokenism and a “*contrary case*” containing none of the defining attributes. None of the papers reviewed identified a contrary case in relation to occupational therapy practice, nor could I identify one from my own experience as a practitioner. Furthermore, such cases would infringe the overarching holistic and person-centred values of the profession.

2.5.2 Defining or describing spirituality

Walker and Avant (2011) suggest that a concept analysis could lead to a clear definition of the concept described. This concept analysis confirms that defining spirituality in occupational therapy practice remains difficult. The definitions that already exist do add clarity in relation to occupational therapy practice. Based on this concept analysis and the application of the PSI conceptual framework, spirituality in occupational therapy practice could be more usefully *described* than *defined*. The following description is offered to increase occupational therapists’ understanding of spirituality in practice;

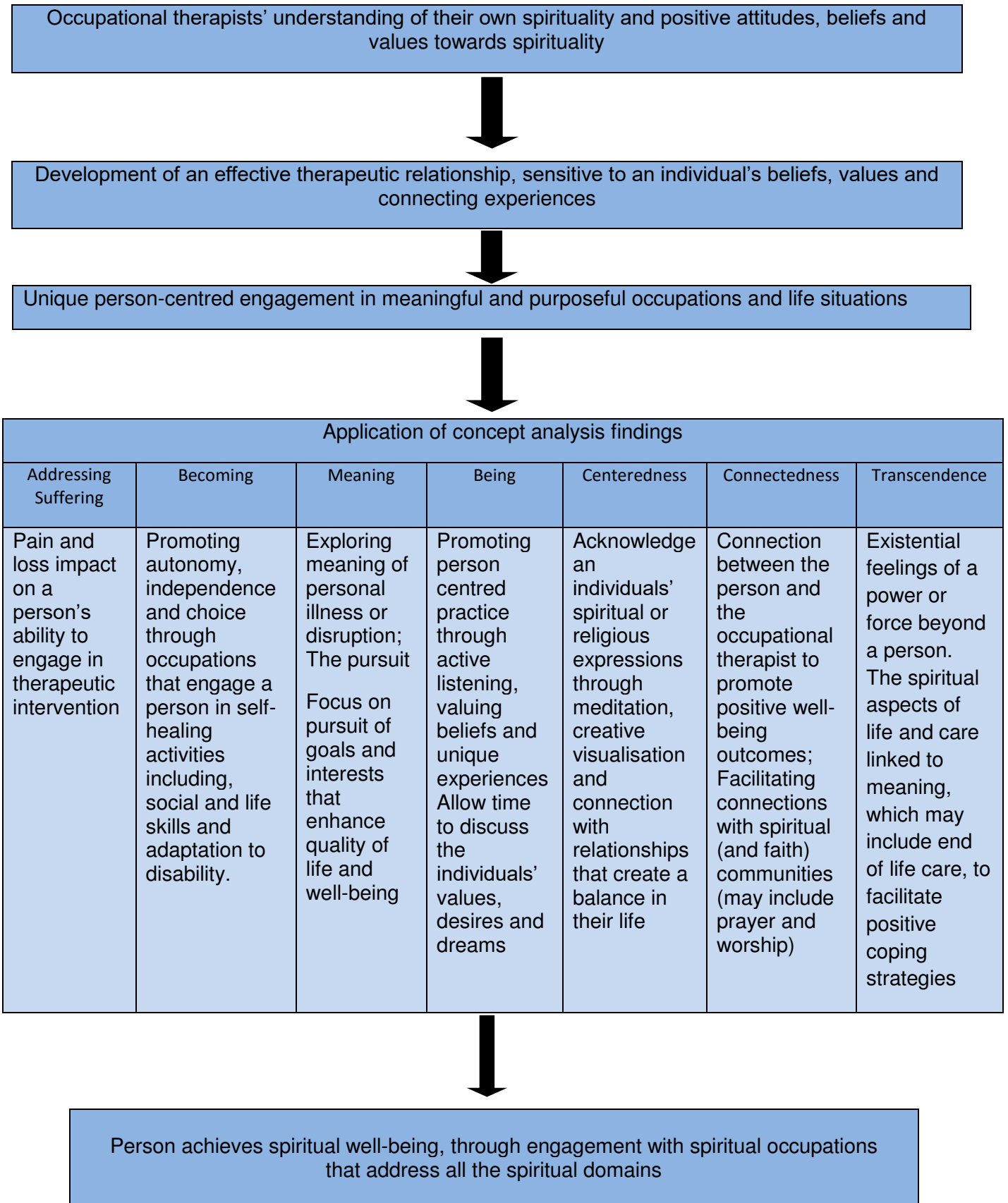
Spiritually competent occupational therapy practice engages a person, as a unique spiritual being, in occupations which will provide them with a sense of meaning and purpose. It seeks to connect or reconnect them with a community where they experience a sense of wellbeing, addresses suffering and develops coping strategies to improve their quality of life. This includes the occupational therapist accepting a person’s beliefs and values whether they are religious in foundation or not and practicing with cultural competency.

2.5.3 Framework for occupational therapy practice

The empirical referents illuminate how occupational therapists address spirituality through occupation and their practice culminating in the presentation of a framework Figure 7: Conceptual framework for spiritually competent occupational therapy practice. This framework is offered as a way occupational therapists could integrate or operationalize spirituality in practice. First the defining attributes of spirituality as applied to the model case study (Table

6, page 84) were organised in a way to reflect spiritual competence in practice. The second stage was to map the identified constructs of spirituality to the domains of spiritually competent practice as suggested by Kang (2003) and Egan and Swedersky (2003). Finally, the outcome of spiritually competent occupational therapy practice was framed as spiritual well-being, which can be achieved by engaging in spiritual occupations that address the spiritual domains.

Figure 7: Conceptual framework for spiritually competent occupational therapy practice.



2.6 Conceptual framework

The conceptual framework for spiritually competent occupational therapy practice, as presented in Figure 7, page 87, describes the process involved in embedding spirituality in day to day occupational therapy practice. It outlines, from the findings of the concept analysis, the stages necessary beginning with the occupational therapist acknowledging their own spirituality. The occupational therapist develops a therapeutic relationship in order to engage an individual in person-centred therapeutic interventions. The skills and attributes required of the occupational therapist to develop a context, where the spiritual domains can be applied to the individual's unique needs, are identified by the framework in the application of the concept analysis findings.

The first stage of developing spiritual competency is that the occupational therapist is aware of their personal understanding of spirituality, and how this might influence their practice. This has been outlined as key to developing spiritual competency in a number of studies exploring how occupational therapists articulate spirituality in practice (Thompson & McNeil, 2006). Once these core competencies are established, the occupational therapists can then develop a therapeutic relationship with the individual, and establish the rapport necessary to engage with them on a personal level. This person-centred approach is central to exploring patients concerns and establishing their goals of engaging in occupational therapy. A person-centred approach underpins the core domains of spirituality as identified by this conceptual framework, namely addressing suffering, becoming, meaning, being, centeredness, connectedness and transcendence. The proposed conceptual framework aims to facilitate an individual therapist delivering occupational therapy interventions in a way that addresses the spiritual domains identified by the concept analysis.

The conceptual framework was used to guide the observations of practice carried out and reported later in this thesis. Initially an observation guide was developed, structured around the conceptual framework and aimed to assist the observation. However, this was found to

constrain the process and abandoned as I became more confident with the process of observation and extracting the domains of spirituality.

2.7 Discussion of the empirical referents

The concept analysis highlighted the complexity involved when embedding spirituality in occupational therapy practice and how patients' and occupational therapists' experiences will be enhanced by a deeper understanding of the concept. The empirical referents are aspects of the concept of spirituality that demonstrate its existence in the real world (Walker and Avant, 2011). This concept analysis of spirituality in occupational therapy practice further illuminates the issue of the theory and practice gap. The empirical referents highlight the application of addressing spiritual needs in occupational therapy practice. This discussion focuses on the dimensions presented in the conceptual framework (Figure 7, page 87), their presence in Kang's framework and the literature reviewed for this concept analysis.

2.7.1 Suffering

Suffering as a dimension of occupational therapy practice addressing the spiritual needs of a person was considered by Egan & Swedersky (2003). Addressing suffering is a significant area of an occupational therapist's practice. Pain and loss are offered as examples of suffering, which would be addressed by an occupational therapist before progressing to the practical aspects of the therapeutic encounter. In terms of the dimensions proposed by the work of Kang (2003) suffering is not included in the six core dimensions, but is applicable in the overall exploration of spirituality as a component of occupational therapy practice.

2.7.2 Becoming

A person's capacity for growth and change throughout life's journey and the potential to achieve self-actualisation is defined as 'becoming' (Kang, 2003). The focus of this domain of spirituality promoted autonomy, independence and choice through an individual's occupations and activities. Occupational therapy interventions enabling a person to engage in self-healing

activities, for example worship, relaxation, stress management, improving social and life skills, promote autonomy, independence, adaptation to disability and choice all facilitate 'becoming' (Farrar, 2001; Egan & Swedersky, 2003). The focus of occupational therapy practice embedding the domain of becoming occurred when occupational therapy interventions focussed on managing distressing symptoms in order that the individual will achieve their full potential.

2.7.3 Meaning

A consistent domain emerging from the research that explores spirituality across healthcare professions is 'meaning' (Clarke, 2013), and this was also reflected in the findings of this concept analysis. Meaning is a well-recognised construct in other disciplines such as psychology and sociology, sometimes relating to extreme experiences of suffering (Frankl, 2000) and authentic happiness when experiencing the meaning in life (Seligman, 2002). The exploration of the meaning of personal illness or disability is part of occupational therapy practice (Collins et al., 2001; Egan & Swedersky, 2003; Hoyland & Mayers, 2005). Exploring what is significant for a person, to establish meaning in their illness and pursuing goals and interests that enhance their quality of life and well-being is an element of the goal setting process (Egan & Swedersky, 2003). Helping an individual to find meaningful occupations to engage in that provide them with a sense of purpose is central to occupational therapy practice and therefore the domain of meaning underpins spiritually competent practice.

2.7.4 Being

The essence of the person, which some people consider to be '*spirit*', and opportunities for self-expression are defined as '*being*' (Kang, 2003). This dimension promotes person-centred practice as central to the core philosophy of occupational therapy (Townsend, 2002). Person centred practice in relation to spirituality is acted out in the skills of the therapist listening to the person and acknowledging their beliefs; all of these are features of the domain 'being' (Udell & Chandler, 2000). Allowing a person time within therapy to discuss spiritual and

religious issues and consider existential questions assists in acknowledging their uniqueness and exploration of their dreams, values and desires (Egan & Swedersky, 2003; Beagan & Kumas-Tan, 2005).

2.7.5 Centeredness

The “*divine spark*” or the “*core of being*” is defined as centeredness (Kang, 2003, p 98). This has been translated in practice as acknowledging the importance of a person’s own spirituality and/or religious expressions and experiences. Achieving spiritual wellness through engagement with meditation or creative visualisation (for example) creates a balance in a person’s life where the chaotic factors from illness or grief pervade (Collins et al., 2000; Udell & Chandler, 2000; Farrar, 2001). The importance of relationship with others, God and a community (not necessarily a faith community) are relevant, for example attendance at worship and religious practices becomes important (Hoyland & Mayers, 2005). The application of centeredness in relation to religious practices linked to the domain of belonging and connectedness. Acknowledging that spiritual domains may or may not connect with religious practices is important to promoting well-being. The North American studies suggested that when appropriate, which may include praying with patients, the use of spiritual language and concepts and encouraging people to participate in religious activities is important (Taylor et al., 2000; Collins et al., 2001). This overt link to sharing religious beliefs has raised some concerns in the UK when the case of a nurse offering to pray with a patient reached the national media (BBC News, 2009). However, assisting a person to attend their place of worship was identified in the Hoyland and Mayers study (2005). These domains of ‘centeredness’ and ‘connection’ both enact spirituality which may or may not be related to a particular religious experience or practice.

2.7.6 Connectedness

The experience of belonging to others, nature, God and family is defined as ‘connectedness’ (Kang, 2003). This is acted out in practice by facilitating connections with communities

(including faith communities) and spiritual practices such as prayer, meditation and worship (Taylor et al., 2000; Egan & Swedersky, 2003). The client-therapist relationship, in facilitating therapeutic interventions, also promotes a positive outcome for addressing connection (Beagan & Kumas-Tan 2005). Additionally, connections to an individual's birthplace or sites of religious significance, including resting places of the dead are considered to enhance spiritual belonging (Wilcock & Hocking, 2015). The focus of practice that embedded the spiritual domain of belonging related to facilitating an individual to connect with a place that provides them with a sense of meaning, purpose and spiritual well-being.

2.7.7 Transcendence

The term '*transcendence*' is used to describe the existential feelings of a power or force beyond a person, and the capacity to develop strategies to cope by drawing from internal resources (Kang, 2003). The development of coping strategies, including facilitating end of life conversations (when appropriate) to discuss transcendent or spiritual aspects of life, illustrated the link between transcendence and meaning and purpose (Udell & Chandler, 2000; Farrar, 2001). Historically spirituality was addressed by occupational therapists encouraging (where appropriate) religious practice alongside activities such as relaxation, anxiety management and other positive coping skills, when for example dealing with loss and facilitating the resolution of grief (Farrar, 2001; Egan & Swedersky, 2003). Therefore, the focus of spiritual practice should be to facilitate the participation in these meaningful occupations effectively.

In summary, many of the studies reviewed recognised the need to address a patient's spiritual need as an essential element of human nature, which needs to be addressed in occupational therapy practice. Irrespective of whether spirituality is defined in religious or secular terms, Kang's (2003) six dimensions offered a useful organising framework and have been developed in the conceptual framework presented. This conceptual framework is based on the findings of the concept analysis, including the attributes and antecedents relating to integrating spirituality within occupational therapy practice. The conceptual framework, developed from

this concept analysis and presented in Figure 7, page 87, is offered as a way to help occupational therapists in addressing the individual patients' spiritual needs, and embedding spirituality in day to day occupational therapy practice. More importantly the framework provided a platform for structuring the observations undertaken in this study.

A survey of occupational therapists from a wide range of practice settings identified that, where occupational therapists used models which promoted spirituality and holistic practice, their confidence to practice and address the patients' spiritual needs increased (Belcham, 2004). However, despite some occupational therapists' theoretical understanding and desire to practice holistically, there is a need for practice guidelines to integrate the theory in day-to-day practice (Finlay, 2001; Belcham, 2004). This concept analysis highlighted the gap between theory and practice, although the attributes of spiritually competent practice have been explained. The limitations of the empirical research to date primarily related to the narrow application of research methods; data collection methods mainly focussed on the accounts, from therapist's narratives, of spirituality in practice. The study outlined in the following chapters focuses on what happened during the occupational therapy encounter.

2.8 Conclusion

This concept analysis sought to clarify the concept of spirituality and how it could be operationalized in the practice of occupational therapists. Spirituality is an aspect of our humanness and practice associated with a holistic, person-centred approach takes this in account, alongside physical, emotional and mental needs. Following this concept analysis, it appears that spirituality in occupational therapy practice is more usefully described than defined. The conceptual framework for spiritually competent occupational therapy practice (Figure 7, page 87) has been proposed to guide practice and future research by exploring the explicit construct of spirituality from a practice perspective. However, the framework has limitations in that it has not been developed with input from patients, or tested in practice to evaluate its to support occupational therapy practice in reality. Using the concept analysis as a starting point for observations, the subsequent chapters present a qualitative ethnographic

study addressing the research question: how do occupational therapists embed spirituality in their day to day practice?

Chapter Three

Methodology

3. Introduction

Chapters One and Two have highlighted the complexity of spirituality in healthcare, especially in occupational therapy, and that as a concept spirituality lacks clarity. A key issue that emerged from these chapters included that a description of spiritually competent practice was likely to be more useful than defining spirituality; many definitions are complex and difficult to apply in practice. The purpose of the study presented in this thesis was to explore if spiritually competent practice existed, how it was enacted in practice, and how established practitioners articulated, perceived and experienced spiritual concerns in practice. This chapter will present the aim and objectives, followed by rationale for adopting a qualitative study design, and more specifically undertaking an ethnographic approach. Alternative qualitative approaches of grounded theory, phenomenology and case study design will be outlined, and the reasons why they were rejected offered.

3.1. Study aim and objectives

This study aimed to explore how occupational therapists embed spirituality in their day to day practice.

The specific objectives were to:

1. Investigate therapeutic interventions that occupational therapists considered to be a dimension of spiritual care;
2. Observe how opportunities to address dimensions of spirituality were identified and incorporated in occupational therapy practice;
3. Explore the facilitators and obstructions to embedding dimensions of the spiritual aspects of care within occupational therapy practice.

3.2. Rationale for adopting a qualitative methodology

A qualitative design based on an ethnographic approach was chosen as the most appropriate to meet the study aim and objectives. Qualitative approaches are particularly suitable for exploring complex situations where an in depth exploration of a phenomenon is needed from the inside, to enhance our understanding of real life settings (Denzin & Lincoln, 2008; Ritchie, Lewis, McNaughton Nicholls & Ormston, 2014). These methods are concerned with exploring participant's experiences making sense of, or interpreting a phenomenon, by employing inductive methodologies to explore phenomenon in depth in real world settings (Robson, 2011). The application of qualitative methodologies enables the study of individuals in their natural surroundings by employing methods of data collection and analysis that are flexible and therefore sensitive to exploring the issues relevant to participants and their context (Ritchie et al, 2014). Qualitative research is valued for its complex and detailed subjective understanding of the social world, while respecting the unique contributions of each participant. Additionally, a reflective approach on the part of the researcher is integral to the research process that brings their unique ability to analyse, interpret and make sense of complex concepts and situations, often in an attempt to solve real world issues.

Qualitative research is complex and difficult to define; it is an overarching term that is devoid of its own distinct paradigm or theoretical framework. Qualitative research is dynamic, continually advancing with a wide range of approaches, reflecting differing epistemological and ontological underpinnings (Streubert & Carpenter, 2011; Ritchie & Lewis, 2013). This can make choosing appropriate methods challenging because of the range of qualitative approaches available and having no recognised taxonomy. Qualitative research remains criticised in the positivist paradigm because of claims of lacking objectivity (Snape & Spencer, 2013). However, there has been a growing commitment in healthcare to understanding the meaning of experiences for patients, resulting in a greater recognition and value placed on qualitative research. Qualitative approaches are particularly useful to illuminate the individuals'

experiences of health and health services in order to improve the provision of services (Streubert & Carpenter, 2011; Green & Thorogood, 2014).

Quantitative studies which adopt a positivist paradigm have been used to investigate spirituality and occupational therapy practice (Taylor et al., 2000; Collins et al., 2001; Farrar, 2001; Morris, 2013). These studies help to illuminate, from an objective perspective, occupational therapist's beliefs and attitudes of how spirituality is addressed by their practice. However, they are limited in exploring and describing how spirituality operates and is integrated in practice. Quantitative studies provide a measurement of occupational therapists declared experiences and behaviours but do not provide a deeper understanding of the phenomenon as experienced in practice. This experience in practice was the focus of this study, therefore fully justifying the choice of adopting a qualitative methodology. Qualitative approaches have been widely adopted to explore spirituality and its relationship to the practice of occupational therapy (Udell & Chandler, 2000; Egan & Swedersky, 2003; Beagan & Kumas-Tan, 2005; Hoyland & Mayers, 2005). However, unlike these studies which report participants' accounts, the focus of the study reported in this thesis was the exploration of naturally occurring events as observed in practice. These naturally occurring events were explored with participants, in order to understand the phenomenon of spirituality in a 'real world' context, the occupational therapists work place.

In summary, qualitative research, and in particular ethnographic approaches, often situates the researcher in the natural setting of participants in order to gain a deeper understanding to interpret phenomenon, and to understand the meaning from the participants' perspectives and worlds. Qualitative research for occupational scientists and occupational therapists has been described as being *"about authentic engagement with the context within which one is situated, for the purpose of advancing understandings in the topic of interest"* (Naylor & Stanley, 2015, p3). Naylor and Stanley (2015) linked occupational therapy practice, that seeks to engage people in meaningful occupation, with qualitative research that explores how people make sense of their world and attach meaning to their experiences. The underpinning philosophies

of qualitative research were in harmony with an exploratory study. The purpose of this study was to discover how occupational therapists embed spirituality in practice, in particular through observing the multiple social constructions of the occupational therapists daily practice. Furthermore, the in depth contact with the participants gave an opportunity to capture the emergent issues pertaining to the complexity of spirituality and occupational therapy practice reported elsewhere but not explored through observation (Robson 2011; Snape & Spencer 2013; Naylor & Stanley 2015).

3.3. Discussion of qualitative approaches

Qualitative approaches are well suited to exploring the everyday practice of occupational therapy, and in particular spirituality which is construed as a complex and sensitive phenomenon (Beagan & Kumas-Tan, 2005). Grounded theory, phenomenological and ethnographic approaches are well established and rooted in the disciplines of sociology, psychology and anthropology respectively; each having its own ontological and epistemological assumptions. Although it can be challenging to the novice researcher to decide which approach to use, the choice is ultimately driven by the study question, aims and objectives and perspectives of the research (Streubert & Carpenter, 2011). An ethnographic approach was chosen as it best fit the research question, and study aim and objectives, which required exploring the phenomenon of spirituality in the natural setting where occupational therapists work. This section provides an overview of the main qualitative approaches to; grounded theory, phenomenology, and ethnography, and the rationale for choosing an ethnographic approach to underpin the study reported in this research thesis. Case study research is also outlined because of its similarity to ethnography.

3.3.1 Ethnography

Ethnography is one of the founding approaches within the broad qualitative research paradigm, and traditionally involved '*studying*' through immersion in native populations. With roots in sociology and anthropology, ethnography grew out of the disillusionment of science

to discover the complexities of groups of individuals, and their context in order to understand phenomenon (Streubert & Carpenter, 2011). For example, the phenomenon of clinical reasoning has been explored using ethnographic approaches to illuminate the differences between professional groups, including occupational therapy (Fleming, 1991). In addition, how clinical reasoning was impacted by worldview to support client-centred occupational therapy practice was illuminated by employing an ethnographic methodology (Unsworth, 2004). Ethnography has been described as a methodology, theoretical framework and a philosophy that can be used to explain health and care in cultural contexts (Pereira de Melo, Stofel, Gualda & Campos, 2014). Criticised as is the most “*chaotic*” method of research design, ethnographic research takes place where the participant is located carrying out the “*ordinary activities*”, and without measures in place to control the setting (Brewer, 2000, p 56,103). The underpinning theories and philosophies of ethnography have polarised qualitative researchers, and the expansion of approaches have led to a variety of research practices and methods associated with ethnography (Creswell, 2007; Huot, 2015).

However, the strength of ethnographic approaches is in the prolonged exposure to the culture under investigation, often referred to as the ‘*field*’, in order to learn from the participants or ‘*actors*’. This process of immersion in the real world context enables the researcher to describe and interpret the shared cultural nuances of the social world, in order to appreciate the culture and beliefs, and to interpret the meaning of the phenomenon under investigation (Spradley, 1980; Creswell, 2007; Streubert & Carpenter, 2011; Snape & Spencer 2013). It has been argued that ethnography is merely a data collection technique, however Pereira de Melo et al (2014, p16) advocate ethnography as “*a way of seeing, learning and interpreting reality*”, and adding to its strength as a research approach.

In ethnography the researcher engages with the participants in their natural environment either overtly or covertly, from an ‘*emic*’ (insider) or ‘*etic*’ (outsider) perspective, to describe the context under investigation. This produces rich data in the form of descriptive and interpretative field notes. By capitalising on the reflexive role of the researcher in the research

process, and as a co-collaborator in the data generated, the study findings are strengthened (Streubert & Carpenter, 2011; Gray 2014). The methods of data collection employed in an ethnographic study design are not solely exclusive to ethnography. Fieldwork engaged in observation of the culture and phenomenon under investigation, follow up in depth interviews, reviewing of materials and artefacts are also common to grounded theory. However, it is the continuous process of engaging with participants and their environments that enables the researcher to identify features of the phenomenon and adds strength to the findings of ethnographic studies (Brink & Edgecombe, 2003).

In comparison to grounded theory, where data collection continues until saturation occurs (Charmaz, 2014), ethnography employs a more pragmatic approach to ending data collection. In ethnography data collection may result in unanswered or additional questions. Therefore, the study comes to an end when time and resources have been exhausted, since what is often referred to as 'data saturation' is problematic to achieve. However, data saturation is unlikely to be achievable across many qualitative research designs when in depth data from a small number of participants may be preferable to achieving data saturation. Moreover, it is likely to be a pragmatic decision to withdraw from the *'field'* (Spradley, 1980; Streubert & Carpenter, 2011).

Ethnography can generate rich description of a phenomenon. Therefore, an ethnographic observational design was deemed appropriate to explore and illuminate spirituality in the social context of occupational therapy practice. The strengths of applying an ethnographic approach to the study reported in this thesis derived from immersion in the occupational therapy practice context. This immersion in the context revealed the behaviours and practices of the participants to the researcher by engaging with the occupational therapists as participants.

The ethnographic approach to the study design enhanced and built on previous qualitative studies exploring occupational therapists' experiences and perceptions of addressing spirituality in practice; phenomenology (Udell & Chandler, 2000) and a qualitative interview

based approach (Beagan & Kumas-Tan, 2005; Hoyland & Mayers, 2005). These studies explored therapists' accounts rather than directly observing their practice, and therefore report practice from the participants' perspectives rather than actual practice. Critically, to date no studies have been identified that used ethnographic observation *of* practice to study the issues involved in addressing spirituality *in* practice. Thus strengthening the rationale for the design of this study to employ participant observation and an ethnographic approach.

There has been some debate in the literature regarding observation of spirituality in occupational therapy practice. Egan & Swedersky (2003) strongly advocated a more in-depth approach to data collection, suggesting observation of occupational therapy practice, would further illuminate how spirituality was addressed by occupational therapists. However, Beagan and Kumas Tan (2005) asserted that observing the patient-therapist interactions could be intrusive when examining such a personal and sensitive phenomenon as spirituality. In contrast to the views of Beagan and Kumas-Tan (2005), observations in the field have been successfully approached in other disciplines where the context was described as sensitive, for example nursing.

An ethnographic study using participant observation and semi-structured interviews explored the experiences of dying elderly patients and nurses in the context of a care setting (Costello, 2001). The strategies necessary to protect the participants were addressed to support the participants through the sensitive nature of the study. The findings of Costello's (2001) study support ethnographic research in sensitive areas, highlighting the valuable insights into the care of dying elderly people that could impact on nursing practice. Therefore, it was deemed appropriate and desirable to the occupational therapy profession to undertake an ethnographic approach that utilised observation of practice to explore spirituality. Ensuring appropriate research ethical principles and procedures were adhered to and that research was undertaken sensitively and respectfully towards participants at all times was a key tenet of the study.

The methodological approach of the study reported in this thesis was participant observation (Kawulich, 2005) of occupational therapists working with patients (ethnographic approach). The observation of practice was followed by semi-structured conversational interviews based on field notes to explore the phenomenon of spirituality in occupational therapy practice. The ethnographic approach was considered ideal for describing how occupational therapists behaved in practice when embedding spirituality. This inductive method enabled me to become immersed in the practice context (Zahle, 2012; Huot, 2015). Observing practice offered the opportunity to view first-hand what therapists' did that appeared to address the patients' spiritual needs (as described in Chapters One and Two). Observing and noting the language, behaviours and values exhibited by the occupational therapist in their 'natural' environment provided the opportunity to collect more detailed data to analyse the thoughts, feelings and actions of the occupational therapists. Thus the objectives of the study were met, bringing new insights to how spirituality was embedded in daily occupational therapy practice.

This ethnographic approach provided the context to observe the opportunities to address spiritual dimensions of occupational therapy practice, therapeutic interventions and the facilitators and obstructions to practice (Creswell 2007, Saks & Allsop 2007, Ritchie, 2013). The follow up semi-structured conversational interviews provided the opportunity to explore occupational therapy practice with the participants, as the interviews explored in-depth the observed practice from participants' perspectives gathered during the observations. This design enabled the process of 'triangulation' or 'crystallisation', where the researcher considered the many facets of the phenomenon observed (Denzin & Lincoln, 2008). Through this process the participants provided a background for the in depth open-ended conversational interviews, where specific issues that had emerged from the observations could be investigated further (Morse & Field, 1996). Data triangulation or crystallisation involved using two or more aspects of research to interpret findings. The process increased the validity and strength of the interpretive potential of the study, thus decreasing investigator biases and providing a range of perspectives (Denzin & Lincoln, 2008). Further consideration

of the process of triangulation or crystallization applied to the data collection will be explored in the following Chapter Four and Chapter Seven. The following sections will present the alternative qualitative approaches and the rationale for rejecting them for application to the study reported in this thesis.

3.3.2. Grounded Theory

Grounded theory is one of the most widely adopted qualitative approaches in healthcare research. The approach was developed in the 1960's, from the perspective of sociology, as a method for developing new theory that was grounded in the experiences of participants (Streubert & Carpenter, 2011). The purpose of grounded theory is to observe a social phenomenon to gain a deeper understanding of psychosocial processes of the phenomenon being explored (Charmaz, 2014). The researcher aims to discover how the phenomenon is acted out in the experiences of the participants without employing any existing theory or preconceived ideas. Although a range of data collection methods can be adopted in a grounded theory approach including observation of practice, focus groups; interviewing is commonly adopted as a method of engaging with the social group and developing theory from the group. However, the main purpose of grounded theory is to explain the way participants resolve their concerns and to generate theory derived directly from the data and grounded in the experiences of the participants (Creswell, 2007; Streubert & Carpenter, 2011).

The key principles employed in grounded theory research are theoretical sampling, saturation and constant comparison (Bryant & Charmaz, 2010; Charmaz, 2014). Theoretical sampling is the refined process of recruiting participants to ensure selection of individuals who can provide focussed explorations of the phenomenon under investigation. Saturation is achieved when no additional data can be found to develop categories further. Finally, constant comparison refers to the process of comparing incidents in the data that are linked to form the concepts that inform the theory generated. The resulting theory develops through exploring the relationship between a participant's behaviour, social roles and the environment to *explain* phenomenon in contrast to approaches that *describe* a phenomenon (Snape & Spencer, 2003;

Creswell, 2007; Streubert & Carpenter, 2011). To date no studies have been identified that have explored spirituality as a phenomenon of occupational therapy practice applying a grounded theory approach to the design. A grounded theory approach would have addressed the question:

*“What are the processes necessary for embedding spirituality
in occupational therapy practice?”*

Grounded theory could have been adopted if the aim of the study had been to consider what processes supported embedding spirituality in occupational therapy practice, and the development of a theory to drive practice. However, the aim and objectives supported the collection of data which provided a ‘rich’ and ‘thick’ description of spirituality embedded in occupational therapy practice. The analysis of the data and potential development of a conceptual framework, as opposed to a theory, for occupational therapy practitioners to use and guide their practice was perceived a more acceptable outcome of the study.

3.3.3 Phenomenology

Whereas the purpose of grounded theory is in exploring phenomenon explicitly to generate theory, phenomenology is a rigorous, critical, systematic qualitative method of investigating the perceptions of human experience (Moran, 2000; Finlay, 2011; Streubert & Carpenter, 2011). Studies employing a phenomenological approach seek to understand the ‘*lived experience*’ of everyday life, found in conversation or text (Flood, 2010; Finlay, 2011).

Phenomenology has been defined as a complex philosophy seeking to investigate and describe a phenomenon, without generating theories to explain them or preconceptions that taint the outcome. The process of ‘*bracketing*’ whereby the researcher declares their preconceptions about a phenomenon is one of the features of some phenomenological approaches (Creswell, 2007; Streubert & Carpenter, 2001, Green & Thorogood, 2014).

Phenomenology describes the individual experiences of a phenomenon by studying the ‘*elements*’ or ‘*essences*’ contained in a phenomenon, and is therefore well suited as an

approach for exploring issues relating to an individual's health and healthcare (Creswell, 2007). Phenomenology has been employed by studies exploring spirituality and occupational therapy practice (Udell & Chandler, 2000; Egan & Swedersky, 2003). Both studies explored how occupational therapists experienced addressing spirituality in their practice through in-depth interviews. Udell and Chandler's (2000) study focused on the experiences of three occupational therapists that were selected because they held Christian beliefs. The study findings illuminated the depth of the occupational therapist's opinions regarding the role of the occupational therapist addressing the spiritual needs of their patients. The participants' exploration of practice focussed on the religious and cultural beliefs of patients, and the role of the occupational therapist in recognising spiritual need and its impact on function. Whilst a phenomenological approach addresses the lived experience of occupational therapists in addressing the spiritual needs of their clients, it may not address how spiritual practice operates.

Similarly, Egan and Swedersky (2003) undertook a phenomenological approach in their study of eight occupational therapists who perceived they considered spirituality central to their practice. Their findings, again illuminated how occupational therapists experienced addressing spirituality in their practice; outlining religious concerns, addressing suffering and developing a therapeutic relationship that facilitates openness by the patient to express the meaning of their situation. To address the limitations of this study, namely the single interview method, the authors suggested that further understanding of spirituality and occupational therapy practice could be achieved by engaging longer with participants, for example by utilising participant observation as a data collection method. Both studies continued to provide an understanding of occupational therapists experiences of addressing spirituality through their practice via interview methods. A design using phenomenology as the approach for the study reported in this thesis would have utilised the following research question:

“What is the lived experience of occupational therapists embedding spirituality in occupational therapy practice?”

Phenomenology has been used effectively in the two previous studies (Udell & Chandler, 2000; Egan & Swedersky, 2003); however, both studies recommended further research focusing on an examination of what spirituality *'looks like'* in practice. This would be achieved by observing occupational therapists in practice. Phenomenology was therefore rejected as a methodological approach because the focus of the study was the in-depth synthesis of how occupational therapists embedded spirituality in their practice, and was more likely to be achieved by adopting an ethnographic approach. The aim and objectives of the study reported in this thesis required an exploration of what could be observed in the practice of occupational therapists. A phenomenological approach would have supported an explanation of the *'lived'* experience of spirituality and the personal impact on the participants (Snape & Spencer, 2003).

3.3.4 Case study

Case study research aims to *"understand complex social phenomena"* by focusing on a *"case"*, characterised by a lack of clarity between the boundaries of the phenomenon and the context (Yin, 2014, p4). There are similarities between case study and ethnography; both use observation and interviews to elicit information to understand the issue being addressed. The case study approach can explore similar areas to ethnography. It uses open ended research questions about *"how"* or *"why"* things happen. Both positivist and interpretative approaches can be used in case study research design. The approach is suited to the study of real life events or situations, for example critical events (Crowe, Creswell, Robertson, Huby, Avery & Sheikh, 2011). However, the purpose of the study reported in this thesis was to gain a broad appreciation of occupational therapy practice and how spirituality was embedded and not to focus on specific interventions or critical incidents. The main differences between case study and ethnography relates to the overall purpose of these approaches. Ethnography has been described as looking *'inwards'* to uncover the assumed knowledge of the participants under investigation. Conversely case study is *'outward'* looking exploring the nature of the

phenomenon by a detailed investigation of individual cases and the context in which they occur (White, Drew & Hay, 2009).

Study design using case study typically would use a “*how*” or “*why*” question, as presented by the study reported in this thesis. However, the aim of this study was to look inwards at the participants and their contexts to explore how they embedded spirituality in their practice. Uncovering the participants assumed knowledge of the phenomenon, again suggested ethnography as the most appropriate methodology. A suggested question that case study approach would answer is as follows:

“Why do occupational therapy interventions embed spirituality in practice?”

This question would achieve some of the objectives of the study but not the depth of the phenomenon as applied to occupational therapy practice.

3.4 Summary

This chapter has explored the methodological approaches and the issues involved with designing this study. A justification has been presented for an ethnographic approach employing participant observation and semi-structured conversational interviews. This ethnographic approach was chosen as it could facilitate the exploration of the practice of occupational therapists in their natural environment, as they embedded spirituality in their daily practice. The overview of approaches identified similarities between grounded theory, case study and ethnography. Observation of the phenomenon and interviews were reported to be an accepted method across approaches. Ethnography was considered a more appropriate approach to underpin a study of how occupational therapists embed spirituality in their day to day practice than the other approaches. Ethnography sought to describe a social and cultural context, in this case the practice of occupational therapy in a range of practice settings, and to collect the appropriate data to answer the research question (Spradley, 1980). Therefore, ethnography as an approach employing participant observation and follow up interviews was deemed most appropriate to capture the experiences of occupational therapists embedding

spirituality in their day to day practice. The following chapter will present how the ethnographic approach was applied to this study.

Chapter Four

Methods

4. Introduction

Chapter Three presented and justified an ethnographic approach as being the most appropriate study design to explore how occupational therapists embed spirituality in their daily practice. This chapter presents and justifies the research methods and procedures undertaken. The thesis so far has presented a concept analysis, culminating in a Conceptual Framework for spiritually competent occupational therapy practice (See Figure 7, page 87), and a description of what spirituality is perceived to be like in practice. The empirical study now presented in this chapter develops the earlier work presented and explores how spirituality operates in the daily practice of occupational therapists. The study setting, ethical approval, sampling strategies and recruitment procedures, data collection methods, data analysis are described and critiqued in relation to the ethnographic approach adopted. Finally, the ethical considerations posed by this study are explored and measures taken to address researching in 'real life' settings, consent, confidentiality, 'insider researcher' and withdrawing from the research setting or 'field' are outlined.

4.1. Study setting

The study was undertaken in a large NHS Trust in the United Kingdom, which delivered occupational therapy services in acute hospitals and the community. The Trust served a culturally and economically diverse population living in urban and rural settings, reflecting typical and familiar practice of occupational therapy. The research settings involved a wide variety of occupational therapy practice. Two community occupational therapy teams served patients with a wide range of physical disabilities and long term conditions. The remit of occupational therapy interventions was; short term rehabilitation interventions in order to achieve patient led goals and maintain their independence at home; assessments and recommendations for housing adaptations and special equipment. The two hospital settings

were acute inpatient services, focusing on occupational therapy interventions to provide short-term rehabilitation and discharge planning.

4.2. Ethical approval

Ethical approval was obtained from the University of Huddersfield School of Human and Health Sciences Research Ethics Panel (SREP), and the Local Research Ethics Committee (LREC) via the National Research Ethics Service (NRES) (NRES reference:12/YH/0225). The study was approved by the NHS Trust research and development department in November 2012 enabling occupational therapists within the Trust to be approached to participate in the study during the period from the 1st December, 2012 to the 30th December, 2015.

4.3 Application of Methods

4.3.1 Sample selection

Choosing who to observe and interview in qualitative studies cannot be approached in the same way as in a quantitative study. Central to the study design is whether the setting and participants are likely to address the aims and objectives of the research (Gelling, 2014). Small samples in qualitative research provide the opportunity for rich in-depth exploration of a phenomenon, and guide sampling strategies, such as purposive, theoretical and convenience sampling (Brewer, 2000; Streubert & Carpenter, 2011; Ritchie, Lewis & Elam, 2013; Green & Thorogood, 2014).

4.3.2 Sampling strategies

A range of sampling strategies can be adopted in qualitative research studies. For the purpose of this study purposive sampling was used, however alternative methods such as theoretical and convenience sampling were considered. Theoretical sampling employs an iterative process whereby the researcher samples participants for their potential contribution to the development or testing of theory generated by the research; and is typically associated with grounded theory (Streubert & Carpenter, 2011). In contrast convenience sampling aims to

recruit participants because of their ease of accessibility (Shorten & Moorley, 2014). Finally, purposive sampling allows participants to be chosen who represent the characteristics or features necessary to explore and understand the phenomenon under investigation (Ritchie et al., 2013).

Purposive sampling aims to recruit participants with the experiences that will facilitate an exploration of the research question, and meet the aims and objectives of the study. The criteria developed to achieve purposive sampling should ensure the relevant participants will be selected and that there is a diverse sample to explore the phenomenon fully (Streubert & Carpenter, 2011; Ritchie et al., 2014). Within purposive sampling there are a range of approaches that aim to ensure the participants are recruited that will meet the study aims and objectives, namely homogeneous, heterogeneous, extreme or deviant or intensity sampling (Robson, 2011; Green & Thorogood, 2014). For the purpose of the study reported in this thesis a homogeneous sample was deemed the most appropriate to ensure a detailed coverage of spirituality embedded in occupational therapy practice. This sampling strategy enhanced the rigour of the research process from participants who all belonged to the same professional background (Holloway and Wheeler 2010; Ritchie et al, 2013). Purposive sampling was based on criteria developed during the design phase of the study, and ensured that the participants recruited had the experiences required to explore spirituality in occupational therapy practice in depth.

Inclusion criteria:

- NHS band 6 or 7 qualified occupational therapists with an individual case load;
- Undertaking direct care with patients who had capacity to give consent to be observed;
- Not supervising an occupational therapy student during the period of observation.

Exclusion criteria:

- NHS occupational therapists below band 6 and above band 7;
- Band 7 occupational therapists without a significant case load;

- Occupational therapists undertaking direct interventions with service users who do not have the capacity to consent to be observed.

Qualitative research collects a wealth of descriptive data (*“thick description”*) to enable an in-depth exploration of the phenomenon under investigation. Qualitative research and in this case, an ethnography approach, does not undertake statistical sampling techniques to estimate sample size. It is not always possible to predict precise sample sizes at the start of a qualitative study, which is not problematic because data collection and preliminary analysis occur simultaneously which guide the final sample size ensuring the study aims are met. A balance needs to be achieved between obtaining data of sufficient depth and breadth and the resources available. Therefore, a pragmatic approach to achieving a final sample size was adopted, while ensuring the aim and objectives of the study were achieved (Spradley, 1980; Green & Thorogood, 2014).

Sample sizes are often small in qualitative research in comparison to quantitative research; with the number of participants’ dependent on meeting the aims of the study. For the purpose of this study it was anticipated that a small number of participants would meet the study aim, which is not untypical in ethnography studies. The issue was more whether the fieldwork was adequate to obtain data required to explore the phenomenon in sufficient depth. The length of time devoted to the fieldwork needed to be long enough to experience the full range of routines and behaviours. Data saturation is said to be achieved when no further information is generated by exploring the phenomenon for a longer period of time with the participants (Brewer, 2000; Atkinson, Coffey, Delamont, Lofland & Lofland, 2001; Stanley & Cheek, 2003). However, data saturation in an ethnographic approach is contentious. Spradley (1980) argues that data saturation is often a pragmatic decision based on resources and time available for the study, since it is unlikely that the field would ever be exhausted of observable features to illuminate the phenomenon. Therefore, since it was not possible to claim data saturation a pragmatic decision was taken to recruit at least four participants, and then consider recruiting further participant/s should further illumination of the phenomenon be required (Brewer, 2000;

Ritchie et al., 2013). This approach to saturation served to justify the small number of cases recruited in this study (Atkinson et al., 2001). Four occupational therapists responded positively to the recruitment information and met the inclusion criteria.

4.3.3 Recruitment procedures

The first contact with the setting to recruit participants was through the Therapy Services Director who distributed recruitment packs to the occupational therapists using the inclusion/exclusion criteria for the study as a guide (*Appendix 1: Letter to Therapy Services Director*). Access to the site was supported by familiarity with the NHS Trust having previously worked as an occupational therapist, and being known as a university lecturer on a pre-registration occupational therapy course. The issues relating to insider researcher issues are covered in more detail in the ethics section of this chapter (4.6.4, page 143 'Insider' researcher). This process of recruitment was aimed at ensuring participants did not feel they were being coerced into taking part in the study, since they were not directly approached by me, as a former colleague.

4.3.3.1 Recruitment of occupational therapists

The recruitment pack contained an information letter advising the potential participants of the study aim and objectives and what they could expect as a participant. The information letter was developed outlining the risks and benefits of taking part in the study, using the style and guidelines provided by the Integrated Research Application System (IRAS) (IRAS, 2011), (*Appendix 2: Occupational Therapist participant information letter*). The invitation included a participant expression of interest form, to be completed and returned in the prepaid envelope by participants willing to take part in the study. This form requested details of how and when participants could be contacted. Four participants meeting the inclusion criteria expressed an interest in taking part in the study. On receipt of their expression of interest forms an appointment was made at a mutually convenient time and location to discuss the study and answer any further queries individually with each participant. Arrangements were made for data collection to commence on days mutually convenient for the participant and myself.

A consent form was developed using the structure and guidance from IRAS (IRAS, 2011). This was completed at the beginning of the first episode of observation, and documented in the fieldwork notes on subsequent occasions to ensure consent to observe practice was achieved at every episode of observation (*Appendix 3 Informed Consent (Observation of Practice) – Occupational Therapist*).

4.3.3.2 Involvement of patients in the study

Patient involvement in the study was essential to provide a context for observing how occupational therapists addressed spirituality in their practice. Ensuring an ethical approach to patients included providing information about the study through displaying posters outlining the study in clinical areas where observations were planned. This was intended to advise patients, relatives and carers about the presence of the researcher in the service area. However, in the likely event that the posters were not read by patients and relatives, patients were also provided with information about the study from the participating occupational therapist (*Appendix 4: Patient information letter*). Prior to any observation of an occupational therapy intervention with a patient, the occupational therapist responsible for their care provided them with the study information and elicited initial agreement, on my behalf, for me to approach the patient to participate in the study. Informed consent was obtained from the patient and established for each episode of the occupational therapist's intervention (*Appendix 5: Informed consent, patient*).

4.4 Data Collection procedures

Qualitative research emphasises using data collection method/s that are flexible in order to explore a phenomenon in depth and include observations, interviews and focus groups. This section will present an analysis and justification for the data collection methods adopted, and their application to exploring spirituality in occupational therapy practice in this study.

Chapter Three described and justified choosing an ethnographic approach as the research methodology underpinning this study. Ethnographic research occurs in natural and familiar

setting to the participants recruited. Exploring how occupational therapists embed spirituality in their day to day practice was best suited to observations of practitioners during their daily practice, and follow up semi-structured conversational interviews to explore in more depth their perceptions and understanding of the observed practice. These data collection methods were integral to an ethnographic approach and provided the strategy to explore spirituality in depth. The first stage of the data collection process was to carry out periods of participant observation with the occupational therapists in their normal work contexts. These observations were carried out over a three-month period (May – July 2013), for between 4 and 5 days at a time (equating to 51 episodes of observed therapy intervention over approximately 140 hours of observation). The arrangements for the observations were agreed at each participant's pre-observation briefing session to avoid over burdening them by taking in consideration the other pressures they experienced in their working lives (Angrosino, 2008; Webster, Lewis & Brown, 2014).

4.4.1 Observation

Participant observation is a well-accepted method in healthcare research and in particular ethnographic research. Immersion in a context, observing the language, behaviours and values exhibited by the participants can offer additional insights compared to verbal accounts alone (Creswell, 2007; Saks & Allsop, 2007; McNaughton Nichols, Mills & Kotecha, 2014). Participant observation is concerned with observing people in their natural environment to examine a phenomenon and answer the research question. Angrosino (2000) identified four categories of observation, complete observer, observer-as-participant, participant-as-observer and complete participant.

1. The complete observer, where the observation is covert, with the observer remaining detached and not visible within the setting;
2. The observer-as-participant, where the observer although adopting an overt approach maintains a distinct role as the researcher, and engages in the setting for brief periods primarily to generate information for exploration in subsequent interviews;

3. The participant-as-observer again is an overt approach but the researcher attempts to become integrated into the setting, and acknowledges their role within the setting;
4. The complete participant is covert approach but rather than remaining isolated the researcher fully integrates into the setting and is often referred to as “going native”. This approach has ethical considerations in health research regarding the participant’s right to choose whether to participate.

For this study participant-as-observer was chosen, because while full immersion and participation in the culture during data collection is often associated with ethnography, ethically and professionally this was not acceptable. Covert methods of participant observation, where participants are not aware of the presence of the researcher or their purpose, have been criticised for being unethical and lack of transparency of the research process (Ritchie et al., 2014). An overt approach to participant observation, adopting the role of researcher as a participant-as-observer, was appropriate because of a desire to develop an effective relationship, based on trust and honesty, and respecting the dignity of the participants. Adopting an overt approach strengthened the effective relationships I made with the participants and avoided deception. The same qualities are found in the development of all human relationships, and a commitment to learning from the participants strengthened the depth of the data collected (Brewer, 2000). Participant observation enabled me to observe how spirituality was embedded in the occupational therapy process that formed part of each episode of care.

The process I adopted in applying the principles of participant-as-observer was to adopt the role of *‘shadowing’* where I followed the occupational therapist around during his/her work. I thought carefully about where to sit or stand during the therapeutic encounters in order to be as unobtrusive as possible and not interfere with what was happening. I engaged with the therapeutic encounters to assist the practitioner where a second person was useful, for example to carry equipment on a home visit or assist with measuring a bathroom area. I maintained a distance so as not to impact on an intervention and not to cause embarrassment to the patients. I considered the clothing I wore, opting for a uniform style of black trousers

and white short sleeved shirt in order to blend into the setting and to comply with the NHS Trust policy for infection prevention (Kawulich, 2005).

Observing the therapists in their '*normal*' environment provided an opportunity to collect detailed data on the actions of participants; thus bringing new insights to the phenomenon. Being a participant-as-observer was guided by the framework advocated by Spradley (1980). First, interactions between patients and the occupational therapist during every day interventions were observed. By incorporating my tacit knowledge as an experienced occupational therapist I was able to critically explore these encounters. Observations were structured around the following key activities:

- Scene survey, undertaking a wide focussed overview of the social situation and the environment for example the context, home or ward, décor and other significant artefacts;
- Consideration of the artefacts for example, cultural effects and functional equipment present;
- Defining the actors for example participant and service user, providing a focussed observation;
- Observing the interactions and interventions carried out, providing selective observations.

Earlier in the design of the study I had developed an extensive observation guide to help with recording the observations in a structured way. The guide was structured around the findings of the concept analysis reported in Chapter Two, and the development of the conceptual framework for spiritually competent occupational therapy practice (refer to Chapter Two, Figure 7, page 87) and (*refer to Appendix 6 Observation guide*). This guide was idealistic and restricted my ability to capture the depth of practice observed. After attempting to complete the observation guide contemporaneously I felt constrained by trying to identify constructs. The observation guide hindered identifying the constructs that emerged naturally.

Second, fieldwork notes were central to this study and aided understanding what was observed; fieldwork notes were also used later during interviews to develop the interview

questions and explore participants' perceptions of their own practice. Fieldwork notes were not recorded during the observation, in order to avoid distractions for the patient, one of the actors in the observed event. Fieldwork notes were recorded immediately after each period of observation. The fieldwork notes were transcribed into a narrative descriptive account outlining what occurred during the intervention. A conscious decision was made not to add interpretation to the narrative, in an attempt to remain 'true' to the observation. This was challenging, therefore my preliminary thoughts and ideas about what was occurring during these observations were recorded as 'memos' highlighting aspects of care for discussion or clarification during participant interviews. The length of time devoted to fieldwork needed to be long enough to experience the full range of routines and behaviours (Brewer, 2000). Reviewing the fieldwork notes after each day of observation it became evident when no further new information was being observed. However, ultimately a judgement had to be made between no further new information emerging and interest in the participants' work. This process was strengthened by using "*thick description*" developed as a strategy for writing fieldwork notes (Kawulich, 2005).

Essential to ethnographic approaches is reflective practice (Finlay, 2008). A subjective reflective diary was kept throughout the data collection process. My reflections contained notes and ideas relating to the data collection experiences and were recorded in what I termed '*the subjective diary*'. The areas included in this diary related to recruitment, sampling, in addition to immediate thoughts both pre and post participant observations and conversational interviews. I also recorded any pre-conceived ideas I had about the practice settings, and the range of interventions and care I anticipated that I would be observing. These reflections on the experiences would not necessarily be included in the participant observation fieldwork notes. A commentary using the reflective notes to support the reflexive account in Chapter Seven (Quality Measures) seeks to present a transparent account of the impact of the researcher on the research process. A reflective account of the research process is also

presented in the same chapter to illuminate aspects of the study which could be improved in future research activity.

4.4.2 Interviews

Observation as a data collection strategy has limitations in that it does not deal with the unobservable, such as care omissions, and participants' feelings and thoughts. The second stage of data collection was to explore events observed with the occupational therapist using a conversational approach to semi-structured interviews. The purpose of these interviews was to discuss what had been observed, and explore in depth issues relating to spirituality as a dimension of occupational therapy practice. The interview was structured; using topic guides based on the occupational therapist's individual observations. This gave the participants an opportunity to raise issues they had reflected on following the observation of their practice (Angrosino, 2008). See Table 7 for an example of an interview topic guide used. Interviews following observation are widely used to investigate further the participant's perspectives and generate an in depth understanding of their context and the phenomenon under investigation (Ritchie et al., 2013).

Table 7: Example of an interview topic guide

Interview topic guide for Mark (taken directly from the interview transcript)

Firstly, can we explore how you began as an OT and your career path

So how did your early appreciation of the philosophy of occupational therapy impact on your values of the profession?

How did your educational experience help you to develop your values of the profession?

How does your previous experience in union activity and private practice impact on your upholding of the core values and philosophy of the profession today?

Your role, in many of the cases I observed, you were the pivotal professional holding the case together. In particular, where trauma and mental health were interlinked. Can you tell me more about [case identified for further illumination] and how you addressed their hope, meaning and purpose?

Further cases discussed as raised by Mark to provide further examples of the embedding of hope, meaning and purpose in practice?

How do you articulate the values linked to spirituality, which are central to your professional practice, to your other colleagues on the ward?

You have mentioned a lot about the opportunities for addressing what you understand to be spirituality (the core values and philosophy of the profession). Can you tell me about some of the organisational issues and maybe what some of the barriers are?

What are the barriers to practicing and embedding your core principles?

An example from the observation was used to delve deeper into Mark's response.

So often your practice looks very straight forward and not very hi tech but you were getting to the heart of your patients concern regardless of the complexity. How do you promote this to your colleagues who may not understand?

You have talked about how you view everyone as occupational beings from the perspective of occupational science and getting to the heart of what is meaningful for them. How does this work in practice for you?

Can you tell me something about the Delirium project you have pioneered on one of the wards and how this has taken you back to the core philosophies of the profession?

Lots of discussion about how this project addressed the core philosophies of the profession and how it had been an excellent example of interprofessional working in addition to applying the core philosophies of the profession to practice.

What do you feel about the environment you are working in and the opportunities to develop a therapeutic relationship?

I'm thinking about the adherence to infection prevention and having to stand not sit when speaking to a patient. Addressing the issue of power, non-threatening and engaging the patient who is in bed?

The literature around spirituality says that an OT needs to be comfortable with and appreciate their own understanding of spirituality in order to address it with your patients. Can you tell me what this means for you?

Further prompts and attempts to delve deeper into this question.

Interviewing has been a well-accepted method of data collection in qualitative research design for many years and has been employed as a key method in social research since the 1980's. The purpose of interviews is to explore in depth an individual's perspective and understanding of the phenomenon under investigation. The follow up individual interviews in this study gave the opportunity to explore in more depth issues raised by the observation of the participants practice, and to illuminate some of the complex situations where spirituality had been observed (Kvale & Brinkman, 2009; Ritchie & Lewis, 2013). Interviewing participants individually poses less risk of unexpected events to manage ethically, however there is the need to manage the extent to which participants feel they want to disclose information. There should be a balance between collecting rich data and ensuring the participants well-being is maintained (Ritchie et al., 2014).

I did not prepare a generic interview topic guide in advance of the study; semi- structured questions were specific to the individual practitioner and generated from the issues that emerged during the participant observation which required further clarification or exploration. Therefore, interview questions were individual to each participant. Participants were provided with broad areas for discussion prior to the interview to avoid participant's feeling unprepared for the interview and, by addressing their expectations, strengthened the transparency of the process. Following the verbatim transcription of the interview by the researcher the transcript of the interview was sent to each to provide the participants. This provided the participants with the opportunity to review the transcripts for accuracy, and to request data to be removed that they were, on reflection uncomfortable sharing (Green & Thorogood, 2014). One participant did request some of their statements were withdrawn as they were concerned about how they could be viewed later by their service manager. Their request was honoured as it related to '*verbal expressions*' used to describe situations that on reflection could out of context be deemed inappropriate, removal of the extract did not compromise the richness of the data collected. Participants were advised in advance they could withdraw their data at any

point in the process (see *Appendix 2: Occupational Therapist participant information letter and Appendix 7: Informed consent (Interview) Occupational Therapist*).

The individual interviews could be criticised for limiting the four participants' opportunity to debate their experiences; a focus group could have illuminated spirituality and occupational therapy practice in more depth (Barbour, 2007; Finch & Lewis, 2013). However, adopting a focus group approach would have limited the ability to explore the individual therapist's observed practice. The individual interviews increased the depth of data collection as the interview was tailored to the individual participant and their experiences. The strength of the interviews undertaken in this study was that they were based on observation of what spirituality '*looked like*' in the individual's practice. They mirrored the effective use of interviews in previous studies exploring occupational therapist's experiences of spirituality in their practice (Egan & Swedersky, 2003; Beagan & Kumas-Tan, 2005; Hoyland & Mayers, 2005).

4.5 Data Analysis

The purpose of data analysis was to organise the narrative data in a way that would facilitate a process of inductive reasoning (Spencer, Ritchie & O'Connor, 2013). This study generated large volumes of descriptive data, collected from observations of occupational therapists in practice (including people's own homes, hospital wards and occupational therapy department facilities), fieldwork notes, participant interviews and reflective diaries. The transcriptions of the data were verbatim retaining the natural language of the researcher in fieldwork notes, and the occupational therapists accounts as revealed from the interviews. The processes illuminated themes, patterns and categories within the data, providing a rich description in order to understand how occupational therapists embedded spirituality in their daily practice (Robson, 2011; Polit & Beck, 2014). The choice of qualitative data analysis strategies depends on the study's underpinning epistemological and ontological perspectives. Choices are difficult because there are no recognised classifications of qualitative data analysis approaches (Rapley, 2011; Spencer, Ritchie, O'Connor, Morrell & Ormston, 2013; Polit and Beck, 2014). However, a key feature of qualitative data analysis in this study was the application of

appropriate iterative processes of analysis across data sets (Observation fieldwork notes and reflective diaries, and interview data) to discover and understand the phenomenon under investigation. For the novice researcher the range of qualitative data analysis methods to choose from can be challenging when considering how to organise and synthesise the volume of data in order to make sense of the data, accurately represent observed practice and practitioner, and illuminate the phenomenon (Rapley, 2011). The following approaches to data analysis are presented in order to justify the reasoning behind the selection of the framework approach that underpinned data analysis for this study. Grounded theory, thematic analysis, content analysis, phenomenological analysis and the framework approach are well established data analysis methods associated with health research (Rapley, 2011; Streubert & Carpenter, 2011; Spencer et al., 2013; Charmaz, 2014; Polit & Beck, 2014).

4.5.1 Overview of qualitative data analysis approaches

There is no one approach advocated for analysing data collected within an ethnographic study, but the key principles of the analysis involved iterative process throughout, beginning when planning the study through to the field and final write up (Ritchie & Lewis 2003; Bradley, Curry & Devers, 2007). However, it was useful, and necessary, to consider, compare and contrast the well accepted methods of data analysis and present a justification for adopting framework approach to underpin the data analysis for the study reported in this thesis.

The similarities between ethnographic approaches and phenomenological methods of data analysis include immersion in the data, and reflective engagement resulting in rich description. Unique to phenomenological methods is rich description to the illumination of the lived experience of the participants as co-constructed by the participants and the researcher (Streubert & Carpenter, 2011, Polit & Beck, 2014). However, central to approaches of phenomenological analysis is valuing and illuminating the unique lived experience of participants about phenomenon, which was not congruent with the aim and objectives of this study, where practice was being explored from observation. The interviews were used to

explore the facets of practice, although perspectives of practitioners were sought. In contrast to phenomenological approaches grounded theory or one of its variations could have been considered as an approach to analyse the data for this study. The most widely applied qualitative data analysis strategy, the strength of grounded theory is the structured iterative processes of analysing the data. The application of constant comparison analysis seeks to compare codes and refine ideas, collecting further data through a process of theoretical sampling (Charmaz, 2014). This refinement of data continues until no new information emerges, and the resulting concepts are developed to construct a theory which has emerged grounded in the data (Charmaz & Bryant, 2011; Rapley, 2011). Grounded theory approach was rejected because the aim and objectives of the study were to explore and describe how spirituality is embedded in occupational therapy practice and not to develop a theory.

Thematic analysis is one of the most widely used methods to analyse qualitative data, often considered the building block of all qualitative analytical approaches, and often associated with ethnography (Sandelowski, 2010). The strength of thematic analysis includes its universal applicability across study designs, it can be used with any textual data and the series of interconnected stages guide the analytical processes (Burnard, 1991). These analytical activities involve immersion in the data, and the developmental extraction of codes and categories to illuminate and extract a common meaning (Braun and Clarke, 2006). Thematic analysis has been criticised for lacking depth, fragmenting data and lacking transparency in relation to the development of themes, which can result in difficulties when assessing the quality of the findings (Attride-Stirling, 2001).

Content analysis is similar to thematic analysis in its analysis of the content of narrative data found in interview transcripts. The strength of content analysis is the flexibility of the approach to data analysis and can be used when the aim of the study is to describe a phenomenon (Hsieh & Shannon, 2009). This flexibility can also be a limiting factor when a definitive structure guiding the analysis could limit the analytical process, as in the case of this study, when the data were complex and included fieldwork notes and interview transcripts. Additionally,

content analysis has been criticised for its simplistic description of the data, and lack of interpretation of the phenomenon being explored (Cavanagh, 1997). Thematic or content analysis could have been adopted in this study. However, the voluminous amount of text data collected from the observations and interviews of four participants' required careful consideration of data management strategies to ensure transparency and rigour. A more structured approach was sought to address these issues, therefore thematic and content analysis were rejected as a data analysis method.

The framework approach underpinned the data analysis process for this study. The framework approach has gained popularity due to the rigorous process of data management necessary for large amounts of textual data. Following data management, a logical and transparent method of engaging with the data aids the construction of a meaningful framework to aid analysis. This framework leads to the development of final themes and core concepts (Smith & Firth, 2011). An additional strength of framework analysis is in the initial stages of data management where the analysis focussed on the meaningful labelling of units of data, or codes, (for example words, phrases, sentences, paragraphs) that are the building block of initial themes. The process then logically progresses through stages to make sense of the data by developing a matrix for managing the linked codes (Ritchie & Lewis, 2003). The reflexive nature of the data analysis was strengthened by the use of an analysis notebook to record salient issues as they arose and support decision making with an audit trail (Ritchie & Lewis, 2003; Ward, Furber, Tierney & Swallow, 2013). Additionally, the process of crystallisation, where I considered the many facets of the emerging phenomenon was facilitated by the iterative interactive nature of the framework approach, which involved forward and backward movement across the stages of data management, descriptive accounts and explanatory accounts. This iterative process was essential to the creativity of the analysis, development of ideas, clarifying meaning and reworking concepts as new insights emerged from the data. The process increased the validity and reliability of the study, and reduced investigator biases (Denzin & Lincoln, 2008). The framework approach has been identified as


being particularly relevant in studies that focus on practice (Ward et al., 2013), and was congruent with the study aim and objectives.

4.5.2 Data analysis process: applying framework approach

Framework approach is a structured iterative approach to data analysis. The following section outlines how the framework approach as described by Smith and Firth (2011) and Ritchie et al (2013) was applied to the data analysis for this study. The interlinked stages of framework approach include; data management, descriptive account, explanatory accounts and finally how data reduction was achieved. An overview of framework approach is presented in Figure 8. This process of analysis is a continuum of analytical activity as ideas develop, meaning is clarified and the concepts were re-worked as new insights emerged from the data from all four participants.

Figure 8: Overview of framework approach (adapted from Smith & Firth, 2011, p55-56)

Stage	Components
Data management (Page 128)	<ol style="list-style-type: none"> 1. Organisation of fieldwork notes into the relevant participant file 2. Transcribe the interview data verbatim 3. Become familiar with the data by reading and re-reading the fieldwork notes and transcribed interviews. Using the recordings to strengthen the context and links to the participants 4. Identify and organise the data into '<i>in-vivo</i>' codes and categories 5. Develop a coding matrix from the initial '<i>in-vivo</i>' codes and initial categories 6. Assign data to the initial categories
Descriptive accounts (Page 132)	<ol style="list-style-type: none"> 1. Summarise and synthesise the coded data, refining the initial themes and categories 2. Identify associations between the themes until a '<i>whole picture</i>' emerges 3. Develop more abstract concepts which will become the core concepts
Explanatory accounts (Page 136)	<ol style="list-style-type: none"> 1. Develop associations and patterns within the core concepts, seen in figure 6 as links 2. Reflect back on the original data as a whole and the analytical stages to ensure the occupational therapists accounts are accurately reflected and reduce the possibility of misinterpretation 3. Interpret and find meaning to explain the core concepts and final themes 4. Seek wider application of the concepts and themes



4.5.3 Data management

Data management was a lengthy but essential process as themes and concepts were generated by labelling, sorting and synthesising the 'raw' data. The purpose of this stage of the analysis was to enhance the familiarisation necessary to portray a full picture of the phenomenon under investigation. Consistently referring back to the aim and objectives of the study during data analysis strengthened the rigour of the framework approach. Throughout the process of data analysis an analytical log was kept in the form of a data analysis notebook. Notes were made of the processes and memos of changes to the emerging categories and themes as the analysis developed. These notes and memos provided an audit trail of the data analysis process and strengthened the transparency of reasoning (Smith & Firth, 2011; Ritchie et al, 2013).

A range of computer assisted methods for qualitative data analysis (CAQDAS) that are compatible with the framework approach and were available to support the data management processes. Whilst significant benefits have been suggested in using CAQDAS, particularly in relation to labelling and retrieval, at the time when data analysis commenced there was not a software package specifically developed for use with the framework approach. Using CAQDAS to support data analysis must be congruent with the epistemological underpinnings of the study (Spencer et al., 2013). The purpose of this study was to explore in depth descriptions of occupational therapists practice, these were contained in fieldwork notes and interview transcripts. Therefore, I decided not to use CAQDAS in favour of extended immersion in the data to strengthen the analytic process and explore the relationship between the categories found in both data collection methods.

Data management began with recording initial thoughts and issues generated from the participant observations to inform the conversational interviews. On completion of the observations the fieldwork notes were photocopied from the fieldwork notebook and combined with the corresponding participant interview transcripts. All interviews were digitally recorded

and I transcribed verbatim, using Express Scribe®, to enhance my familiarisation and immersion in the data, which aimed to achieve a deeper understanding of the interview data and enhance the analysis. The transcripts were cleansed of all identifying information and were made available for the participants to check for accuracy. The pseudonyms, which had been selected by each participant, were inserted in place of names. The recordings were repeatedly listened to, and initial thoughts along with summarising the issues discussed with my supervisory team were documented. One of the challenges with the large volume of data collected by participant observation related to creating order and management of the analytical processes.

The data were annotated line by line using a highlighter and memos to note initial ideas and thoughts during a process of listening many times to the recordings. The same process was applied to the fieldwork notes, after each episode of observation the notes were reviewed and a note was made of what was perceived to be occurring. These notes were then used to develop an interview guide for the follow up interviews, so that themes could be clarified or explored in more depth. For example, participant 1 (Patsy) spoke a lot about “*journeying*” with her patients, and this was explored further in the interview. The strength of the framework approach is that it stays close to the language of the participants (Ritchie et al 2013). The framework approach provides a “*scaffold*” that supports the integrity of the data analysis.

After familiarisation with the data a coding matrix was developed. Figure 9 presents an example of how the coding matrix was developed to identify the ‘*in-vivo*’ codes and initial categories. In order to remain close to the data the ‘*in-vivo*’ codes were constructed from the participants own words or direct extracts of the fieldwork notes. Following the construction of ‘*in-vivo*’ codes preliminary thoughts were developed to explain the meaning of the ‘*in-vivo*’ code. This process of refinement supported the final stage developing ‘*initial categories*’.

Figure 9: Example of coding matrix

Interview transcript (IN)/ Fieldwork Notes (FN)	Page no/ identifying position in data	In-vivo code	Preliminary thoughts (What is this about?)	Initial Categories
Observation/ Participant 1/ Day 1				
“...exploring recent weekend away to celebrate a family member 90th birthday”	FN -1	Exploring a weekend away	Patient’s experiences are part of the therapeutic encounter with the OT.	Valuing the individual in the therapeutic encounter
“...explored fatigue management techniques with patient. Traffic light allegory. Discussed how to improve quality of life and manage fatigues.”	FN -2	Exploring with patient meaning of fatigue and working on an individual coping strategy	Patients experiences of symptoms are addressed by the OT considering the individual meaning and how to cope	Addressing the meaning of symptoms
<p>“Discussed multiple losses and anxiety experienced by the patient... “</p> <p>“...(patient) given Kubler Ross grief theory to understand the grief process and its effect on her”</p>	FN – 2	<p>Multiple losses. Anxiety.</p> <p>Understanding grief and effect on patient.</p>	Patient helped to understand the impact of multiple loss on her and information to explain this provided	<p>Recognised the meaning of grief</p> <p>Providing hope for individuals</p> <p>Using theory to normalise and educate</p>
<p>“Patient became tearful at this point”</p> <p>“OT was reassuring, placing her hand on patient’s shoulder as she became upset”</p> <p>OT said “affects something deep down in your spirit”.</p>	FN – 2	<p>Hand on shoulder – physical reassurance</p> <p>“deep down in your spirit”</p>	Observed listening skills and responding; reflecting significant impact of patient’s situation, providing reassurance	Observed verbal and non-verbal development of therapeutic relationship

Interview 1 - Participant 1				
"I just think that that I think it's (spirituality) the essence of what we do as occupational therapists....."	IN -1	Spirituality is the "essence of OT practice"	Spirituality is valued as the essence of occupational therapy practice	Spirituality valued in practice
"mind and body interact with one another get someone to a better place....."	IN-1	"mind body interact"	The interaction between the mind and body facilitates practice	Values embedded in practice
"Physical dysfunction the whole thing about quality of life ..."	IN-1	"quality of life"	OT promotes quality of life for people with physical dysfunction	Promotes quality of life
"To enable someone no matter how little they have in terms of physical function to have quality in their life."	IN-1	"...how little in terms of physical function.... quality of life"	OT promotes quality of life for people with physical dysfunction	Promotes quality of life
"...it doesn't matter how small your life becomes there's something very sweet at the essence of it."	IN -2			Quote supports above
".... going to look at how this person and getting their tights on..... bigger picture.....goes to vintage fairs and found some Mary Quant tights.....put on a pair of tights and do it independently."	IN -2	"...bigger picture....do it independently."	Intervention, seemingly insignificant demonstrates attention to individual concerns of the patient.	Attention to the individual concerns of the patient
"...essence of who I am"	IN-2	"Essence of who I am"	Individual values personal to the OT's practice	Values influence practice
"so how to teach people that and that's the frustration for me."	IN-2	"...how to teach people..."		Valuing the individual is difficult to teach
"... I think it's how you do it."	IN -3	"how you do it"	How practice is enacted	Values in practice

4.5.4 Descriptive accounts

Descriptive accounts involved developing and refining the categories and prepare descriptive accounts. Key to this stage was to retain the words used by the participants and to resist imposing the language and terms reflected in the literature outlined in Chapters One and Two. Referring back to the original transcripts was central to this process (Smith & Firth, 2011; Spencer et al., 2013). The process described in the previous section yielded a large number of initial categories, for example forty-four were developed from participant one. The initial categories required reviewing and grouping into themes. For each of the occupational therapists observed and interviewed, the process of refining was achieved using post it notes, and through iterative discussions and debates with research supervisors. Each initial category was written on post it notes and then sorted into the initial themes that I perceived to be emerging. Six themes were initially identified through this process of refining and represented on the coding index. This was refined to four themes in the final stage of the analysis.

Figure 10: Flow diagram of the process refining the initial categories to final themes

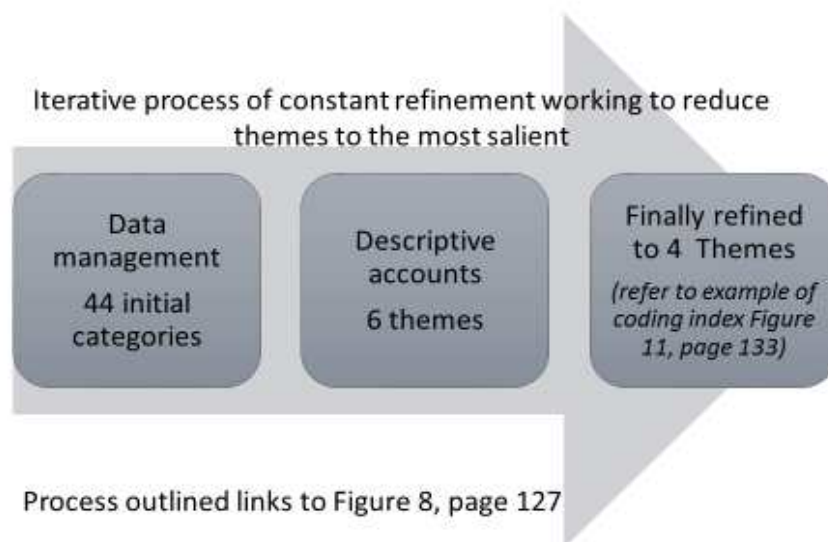


Figure 11 which follows presents an example of the final coding index following refinement of the initial categories.

Figure 11: An example of the coding index

Key to shading: Grey = Fieldwork notes. White = Interview transcript

Initial Themes	Initial Categories
1. Valuing the individual & developing a therapeutic relationship	The individual is central to the therapeutic encounter
	Acknowledging the impact of events affecting emotional well-being
	Attending to concerns of patients' and their experience of disability
	Attention to comfort and support for patient
	Recognising the impact and experience of symptoms on well being
	Enabling the patient to take control of life and make decisions
	Recognising the individual's experience of meaning and purpose
	Recognising the opportunities in the patient's environment
	Attention to the individual's needs and wishes promotes well being
	Patient-centred journeying
	Development of therapeutic relationship using verbal and non-verbal cues to facilitate engagement and hope
	Valuing the individual is difficult to teach to healthcare practitioners
	Acknowledging the individual's wishes
	Acknowledging the individual's capacity to progress
Facilitating hope through practice	
2. Integration of individual goals within therapeutic intervention	Addressing the personal meaning of symptoms and developing strategies to improve performance
	Recognising the impact of grief to a patient
	Coping strategies to manage distress and anxiety
	Promoting meaningful occupation to improve well-being and function
	Support a patient with decision making
	Negotiating individual goals and facilitating independence
	Therapeutic interventions that promoting quality of life
	Recognising the cognitive and emotional aspects in OT practice
	Combining physical and mental health in practice
	Addressing the relationship between mind and body
	Hope, meaning and purpose important for patients' well-being
	A patient achieves "wholeness"
3. Using knowledge, understanding & theory of spirituality to guide practice	Using theory to normalise and educate
	Application of theory and personal philosophy of spirituality shapes practice
	Faith is part of spirituality; religion is not significant
	Spirituality difficult to define, is the guiding values / principles of the person
	Spirituality integral to occupation when it facilitates connections with God or higher power
	Personal Christian values influence worldview
4. Self-awareness of personal & professional values that influence and enhance practice	Spirituality is valued in practice
	Creativity is integral to addressing spirituality in practice
	Professional experience shapes philosophy of occupational therapy practice
	Promote professional values highlighting hope, meaning and purpose through telling patients stories
	Family influence and experience of occupational therapy on career choice
	Practicing in a target driven context influences practice

The purpose of the thematic chart was to return to the original data and apply the initial categories to the codes and description. An example of the thematic chart is outlined in Figure 12. All four of the participants' data were analysed and merged into the thematic chart. Additional categories were added and further refinement of the categories and themes was undertaken as the merged data brought new insights to the analysis. The process of refining the initial categories and initial themes was strengthened by synthesising the initial categories, finding similarities and deviancies, and linking the data according to a relevant theme.

Figure 12: Thematic chart

Interview transcript (IN)/ Fieldwork Notes (FN)	Page no	In-vivo code	Preliminary thoughts (What is this about?)	Initial Categories	Miscellaneous	Theme
"...exploring recent weekend away to celebrate a family members 90th birthday"	P1-FN -1	Exploring a weekend away	Patient's experiences are part of the therapeutic encounter with the OT.	The individual is central to the therapeutic encounter		Valuing the individual
"...explored fatigue management techniques with patient. Traffic light allegory. Discussed how to improve quality of life and manage fatigues."	P1-FN -2	Exploring with patient meaning of fatigue and working on an individual coping strategy	Patients experiences of symptoms are addressed by the OT considering the individual meaning and how to cope	Addressing the personal meaning of symptoms and developing strategies to improve performance		Supporting individuals to maintain health and well-being
"Discussed multiple losses and anxiety experienced by the patient.... "	P1-FN – 2	Multiple losses. Anxiety.	Patient helped to understand the impact of multiple loss on her and information to explain this provided	Acknowledging the impact of events affecting emotional well-being		Valuing the individual
"...(patient) given Kubler Ross grief theory to understand the grief process and its effect on her".	P1-FN -2	Understanding grief and effect on patient.		Using theory to normalise and educate		Supporting individuals to maintain health and well-being
"Patient became tearful at this point" "OT was reassuring, placing her hand on patient's shoulder as she became upset" OT said "affects something deep down in your spirit".	P1-FN - 2	Hand on shoulder – physical reassurance "deep down in your spirit"	Observed listening skills and responding; reflecting significant impact of patient's situation, providing reassurance	Facilitating hope		Recognising spirituality as a dimension of holistic practice

Overlaps and repetitions in relation to initial categories and themes were evident on reviewing and refining the thematic charts. A spreadsheet was created for each initial theme itemising the initial categories. This served as an audit trail to identify where categories could be combined across the data set. An initial category that appeared to be under-represented was not subsumed unnecessarily, acknowledging that qualitative data is not necessarily about the number of occurrences but the richness of the description of the phenomenon. This necessitated continual reflection back to the original raw data to extrapolate the significance of the initial category under question and referring back to the aims and objectives of the study.

4.5.5 Explanatory accounts

Explanatory accounts were constructed during the final stages of data analysis on completion of the descriptive stages. Constructing explanatory accounts involved the process of reviewing the data and refining it to find patterns, associations and explanations within the analysed data. Attempting to account for these occurrences was consistent with qualitative data that was rich in explanations of the phenomenon under investigation. The purpose of these explanatory accounts was to ensure that the experiences of the occupational therapists were reflected accurately (Smith & Firth, 2011). The final stage in data analysis was to construct the final themes, refined categories, and links between the categories and present the core concepts. See Figure 13 (page 137) for the presentation of final themes, refined categories, links and the core concepts. The core concepts developed to reflect how occupational therapists embedded spirituality in their practice were; *'person centred occupational therapy practice'* and *'occupational therapy practice: professional attitudes and values'*. The final themes, refined categories and core concepts will be presented in more detail in Chapter Five (Findings). The *'Embedding Spirituality in Occupational Therapy'* (ESpiOT) model was developed from the findings to guide practice and will be discussed in Chapter Six (Discussion).

Figure 13: Final themes and Core concepts

Final Themes	Refined Categories	Links between categories	Core concepts
1. Valuing the individual	1.1 The therapeutic encounter centres around the patients' needs	1.1 The therapeutic encounter centres around the patients' needs 2.1; .2.2; 2.4; 2.5; 3.3; 3.4 all link as the outworking in practice of person-centred therapy. 1.3 links to 2.1 in the application to practice of an appreciation of the impact of the problem. Final themes 1 and 2 are concerned with the person, the professional and the agency of occupational therapy.	Person centred occupational therapy practice
	1.2 Understanding the diversity of factors that impact on patients emotional well-being		
	1.3 Being sensitive to and responding to the impact and experience of symptoms on health and well-being		
2.Supporting individuals to maintain health and well-being	2.1 Addressing the impact of symptoms and strategies to improve the patient's occupational performance	This section is concerned with the agency of occupational therapy, linking to the person-centred attributes of theme 1 (Valuing the Individual), links between 1.2 and 2.4	
	2.2 Facilitating patient's autonomy in decision making		
	2.3 Recognising the opportunities in the individual's environment to promote health and well-being		
	2.4 Sensitivity to patient's diverse perspectives of health and illness promotes well-being		
	2.5 Promoting meaningful occupation and therapeutic interventions that improve function, well-being and quality of life		

3. Recognising spirituality as a dimension of holistic practice	3.1 Application of theory and the occupational therapist's personal philosophy of spirituality shapes practice	3.1 Application of theory and personal philosophy of spirituality shapes practice, links to 4.3 Professional experience shapes philosophy of occupational therapy practice The occupational therapists professional experience is the outworking of the application of theory and personal philosophy of occupational therapy	Occupational therapy practice: professional attitudes and values
	3.2 Facilitate hope through practice		
	3.3 Patient-centred journeying is central to well-being		
	3.4 The patient's values and experience of hope, meaning and purpose are central to embedding spirituality in practice		
4. Personal and professional influences	4.1 Influence of family and experience of occupational therapy on career choice	4.4 Promote professional values highlighting hope, meaning and purpose and 3.2; 3.4 The spiritual dimensions and the influences on practice link	
	4.2 Working in a context driven by finance and targets influences practice		
	4.3 Professional experience shapes philosophy of occupational therapy practice		
	4.4 Promote professional values highlighting hope, meaning and purpose		

4.6 Ethical considerations

The unpredictable nature of qualitative research necessitates a design that allows for unexpected events and outcomes of qualitative fieldwork, maintaining the participants' interests and well-being at all times. This was particularly applicable to this study where data collection was carried out in the “*real world*” context of occupational therapy practice in the community, in patients own homes, and on hospital wards in an acute hospital. The study posed a number of ethical issues. The main issues concerned:

- Researching in a ‘*real life*’ context;
- Gaining consent;
- Confidentiality;
- ‘*Insider*’ researcher;
- Withdrawing from the research setting or ‘*field*’.

This study adhered to the College of Occupational Therapists Code of Ethics and Professional Conduct (COT, 2010) and the Health and Care Professionals Council Standard of Proficiency for Occupational Therapists (HCPC, 2013). Both outline the general principles for ethical practice as an occupational therapist that are also applied to research i.e. acting in the best interests of individuals to ensure their welfare; safeguarding the interests of vulnerable people; providing information to ensure informed consent can be achieved and safeguarding confidential information and respect as participants share their lives with the researcher (COT 2010). Ethical considerations for qualitative research, and in particular relating to ethnography, require a creative application of the ethical principles and codes of practice to ensure that the ethical perspectives of the participants are upheld. The section that follows explores the specific considerations for qualitative research practice, further detailed application to ethnography and then applied to the specific nature of this study.

4.6.1 Researching in ‘real life’ settings

The occupational therapists were required to be working for a service manager who gave permission for the research to be undertaken in the clinical setting they held responsibility for

during normal working hours. Recruitment was through the Therapy Services Director in order to ensure potential participants were treated fairly and not coerced into taking part (Gray,2014). This study employed a data collection strategy observing the practice of occupational therapists in '*real life*' situations where it was difficult to predict circumstances. This demanded a creative and flexible approach to unexpected and unplanned circumstances as they arose. The research design protocol covered in depth the issues relating to observing practice and ensured the process was transparent. Adopting an overt participant-as-observer position ensured the patient and the occupational therapist were fully aware of the purpose of the study, avoiding any elements of deception. Provision was made in the research design and information sheet in the event that practice was observed which contravened the Occupational Therapy Code of Ethics and Professional Standards and the Standards of Proficiency for Occupational Therapists (COT, 2010; HCPC, 2013). The participants were advised that adherence to the NHS Trust service policy and procedures for this issue would be followed.

The study design also acknowledged that spirituality could be an emotive and sensitive issue, and that observation might cause distress to the participant (Beagan & Kumas-Tan, 2005). Additionally, for the occupational therapists, reflecting on their practice during the interview might also have evoked an emotional response. The information and consent paperwork detailed how this would be dealt with and the participant's right to withdraw at any stage. During the design phase of the study the researcher needed to be mindful of the pressures participants were under in practice, and the potential additional burden imposed by the research on their work load (Webster et al., 2014). The information letter outlined that participants should ensure they discussed their engagement in the study with their line manager. Additionally, they should not be supervising an occupational therapy student on practice placement to avoid confusion and additional burden. The patients, although not the direct focus of the observations of practice, played an essential role in the fieldwork stage of data collection. In order to ensure that they were treated beneficently measures were in

place to ensure any adverse consequences were avoided (Beauchamp & Childress, 2013). For instance, in the event that a patient became distressed by being observed during the occupational therapist's intervention, the researcher would withdraw from the field.

4.6.2 Consent

The issue of obtaining ongoing consent in a study where there was likely to be sustained periods of contact by the researcher with the participants was given consideration during the design stage. Research ethics determine that informed consent must be gained from participants before entering into a process of data collection, and that the legal frameworks governing consent must be adhered to (Royal College of Nursing (RCN), 2011, Webster et al., 2014). The dilemmas for the researcher encountered in this study related to lengthy periods of observation, the nature of the situations patients were encountered in and the potential for those situations to change.

Process consent was deemed the most appropriate method for ensuring informed ongoing consent. Process consent (Usher & Arthur, 1998) is a consensual process ensuring the service user is kept informed at all stages. In practice this involved ensuring the occupational therapist participant consented at every episode of observation and noting this in the fieldwork notebook. For the patient they were the keeper of a copy of their informed consent paper and this was signed at every repeat intervention observed. An example of this was a visit from hospital to the patient's own home to assess their performance in their own familiar context, an episode which lasted a whole morning of observation. All parties involved in the observation of practice were asked at regular intervals to consent and this verbal consent recorded for the patient on their original consent form, the occupational therapist in the fieldwork notebook. This ensured the patients' and occupational therapists' rights to withdraw at any stage could be upheld (Edwards, 2005). This process was preferable to obtaining consent via assent, where it is assumed by the person's action of cooperation that they consent (Slaughter, Cole, Jennings & Reimer, 2007). Thus, by applying process consent the service user and therapist

involved in the observation were regularly reminded of their rights. Additionally, in any situations where the service user became aware that they did not wish to participate in the research process, they could withdraw. By carefully constructing the process of consent at key points in the observation the researcher assured the participants that their right to consent had been addressed. Measures were also in place in the study design to address risks such as the service user losing the capacity to consent during the period of observation. Service users without the capacity to consent were excluded from the study and the occupational therapist's intervention was not observed.

4.6.3 Confidentiality

Confidentiality refers to the measures taken in the design of the study to ensure that the rights and protection of the study participants were ensured so that the data they provided was never publically divulged. Research participants have the right to expect their data will be treated confidentially, and their privacy protected (Polit & Beck, 2014; Webster et al., 2014). This study posed challenges for the researcher as the small sample sizes and rich descriptive data gathered from very public settings in hospital wards meant it was not possible to ensure anonymity for the occupational therapists studied. However, measures were put in place to ensure that they could not be linked to their data. In any writing up of the thesis, publications or conference presentations, the potential for disclosure was minimised. To ensure confidentiality all data was handled, stored, transferred and (will be) disposed of in compliance with the Data Protection Act (1998). All consent forms were stored as soon as possible after signing by the patients and participants in the researcher's locked filing cabinet. Participants were given a number in the fieldwork notes and interview transcripts. Tensions can result when the researcher chooses pseudonyms because of attributing the participant to a particular age group or social status that can be associated with names (Dearnley, 2005). Although data extracts can be given a code, pseudonyms can bring the data to '*life*'. In order to address the tensions around using pseudonyms, participants were asked during the early stages of data collection to choose their own pseudonym. The participants described the diversity of their

experiences, and their key characteristics, thus avoiding attributing the participant to a particular age group or social status (Dearnley, 2005). Interview transcripts were transcribed verbatim by the researcher. They were cleansed of all personal information and locations mentioned during the interview and stored on the secure drive of the University computer storage system. Paper copies used for data analysis were stored in the researcher's locked filing cabinet.

4.6.4 'Insider' researcher

The purpose of this study was to explore from the inside the practices by which occupational therapists embedded spirituality in their practice. The ethnographic approach that utilised observation of practice and follow up interviews required the researcher to become immersed in the setting in order to gather rich descriptions (Simons, 2007). The researcher's role posed some ethical challenges, notably the adoption of the role of *'insider'* researcher allowing the process of practice to be explored (Bonner & Tolhurst, 2002). As a former employee of the NHS Trust and being known to the participants, established relationships were already in place to facilitate the gathering of rich data (Ritchie et al, 2014). Being an occupational therapist placed me as an *'insider'* to the profession, and with a substantial understanding of the practice observed. Familiarity with the observed practice and missing the subtleties of practice observed has been considered a limitation of *'insider'* research (Bonner & Tolhurst, 2002; Hammersley & Atkinson, 2007). To address this further, a de-briefing session with the occupational therapists, which involved clarification and underpinning rationales for practice, were sought after each episode of observation and at the follow up interviews. Additionally, the subjective reflective diary was used to note impressions and experiences relating to the role of the researcher and perceived impact on the process of observation.

Ritchie et al (2014) suggest that subjects might be motivated to take part in research by the prospect of improving knowledge or the privilege of association with the researcher. Balancing the role of occupational therapy lecturer and researcher was challenging. Participants viewed

me as the expert in the area of occupational therapy practice and spirituality; nearly all the participants expressed their motivation for taking part in the study was to learn more. This balance of power was addressed at the pre-observation briefing meeting where the purpose of the study was discussed and the role of the researcher as theoretically expert, learning from occupational therapists who were expert in their practice (Bonner & Tolhurst, 2002). No direct hands on practice was carried out during the observations, however on a few occasions the participants did ask my opinion about situations they were finding difficult to manage. When these occurred during the debriefing they sought to illuminate situations relevant to the study. Additionally, balance of power issues within the relationship were considered. These balance of power issues, where the possibility that participants might disclose more than they anticipated, or the researcher might adopt the role of counsellor as sensitive areas of practice were explored were addressed in de-briefing sessions. The process of de-briefing after each episode of observation and the interviews involved inviting the participants to raise any issues or concerns, in addition to discussing the day's observation. Participants were also advised to seek further support, if necessary, during their clinical supervision sessions (Ritchie et al, 2014; Webster et al., 2014).

4.6.5 Withdrawing from the research setting or 'field'

Exit strategy was important in the research design to ensure withdrawal caused no undue pressure or disturbance to the participants. The participants were all made aware in the recruitment information letter that observations of practice were expected to continue for no more than five days.

Two phases of withdrawal from the field are described by Brewer (2000, p101):

1. *"Physical removal"* from the fieldwork setting, a mechanical process of withdrawing from the setting;
2. *"Emotional disengagement"*, this entails ending the relationships in the context of research and is more difficult.

For this study the withdrawal was gradual since following the period of participant observation in the services a follow up interview was carried out some time later. This gave both the participants and the researcher some time to re-adjust to the original relationships. Brewer (2000) also suggested that participants could become attached to the data collected. To address this, an executive summary of the study findings will be provided to the NHS Trust Therapy Services Manager. Additionally, a workshop will be offered to the Occupational Therapy Service on completion of the thesis. The purpose of the workshop will be to disseminate the findings of the study and present the conceptual frameworks to educate and guide practice.

On the other hand, the physical removal was more complex. Spradley (1980) advocated a pragmatic approach to ending a period of observation that is driven by the timescale for the project and resources. The physical removal from a field where the researcher had become part of the group being studied and included in the activities and routines of the participants was complex. Kawulich (2005, p2) suggested that the time to withdraw was when the observer became so integral to the group that they were involved in their "*gossip*" and asked for opinions. This occurred in one of the settings where 2 participants were observed. The extended exposure to the context provided a rich exploration of spirituality embedded in occupational therapy practice. However, the cohesive relationships between the researcher and participants' precipitated discussion which was not part of the research brief, and therefore prompted that the time had come to withdraw from the setting.

4.7 Summary

The qualitative research design employing observation of practice and follow up interviews addressed the aim and objectives of this study. The methods appropriately enabled detailed explorations of how occupational therapists embedded spirituality in their practice. The framework approach to data analysis provided an iterative structure. This structure enabled a transparent presentation of each stage of the analytical process, the findings and the

interpretations represented as the final themes and core concepts. The data management and development of the coding index within the process enabled the data to be compared between participants. Chapter Five presents the findings from the application of the methodological approach – ethnography, and the procedures presented in the method.

Chapter Five

Study findings

5. Introduction

This chapter presents the study findings, illuminating the themes and core concepts that emerged from observing how dimensions of spirituality were incorporated in occupational therapy practice. The core constructs, '*person-centred occupational therapy practice*' and '*occupational therapy practice: professional attitudes and values*' are presented. The findings are presented separately from the discussion (Chapter Six), in order to ensure transparency between field observations and participants' perspectives, and the interpretation of the findings.

Reporting the findings of qualitative research is challenging. Reducing vast amounts of data in a way that explains its subtlety and complexity needs to be undertaken in an insightful manner. The reporting of findings is a dynamic, iterative stage of the study with further insights developing as the data is ordered, reflected on, assembled and refined into the final account (Marvasti, 2011; White, Woodfield, Ritchie & Ormston, 2014). There is no uniform way of presenting qualitative research findings, which will be influenced by the study design, aims and personal preferences. The findings are presented with the underpinning core constructs, using the themes to illuminate their development, and a separate discussion of the findings presented in Chapter Six. Direct extracts from the data aim to illustrate the themes and contextualise the rich thick descriptions offered (Brewer, 2000; Light, 2010). Thoughtful use of verbatim quotes throughout illuminates the themes underpinning each core concept and gives credence to the participants' voices. Presenting the findings of ethnographic research poses the ethical problem of ensuring participant anonymity, particularly with small participant numbers. To avoid compromising the confidentiality of participants, pseudonyms were used as outlined in Chapter Four, Section 4.6.3, page 142. Similarly, the use of the term "*patient*" was applied to remain consistent to the occupational therapists' language.

5.1 Introducing the participants

Throughout this chapter, the participants will be referred to as the occupational therapist(s). Some of their unique characteristics have been changed to preserve their anonymity and ensure confidentiality in this thesis. An extract from their individual interviews outlining the impact of taking part in the study has been included to further illuminate the participants' unique contribution to the study. All of the occupational therapists reported that taking part in the study had been a positive experience, enhancing their understanding of spirituality and their practice through reflection and discussion during the period of observation.

Patsy

Patsy is a woman in her late forties who has been a qualified occupational therapist for nearly 30 years. Training and qualifying at the height of the reductionist period of occupational therapy practice, Patsy was inspired with the opportunities to be creative within the occupational therapy profession. Patsy has worked in a wide range of specialities over her career, currently working in an interdisciplinary community team providing short term rehabilitation interventions for a wide remit of patients with physical disabilities. Patsy described herself as having a strong Christian faith. Patsy's description of the impact of taking part in the study as follows:

...um I think I said to you the other day that (pause) you never get the quietness of time out to think about what you do and I would describe myself and so would others as being totally committed to my job, loving it, it's what I get up for but there's I noticed in the weeks since you started with me even from day 1 that when people ask how my work is I used to kind of talk about the things were difficult in it so how difficult it can be in the NHS and stuff. Urm, I don't any more I just go I just love it I'm blessed and it's kind of turned up the flame on the Bunsen burner if you know what I mean.....I feel quite emotional talking about it but it just feels like at last someone's understood the essence of what I'm trying to doAnd for actually for someone to say I really value it enough to spend time watching it to write it up and to tell you about it, um. I think it would have been very different if you hadn't been able to give feedback at the end of every session....I don't know it's just felt. It's as if someone's given me the biggest Christmas present...It's been lovely... (Interview)

Mark

Mark is in his mid-forties has been a qualified as an occupational therapist for nearly twenty years. Following a period as a generic support worker, his career path has been varied, working in acute hospitals and mental health services. A short period away from clinical work employed in the medico legal sector as a personal injury manager challenged Mark's view of his own occupational balance, the need to redress that and return to a context where he could embed the core values of occupational therapy in practice. Currently he works in a large acute hospital specialising in orthopaedic, trauma and vascular surgery. Mark made no references to his personal philosophy of spirituality; he was committed to embedding the core philosophy and values of the profession which he understood to incorporate spirituality. Mark described the impact of taking part in this study as follows:

....for me, we hear day in day out, the OTs causing this delay, the OTs needs to sort this delay out...it becomes wearing that this is what you're about, you're about discharge planning, you're about bits of equipment, and you're about blocking delays. You start to get to a point where you think, is that all I'm there for, what is the point? Why am I trying to do, you know, practice as I practice? Um, and it, over time it niggles away and you think, why do I bother? Um, you know and you sort of think, well if there's no value out there for what I'm doing then it just, it becomes hard work, it becomes, you become a bit de-motivated...So, it's been fantastic to kind of, um, come in and have you kind of hovering in the background - 'cause inevitable...it makes you feel like a student again initially, and it's kind of like, oh what am I doing, and it does make you think about kind of how am I saying, and I have to say I've not practiced any different to what I normally do, but it's the whole kind of reflective piece that you have...And, that's not, not to say it's been at all a negative experience, or that it's felt uncomfortable or anything. But it's challenged my reflection and it's challenged my thought processes around kind of, um, what I do and why. And it's also, you know, it's also kind of re-energised I suppose my view, I've always held a strong view around core philosophy, err, and, and core skills of practice and underpinnings...But actually it's been really good, to sit down and think no. The core values are as I believe the core values. You know underpinnings are as I believe the underpinnings. And it's just reaffirmed for me, it sounds really arrogant but, I'm right. You know, that, that what I teach the students what I instil in the staff and what I advocate beyond to others, um, is actually what it should be. And I think just from a PR point of view, um, and on the wards it, its novel for a researcher to follow you around. So the wards have been very, well what's going on? And they've said, you know, when I've said it's been around spirituality they're like, what like religion? No it's not religion, and it's afforded me some opportunity for some engagement. (Interview)

Phoebe

Phoebe is in her early thirties and has been qualified as an occupational therapist for just over ten years. Her career has been very varied working in physical and mental health services, and currently working in community occupational therapy service providing equipment and adaptations for people with long term physical disabilities. Phoebe described her personal understanding of spirituality in relation to the journey or path she on needs to be meaningful and purposeful in order for her to achieve inner happiness. In the following extract, Phoebe described the impact of taking part in the study:

Well, I've really enjoyed being part of this study. And I think it's been interesting to look at hope, meaning, and purpose in more detail. 'Cause having this, questions and answers today has made me think about it, in terms of what my understanding is and how it affects me and how that impacts on how I practice. So we don't always allow the time to get down to the nitty gritty of what we're doing. So actually being part of this study has, sort of, given me the permission or the motivation to actually think about it more detail... And be able to inform other people as well, so you know sharing what I've learnt from it, with others.
(Interview)

Julie

Julie is in her mid-forties and has been qualified as an occupational therapist for over twenty years. She has worked in a range of physical health settings. After a series of rotational posts in orthopaedics, care of the elderly, spinal injuries and a stroke unit, Julie decided to travel visiting Australia, USA and South East Asia. During this period Julie didn't work as an occupational therapist funding her travels by undertaking a range of casual work including a cake shop assistant, cleaning and telesales. On returning to the UK and after a series of locum posts Julie took up post at a NHS trust where she has been for the past twenty years, mainly working in orthopaedics, trauma in-patients and hand therapy outpatients. Julie found great difficulty articulating how her own personal experience of spirituality guided her practice. She described the impact of taking part in the study in the following extract:

I don't think it's changed me.... I don't think it's changed what I do. I think I've continued what I have always done. 'Cause when I first knew about your study and I thought, well no chance you're not gonna see any of that here. But it's good to see that you do...I thought, oh you'll be looking for a needle in a haystack you'll go away with nothing at all. And then when you started writing pages and pages...I was thinking, oh good grief what on earth has she written. What on earth is in that notebook? (Interview)

The core concepts, '*person-centred occupational therapy practice*' and '*occupational therapy practice: professional attitudes and values*', and the themes that formed these concepts will now be described, summarised in Table 8.

Table 8: Study core concepts and themes

Core Concepts	Themes
Person-centred occupational therapy	<ul style="list-style-type: none">• Valuing the individual• Supporting patients to maintain health and well-being
Occupational therapy practice: professional attitudes and values	<ul style="list-style-type: none">• Recognising spirituality as a dimension of holistic practice• Personal and professional influences

5.2 Person-centred occupational therapy practice

'Person-centred occupational therapy practice', emerged as a consistent feature of the occupational therapists' experiences of embedding spirituality in their practice. The occupational therapists demonstrated and described a range of situations where they considered the unique characteristics of the interaction between themselves, the patients and the agency of occupational therapy. The core concept, *'person-centred occupational therapy practice'* was associated with two themes, *'valuing the individual'* and *'supporting patients to maintain health and well-being'*. These themes were interlinked and represented the way in which the occupational therapists developed their relationship with patients in a person-centred manner. The occupational therapists developed a therapeutic relationship that valued the uniqueness of each patient's situation, and supported engaging patients in interventions that support and improve their quality of life and well-being.

5.2.1 Valuing the individual

'Valuing the individual' was an attribute observed during patient-therapist interactions and described by the occupational therapists during the follow up interviews. The occupational therapists demonstrated how they valued individual patients and practiced in a person-centred manner during the therapeutic encounters, by keeping the patients' needs central to care delivery. Strategies were employed that ensured the encounter focussed on the patients' presenting concerns. By adjusting their communication style to suit individual patient's perspectives the occupational therapists were observed motivating their patients to engage in the interventions or to explore sensitive issues relating to their future. Despite interruptions caused by external factors to the context, for example the busy acute ward setting, the occupational therapists remained focussed on the patient at the heart of the therapeutic encounter. The occupational therapists used every opportunity to ensure that they focussed on the patient's individual needs and that the patients were at the heart of the decision making.

The following extracts illustrate how the occupational therapists considered the patient to be central to the therapeutic intervention:

Mark explored planning the patient's discharge and the issues surrounding this problem. He described the patient as a "rough diamond" and a "man's man" and that his approach would be underpinned by acknowledging the patient's unique characteristics. During the conversation the patient appeared lacking in motivation and Mark described how he felt he was going to have to try something different to engage him. Overall the impression was of Mark working hard with a passive patient to motivate him and get him to take some initiative in his situation. Mark (Observation)

During the initial assessment a friend of the patient came into the room and attempted to dominate the conversation about her own issues. Phoebe gave time to her and listened to her issues, it was difficult not to as she was very forceful. However rather than being diverted Phoebe maintained her focus on the patient and the issues she had come to explore. Phoebe (Observation)

I think, I am aware that everyone's an individual, everyone has individualistic needs...I think I just do what I...I do what I do, and I take cues from obviously the individual and their relatives...and trying to appreciate what they're going through. Trying to see things from their point of view, look at the impact it would have on their lives and roles in the future...try to empathise with how they're feeling. You know, about what I'm suggesting or changes that need to be made....and the reason why that would be the case. But try to work with them at the same time. Julie (interview)

Understanding the diversity of factors that impacted on the patient's emotional well-being underpinned the values of the patient being central to the therapeutic encounter. The occupational therapists' interventions were seemingly simple. However, in practice the complex diverse presenting factors required an appreciation of how the patient's home circumstances, mental health, anxiety, fatigue and grief impacted on their well-being. Additionally, the unexpected nature of traumatic events challenged the occupational therapists as they had to consider the consequences of the unexpected outcome of trauma, sometimes self-inflicted. The following extracts illustrate how the therapists managed diverse situations while remaining focused on the individual:

The purpose of this visit was to explore anxiety and fatigue management with the patient in their own home. Patsy was discussing with the patient the multiple losses that she had experienced recently. She talked with her about the impact of the recent surgery to remove a brain tumour, the loss of her job and car as a result of her illnesses.

In addition to these losses she had just lost her mother and the recent funeral was discussed, exploring how the patient was feeling. Her resulting anxiety and grief from these multiple losses was acknowledged and the patient reassured that grief and anxiety in all its forms can have an impact on fatigue. Patsy reflected to the patient of how this affected her [the patient] spirit saying, 'This all affects you deep down in your spirit'. Patsy (Observation)

...for some of the, particularly some of the trauma cases...it can be a completely unanticipated, um, catastrophic situation that's just descended on them. Um, and, you know, particularly thinking around some of the more active people. I... a couple of cases we've had, and have at the moment where, um, mental health has been a big issue. Um, and so there's certain elements when things are predictable but for me the important thing is that, there's not value judgement on what has happened, it's about then kind of looking at drawing line in the sand and saying right this is where we're at. Mark (Interview)

Valuing the individual required the occupational therapist to be sensitive, responding to the impact and experience of symptoms on the individual patient's health and well-being. The occupational therapists were observed using assessments to explore symptoms such as fatigue and cognitive deficits. The occupational therapists used the outcomes of the assessments to explain the meaning of patients' experiences. These outcomes provided explanations about how the symptoms impacted on the patient's well-being. The assessment was used to suggest how strategies to manage the symptoms could be developed; this sometimes included the provision of equipment and adaptations. The occupational therapists' skills in delivering bad news also demonstrated this sensitivity. The following extracts provide examples of these issues:

The purpose of this visit was to explore the outcome of the patient's fatigue assessment scores and narrative diary detailing her experience throughout the previous week. Patsy discussed the results of the Modified Fatigue Impact Scale. She identified that there were no issues with cognitive fatigue. Some moderate impairment of social fatigue and physical fatigue was extremely impaired. Patsy reassured the patient with her explanation of why she [the patient] felt social situations were so difficult. The impact of physical fatigue was explored further, the patient articulating that the impact of physical fatigue was enormous, exploring with Patsy the activities that caused fatigue. Strategies were discussed to manage the impact of physical fatigue, Patsy clearly reflecting her interpretation of the impact of physical fatigue on the patient's life to illuminate the issues for the patient. Patsy (Observation)

...think back to the gentleman we saw who was never going to walk again, and you know none of the doctors would make that, have that conversation with him. They'd have it amongst themselves; they'd have it with me. And it was a real challenge to kind of find the place, find the words, set the environment up; without just coming out and doing...saying you know...you're not going to walk again. Um, but they couldn't find the words.... Whereas it's building that therapeutic relationship, using the best environment and articulating that in, in a functional perspective and actually then looking at, you know, whilst that is the case, it goes back to the whole thing of hope. You know and looking about kind of, you know, that is catastrophic. Mark (Interview)

So I have this lady with severe breathing issues, um, she can't walk any distance without being very fatigued, um, and wiped out for the rest of the day. So I actually know that she can't get out of the property without what is equivalent to a powered wheelchair. But she is young and only wants to use a scooter; potentially she is going to use a scooter at some time in her life. But at this moment if her life it is more appropriate for her to use a scooter...so you can be as client centred as necessary when recommending adaptations within the criteria set. Phoebe (Interview)

5.2.2 Supporting patients to maintain health and well-being

'Supporting patients to maintain health and well-being' was a consistent theme observed in practice and throughout occupational therapists accounts during the interviews. Central to this theme was practicing person-centred occupational therapy, which linked to the theme, '*valuing the individual*', previously outlined. Early within the patient encounter occupational therapists addressed the patient's health and well-being. Therapists discussed the impact of the patient's illness and symptoms, and provided strategies to improve their occupational performance. Managing symptoms such as fatigue, anxiety, cognitive deficit and the psycho-social impact experienced by patients were recurrent issues. Occupational therapists revealed how distressing it was for patients living with symptoms that significantly impacted on their everyday life. The occupational therapists demonstrated by their practice how they appreciated the impact of the symptoms expressed by their patients, and sought strategies to help them improve their abilities to perform everyday occupations. The uniqueness of each patient's experience is highlighted in the following extract from an interview discussing an interaction observed between Patsy and a patient;

...she was on empty... manifesting in her symptoms [fatigue and anxiety] so I was trying to think of things that I tried a variety of methods to get her to look at what she

loved. To put that into her life and give her that joy and hope...it sounds really simple I just find that write down things that cost nothing like watching the rain running down the window...looking at the blossom on the tree outside...that was a breakthrough moment for her...Fatigue management isn't about managing fatigue it's actually completely changing your way of life that brings you meaning and purpose. Patsy (Interview)

Facilitating patient autonomy in decision making appeared to be a common feature of the occupational therapists' practice. The underpinning principle that the therapeutic encounter centred on the individual supported the occupational therapists to enable their patients to make decisions in a range of situations. Participants described that knowledge gleaned from cognitive assessments was used as a guide to information provision. This knowledge also assisted the occupational therapists to support patients in making decisions about healthcare treatments. The occupational therapists accounts highlighted that they perceived one of their roles was to develop patient's decision making skills, thus facilitating greater independence and control over their health and lives. The skills of the occupational therapists in providing realistic feedback to patients to help them make decisions about their future health and lifestyle were observed across all participants. Examples of the types of decisions the occupational therapists supported included, planning discharge from hospital or considering housing options and adaptations in the community. The following extracts illuminate how occupational therapists facilitated patients' autonomy in decision making;

Patsy explored with the patient the results of the cognitive assessment, interpreting them to her and linking the meaning to the patient's capacity to make decisions for herself. Patsy (Observation).

Mark explored with the patient his accommodation in preparation for discharge from hospital. He elicited a subjective opinion from the patient of his abilities. Some freedom was noted within the assessment form to consider things that were important to the patient, for example they discussed sport and watching football and television. Mark explored how the patient felt he would manage at home in his current state as bilateral non weight bearing amputee. From the responses given by the patient Mark skilfully continued to inject some realism into the situation in order to progress the discussion and guide the patient towards a realistic agreed plan for discharge. Mark (Observation).

Julie ensured that she had everything needed to hand and discussed the aim for the session with the patient. She outlined that in order to assess her effectively this would need to be carried out in the occupational therapy department activities of daily living suite. The aim was outlined to assess transfers on and off the bed, chair and toilet at the height provided by her family from her home. Julie then outlined that this would provide the information they both needed to help make the decision where to go next before going home. Options were outlined: rehab ward or intermediate care bed. Julie (Observation).

And I think there's a duty to the patient to actually give them the right information from the start. And if you know the extension would not be progressed, I think it would be unfair to say we would look at the extension if you know it would be rejected. Phoebe (Interview).

Occupational therapists were observed discussing with patient's their social and physical environment, and acknowledging the opportunities to promote health and well-being. The benefits within the patient's environment, in terms of location and the meaning of their home were discussed during therapeutic encounters. The positive impact of the environment on a patient's mental health, and opportunities for engagement in a familiar environment were evident. The occupational therapists were also observed assisting patients with planning for their future. Issues included discussing the adaptations required to a patient's home to facilitate their expectations as a new wheelchair user; or to accommodate deteriorating needs or capabilities to promote their health and well-being. In contrast to the positive experiences of the patient's environment on their health and well-being, there were exceptions for example when discussing how the patient's environment was not conducive to change in mobility status and becoming an independent wheelchair user. The following extracts highlight the care issues outlined:

As we arrived to the patient's house, she was observed standing outside in the sun looking at the view over the valley. Patsy discussed with the patient the beautiful view and the value of sunlight to increased vitamin D uptake. We listened to stories of the house from the past and what her home meant to her in terms of peace and happiness. Patsy (Observation)

The purpose of this visit was to explore with a patient who was well known to Phoebe, her accommodation and the impact of her deteriorating condition. The environmental issues affecting the patient were discussed before Phoebe asked the patient to propel

herself into the bedroom to assess the difficulties with hoisting, the problem was identified and a solution offered. The assessment progressed to the bathroom area, exploring the door widths to facilitate the movement of the wheelchair and reduce the exertion of multiple manoeuvres. Phoebe (Observation)

Mark continued his discussion with the patient regarding discharge plans and the potential need for re housing. The current accommodation was discussed and they agreed that it was not suitable for a wheelchair user. Future housing options were discussed. Mark (Observation)

The occupational therapists' accounts revealed that they promoted well-being by supporting patients to maintain healthy life choices. They demonstrated sensitive and respectful attitudes towards the patients' personal perspectives of health and illness. Respecting individuals' perspectives linked to the previous theme, '*valuing the individual*', and the sensitivity observed when the occupational therapists responded to the impact of symptoms on the patients' health and well-being. The interventions observed and discussed included working with patients to improve their experience of disability. For example, a discussion of the provision of equipment to manage posture and its positive impact on sleep and fatigue management was observed. Evident during time in the field and from the occupational therapists' accounts was the method of problem solving employed. Problem solving was carried out in a meaningful way to facilitate independence and promote health and well-being. The following extracts illuminate the ways in which patients' perspectives of health and illness were incorporated in practice:

The purpose of the visit was to demonstrate to the nursing staff in the hospice how the patient's sleep system worked to ensure he had the best possible opportunity to have a good night's sleep during his respite. This visit facilitated the demonstration of the sleep system to ensure the patient had the opportunity to rest and ultimately promoted his well-being. Phoebe (Observation)

You know, in terms of somebody's sort of condition and being at the end of their life, you know, in terms of their sort of functional ability and being very impaired, um, I've sometimes found that it is the smallest of things that have made such a big difference to people and like the gentleman we saw about the sleep system. He cannot sort of actively engage in any tasks now. But having the sleep system prevented pain and discomfort. And made him, knowing he could sleep aligned, psychologically made him feel better.... I think it's giving him a sense of comfort and safety...cause having a good night's sleep has a massive impact on the next day, doesn't it? Phoebe (Interview)

I remember going to see a patient to see how she could get her tights on. The patient had a progressive neurological condition and was deteriorating. Her roles had really taken a knock and she was no longer working having worked as an English Foreign Language teacher. But she's really funky in her dress and she goes to vintage fairs and she'd found some Mary Quant tights...It was, um, for her being able to put on a pair of tights she wants and do it independently was so big, and would make her feel really good about herself. Just a small thing but the essence of what we do. Patsy (Interview)

Finally, promoting meaningful occupation and therapeutic interventions that improve function, well-being and quality of life were commonly expressed by participants. Meaningful occupation is at the heart of occupational therapy practice; described by the occupational therapists as the vehicle to promote well-being and quality of life in a range of situations. The value of gardening, knitting and reading as meaningful occupations to improve function and engagement with patients were recurrent examples. The ability to appreciate the patient's quality of life, no matter how small the contribution they could make, was notable. Exceptionally a barrier to promoting meaningful occupation was considered by one occupational therapist due to a lack of understanding by other professionals. The following extracts illuminate these examples;

Patsy led the patient through an anxiety management technique to control her breathing using the imagery of hanging her distressing thoughts on clouds. As she left she noticed the garden and talked with the patient about gardening. Patsy acknowledged the benefits of engaging in some light gardening activities and encouraged the patient to start taking an interest in the garden again. Patsy (Observation)

Mark explored meaningful occupations with a patient who was difficult to engage in rehabilitation activities in order to motivate her. He identified that she enjoyed knitting.... seen later during the week knitting blankets and engaging in daily rehabilitation activities..... He reported later this week that the patient had become so engrossed in her knitting that when she was approached by one of the healthcare team she notably told them to 'bugger off I'm knitting'. Mark (Observation)

The purpose of the visit was to assess the patient for environmental controls to facilitate opening the door, controlling the radio and television which the patient had expressed was important to her. Phoebe (Observation)

Physical dysfunction and the whole thing about quality of life...to enable someone no matter how little they have in terms of physical function to have quality in their life...it doesn't matter how small your life becomes there's something very sweet at the essence of it. Patsy (Interview)

I've brought into the middle of a busy trauma ward...setting up a library for patients have access to literature. Um, because many patients like to sit at home, they like to sit quietly, they perhaps live on their own and literature brings out their world...I mean we're looking at people as occupational beings, and what I started to do was not be shy about using the language...but it's almost moving on at the minute in that nursing staff are seeing these activities, occupations, going on and trying to replicate it. And whilst they're getting the response they're not getting the therapeutic value of occupation that we would bring. Um, what they're seeing is containing a number of patients in a room...trying to get them to see the distance between occupation and activity is a challenge at the moment. Mark (Interview)

In summary, person-centred occupational therapy underpinned the occupational therapist's commitment to valuing the individual and ensuring the therapeutic encounter centres on their needs. This core value was acted out by the occupational therapist in practice, by their behaviour and actions that supported person-centred occupational therapy practice.

5.3 Occupational therapy practice: professional attitudes and values

The core concept, '*occupational therapy practice: professional attitudes and values*', was underpinned by the two themes, '*recognising spirituality as a dimension of holistic practice*' and '*personal and professional influences*'. The themes were concerned with how the occupational therapist's professional experience was shaped by the application of theory and a personal philosophy of occupational therapy. The occupational therapists demonstrated and described a range of spiritual dimensions necessary for embedding spirituality in their practice. In contrast to '*person centred occupational therapy practice*' this core concept explains what it meant to embed the specific aspects of spirituality in practice.

5.3.1 Recognising spirituality as a dimension of holistic practice

Recognising spirituality was a common theme found in the observations and interviews of all the occupational therapists. The occupational therapists described what they perceived spirituality was like in practice, for themselves and their patients. Despite the difficulty they found with defining spirituality, they articulated how their own personal experiences of meaning

and purpose shaped their practice. The occupational therapists described a range of practice situations where their professional experience was shaped by their application of theory and personal philosophy of spirituality. Engaging an individual in therapy was described in terms of getting to the heart of what the patients' needs were, which was associated with addressing the patient's spiritual needs. The therapeutic relationship, therapeutic use of self and the importance of compassion were highlighted as key components in this process of addressing spirituality in practice. Similarly applying theories of motivation was considered an important aspect of embedding spirituality in practice.

The occupational therapist's life experience was articulated as an influencing factor in the development of their personal philosophy of spirituality and embedding the core values of the profession in practice. The following extracts illuminate how the occupational therapists described spirituality and how their application of theory and personal philosophy shaped practice:

I think that spirituality is the essence of the person, which is why I ask them two questions, what makes you tick and how would you describe yourself, that's the essence that will guide their journey. Julie (Interview)

Spirituality is engrained in occupation. I'm thinking of the patient who just said that he connected with something bigger than himself when he was out in the garden in the open air. You know that's sometimes described as a higher power. To me that's, oh so spiritual you know that he connected to God with doing something outside. Patsy (Interview)

I don't know entirely what spirituality means; I know what it feels like in practice...it's about helping a person find what is meaningful and purposeful in their lives over and above everything else that they experience. Religion is the least part of it, spirituality is something much bigger. I think that people's homes have such value for them. Because you know anyone can throw a raised toilet seat through the door. And the patient may never use it so, um, I think what's important for me is that they feel they have been heard and their deepest needs addressed. I just think it's [spirituality] is the essence of what we do as occupational therapists. I don't know whether sometimes we do [address hope, meaning and purpose through interventions], it just kind of happens, part and parcel of what our objectives are. They kind of, it's just sort of tagged onto it. Julie (Interview)

[Addressing spirituality] ...it all goes back to being able to develop that therapeutic relationship, doing that in the most alien environment, very clinical environment, very noisy environment, particularly with some of the mental health patients, um, in the middle of a physical setting where the rest of the staff around me perhaps don't have the insight, the understanding or the compassion for the mental health needs of the patient. Um, so I kind of go with this, with this mind set of, I need to know how we've got to where we're at, what's some of the psycho-social background is to it, and then for me it's, it's kind of I always go in with the same kind of, of explanation that I'm here to look at how they normally manage things at home and how we can get back to managing daily life. It informs therapeutic use of self and you know, I think the spirituality piece really does inform therapeutic use of self and knowing when to say and when not to say and do and not do... Mark (Interview)

...but I try to put myself in that person's shoes. What would be, you know, why it wouldn't be appropriate to recommend that or to suggest that? Um, because I found with spirituality, in its broadest sense, is I'm thinking it is what really motivates the person. And we're not really looking at an activity session to motivate someone, but it's about activity in the home or the task in the home, what it is that they really want to do. Um, I think if we can get that right, we can get the rest right. Phoebe (Interview)

.... for me the whole life experience that influences my spirituality in practice.... Um, and I think going back to, you know, back to my professional training. That connected me with things like, you know, the underpinning core philosophy, the values of the profession, my life experience had made, that'd made a connection to the underpinning theory, um, it gave a framework I suppose. Which kind of married the two together and that gives a basis of how I, kind of think about spirituality in my practice. Yea, that person I saw could have been my mother could have been my grandmother, or whoever. And it's putting yourself in that other person's situation. Either having been there or having been near there you know. Mark (Interview)

Exceptionally, one occupational therapist (Patsy) described how using the Kawa 'river' model (Iwama, 2006) made sense to her in practice. Patsy cited an example of applying the model to a patient's situation had enabled her to illuminate the patient's experience of 'life flow' and the 'boulders' or factors that had hindered their progression. The diagram Figure 3, page 63 highlights the process of the Kawa model, representing a person's life flow as the river and factors hindering their progress as boulders.

I talked to the patient in terms of things that were blocking him from making sense of his situation and hindering his progress. This is unusual for me because I'm not good in the detail. So I've never been a person that would take a model and know every last thing about it. That's why that model [Kawa model] made sense to me. It feels like it uses my language. Patsy (Interview).

Recognising spirituality as a dimension of holistic practice was observed and discussed as the occupational therapists facilitated hope through their interactions with patients. The occupational therapists demonstrated how responding to patient's situations by listening and using verbal and non-verbal communication they could facilitate hope in difficult circumstances. By delving deeper into patient life stories to identify the issues that were highly significant the occupational therapist was able to offer hope in difficult circumstances. Delivering bad news was a visible feature of the interactions observed, particularly when intervention options had been exhausted. The occupational therapists explained the lack of suitable therapeutic interventions in a manner that was sensitive and maintained a sense of hope for the patients' future. The following extract illustrates how Patsy facilitated hope through her practice:

Patsy had been discussing the impact of the patient's surgery to remove a brain tumour was affecting the performance of daily activities and in particular her ability to use her higher level executive cognitive function. This was very frustrating for the patient as she felt she was at risk of losing her role within the family and feared she would never go back to work. The patient became tearful as she recounted her deep concerns to Patsy. She became tearful at this point. Patsy didn't say anything to interrupt the patient's flow, she reassuringly placed her hand on the patient's shoulder as she became upset and said, 'and this all affects something deep down in your spirit doesn't it?' She continued to explore with the patient what things in her life were the most important to explore at this stage, that would give her hope if she could achieve them.... a plan was made....as we were leaving Patsy was thanked for coming and told she had made the patient feel better. Patsy (Observation)

The event above was explored further in the interview with Patsy where she described the challenges of facilitating hope, and how she had developed the concept of facilitating hope through her practice. Patsy outlined how she adopted the stance of speaking truthfully to patients about their presenting circumstances and not giving false hope. Delivering bad news was a common experience of the occupational therapists, and how to facilitate hope in the difficult circumstances when all the options have been explored. The following extracts highlight these issues for occupational therapists; in particular drawing on examples of working in an acute hospital setting focusing on discharge planning.

This has taken me a very long time to understand, how to deliver hope, which is very important because without hope you don't want to go on on the journey, you want to stop and even finish it. That's I think where people get suicidal, it's where they run out of hope...it's taken me a lot of years to find the place that can give people hope but doesn't promise something because you don't know where they are going to get it and I think that's part of the journey...You know I'm as truthful as I can be knowing the person's condition and what I see in front of me so if I know that my eyes are telling me something and it would be wrong not to say it, I'll say it...but I hold back on saying an awful lot other than let's see where we get to. I just know if we start on this we'll get somewhere. Patsy (Interview)

How you can still manage to retain working with peoples hopes, wishes and values on a busy acute ward. I don't know it just seems to be part and parcel of what we do as OT's. It's just kind of tagged onto what we are about. I think other professions often mostly see things as black and white. You know patients either can or they can't, or they will or they won't. With delving into their story a bit longer, or a bit deeper I feel that's what we can extract sometimes with our initial interviews you know getting to know the patient, spending that time, little bit of time, not great amounts of time, getting to know them and what makes them tick. And we can go back and say well did you know this? Did you realise her husband only died a month ago? Or, you know those sorts of really important things that might have been overlooked...we do a bit more digging I feel in order to find out what really matters to the person and so we can be more hopeful. Julie (Interview)

Julie ensured that we were in a comfortable and quiet environment that would avoid interruptions as she explained to the patient that all the options to get her home had been exhausted at this stage. Julie was visibly nervous of the reaction but continued to explain clearly and compassionately how the patient's current level of function was not sufficient for her to manage safely at home even with the maximum care package and that further intensive rehabilitation was needed to give her the best possible chance of returning home successfully. Julie was open to the patient's concerns and questions and explored all possible opportunities carefully and sensitively adjusting her language to ensure the patient could understand. Julie (Observation)

And we can't control the way illness progresses, or how somebody experiences changes in their life. And that one piece of equipment could've given that lady hope that she was still hanging on to, being able to open the door and, I was thinking what other options are available for this lady and there aren't any options. I just couldn't think of how I could have changed the outcome. Because unfortunately she's at the end stages of her condition, so I explained this to her hard as it was for both of us, because you see I have known this lady when she was in the early stages of her illness and still walking. What do you do, you can only give people the honest truth? Phoebe (Interview)

Patient-centred journeying was a feature of the occupational therapists' interactions with patients, and was linked to meeting patient's spiritual needs over the duration of their

intervention. For example, when discussing episodes of therapeutic intervention with patients, the occupational therapists linked the patient's specific health journey to their spiritual journey using language such as having been on a 'pilgrimage'. However, patient-centred journeying was only described by one participant during the follow up interviews. Her experiences were linked to the previous section exploring the application of theory to practice through the Kawa model. The following extracts illuminate how patient journeying was a feature of embedding spirituality in to the occupational therapist's practice:

Patsy talked about how the period she was going to be involved with the patient was like journeying. She reiterated how the agreed treatment plan was to be focussed on the patient and she would journey with her at her speed with her priorities. Patsy (Observation)

It's been a theme in my own life [journeying] so it made sense to translate that into practice. You realise you don't want people to be dependent on your enthusiasm and so it made sense to start talking about this journey 'cause then what I called the metaphor I could use to help them see what I want to do and was prepared to do whilst they were on a pilgrimage which is the journey of their life that like pilgrim people you would come and walk...pilgrimage people come and walk and join you and drop off. Patsy (Interview)

The centrality of the patient's values and their experience of hope, meaning and purpose was observed in all occupational therapists' practice, and discussed during the interviews. The occupational therapists described how they used open ended narrative assessments to ensure meaningful and purposeful dialogues with patients and to incorporate patients' perspectives during interventions as a way of achieving best patient outcomes. The following extract illuminates how the assessments were structured to ensure the spiritual components were considered:

Julie was observed carrying out an initial assessment with a patient who was an inpatient on an acute trauma ward. She asked the patient if they had any spiritual or religious beliefs that she should know about to encompass within their treatment. She reiterated that she was talking not necessarily about religious affiliation but also about any guiding principles or values that would help in ensuring the patient's needs were met holistically. Julie (Observation)

By exploring the observation above during the interview with Julie further enlightened how components of spirituality were integrated in patient encounters:

...I know that works for me and it seems to work for the people that I'm working with. So I then, I still have that open dialogue, getting to what's meaningful straight away and then adding in the further information, sort of after. Um, and if I've not asked something as part of the assessment I'm quite confident in saying not asked at the time of assessment or not appropriate or, um. So I don't feel the assessment form hinders what I do, I feel the form can be a barrier to getting to the heart of what the patient's values and meaning are. Julie (Interview)

5.3.2 Personal and professional influences

'Personal and professional influences' was a recurrent theme found during observation and confirmed in the interviews. During the interviews each occupational therapist was asked to recount what had influenced them to become an occupational therapist. Participants recalled that experiences of healthcare and disability within their families had influenced them to explore occupational therapy as a career. These personal experiences and the exploration of occupational therapy as a career cemented their impressions of the unique contribution occupational therapists can make to the lives of patients. One occupational therapist described that their initial perception of the contribution of occupational therapists to the health and well-being of individuals was reinforced throughout their academic education. Additionally, this was strengthened by developing an understanding of the core values and philosophy of the profession. The following extracts, from each participant highlighted the importance of family and the experiences of occupational therapy influenced career choice:

For me, my mum was a nurse and I always thought that I would follow her into nursing. However, when I was in the sixth form I went to look round a physio and OT department. It was nothing the OT's were doing; it was how they were. So there was this sense of freedom, one to one talking about patients' lives with them. So what was really significant for me was doing mental health and physical dysfunctions together. Patsy (Interview)

Kind of starts at home I guess rather than anything to do with work. Um, it stems from my patients. My dad had ankylosing spondylitis and my mum has been visually impaired from birth and so we always had physios and OT's in and out of the house. There was just this stark difference between the two disciplines. And it kind of, the physio side didn't sit comfortably, it was very much, one of my Dad's physios said do as I say not as I do, and that just didn't sit comfortably. And I heard how that didn't sit comfortably with my Dad, you know, he'd kind of like, who does she think she is, you know, and that real kind of niggled him. And then to witness in practice as well that, whereas OT was much more, it wasn't do as I say not as I do or you will do it. It was very you know OT was how do we work together, why's this important to you. The whole thing that I now know around client centeredness and, um, you know kind of

underpinning values of the profession. Um, and I just thought that's actually the way to do it, that fits better with my beliefs, my views, my kind of morals as it were..... Mark (Interview)

I grew up with both my grandparents, um, both grandmothers being in sort of a healthcare professional role. One was a midwife and one was a nurse with people with learning disabilities. So I sort of grew up around that. Um, and I always thought I was going to be a nurse and then when I did my careers choices, the advisor at the time suggested OT, and asked me to look a bit more into it. And I just knew as soon as I read, um, enabling people to be independent, just felt far well suited than actually doing for people. So that's sort of what drove me into OT. Phoebe (Interview)

So I remember first coming into contact or finding out about OT when I was at 6th form college, so between the ages of 17 and 19. I think it was then. And I think we obviously had to get some work experience so I did make contact with a local OT department.... I went for one afternoon a week. I used to go down to the OT department and get some experience down there. Although I think it was a bit limited because it was an acute physical hospital. And they used to sit me next to the same guy every afternoon. So I felt, maybe a bit limited, in that, but it must have struck a chord. I knew there were opportunities to go into all sorts of field of work. So I guess that appealed. Julie (Interview)

During the interviews, the occupational therapists described a range of professional experiences that had shaped the philosophy of their practice and how they attempted to embed spirituality in their practice. They considered their experience, gained over a period of time, to be significant in developing their skills to embed spirituality in their daily practice. Additionally, respecting each individual's unique characteristics supported spirituality in practice. Linking with the previous theme '*recognising spirituality as a dimension of holistic practice*' the occupational therapists described how they promoted their professional values to highlight hope, meaning and purpose in their practice, as described in the following interview extracts:

I think that most of what I do is to be intuitive to what the patient is saying to me about their concerns. You just have to pick up on the cues that they're giving you as well... it's about developing your communication skills built up over years of practice to see what's important to people...and that's my philosophy. Julie (Interview)

My philosophy of practice is the essence of who I am and engrained in the philosophy of my profession, but how to impart it to other people [other occupational therapy colleagues] can often be frustrating for me. You know the kind of person that really

lacks hope in their life for themselves. I'm thinking of one particular person that really struggled to give hope to anyone else so their interventions were very flat and just a process. The big thing for me is also that people don't feel judged. I say as long as you're motivated and improving then I'll journey with you. I absolutely listen to them, don't judge it, don't try and interpret it just accept it and say well that's you and we'll work with that...I love to see them [patients], I love to see them physically get in a better place, I absolutely adore that, but it's just seeing people's head switch. A light goes on. You see this spirituality stuff for me is that you just accept someone how they are and sometimes that's a real challenge. Patsy (Interview)

I had a range of experiences from case management to returning to psychiatry before this post here. But when I got this post I thought um, yeah, I'm going back to my roots I'm back to the core values and core philosophy of my profession back to the kind of values of what I believe in, client centred practice. It's thinking back to how we as people feel and re addressing the power of the consultant at the end of the bed. We're all kind of people, we're all beings, we're all, you know, what I am, what do I value when I've been a recipient of healthcare or you know my family have been recipients. What have I valued and found important and that gives me insight into another element of my practice. Mark (Interview)

I suppose I learnt a lot from my mental health practice that shapes how I practice today in this team. We didn't have many patients to see which meant that we had a lot of time to think and work...work with our patients in what was really important to them. And I got a real feel for value of meaning at that early stage because when trying to engage somebody in therapy when they are mentally sort of unstable, it was a very different approach to what I would use today... so I think that really helped me to understand people. Phoebe (Interview)

Spirituality is sort of soft and woolly, but I think if you can fit it into the quantitative stuff, I'm thinking about what the commissioners' want because that's where the power is within health services. The thing that's key to me and you'll hear lots of people starting to do this is tell a patient's story. Telling the patients story, starting to appeal to the hope and the meaning and the purpose in other people's lives, I try and kind of connect with that even though their heads are telling them they want figures. Patsy (Interview)

Working in a healthcare context driven by finances and targets was seen as a challenge for the occupational therapists as they balanced the demands of practice and upholding their professional values. Some incidents observed in practice were followed up during the interviews. For example, the occupational therapists described how time pressures, bed management issues and targets driven from policy and management initiatives, impacted on their ability to embed spirituality in their practice. However, a common perception of the occupational therapists was that they had developed strategies to manage these situations

realistically and creatively to still achieve quality patient care. The following extracts highlight the challenges revealed by the occupational therapists and the strategies adopted to maintain professional values and ensure quality care provisions:

We were on an acute ward and looking at the ward progress board. Mark explained to me that the recent service pressures around bed management were driving practice. There was a pressure not to rehab but to discharge patients as soon as possible. He explained that he had to reduce the blame culture; as soon as he sees discharge delayed he knows that they are looking at the occupational therapist's input. He explained that this was not the case on every ward, and described the ethos of a ward where the working environment was conducive to working with the core philosophies of the OT profession. He described his strategy was to promote the good working ethos on one ward and share it with others by explaining case studies and pointing out how the outcomes for the patients could be improved. Mark used the following illustration to highlight what he was taking about. He said the environment we are working in is incredibly challenging. And, you know, sometimes that's about people within the environment as well. And it's, it's that whole thing of, we're there to wash bed three and its kind of let's get the patient out of bed first and then wash it. Mark (Observation).

Time, staffing, bed pressures, other demands, how you divide up your time, I guess. Maybe there's times where we'd like to feel we'd like to take things further but you've got to divide out your time between the pressures of the referrals that you've got to be working with. So I guess you do dilute yourself sometimes...I do, Stats, Stats. I mean I don't know what percentage of my stats is meant to be clinical. But I'm quite conscious of the time and getting it right. Because I don't want anyone saying to me I've only done two hours' work today when in fact I've spent time listening to what most concerns the patient and how I can facilitate their discharge home to a place they feel at peace in...Thinking around these complex patients and the complexity of people's lives and circumstances it has to be as long as it takes. So a lot of time goes in conversations. We're lacking in staff and we've got complex cases to see, we need to be sure we don't cut corners for the patients' sake. And if we have to build up waiting lists of people waiting to see us that just shows the strain on our services. It's a balance but obviously maximising our time and keeping things safe as well, making sure the right cases are with the right people with the right skills and that the patients' needs are met. Julie (Interview)

... I think in this job you have to be quite creative in how you find funding...because I know that funding for the toilet raiser, you remember that visit? Was thousands of pounds, the cost of it was thousands of pounds. And I know that funding is drying up...So I've managed to secure funding via a grant instead, I've managed to incorporate the raiser as part of the toilet and the bathroom adaptation. So [patient] can stay in his home and will avoid hoisting for the time being which is what he was most concerned about and was making him anxious. Phoebe (Interview)

It must be acknowledged that this chapter has so far presented a positive view of occupational therapists embedding spirituality in their daily practice. While there were no examples of

practice giving rise to any concerns, there was an exceptional example where the occupational therapist used language during the interviews that did not wholly support the person-centred practice observed. The following extracts present the contrasting view. First, occupational therapists found it difficult to consistently articulate person-centred values in their practice and at times lapsed into language suggesting their own priorities for patients as opposed to collaboration when setting goals. Notably the challenges of practicing in a context impacted on by austerity measures led to the occupational therapists articulating less favourable person-centred language. Additionally, the issue of not presenting the core values of the profession favourably leading to lack of inter-professional understanding was highlighted. Second, there were two occasions when the occupational therapists were observed and the recorded fieldwork notes identified a lack of depth to exploring meaningful issues with patients. The following extracts are examples which highlight these issues further:

....so I put processes are round everything so if you [the patient] are referred for fatigue management I tell people they get five sessions with me and in those five sessions; I can do what I like. That's how I see it...one day we might only be able to go through the door and say hello and go out again but we'll make sure we're [bloody] good at it when we do. You see we're working in a very statistically driven, very goal driven, very scientific nature and all these things around spirituality and and the words that you use around hope, meaning and purpose sound soft. We're battling with society's thing...people generally value lots of money, lots of possessions.... getting up in the hierarchy is what I see as the overall thing that is really held up in esteem...whereas I'm saying the little things matter. Patsy (Interview)

So the whole journey I've taken her on was to help her to start to see that she was this most beautiful person....To put that into her life, to give her that joy....What I say to my patients is that I'm prepared to come on the pilgrimage and it will be whilst ever this and this is there and we need to deal with that or whilst ever you're still improving and engaged. So it means as soon as they plateau is definitely happening or that they become disengaged or de-motivated that I'll just drop off. I do expect them to carry on journeying, it's not I done my bit end of story full stop it's carry on, carry on that's what I'm trying to do for you. Patsy (Interview)

But then it was very hard for him maybe to focus on our values and our objectives, our meaning and purpose it kind of reversed somehow. He was home, that was it, and he could sit on his sofa and watch that huge TV, that's what he, wanted to do. Julie (Interview)

And I had that wonderful statement from one of my nursing colleagues that was quite literally I just thought he did rails and commodes. Um, and I think part of the barrier is we don't, we don't sing out about our broader skills, we don't sing out our core philosophy. Um, yea, you know about our core values and when we do, um, it doesn't necessarily fit with the acute setting...or we can't articulate it comfortably within the acute setting. Mark (Interview)

My overall impression of this visit to sort out the sleep system was rushed and led by the time pressures of the other staff involved. Phoebe also talked afterwards about how the patient was very talkative and that she had had to learn how to limit her interactions as he could be very demanding. She explained how she adjusted her style to be directive and process led. Phoebe (Observation)

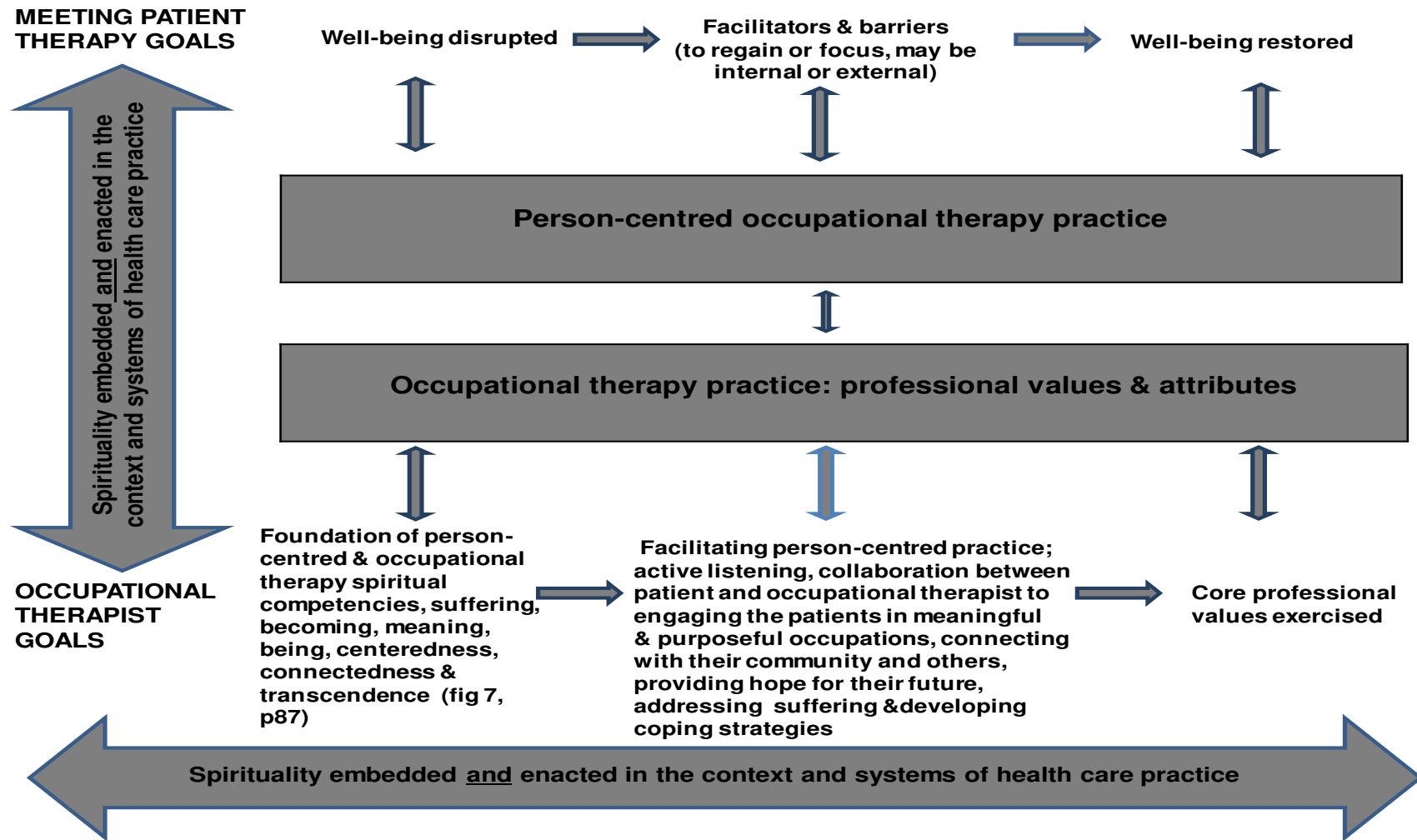
Julie discussed with the patient what she had done with her life. They talked about the patient's work in the mill and training as a weaver, enjoying making patterns. This was not explored in much depth by the OT as she moved onto the more pragmatic issues of how she managed at home and what she saw might be difficult with her present level of functioning. Julie (Observation)

In, summary the core construct '*occupational therapy practice: professional attitudes and values*', emerged as a commonly held feature of the occupational therapist's experience of embedding spirituality in their practice. Delving deeper into the agency of practice this core construct extracts the dimensions needed to support embedding spirituality into practice. A continuum of practice presented in the findings is depicted in the conceptual framework presented in the following section.

5.4 Embedding Spirituality in Occupational Therapy model

The model '*Embedding Spirituality in Occupational Therapy (ESpiOT) model*', presented in Figure 14 supports the dynamic interaction between patients and the occupational therapist. The model offers a practical explanation of how spirituality is embedded in practice and has been developed by synthesising the findings from this study and combining with the "*Conceptual framework for spiritually competent occupational therapy practice*' developed from the concept analysis (Chapter Two, Figure 7, page 87). In addition, the model also embeds the description of spiritually competent practice offered in Chapter Two.

Figure 14: Embedding Spirituality in Occupational Therapy model



The conceptual framework developed from the concept analysis, as shown in Figure 7 (page 87), presents spirituality applied to occupational therapy practice from a theoretical perspective. The framework applied Kang's (2003) PSI conceptual framework to scaffold the findings from the literature. The conceptual framework explains a process to determine how the domains outlined, namely being, meaning, becoming, centeredness, connections and transcendence, and including suffering (Egan & Swedersky, 2003; Kang 2003) can be applied to occupational therapy practice. Examples of what these domains look like in practice were offered. The strength of the conceptual framework was that it could provide occupational therapists with an outline of the constructs associated with integrating spirituality in practice, and the process that could enable them to deliver spiritual care. However, the limitations of the conceptual framework related to it not being developed from occupational therapy practice, and it is unlikely to represent the current political and social context. This is the overriding strength of the '*ESpiOT model*'. Additionally, there is limited consideration of the patient in its development, apart from the suggestion that spiritual well-being can be achieved by addressing the domains articulated as spiritual (Kang, 2003). The domains from the framework derived from the Concept Analysis, necessary for addressing spirituality, namely suffering, becoming, meaning, being, centeredness, connectedness and transcendence (Chapter 2, Figure 7, page 87) were incorporated into the ESpiOT model. However, the ESpiOT model was broader, for example the findings of the observational study were not limited to specific domains, and reflected the diverse nature of occupational therapy practice in the real world.

The overriding strength of the ESpiOT model is its derivation from observation of real-life occupational therapy practice in challenging circumstances. In contrast to the '*Conceptual framework for spiritually competent occupational therapy practice*', the '*ESpiOT model*' offers a dynamic process for embedding spirituality in occupational therapy practice. This model has been derived from the study findings focussing on how occupational therapists were observed embedding spirituality in practice. The arrows labelled, "*Spirituality embedded and enacted in the context and systems of health care practice*", identify occupational practice as a continuum

between meeting patient needs and therapist goals across the care contexts and organisational challenges, while remaining focused on the delivery of person centred-care. However, a limitation is that the study focussed on the occupational therapists and did not engage with the patient's perspective. Therefore, the reference to the patient '*meeting patient therapy goals*' refers to what was known about the context of the observations, namely that the patient's well-being had been disrupted. There are '*facilitators and barriers*' to them meeting their therapy goals. Addressing the '*facilitators*' or '*barriers*' to meeting their therapy goals enables the patient to '*regain*' their sense of well-being or '*focus*' where an adaptation of their circumstances was necessary. For example, where the occupational therapists addressed the patients sense of hope through facilitating discharge back home, where they felt a sense of connection and well-being. Thus, the patients can achieve a status of restored well-being.

From the perspective of the occupational therapists practice the '*ESpiOT model*' reflects how they embedded spirituality in practice; with the two core concepts '*person-centred occupational therapy practice*' and '*occupational practice: professional attitudes and values*'. These two core concepts are fundamental to the therapist's response to individual patient therapy goals, while retaining their professional role and core professional values. These core concepts are represented as the interdependent constructs necessary to shape how spirituality is embedded in practice, and how the therapist's competencies and behaviour impact on the patient's experience. Professional attitudes and values (including recognition of the spiritual dimension) underpin the person-centred behaviour of the occupational therapist in practice. Facilitating person-centred practice and embedding spirituality is evidenced by the engagement of patients in meaningful and purposeful occupations that connect them with their community. By delivering therapy, in a context of providing hope for their future, the occupational therapist addresses the patients suffering through developing therapeutic coping strategies. This model of person-centred occupational therapy practice is central to embedding spirituality; emphasising how occupational therapists value the patient as a unique

spiritual being, accepting their beliefs, values and culture as central to professional interactions.

An application of the core concepts and the '*ESpiOT model*' illustrates the relationship between the core concepts and illuminates the practical application of the '*ESpiOT model*' (Figure 14, page 173), is offered using an example from Patsy's practice. This example presents one observed visit, and relates to how Patsy demonstrated embedding spirituality in her practice through the application of the core concepts and themes outlined in this chapter.

Figure 15: Occupational therapists embed spirituality in their practice: example from an observation of Patsy's practice

As we arrived at the house Patsy explained that she was expecting the patient to be tired after the weekend away...Patsy explored with the patient the recent weekend away to celebrate a family member's 90th birthday. She acknowledged the significance of the event as it was a reunion of family members. The event held great meaning for the patient and she expressed the significance to Patsy. They discussed together how she [patient] had managed her fatigue and how meaningful it was to attend the event despite how tired it had made her. Patsy explored the fatigue management techniques they had been working on together and how to improve the patient's quality of life and manage fatigue.

Theme: 'Valuing the individual', links to 'supporting patients to maintain health and well-being'

They discussed anxiety and the multiple losses the patient had experienced; marriage break up, loss of home, car, job, death of her mother and loss of function following surgery. Patsy explained to the patient using a diagram, the Kubler Ross theory of grief, to help her understand more about the grief process and its effect on her. The patient became tearful at this point and Patsy was reassuring, placing her hand on the patient's shoulder as she became upset. Patsy said to the patient, 'it affects something deep down in your spirit'.

Theme: 'Supporting patients to maintain health and well-being', links to 'recognising spirituality as a dimension of holistic practice'

Patsy led the patient through an anxiety management technique to control her breathing. She added to this a technique to manage distressing thoughts by hanging them on clouds. This was difficult for the patient to focus on fully and she became tearful again. Patsy talked about how grief, fatigue and anxiety affect your spirit and gave an example from her own day.

Theme: 'Personal and professional influences', links to 'supporting patients to maintain health and well-being', and 'recognising spirituality as a dimension of holistic practice'

A further appointment was made to follow up the seven-day fatigue diary the patient had started to complete.

As we were leaving and walking down the garden path the patient talked about how she liked gardening and we looked around the garden with her. Patsy discussed with the patient how gardening made her feel and acknowledged the positive impact gardening had on her [patient]. Patsy acknowledged the benefits of gardening and encouraged the patient to start doing some light gardening and incorporate it in her daily routine." (Observation)

Themes: 'supporting patients to maintain health and well-being'

The dynamic interaction between the core concepts 'Person centred occupational therapy practice' and 'occupational therapy practice: professional attitudes and values.'

5.5 Summary

This chapter has presented the study findings and core concepts, themes and issues that describe how the occupational therapists who participated in the study embedded spirituality in their practice. The presentations of the findings have been strengthened by verbatim quotes derived from the rich description of the phenomenon of spirituality found in occupational therapists practice. The dynamic process of embedding spirituality in practice has been described using a conceptual framework and examples from the observation of one of the occupational therapists practice. The following, Chapter six will discuss the core concepts and how they relate to the literature and concept analysis findings.

Chapter Six

Discussion

6. Introduction

The purpose of the study reported in this thesis was to understand how spirituality was embedded within occupational therapy practice, and ultimately whether practice supported meeting patients' spiritual needs. The initial research question was framed as:

“How do occupational therapists embed spirituality in their day to day practice?”

This study aimed to explore how occupational therapists embed spirituality in their day to day practice, and more specifically; the therapeutic interventions that occupational therapists considered to be a dimension of spiritual care and observe how opportunities to address dimensions of spirituality were identified and incorporated in occupational therapy practice.

This chapter is divided into two sections. The first section discusses the *‘Embedding Spirituality in Occupational Therapy’* (ESpiOT) model for embedding spirituality in occupational therapy practice, comparing and contrasting it with the findings and conceptual framework of the concept analysis presented in Chapter Two. The second section explores the ways in which occupational therapists embedded spirituality in their practice, by considering the core concepts, *‘person-centred occupational therapy’* and *‘occupational therapy practice: professional attributes and values’*, which emerged from the findings presented in Chapter Five. The conceptual framework for spiritually competent occupational therapy practice (Chapter 2, Figure 7, page 87) and the ESpiOT model (Chapter 5, Figure 14, page 173) are presented together to illustrate the how they interlink, and add clarity to the discussion.

Figure 7: Conceptual framework for spiritually competent occupational therapy practice

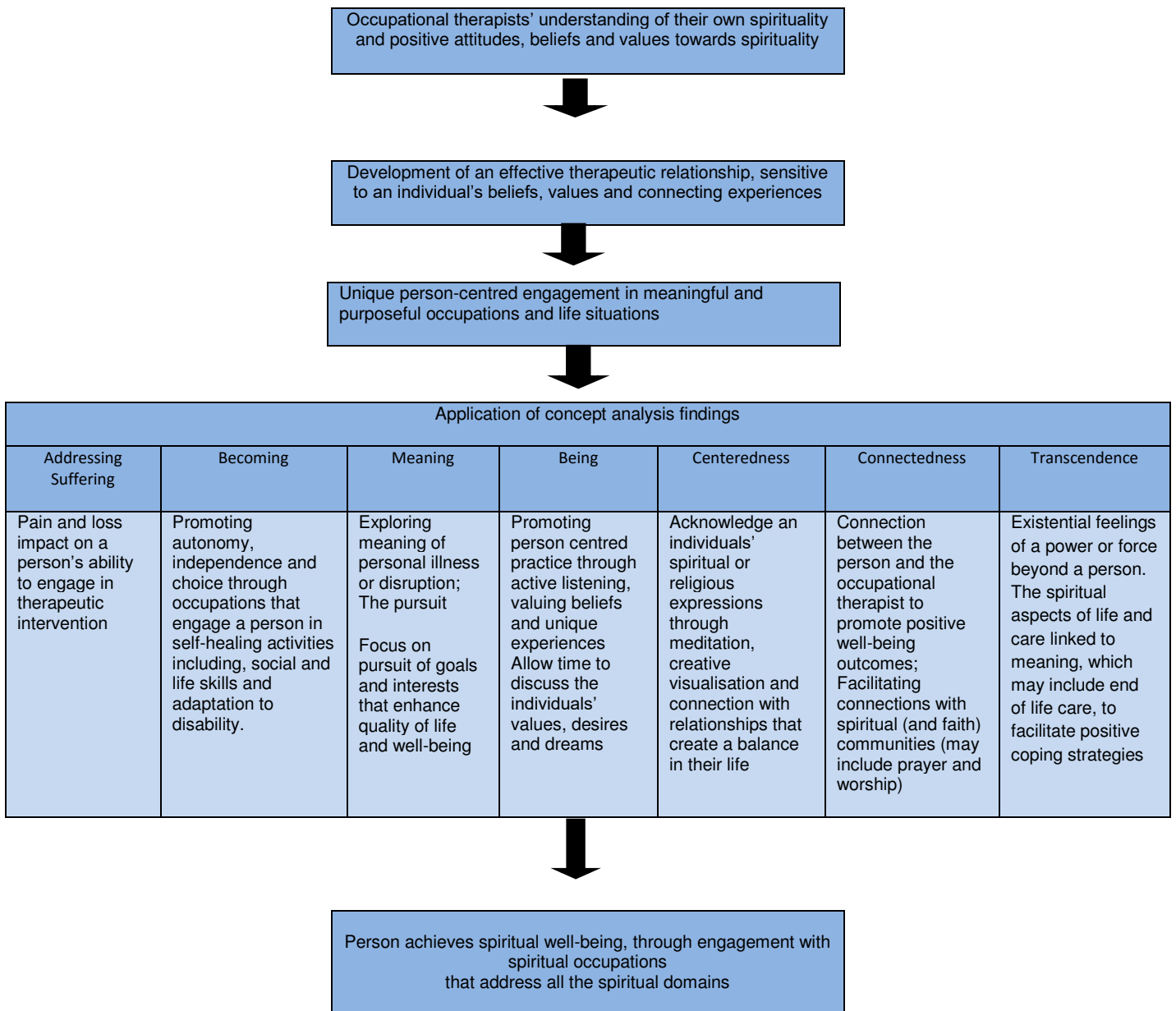
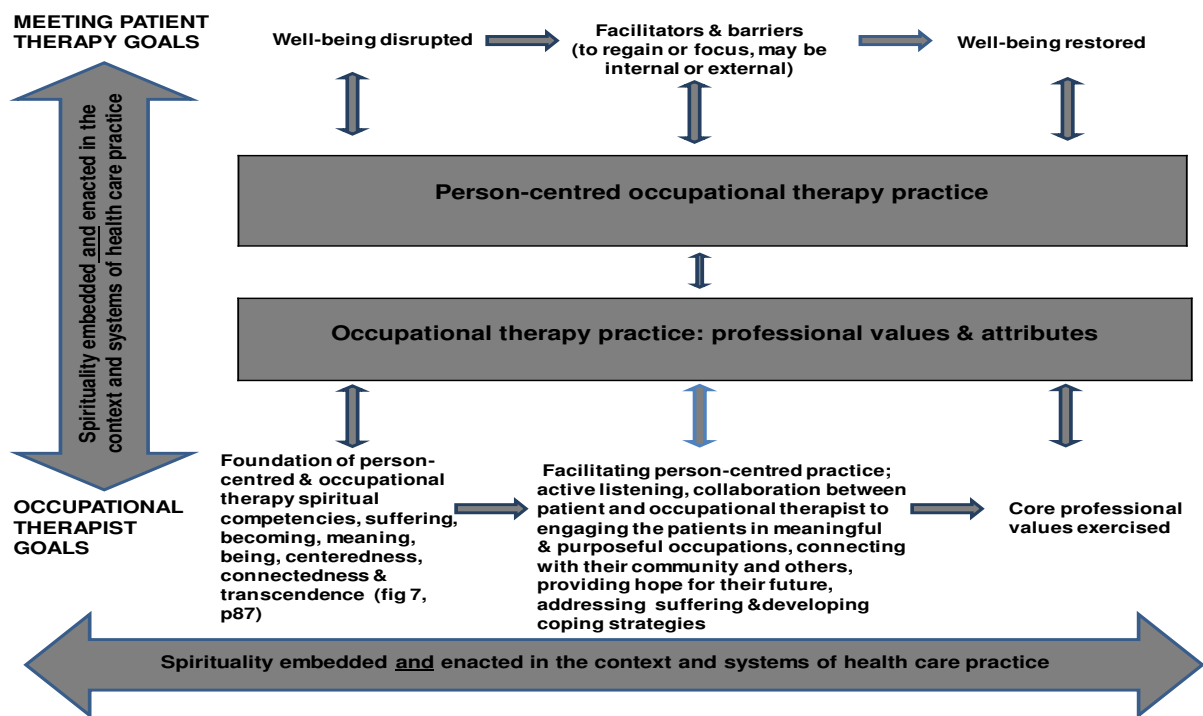


Figure 14: Embedding Spirituality into Occupational Therapy (ESpiOT) model



6.1 Embedding Spirituality in Occupational Therapy model

The model, derived from this study represents how spirituality can be embedded in occupational therapy practice. It presents both a patient and an occupational therapist view of therapy goals. The ESpiOT (Embedding Spirituality in Occupational Therapy) model (Chapter 5, Figure 14, page 173) brings together the two core concepts that emerged from the study findings; '*person centred occupational therapy practice*' and '*occupational therapy practice: professional attitudes and values*'. In addition, meeting patient therapy goals and the occupational therapist's goals have been incorporated in the model to emphasise its dynamic nature, and ensure a focus on these dynamic and interlinked roles. The model also recognises the challenges which are present in the context and systems of healthcare practice. The core dimensions of the model are now discussed and developed in more detail following the presentation of the model in Chapter Five, section 5.4, page 172 and on the preceding pages.

6.1.1 Meeting patient therapy goals

The patient therapy goals, identified by the participants, have been represented as a continuum of well-being that is disrupted by illness, disability or dysfunction. Valuing the experience of the patient has become central within healthcare research (Kings Fund, 2011), and one that has been particularly considered in the context of end of life care and terminal illness (Chochinov, 2013). Illness disrupts an individual's well-being and regaining well-being should be central to healthcare delivery (Spichiger, 2013). Recognising the importance of patient well-being was mirrored in previous research. For example, a study exploring the experiences of patients being labelled as '*delayed discharges*' highlighted the need for patients to feel supported about the future, and to reduce the stress levels experienced when their futures were uncertain (Kydd, 2008).

Occupational therapists in the present study sought to ameliorate the distressing experiences of uncertainty caused by delayed discharge. They recognised the details unique to the individual patients, and addressed them through their discharge planning activity. They were observed paying meticulous attention to the detail of their patients' needs, and the uniqueness of their experiences and concerns relating to discharge from hospital. Central to discharge planning were observations of collaboration between patient and occupational therapist. The focus of these collaborations was decision making regarding the patient's opportunities to receive further rehabilitation in order to improve the outcome of their discharge. In addition to discharge planning occupational therapists acknowledged that patient well-being was disrupted during illness, and they offered interventions to help patients regain or restore well-being. For example, an occupational therapist was observed helping a patient to adjust to life dependent on a wheelchair for mobility. The occupational therapist discussed the significance of the patient's disruption and that restoration of well-being as an important part of the patient's experience. The link to patients' finding meaning and purpose in their situations was an important focus of therapy.

The facilitators and barriers, represented in the ESpiOT model, related to the opportunities for the patient to regain or re-focus their experience of well-being. The facilitators related to internal resources which motivated the patient to regain their well-being, often used by the occupational therapist in order to develop patient centred goals. For example, working with a patient who needed to re-focus her life following an exacerbation of symptoms, Patsy used a creative approach to help the patient find a sense of hope, meaning and purpose in her life. Patsy focused on how the patient could achieve well-being whilst recognising financial constraints. However, within the context and systems of current healthcare practice external barriers to meeting spirituality in care include lack of time to embed spirituality in the care process, and lack of capacity within healthcare practitioner's workloads (McSherry, 2006). This challenge of meeting the time pressures of the organisation and staffing capacity issues can also hinder the patient's goals for the restoration of well-being. The recognition of patient therapy goals within the ESpiOT model represents the aspiration of occupational therapists to support the restoration of well-being through appropriate interventions. The collaboration between the patient and occupational therapist in setting goals, which address the unique experience of the patient's situation, and focus on what is meaningful and purposeful to them ensure that spirituality is embedded in occupational therapy practice.

6.1.2 Occupational therapist goals

The occupational therapist's goals (Figure 14, page 173) represent the continuum of practice, which commences with an underpinning foundational understanding that occupational therapy practice is person-centred. In order to facilitate person-centred practice, the competencies, outlined in the description of spirituality competent occupational therapy practice in Chapter Two were applied. These competencies included, facilitating the patient's quest for hope and a sense of meaning and purpose in their new situation through appropriate interventions. The following interventions were highlighted in the description of spiritually competent occupational therapy practice:

- Engaging the patient in occupations that provide a sense of meaning and purpose;
- Connections with their community;
- Addressing aspects of their suffering;
- Developing coping strategies based on the patient's own strengths.

The desired outcome from the occupational therapists' perspective relates to facilitating the patient's restoration including a recovery of a sense of hope, meaning and purpose. This can be achieved by exercising the core professional values in practice.

The ESpiOT model has acknowledged the healthcare systems and the context in which the occupational therapist's practice is carried out. Healthcare is delivered in a challenging context; however, there is a focus on positively facilitating practice which focusses on the unique needs of individual patients. There is a drive to support person-centred care, which includes shared decision making and supporting patients as the experts in their experiences of conditions that limit their well-being (Ahmed, Ellins, Krelle & Lawrie, 2014). However, it must be recognised that some aspects of the systems and context can also be seen as barriers to recovery. For instance, practising in a context of austerity measures and externally imposed targets that are not sensitive to whole-person (including spiritual) needs can limit and cause a barrier to practice. Practising in the current context of healthcare demands the occupational therapist to balance the underpinning values and philosophy of the profession, and the policy drivers to embed person-centred care in practice. By focussing on the person as central to the occupational therapy encounter, understanding their unique experiences and needs, spirituality is embedded in occupational therapy practice.

6.1.3 Application of the conceptual framework and ESpiOT model

The '*Conceptual framework for spiritually competent occupational therapy practice*' page 180 and the ESpiOT model for '*Embedding Spirituality in Occupational Therapy*' page 181, offer ways for approaching spirituality in occupational therapy practice. The conceptual framework was derived from the concept analysis in Chapter Two based on a critical review of the literature, and underpinned by the work of Kang (2003). Incorporating spirituality in practice

was referred to in terms of, '*meaning*', '*connectedness*', '*transcendence*', '*becoming*', '*being*' and '*centeredness*' to which '*addressing suffering*' was added. The limitation of the framework, as previously discussed in chapter two and chapter five was the lack of application to meeting both the patient and occupational therapist goals. However, the framework did offer some theoretical guidance for occupational therapists to embed spirituality in their practice. The ESpiOT model presented in Chapter Five reflected how spirituality was acted out in practice during the study. It emphasised that addressing spirituality was a dynamic process, integral to and dependent on the core philosophy and values of occupational therapy practice.

The ESpiOT model has been developed to support occupational therapists to consider ways in which spirituality can be embedded in occupational therapy practice. The core philosophy and values of occupational therapy practice are commonly held as client-centred, holistic practice, which acknowledges the value of occupation as health promoting and health sustaining (Duncan, 2011). The ESpiOT model presented supports the application of these core philosophies and values in what is described elsewhere as '*authentic*' occupational therapy practice (Yerxa, 1967; Molke, 2011). Holism supports embedding spirituality to help patients to restore well-being through occupational therapy interventions. Holism applied to occupational therapy practice is concerned with the unity and interdependence of the body, mind and spirit in the execution of meaningful and purposeful occupations (Turpin, 2007). These meaningful and purposeful occupations meet an individual's physical, emotional and well-being needs, giving a sense of meaning and purpose as the unique '*essence*' of an individual (Finlay, 2001; Algado & Burgman, 2005). The application of holism in a person-centred manner, as understood by occupational therapists, acknowledges the uniqueness of the individual's needs and wishes, and thus links to the spiritual domains of occupational therapy practice. Holism is considered further in this discussion as it links to the professional attributes and values of occupational therapy practice (Section 6.3.1, page 199).

The strength of the ESpiOT model are the links to the patient's experience, as observed during occupational therapy interventions where spirituality had been successfully embedded in

practice. The challenge for practitioners using conceptual frameworks and models in practice is translating abstract constructs into every day practice. The ESpiOT model is derived from practice as well as theoretical constructs, and avoids the use of ambiguous and complex terminology, as an attempt to support occupational therapists in their quest to embed spiritual competence in their practice. A further strength of this ESpiOT model is its dynamic nature, with each dimension within the model being interlinked and interdependent. For example, the patient's and the occupational therapist's experiences of the therapeutic encounter are interlinked and interdependent with person centred occupational therapy practice, in order to effectively engage in meeting, the patient's therapy goals. The model uses familiar dimensions to occupational therapist practice; enabling the application to embed spirituality. The occupational therapists in the study presented were able to confidently articulate the core values and philosophy of the profession. This ESpiOT model has been developed from the study findings, and represents the participants' application of their underpinning knowledge of occupational therapy practice, and values of holistic patient centred care. The model attempts to clarify the construct of spirituality based on sound empirical foundations. Embedding the ESpiOT model in practice will require a planned strategy of dissemination and educational activities, and evaluation of the model's usefulness to occupational therapists and patients. A dissemination strategy is presented in Chapter Eight, (refer to Table 14, page 262).

The following sections discuss how the core concepts link to the ESpiOT model. The core constructs will be contextualised by making links to the established literature, highlighting how this study contributes to the existing knowledge of spirituality in occupational therapy practice.

6.2 Person-centred occupational therapy

Person-centred occupational therapy practice is pivotal to practice and was a consistent feature of the study findings, articulated through the two themes, '*valuing the individual*' and '*supporting patients to maintain health and well-being*'. The term "*person-centred*", was favoured by the occupational therapists that took part in this study, and has been used in this

account. It conveys a more individual and collaborative approach and reduces the power imbalance implied by the terms “*patient-centred*” and “*client-centred*” (Brown, 2013; WFOT, 2010a). Person-centred care is of paramount importance for healthcare professionals in the current context of health and social care. A series of high profile investigations into the failings of care by healthcare professionals has heightened policy makers and the public’s awareness that achieving person-centred practice by all healthcare professionals is of vital importance (Parliamentary & Health Services Ombudsman, 2011; Health and Social Care Act, 2012; Francis, 2013; Keogh, 2013).

Person-centred care is enshrined in the components of compassionate care that puts the patient at the heart of all professional interactions. These components are commonly understood as treating patients with respect, dignity, sensitivity and kindness that focuses on the patient’s experience of feeling valued partners in their care (NHS Constitution, 2013). Additionally, person-centred care is a requirement monitored by the Care Quality Commission (CQC) in Regulation 9 (Firth-Cozens & Cornwell, 2009; Care Quality Commission (CQC), 2014). Person-centred practice is challenging in the current market-led, target-driven healthcare context. Tensions have been identified in how to maintain a workforce that is imbued with the values of person-centred compassionate care (DH, 2011; National Institute for Health Care Excellence (NICE), 2013). The NHS Outcomes Framework (Health and Social Care Act, 2012) and The Francis Inquiry Report (Francis, 2013) asserted that a workforce that is valued, empowered and supported was more likely to produce safe and effective care focussed on the patient.

A number of challenges for occupational therapy practice were highlighted by participants in this present study as they practiced in a target driven, service needs led context. For example, the participants working in acute in-patient care felt pressured to focus solely on discharge planning in order to contribute to the bed management issues of the hospital, and not rehabilitate patients in a holistic person-centred way. A heightened focus on issues of bed management is a commonly understood to cause healthcare practitioner stress within the NHS

(Gilbert & Proctor, 2006). The participants in the present study were experienced and resilient occupational therapists; they discussed how this challenge was managed effectively. They described the strategies they had developed to retain adherence to their professional standards and understanding of the core values and philosophy of the profession, which they believed embedded spirituality in their daily practice (Keogh, 2013).

The occupational therapists' practice appeared to share the values outlined and key messages within the NHS Outcomes Framework, in order to move away from a target culture to a focus on measuring patient outcomes, thus ensuring that patients experience positive high quality care (Health and Social Care Act, 2012). The positive response to environmental challenges demonstrated by the occupational therapists working with patients within acute care was not always sustained. For example, in the community occupational therapy teams there were examples of rushed care where task-centred practice focussed on demonstrating equipment to other care staff. An example of this was highlighted by Phoebe's demonstration of the sleep system to care staff. Phoebe's response to the time pressures of the context forced her to adopt a rushed process driven demonstration, as opposed to focussing on a demonstration which was applied to the individual patient's needs. Similarly, the pressure to achieve patient goals in time limited-sessions resulted in practice that challenged person-centred occupational therapy practice. For example, Patsy's assertion that she put processes around her interventions in order to protect the opportunities for patients to achieve their goals within a limited time frame.

Person-centred practice is integral to professional practice embedded in the College of Occupational Therapists Code of Ethics and Professional Conduct (COT, 2010), the Standards of Proficiency for Occupational Therapists (Health and Care Professionals Council (HCPC), 2013). These two documents support person-centred occupational therapy practice. The purposes of these profession specific policies are to govern the professional values and attributes of safe and effective occupational therapy practice. The Code of Ethics and Standards of Proficiency support person-centred spiritually competent practice by specifically

articulating the importance of the occupational therapist, acknowledging the spiritual, religious, faith and beliefs of a patient. These overt links to spirituality acknowledge an appreciation of the diverse cultural backgrounds which impact on a patient's needs and the occupational therapist's practice. In addition to acknowledging the diverse spiritual needs of a patient, occupational therapists are expected to consider the impact of their own spiritual and religious expressions on their practice. These profession specific policies outline the duties, knowledge, skills and behaviours of good practice to support competent occupational therapy practice. Additionally, their purpose is to protect the well-being of individuals accessing their practice, employers and the reputation of the profession. In relation to embedding person-centred practice and links to spirituality the following elements apply; Table 9: Person-centred care: Code of Ethics and Professional Standards.

Table 9: Person-centred care: Code of Ethics and Professional Standards

Code of Ethics and Professional Conduct College of Occupational Therapists (COT, 2010)	Standards of proficiency for Occupational Therapists (Health and Care Professionals Council (HCPC), 2013)
<p>“You must always recognise the human rights of service users and act in their best interests.” (p.6)</p>	<p>“Understand the need to act in the best interests of service users at all time.” (p.7)</p>
<p>“You should enable individuals to preserve their individuality, self-respect, dignity, privacy, autonomy and integrity.” (p.7)</p>	<p>“Understand the need to respect and uphold the rights, dignity, values, and autonomy of service users including their role in the diagnostic and therapeutic process and in maintaining health and well-being.” (p.7)</p>
<p>“You have a continuing duty to respect and uphold the autonomy of service users, encouraging and enabling choice and partnership-working in the occupational therapy process.” (p.9)</p>	<p>“Understand the requirement to adapt practice to meet the needs of different groups and individuals.” (p.8)</p>
<p>“You must offer equal access to services without bias or prejudice on the basis of age, gender, race, nationality, colour, faith, and sexual orientation, level of ability or position in society. Practice should at all times be centred on the service user.” (p.14)</p>	<p>“Understand the specific local context of practice, including the socio-cultural diversity of the community.” (p.8)</p>
<p>“You should be aware of and sensitive to how the above factors affect service users’ cultural and lifestyle choices, incorporating this into any service planning, individual assessment and/or intervention where possible.” (p.14)</p>	<p>“Recognise the socio-cultural environmental issues that influence the context within which people live and work.” (p.8)</p>
<p>“You must report in writing to your employing authority, at the earliest date in your employment, any religious and/or cultural beliefs that would influence how you carry out your duties.” (p.14)</p>	<p>“Recognise the effect of inequality, poverty, exclusion, identity, social difference and diversity on occupational performance.”(p.8)</p>
<p>“You should work in partnership with the service user and their carer(s), throughout the care process, respecting their choices and wishes and acting in the service users best interests at all time.” (p16)</p>	<p>“Be aware of the characteristics and consequences of verbal and non-verbal communication and how this is affected by factors such as age, culture, ethnicity, gender, socio-economic status and spiritual or religious beliefs.” (p.9)</p>

The challenge of embedding person-centred care in healthcare practice is highlighted in the literature concerning compassionate care (Firth-Cozens & Cornell, 2009). The commonly understood motivation for most students entering healthcare professions is to make a difference to the patient's experience of care. However, this motivation has been reported as significantly diminishing during their training (Wear & Zarconi, 2008), and in nursing during the first two years post qualifying (Maben, Latter, & Macleod Clarke, 2007). The impact of not treating patients with compassion, or being thwarted in their efforts is identified as a cause of distress to the healthcare professional and a contributing factor in professional 'burnout' (Lowenstein, 2008). There are two solutions suggested in the literature to support embedding person-centred compassionate care in healthcare practice. First, *'The Point of Care Programme: Enabling compassionate care in acute hospitals settings,'* (Kings Fund, 2009) highlighted complaints where healthcare had been found inadequate centred on the lack of compassion in the patient's experience. Drawing on research, this programme offered a series of workshops that aimed to improve patient's experience of care in hospitals, embedding the notion of seeing the person in the patient. The programme was underpinned by the understanding that compassion should be a normal response to an individual's suffering, and the support which should be offered to alleviate painful experiences.

Second, role modelling compassionate care has been championed as the responsibility of all health professionals, ensuring that behaviours such as facial expressions and tone of voice model compassionate care (Firth-Cozens & Cornwell, 2009). Studies have shown that a good skilled role model imparts good clinical competence and also highlights the compassionate integrity in their relationships with patients (Paice, Heard & Moss, 2002; Gilbert & Proctor, 2006). These two suggested strategies for embedding compassionate person-centred practice resonate with occupational therapy practice, and challenge a model of teaching spirituality that typically occurs in isolation of other essential aspects of healthcare practice. Isolating spirituality as a construct of occupational therapy practice can lead to spirituality remaining a concept *removed* rather than *embedded* in practice, and may contribute to a lack

of confidence in articulating spirituality as a central tenant of occupational therapy core values and philosophy.

Person-centred practice has long been a core philosophy for occupational therapists (Sumsion & Law, 2006). Person-centred occupational therapy practice has largely been shaped by the work of the Canadian Association of Occupational Therapy, enshrined in a theoretical model, the Canadian Model of Occupational Performance – Enhancement (Hong, Pearce & Withers, 2000; Townsend & Polatajko, 2007; Parker, 2011). There have been challenges to practicing person-centred care in the 21st century healthcare environments, highlighted in Chapter One. Measures aimed at containing expenditure and meeting imposed targets have made person-centred care more difficult for occupational therapists striving to embed spirituality in practice. Despite this, person-centred occupational therapy practice still emerged as a dominant core concept in this study. The occupational therapists demonstrated person-centred practice, and an underpinning application of the core philosophy and values of the profession. Person-centred occupational therapy practice was linked to the two themes '*valuing the individual*' and '*supporting patients to maintain health and well-being*'; these themes are discussed in the following sections.

6.2.1 Attributes of valuing the individual

Central to person-centred practice is valuing the patient as a person, acknowledging their uniqueness and humanity. These attributes were demonstrated by the occupational therapists in this study. Spirituality is fundamental to our humanity, influencing and influenced by our experiences of health, illness and disability (Taylor et al., 2000; Farrar, 2001; Hoyland & Mayers, 2005). An acknowledgement that each individual has a spiritual dimension to their lives, shaping who they are, is essential in acknowledging the uniqueness of the individual (Gutterman, 1990; Hoyland & Mayers, 2005). Pivotal to acknowledging the uniqueness of individual patients is the development of effective therapeutic relationships in order to initiate and progress occupational therapy that addresses spiritual needs (Udell & Chandler, 2000;

Collins et al., 2001; Farrar, 2001). The occupational therapists in this study demonstrated how they developed therapeutic relationships with patients from diverse backgrounds; embracing the uniqueness of each patient's experience as they addressed individual issues. The literature reviewed in Chapter Two supported the notion that in order for spirituality to be embedded in daily practice it was essential to place the patient at the centre of the therapeutic encounter (Townsend, 2003; Smith, 2008; Townsend & Polatajko, 2013).

The challenges of placing the patient at the centre of the therapeutic encounter are related to the patient and the context. First, patients from diverse backgrounds view health and health professionals in differing ways. For some patients the healthcare professional is viewed as the decision maker, leading the therapeutic encounter (Iwama, 2006). This mirrors tenets of spiritually competent occupational therapy practice (Chapter Two), where cultural competency was an important component of spiritual practice. Second, in order to practice with spiritual competency participants in this study typically acknowledged that the person was central to care delivery, including spiritual care, focussing on patient needs and goals, concerns and emotional well-being. The spirituality of the person has been described as the '*core of the individual*', '*divine spark*' and what makes an individual '*tick*', supporting the notion that the individual must be central to the therapeutic encounter (Unruh et al., 2002). The context of practice was influenced by many factors that potentially limited placing the patient centrally. For instance, on a busy acute ward, bed pressures led to a priority on discharge planning that could mitigate against attending to patients' spiritual needs. This reflected the findings of Collins et al (2001), who suggested that meeting acute care needs took priority over meeting emotional and spiritual well-being needs. These pressures challenge embedding spirituality in occupational therapy practice, and at times the context of practice does not support professional standards of practice.

Trust is essential to building rapport and person-centred care. Trust can be fostered through active listening and effective communication, essential features of person-centred occupational therapy practice, when undertaking an assessment of a patient's needs (Hong

et al., 2000; Sumsion, 2000; Sumsion & Law, 2006; Hammell, 2013). Embedding spirituality in practice can be expressed through listening to patients, giving them time to talk about what is important to them, addressing uncomfortable or deeply personal questions, supporting them in expressing their feelings and concerns and acknowledging diversity (Udell & Chandler, 2000; Beagan & Kumas-Tan, 2005; Hoyland & Mayers, 2005). Person-centred care is enhanced by eliciting patients' perspectives, identifying their concerns and exploring the impact of illness and symptoms on their lives.

Active listening and effective communication are also important attributes of developing a therapeutic relationship, embedding spirituality in practice, and of the domain of '*being*' highlighted in the '*Conceptual framework for spiritually competent occupational therapy practice*' developed from the concept analysis (Chapter Two), and Kang's (2003) psycho-spiritual framework. '*Being*', was identified by Kang (2003) as a construct for promoting person-centred practice, achieved through active listening. The acknowledgement of the patient's beliefs and the uniqueness of their experience are central to spiritual practice (Udell & Chandler, 2000, Johnston & Mayers, 2005). The actions that contributed to '*being*', although not articulated by the practitioners in the present study findings, were observed as they dedicated time to discuss an individual's values, dreams and desires. Despite challenging environments and contexts, for instance a busy in-patient trauma ward, the occupational therapy practice observed found the occupational therapist focussed on the patient's presenting concerns. The occupational therapists were observed adjusting their communication styles appropriately to engage a diverse patient population. For example, during discharge planning efforts were made to attend to the patient's wishes and needs (such as preferred place of discharge), to support meaningful connections with family and communities and thus improve spiritual well-being.

Active listening was also evident as the occupational therapists responded sensitively to the impact of symptoms on patients' health and well-being, sometimes linked to the delivery of bad news. Delivering bad news sensitively was an important aspect of the occupational

therapists' interventions (in common with a number of healthcare professionals). The literature about delivering bad news is largely, but not exclusively, informed by studies in oncology and palliative care settings (National Council for Hospices and Specialist Palliative Care Services (NCHSPCS), 2003; Bryant, 2008; Paul, Cinton-McHarg, Sanson-Fisher, Douglas & Webb, 2009; Griffiths, Ewing, Wilson, Connolly & Grande, 2015). However, the principles apply across professional groups, since the definitions provided for end of life care are appropriate across healthcare settings. Bad news is defined as any news that alters the patients understanding of their view of the future causing a threat to their experience of hope and well-being (Buckman, 1992; Warnock, 2014). The evidence of patient's expectations from cancer and palliative care settings is transferable to other contexts, in that patients want to know the bad news, and the healthcare professionals require skills to manage this complex communication task. Studies suggest that healthcare practitioners need to develop skills and strategies to manage situations where information provided was contrary to the hopes of patients to continue to maintain their well-being (NCHSPCS, 2003; Bryant, 2008).

A number of instances were observed in this present study where the occupational therapists delivered bad news sensitively. For instance, delivering the news to a patient that they would not walk again had a devastating impact on their well-being. Observing occupational therapists deliver this information sensitively, and addressing the patient's concerns for the future, highlighted that the sensitive and careful management of these situations positively impacts on a patient's well-being. The study supported findings from the literature that active listening was an essential skill for "*hearing*" what was meaningful to the patient. This was a prerequisite for embedding the patient's need for meaning in occupational therapy interventions. Even in challenging contexts, creatively addressing this issue appeared to improve the quality of interactions and outcomes. In order to effectively embed spirituality in daily practice occupational therapists need to maintain and apply effective communication skills.

6.2.2 Respect, partnership and decision making

Person-centred occupational therapy is dependent on respect and sensitivity for the patient's values, beliefs and diversity. A non-judgemental appreciation of the patient's diverse life experiences can support developing an effective therapeutic relationship, and embedding their beliefs, religious traditions and values in occupational therapy interventions (Sumsion, 2000; Udell & Chandler, 2000; Beagan & Kumas-Tan, 2005; Sumsion & Law, 2006; Brown, 2013; Hammell, 2013; Townsend & Polatajko, 2013). The importance of developing a meaningful therapeutic relationship and harnessing the therapeutic use of self is an essential component of embedding spirituality in occupational therapy practice. Reflection is a key skill for occupational therapists to develop to establish a personal awareness of responses to spiritual issues manifested by patients (Collins, 2007).

Empowering the patient to achieve their goals requires the occupational therapist to demonstrate respect by sharing the responsibility and power in decision making (Law, Baptiste & Mills, 1995; Hong et al., 2000; Sumsion & Law, 2006; Brown, 2013; Hammell, 2013). In this present study embedding spirituality in occupational therapy practice was intrinsically linked to respect, and working in partnership with a patient in order to embed what was meaningful and purposeful to them. Notably this was evident as Mark sought to work with the patient who was unable to walk to help him adjust to life in a wheelchair. By suggesting opportunities which were meaningful to the patient he was able to work in partnership to achieve the patient's goal to master his new life in a wheelchair. The outworking of this partnership challenges the endemic notion of paternalism which maintains an unhealthy dependency by patients on healthcare professionals to make decisions on their behalf (Coulter, 2010; Coulter & Collins, 2011). Health policy supports shared decision making and challenges the historic paternalism of healthcare services urging patients and clinicians to be '*co-producers of health*', sharing the decision making (Bryant, 2012). Equity and Excellence: Liberating the NHS (2010) advocated shared decision-making, respecting the choices and expertise of the individual espousing the ideal, "*no decision without me*". Participants in this study were observed avoiding working in a

paternalistic way by ensuring they acknowledged the patients' expertise, and the patient was at the centre of the decision-making processes. Respect for individual patients was a feature of the observed practice in this study. The occupational therapists demonstrated an understanding of the diversity of factors impacting on their patients' decision making and emotional well-being. This understanding formed the basis for their person-centred practice. Appreciating the complexity of the patients' home circumstances suggested their deep-rooted respect for the patients, and provided a focus for decision making during discharge planning or making adaptations to the environment.

Health policy within Western societies endorses a model of service and care delivery based on patient-centeredness (Health and Social Care Act, 2012; Care Quality Commission, 2014). A patient-centred model of healthcare places the patient at the centre of decision-making processes, and acknowledges the importance of involving patients in decisions about their care and care delivery. Attending to patient-centred goals is a central feature of occupational therapy practice. Supporting collaboration between patient and occupational therapist in decision making promotes patient control and choice (Hammell, 2013). Brown (2013) suggested collaboration and consultation in decision-making promotes the core values of occupational therapy by engaging patients in meaningful and purposeful occupations through partnership. This collaboration can be supported by the use of participatory outcome measures and evaluations within occupation therapy interventions, such as the Canadian Occupational Performance Measure (Wilcock & Townsend, 2004; Townsend & Polatajko, 2007). The findings of the present study supported the commonly held belief that occupational therapists were committed to collaborating with patients, and respecting their autonomy when making decisions. There were notable instances where the occupational therapists provided the patient with realistic feedback in order to help them make decisions. Additionally, there were a number of examples illustrating how sensitive issues relating to future plans were discussed with patients. These findings mirrored the literature, as examples offered how occupational therapists collaborated with patients to discuss feelings related to loss and pain,

assisting with decision making in relation to how these symptoms impacted on patient's lives and future (Egan & Swedersky, 2003).

Chapter Five also presented findings related to the perceived challenges of time limited interventions and the pressure to discharge in acute settings (see also Hoyland & Mayers, 2005). Examples from the data in Chapter Five highlighted how the occupational therapists working in the acute setting (Julie and Mark) supported their patients when working with them to facilitate their discharge planning. Their respectful acknowledgement of the patient's dignity and choice when addressing the significance of discharge situations recognised the impact to the patient's health and well-being. The application of collaborative decision making, respecting the autonomy of the patient, and reflecting the expertise of the patient in their unique circumstances is an example of *'becoming'*. *'Becoming'* (Chapter Two, Table 5) was defined by Kang (2003) as promoting autonomy, independence and choice through occupations that engage a person in self-healing activities and the adaptation to disability. The occupational therapists demonstrated how they respected their patients' decisions as an essential aspect of embedding spirituality in their practice. The occupational therapists' application of *'becoming'* in practice was also seen as they addressed issues of deep personal significance, for instance decisions affecting the patient's future lifestyle and discharge from hospital.

6.3 Occupational therapy practice: professional attributes and values

Embedding spirituality in occupational therapy practice requires the occupational therapist to recognise that spirituality is a dimension of holistic practice, which is dependent on their personal and professional attributes, and values. Professional attributes and values were underpinned by how the philosophy of the profession embraced and enacted holistic, person-centred care, and valued the unique contribution of occupation to well-being and quality of life (Duncan, 2011). In the present study personal values were shaped by the occupational therapists' experiences of occupational therapy and the factors motivating them to join the

profession. The professional attributes necessary for embedding spirituality in occupational therapy practice found in the concept analysis (Chapter Two) were also reflected in the findings of this study.

6.3.1 Recognising spirituality as a dimension of holistic practice

The core underpinning elements of occupational therapy philosophy, holistic client-centred practice, related to how the occupational therapists in this study recognised spirituality as a dimension of holistic practice. Holism is a much debated construct (Pollard & Kronenberg, 2008), however is widely associated with occupational therapy practice. Finlay's (1998) study exploring the experiences of occupational therapists practicing holistically found that they intuitively understood the concept of holistic occupational therapy practice, but referred to pragmatic and strategic practice which depended on the needs of the situation. Holism was understood to refer to the treatment of individuals a "*complex whole beings*", and not to isolate individual components of holistic practice (Finlay, 2001, p. 269). The challenges of practicing holistically were reported (by Finlay) to be frustrating for occupational therapists, as they perceived their practice often to be at variance with the ideals of the profession. The present study sought to emphasise the spiritual dimension of holism, in contrast to the broader consideration reported by Finlay (1998 and 2001). The commonly held attributes of holism for occupational therapy practice, discussed earlier in section 6.1.3 (refer to page 199), included the mind, body and spirit. Spirituality has been considered essential to holistic patient-centred occupational therapy practice, as the ideals of holism are recognised. However, in acute care holism has been considered a challenge owing to the time constraints of practice (Hoyland & Mayers, 2005).

In contrast to appreciating a broad understanding of holism, the occupational therapists involved in this present study struggled to define the '*spirit*' dimension of holism or spirituality. They considered their experience of spirituality in the context of their day-to-day practice, rather than conceptualising it in theoretical terms. They discussed spirituality for their patients

in terms of *'the essence of the person'* and *'what made them tick'*, linking with the earlier discussion regarding the unique humanity of each individual. The opportunity for engaging in occupations that promoted spiritual well-being was considered to be a way to address a patient's spiritual needs. Julie was the only occupational therapist in the study who told me that she didn't know if I would find anything relevant to the study when I observed her practice. She explained how surprised she was when it was evident that she did embed the commonly perceived constructs of spirituality in her practice. This confirms the suggestion in Chapter Two that a description of spiritually competent occupational therapy practice appears to be more useful than an abstract definition.

The challenge of defining spirituality described by the occupational therapists in this study was also found in other occupational therapy studies. The consensus that spirituality was not well defined for occupational therapy practice (Hammell, 2001; Unruh et al., 2002) has been a consistent theme in studies exploring occupational therapy practice (Taylor et al., 2000; Udell & Chandler, 2000; Morris, 2013), and reflects similar issues in all healthcare professions (as reported in Chapter One). In contrast to the views expressed in the findings reported in this thesis, spirituality has been defined in terms of religious or sacred concepts by occupational therapists surveyed in Canada, the USA and the UK (Taylor et al., 2000, Udell & Chandler, 2000; Collins et al., 2001). Another way of defining spirituality was in terms of existential beliefs (Egan & Swedersky, 2003). Consequently, many authors recommend the development of a congruent definition for spirituality for occupational therapy practice, linked to guidelines for practice (Taylor et al., 2000, Udell & Chandler, 2000; Collins et al., 2001, Egan & Swedersky, 2003; Morris, 2013). Whilst the quest continues for a working definition of spirituality for occupational therapy practice, occupational therapists continue to carry out their daily work addressing spirituality (Beagan & Kumas-Tan, 2005). The findings from the concept analysis (Chapter Two) presented a description of spiritually competent occupational therapy practice (refer to page 85) that was postulated as being a useful way of conceptualising spirituality in practice and was supported in the findings of the empirical study presented in Chapter Five. It

appears to be more meaningful to occupational therapy practice to describe, rather than define, spirituality because of the unique meaning of the concept to the individual patient, practitioner and professional group.

Occupational therapists have been criticised for not clearly articulating spirituality as a key domain of holistic practice (Unruh et al, 2002). For some occupational therapists' spirituality is considered to be a very private domain (Collins et al., 2001; Farrar, 2001; Beagan & Kumas-Tan, 2005). As an alternative to using the language of spirituality to describe their practice, occupational therapists talk about their deep respect for patients, and facilitating their unique humanity by treating everyone with respect and dignity (Beagan & Kumas-Tan, 2005). The findings reported in this thesis support the literature, as the occupational therapists in this study articulated spirituality in terms of their core values and professional philosophy. The lack of understanding and uncomfortable feelings about articulating spirituality and spiritual care may be barriers to embedding spirituality in practice, and may explain the reluctance by occupational therapists to articulate the spiritual element of holism (Hoyland & Mayers, 2005).

6.3.2 Professional influences on spirituality in practice

Personal and professional influences on spirituality in occupational therapy practice are inextricably linked. Occupational therapists combine their personal attributes with a professional understanding of their role as an occupational therapist and with the context of their practice setting (Udell & Chandler, 2000). This section will discuss the professional influences on spirituality and occupational therapy practice. Professional influences have been related to the occupational therapists' knowledge about their role and attitudes to spirituality; practice context; application of theoretical models and philosophy in practice (Taylor et al., 2000; Udell & Chandler, 2000; Collins et al., 2001; Morris, 2013).

The occupational therapists in the present study were observed engaging individuals in a range of therapeutic interventions to improve well-being, quality of life and the self-management of distressing symptoms. The occupational therapists identified that an

understanding of the patient's needs was one way of addressing spirituality, and thus embedding the core philosophy of the profession in their practice. Listening skills, person-centred practice, valuing meaning and upholding personal standards of healthcare were all described as influencing the occupational therapists' professional practice. The occupational therapists practicing in the acute hospital setting described how they worked through the challenges of current service pressures in order to ensure that the core values and philosophies of the profession, perceived as addressing spirituality were not compromised. This was in contrast to the studies reporting similar challenges, where meeting services demands often compromised the underpinning values and the philosophy of the profession and individual therapists (Egan & Swedersky, 2003; Hoyland & Mayers, 2005).

The present study, similar to the published literature, supported the value of theory to explain and build a foundation for embedding spirituality in occupational therapy practice. Despite the central place of spirituality in the occupational therapy practice model, CMOP-E (Townsend & Polatajko, 2007), it has been suggested that occupational therapists do not generally think about their practice in these terms (Parker & Sykes, 2006). However, in a later study Morris (2013) suggests that the application of theoretical models of occupational therapy practice, for example the CMOP-E (Townsend & Polatajko, 2007) has led to a more positive attitude to addressing spirituality in practice. This contradiction is reflected in the findings of the present study where there was no direct observation of theoretical models applied to practice. However, during the interview Patsy discussed how she used the Kawa model (Iwama, 2006) to support her metaphor of '*journeying*' with patients. She used the constructs of the model and the river metaphor to help clarify a patient's situation. The idea of journeying with patients through a period of their illness experience was expressed in the Hoyland and Mayers study (2005), as a way of making sense of patient's experiences. Whereas journey is commonly linked to a religious connotation of pilgrimage, it has been suggested that the use of the terms '*journeying*' and '*pilgrimage*' have been given contemporary definitions which resonate with

ideals of promoting well-being (Courtney, 2013). The application of the Kawa model, discussed by Patsy, was not observed in practice.

The Kawa model (Iwama, 2006) has a limited evidence base supporting its application in practice. The model has been criticised for its lack of application to the inner self, focusing on observable constructs of a patient's journey i.e. self, occupation and life flow (Wada, 2011). This lack of focus on the inner self suggests the Kawa model is not a useful model for embedding spirituality in occupational therapy practice, since the spiritual domains require the exploration of deeply personal factors. However, the Kawa model has been applied to practice in mental health and when managing patients with multiple sclerosis (Carmody, Nolan, Chonchuir, Curry, Halligan & Robinson, 2007; Paxson et al., 2012). The application of the Kawa model to these areas of practice supported the occupational therapists in developing their relationship with the patient, an element understood as necessary to embed spirituality in practice effectively. Developing effective relationships supported the occupational therapists to elicit opportunities and challenges that patients faced, and to facilitate occupation-based practice (Carmody et al., 2007). The Kawa model does appear to indirectly support spiritual care through person-centred practice, and to facilitate meaningful information from the patient in a culturally sensitive way. A further strength of the model has been highlighted in supporting the occupational therapists' own personal practice reflection by providing a structure for recording critical incidents (Carmody et al., 2007; Paxson et al., 2012).

So far in this chapter the importance of developing a therapeutic relationship has been highlighted as a necessary vehicle to spirituality and occupational therapy practice. Developing effective therapeutic relationships, which places the patient central to the therapeutic encounter, was an attribute of valuing the individual in order to address patients' spiritual needs. The importance of effective communication skills, including active listening, has been highlighted in the development of a therapeutic relationship. Further links supporting effective therapeutic relationships to embed spirituality in practice were made when discussing respect and partnership in decision making. These links suggest that professional influences

on spirituality in practice were a feature of the relationships developed between the patient and the occupational therapist. Developing a therapeutic relationship and therapeutic use of self were also recognised as features of professional influences which supported embedding spirituality in practice (Collins, 2007). Therapeutic relationships are understood by occupational therapists as the development of the patient/occupational therapist relationship that is essential for the therapeutic encounter (Taylor & Melton, 2009). By developing an effective therapeutic relationship, the occupational therapist is able to elicit the uniquely personal information to facilitate collaborative patient-centred approaches to occupational therapy interventions. Integral to developing and maintaining an effective therapeutic relationship is therapeutic use of self. This complex, dynamic interpersonal process serves to maximise the patient's response to occupational therapy interventions and supports engagements in meaningful and purposeful occupations (Townsend, 2003; Duncan, 2006; Taylor & Melton, 2009).

The occupational therapists in the present study were consistently observed in all contexts developing therapeutic relationships with patients. They used these relationships to delve deeper into the presenting issues, and identify meaningful and purposeful areas to address through occupational therapy interventions. The occupational therapists were also observed modifying their approaches to individual patients, using motivational theory to achieve personalised interventions which addressed meaning and purpose for their patients in specific situations. This was evident when observing the occupational therapists working in the acute hospital using these skills to motivate patients towards discharge home.

Developing a therapeutic relationship to support embedding spirituality in occupational therapy practice was a feature of studies reporting spirituality and occupational therapy practice (Udell & Chandler, 2000; Hoyland & Mayers, 2005). In order to recognise and deal with suffering effectively the need to engage authentically with the patient was highlighted. Effective relationships which involved the therapeutic use of self to develop and understand meaningful occupations to engage the patient were considered necessary to embed spirituality in practice

(Egan & Swedersky, 2003). In support of this, Hoyland & Mayers (2005) suggested the features of a therapeutic relationship were listening to and accepting the patient as a unique individual. Additional components of the effective therapeutic relationship identified by participants in the study presented in this thesis included respecting the patient's values, meaningful experiences and aspirations.

6.3.3 Personal influences on spirituality in practice.

Personal life experiences are important when embedding spirituality in occupational therapy practice; it has been argued that understanding and being comfortable with their own expression of spirituality is essential if occupational therapists are to be effective in delivering holistic occupational therapy practice (Hoyland & Mayers 2005). While Section 6.3.2 (refer to page 201), highlighted the professional attributes that impact on embedding spirituality in occupational therapy practice the potential synergy (and, sometimes, tension) between personal approaches to spirituality professional values also impact on the way occupational therapists practice. The positive influence and application of the occupational therapists own beliefs and their empathy for a patient's situation was highlighted by Taylor et al., (2000) and Morris (2013). However, concern has also been expressed that for some occupational therapists addressing spiritual issues was not considered to be part of their role (Taylor et al, 2000; Beagan & Kumas-Tan, 2005; Hoyland & Mayers, 2005; Morris, 2013). Additionally, concern regarding proselytising patients produced a less favourable attitude towards spirituality and occupational therapy practice (Taylor et al., 2000; Udell & Chandler, 2000; Collins et al., 2001; Morris, 2013) reflecting the common confusion between spirituality and religion.

Occupational therapists' own understanding and development of spirituality has been identified as essential to support good spiritual care (Egan & Swedersky, 2003, Thompson & MacNeil, 2006). Udell and Chandler (2000) discussed the role of personal and professional influences for embedding spirituality in practice. The same influences were observed and

discussed in the present study. The personal life experiences of therapists were seen as an influence in developing a personal philosophy of occupational therapy, and embedding the core values of the profession in practice. All four occupational therapists described how family had influenced their choice of career. In Mark's case, his personal experience of healthcare had caused him to recognise the unique characteristics of occupational therapy interventions. He was attracted by the philosophy of the therapists he encountered. The philosophy of the profession was described by Patsy as the essence of who she is, embedded in her practice.

Personal beliefs, values and ethical views influenced the occupational therapists' approaches to addressing patients' spiritual needs and helped the occupational therapists in carrying out their professional responsibilities (Farrar, 2001; Beagan & Kumas-Tan, 2005; Hoyland and Mayers, 2005). One survey suggested spirituality was essential to the occupational therapist's life (Taylor et al, 2000). Participants in a study by Udell & Chandler (2000) emphasised how their personal (in this case, Christian) beliefs gave them a framework for exploring spirituality. Diverse attitudes to religious beliefs and values have been reported in the literature relating to occupational therapy and spirituality.

Occupational therapists who considered themselves religious expressed more positive views regarding embedding spirituality in practice (Taylor et al, 2000). The findings from surveys of occupational therapists in Canada and North America (Taylor et al., 2000; Collins et al., 2001; Farrar, 2001; Morris, 2013) reflected a different context to healthcare from the current study where only one of the occupational therapists chose to disclose she had a Christian faith. Patsy, who declared her Christian faith during the interview, expressed how her Christian faith helped to give her a perspective that recognised the diversity of patients' experiences of spirituality. She acknowledged how individual patient's experiences of spirituality were expressed in the guiding principles of their own lives, and that she used her patients' guiding principles to influence her interventions. In contrast to the open discussion of Patsy's Christian beliefs that supported her practice, the other participants expressed their own spirituality in terms of embedding the core values and philosophy of the profession. The core values and

philosophy were reinforced during participants' academic training and were seen as part of the contribution occupational therapists made to health and well-being. Understanding and being confident with one's own expression of spirituality can facilitate the delivery of effective holistic care (Hoyland and Mayers (2005). Furthermore, addressing patients' spiritual needs can be a transforming experience facilitating the provision of companionate care, personal growth and satisfaction of providing patient care (Egan & Swedersky 2003).

In summary, the core concept '*occupational therapy practice: professional attributes and values*' was found to be interdependent with the earlier core concept of '*person-centred occupational therapy practice*'. The literature raises concerns about how spirituality is enacted out in occupational therapy practice. This study found that spirituality was positively supported in daily occupational therapy practice by the application of person-centred practice; addressing what is uniquely meaningful and purposeful to an individual that provides them with a sense of hope for their future (refer to Figure 14, page 173). The challenges to embedding spirituality were found in the context and included constraining factors linked to organisational targets and budgets. The following section focuses on the practicalities of putting the two core concepts of person-centred practice and professional attributes and values into practice.

6.4 Opportunities for embedding spirituality in practice: therapeutic interventions

When carrying out interventions to improve functional independence in everyday tasks, the occupational therapists in the study presented were observed focussing on the personal meaning and purpose the tasks had for the patient. They viewed person-centred practice as addressing the diverse needs of the patients, and saw that addressing spirituality was part of their everyday practice. The link between spirituality and engaging in occupations has been reported in the literature exploring occupational therapy practice. Studies highlighted the importance and value of meaningful occupations to engage patients in health-promoting occupations that addressed the spiritual (including religious) dimensions, for example dressing

for worship (Farrar, 2001; Egan & Swedersky, 2003). However, further clarity is needed to determine how the activities of daily living can be applied to the spiritual dimensions, and support occupational therapists with spiritually competent practice. Studies have developed the engagement between spirituality (including religious expressions of spirituality) and occupations further by suggesting the following examples of practice: facilitating attendance at worship (Hoyland & Mayers, 2005); meeting cultural needs in the preparation of food during domestic activities of daily living (Udell & Chandler, 2000); creative activities providing the patient with feelings of positive self-worth and developing positive coping strategies such as relaxation and anxiety management (Farrar, 2001). Finding out what the patient values and facilitating meaningful connections with significant people has also been recognised as part of a spiritual approach (Beagan & Kumas-Tan, 2005).

'Authentic' occupational therapy practice has been linked to imbuing meaning and purpose and realising occupational therapy philosophy in practice (Yerxa, 1967; Molke, 2011). This position of, *'authentic'* holistic occupational therapy practice appears to automatically embed spirituality in practice, where spirituality is seen as part of a whole-person approach. This view of *'authentic'* occupational therapy practice is supported by the findings of the present study, as the occupational therapists were not seen to be striving for a definition, conceptualisation or guidance to practice with spiritual competency. What they did respond to was the open discussions of their practice, and the reassurance that they were practicing embedding spirituality through their adherence to the core values and philosophy of the profession. However, this view of *'authentic'* occupational therapy practice was not supported in all the literature. Spirituality was largely seen as a separate dimension requiring definition; specific guidelines and assessments without which it was reported to be difficult to embed spirituality in practice (Taylor et al., 2000; Udell & Chandler, 2000; Collins et al., 2001; Morris, 2013).

The conceptual framework for spiritually competent occupational therapy practice presented in Chapter Two (Figure 7, page 87), described three dimensions that related to the therapeutic interventions considered as a dimension of spirituality in practice. These three dimensions

were: '*centeredness*', '*transcendence*' and '*connectedness*.' First, '*centeredness*' was described as acknowledging the individual's spiritual and religious expressions through meditation, creative visualisation and connections with relationships that created balance in an individual's life. Strategies advocated to address spirituality, through therapeutic interventions appeared to be overtly religious in nature for example, by respecting the patient's unique preferences for prayer, participation in spiritual groups, meditation and using spiritual and religious rituals or traditions in therapy (Taylor et al., 2000; Udell & Chandler, 2000). These overtly religious therapeutic interventions advocated in the literature were not observed or discussed by the occupational therapists in the present study. However, there were a number of instances where the occupational therapists practice embedded the spiritual construct of '*centeredness*' by using creative visualisation to manage symptoms of anxiety. The participants had opportunities to develop these areas in their practice, often limited by time factors as reported in exceptions to person-centred practice in Chapter Five. The ESpiOT model (Figure 14, page 173), supports incorporating '*centeredness*' in occupational therapy interventions as an aspect of facilitating person-centred practice. This can be achieved by helping a patient to engage in meaningful and purposeful occupations that address the suffering experienced from distressing symptoms, such as anxiety by developing coping strategies.

Second, '*transcendence*' was described in Chapter Two, (refer to section 2.7.7., page 92) as the experience of existential feelings of power, a force beyond a person and linked to development of coping strategies, in particular in end of life care. Life changing events prompt conversations with patients of a spiritual nature, for example end of life conversations that link to meaning and purpose to facilitate positive coping strategies (Udell & Chandler, 2000). This was evident in the observations of occupational therapists practice for the present study. The meaning of sleep in the management of fatigue for a patient who was experiencing end of life care in a hospice, and the provision of a sleep system to facilitate rest could be seen as example of '*transcendence*'. In this instance the occupational therapist provided the strategies

to facilitate sleep and enable the patient to have some sense of control over this fundamental need. Further examples of positive coping strategies to address spiritual well-being such as relaxation and anxiety management (Taylor et al., 2000; Farrar, 2000), were observed in Patsy's practice to alleviate distressing symptoms, and enable the patients to gain a sense of control over their lives again. *'Transcendence'*, in contrast to *'centeredness'*, does provide the occupational therapist with tangible therapeutic interventions (coping strategies) to embed spirituality in their practice. The ESpiOT model incorporates aspects of transcendence through facilitating person-centred practice and the alleviation of suffering through developing coping strategies in order to restore the patient's well-being.

Finally, *'connectedness'* includes facilitating connections with communities, which may include faith communities, or spiritual practices such as prayer and worship. Connection between the patient and the occupational therapist also promotes positive outcomes, and has been suggested in the theory of therapeutic relationships and therapeutic use of self (Taylor & Melton, 2009). The importance of therapeutic relationships in connecting with professionals to progress therapeutic goals was evident in the practice of the occupational therapists in this present study. Udell and Chandler (2000) asserted that facilitating attendance at church and meeting cultural expectations could be ways of addressing patients' spiritual needs. Additionally, *'journeying'* and *'pilgrimage'* linked the patients' health journey with the therapist in their own spiritual journey. Patsy used this language with her patients to explain the nature of her therapeutic relationship with them and the boundaries of her time limited interventions. Hoyland and Mayers (2005) suggested the therapist journeys with the patient for a period of their lives involving their occupational therapy intervention. The term *'pilgrimage'* has religious connotations and requires the occupational therapist to select carefully because for some patients the metaphor would resonate with religious ideology. However, for others it may not be helpful in describing their experience. In contrast to the positive presentation of *'journeying'* presented by Patsy, her description of the outworking in practice was less positive (*"I'll just drop off"*) when patients become de motivated, plateau or disengaged. This suggested that

the occupational therapist might not always adhere to person-centred ideals in practice. The ESpiOT model places the construct of facilitating person-centred practice centrally, linking between the constructs relating to the patient's and occupational therapist's experience of meeting therapeutic goals. This supports patients to connect with their community and others of significance in order to regain or focus their experience of well-being.

The opportunities for embedding spirituality in occupational therapy practice and facilitating person-centred practice incorporated in the ESpiOT model presented in Chapter Five (Figure 14, page 173), included: active listening, collaboration between patient and occupational therapist to engaging the patients in meaningful & purposeful occupations, connecting with their community and others, providing hope for their future, addressing suffering and developing coping strategies. The literature positions spirituality as part of the everyday practice of occupational therapists. This everyday practice includes the following aspects:

- Addressing the meaning and purpose of illness;
- Addressing suffering related to feelings of loss and pain, in an attempt to relieve distress and help patients improve functioning.

(Collins et al., 2001; Farrar, 2001; Egan & Swedersky, 2003; Hoyland & Mayers, 2005)

Spiritual care has been identified as an essential aspect of occupational therapy practice despite an uncertainty how spirituality can be incorporated in all areas of practice, for example a busy surgical ward where discharge planning is the focus of intervention (Farrar, 2001; Hoyland & Mayers, 2005). The everyday practice of occupational therapists addressing the constructs of spirituality, mentioned above, was evident throughout the observations of practice in the present study. The occupational therapists across care settings addressed the unique meaning of illness and addressed patients' suffering with practical strategies to manage distressing symptoms such as fatigue, anxiety and pain. These examples support the links occupational therapy practice makes to psychological and physical impact of illness on well-being. This intrinsic link supported the occupational therapists to address issues of suffering related to grief and loss during their interventions.

Assessing spirituality has been seen as a problematic and contentious issue across all healthcare professions, including occupational therapists. Whereas assessing spirituality was considered to be an essential part of a holistic assessment (Udell and Chandler, 2000; Collins et al., 2001; Morris, 2013), Udell and Chandler (2000) did not consider occupational therapists equipped for the task. The occupational therapists observed in the study presented used a range of assessment techniques from open ended narrative assessments to structured assessment forms. A discussion of the assessment methods revealed that the occupational therapists considered the underpinning principle was to achieve meaningful and purposeful dialogue to understand the patient's perspectives, whatever method they used. Patsy considered an open dialogue the most appropriate method to get to the heart of the patient's issues, and that a structured assessment form could be a barrier to this. Her long experience as an occupational therapist supported this unstructured approach effectively. The application of active listening skills and working collaboratively with the patient effectively assessed spirituality, and facilitated embedding spiritual issues in practice as the individual patient's needs were articulated and incorporated in therapeutic interventions.

6.4.1 Embedding spirituality in practice through hope, meaning and purpose

Commonly held elements of spirituality are hope, meaning and purpose. Meaning and purpose, and its relationship to spirituality for occupational therapy practice have been described as: '*spirituality is meaning-making through purposeful activity*' (Rosenfield, 2000, p17). Acknowledging the importance of each individual's personal definition of hope and their perspective of well-ness was also considered important in addressing spirituality in occupational therapy practice (Farrar, 2001; Egan & Swedersky, 2003; Sumsion & Law, 2006). A core element of person centred occupational therapy practice observed in the present study was hope, and how the occupational therapists supported their patients to experience hope through their diverse situations. The present study findings identified hope in occupational therapy practice as a key dimension to embedding spirituality in care. Facilitating hope in difficult circumstances where the occupational therapist was delivering bad news to the patient

was observed on a number of occasions. Similarly, focusing on occupations that were meaningful and purposeful to the person and enhanced quality of life were considered spiritual dimensions of occupational therapy practice (Egan & Swedersky, 2003; Townsend, 2003; Brown, 2013). Kang (2003) asserted that all occupations were spiritual and meaning was a construct of his psycho-spiritual framework.

The conceptual framework for spiritually competent occupational therapy practice (Chapter Two, Figure 7, page 87) identified a twofold function of meaning. First, meaning was found in the exploration of the meaning of illness or disruption experienced personally by the individual, alternatively considered as loss of meaning. Second, the pursuit of goals and interests that enhanced quality of life and well-being through occupations that were meaningful and purposeful could help restore or recover a sense of meaning. In contrast to finding meaning in '*extrinsic factors*' such as occupations, spirituality has been described by some as the '*intrinsic*' search for meaning and purpose in a patient's life that interprets their situation (Johnston & Mayers, 2005). The ESpiOT model supports the occupational therapist when considering the internal facilitators which are important to a patient finding a sense of meaning and purpose in their situation. This can be achieved through setting collaborative therapy goals aimed at restoring the patient's sense of well-being.

Engaging patients in meaningful occupations in order to help them progress with their goals was commonly observed when collecting data for the study presented. Meaningful occupations were described by participants' as the essence of what occupational therapists did to improve function and promote well-being and quality of life. Research suggests there is a distinction between how occupational therapists and pastoral care workers constructed meaning for their practice (Beagan & Kumas Tan 2005). Occupational therapists were found to '*identify*' meaning for their patients through their therapeutic interventions. This was in contrast to pastoral care workers who focussed on '*searching for*' or '*creating*' meaning in a patient's situation. In contrast, the findings of this present study found occupational therapists using opportunities to *create* meaning through their interventions, for example encouraging a

patient to take up gardening as well as *identifying* and acknowledging the meaning a person's home had in providing peace and happiness when planning discharge. The participants took other opportunities to promote '*searching for*' and '*creating*' meaning, for example the setting up of a library on a busy trauma ward. The occupational therapists found that their unique understanding of meaning and purpose was often misunderstood by other professionals who often viewed their contribution to care as merely occupying the patients.

The ESpiOT model supports interprofessional working by suggesting the areas of practice which are common ground, namely person-centred care and the aspiration to restore patient's well-being. The model develops this common ground by demonstrating the unique value of occupational therapy interventions through meaningful and purposeful occupation that facilitates the restoration of well-being. Additionally, the focus on the underpinning core professional values, and philosophy, are depicted by the model. A further potential application of the model to support practice could be its use as an educational tool to promote the role of the occupational therapist in interprofessional contexts.

6.4.2 Facilitators embedding spirituality in practice

Embedding spirituality in occupational therapy practice was reported to depend on personal, social and institutional factors (Egan & Swedersky, 2003). The present study confirmed the findings in relation to the personal and social factors. Institutional factors will be considered in the next section. The occupational therapists in this present study discussed how their own experiences of suffering, for instance within their family, had impacted on their motivation to become an occupational therapist and informed their own practice. These experiences promoted a wider understanding of the diverse issues that patients' experience. Suffering was a construct not found in Kang's (2003) conceptual framework of spirituality, but was described in Egan and Swedersky's (2003) study. Suffering, in relation to management of distressing symptoms such as pain, was addressed by the occupational therapists in this study. For

example, the therapist addressed symptoms such as pain by recommending corrective seating to alleviate poor posture.

The social factors were related to the opportunities for reflection on practice and increasing the occupational therapist's own personal appreciation of spiritual concepts in practice. Each occupational therapist taking part in this study articulated the benefit of taking time to reflect on their practice, and engage in discussions following each observation of their practice. For two participants, Julie and Phoebe, this was illuminating as neither had considered their practice to embed spirituality prior to taking part in the study. The ESpiOT model supports the education of occupational therapists in their embedding of spirituality in their practice by demonstrating visually the process linking the patient and the occupational therapist goals, using familiar language and expressions.

Embedding spirituality in practice has been reported to require engaging in personal and professional development activities that promoted personal spiritual well-being and health (Egan & Swedersky, 2003). The observations of practice reported in the study presented highlighted how the occupational therapists' past experiences facilitated their understanding of the profession, and the values they espoused in practice helping embed the spiritual constructs in their practice. Spirituality can also be facilitated in practice by the patients, for example by introducing spirituality, or issues relating to the constructs understood to be relating spirituality and how they impact on their health (Farrar, 2000; Hoyland & Mayer, 2005). The occupational therapists in this study demonstrated that their responsiveness to the spiritual needs of their patients was an essential aspect of their practice, and they remained focussed on the patients' needs throughout the observed encounters. Notably this was evident when attempts were made to divert the therapist's attention, either by other parties present on community visits, or interruptions from professions in the busy acute ward environment. In summary, the ESpiOT model supports occupational therapists whose practice is permeated by a person-centred focus, and underpinned by professional values in their quest to embed spirituality in their encounters with patients, whether or not they conceptualise it in these terms.

6.4.3 Barriers to embedding spirituality

The following barriers to facilitating spirituality in occupational therapy practice have been described: lack of experience and knowledge, discomfort with the subject, (lack of) time to address patient's spiritual needs, meeting organisational targets and a lack of educational preparation to develop skills in this area (Taylor et al., 2000; Collins et al., 2001; Farrar, 2001; Egan & Swedersky, 2003; Hoyland & Mayers, 2005). However, where the curriculum supported the development of spirituality in occupational therapy practice more positive attitudes were evident (Thompson & MacNeil, 2006; Morris, 2013). To address this, issue pre-registration and post-registration education curriculum need to cover this area. A discomfort with spirituality leading to lack of experience, and fear of intrusion or projecting the therapist's own spiritual beliefs was considered a barrier by Collins et al (2001). A good working knowledge of spiritual practices and beliefs was considered essential for occupational therapists (Taylor et al., 2000; Farrar, 2001). However, the occupational therapists in the present study did not cite lack of education or discomfort with the subject of spirituality as issues for them; this may have partly been due to seniority and self-selection. They focussed on their perception of embedding spirituality in practice, and were concerned more with barriers relating to time pressures and organisational targets.

Linking to the previous section 6.4.2, the institutional factors acting as barriers to embedding spirituality have been articulated, in both the literature and the present study, and related to time pressures and organisational demands. Lack of time, especially in acute care, limiting the opportunity to address spiritual needs of patients had already been identified as a potential issue (Collins et al, 2001; Egan & Swedersky, 2003). The occupational therapists in this study also reported a range of issues relating to their time pressures, in particular in the acute context where bed management was an issue. However, they also discussed strategies they had developed to manage the time pressures, and still practice in line with the core values and philosophy of the profession, taking the time necessary to manage the complexity of the patients on their case-loads. The occupational therapists' main concern was working in a

healthcare context driven by finance and targets, and balancing this context with upholding their professional values. They were concerned how recent pressures not to rehabilitate patients, but to focus on early discharge would impact on the quality of patient care. The ESpiOT model would support the occupational therapists by articulating to commissioners and service managers a sound evidence base for their practice, which addresses current policy and drivers for person-centred, compassionate care.

6.5 Summary

This chapter has presented a discussion of the core concepts and the ESpiOT model for embedding spirituality in occupational therapy practice in the light of the previous literature, and the findings from the present study. A key finding of the study presented was that spirituality does not, in practice, have to be considered as a series of exclusive constructs. Moreover, the study suggested that, for these occupational therapists at least, spirituality was integral to '*authentic*', '*holistic*' occupational therapy practice. The occupational therapists reported in this study demonstrated a positive approach to embedding spirituality in their practice, as part of their adherence to their professional core values and philosophies. Integral to these core values and philosophies was the uniqueness of each patient, and addressing what was meaningful and purposeful to each of them, providing hope for the future through interventions that improved their quality of life. Despite conceptual confusion it was clearly demonstrated by the occupational therapists in this study that spirituality was '*implicit*' in their daily practice and considered an important component of good health as reported in the literature (Egan & Delaat, 1997, Collins et al., 2001). The following chapter presents the measures undertaken to ensure the findings were credible and a reflexive account of personal values and preconceptions relating to the study focus.

Chapter Seven

Quality Measures

7. Introduction

This chapter explains the measures that were taken to improve the rigour of the methods used in this study. The credibility of the findings will be discussed in relation to reliability, validity and generalization. The reliability of the study is defended through the application of crystallisation and reflexivity. Finally, possible sources of bias and the strengths and limitations of the study are considered.

7.1 Credibility of findings and issues of rigour

Terminology concerning the rigour of qualitative studies is somewhat different from quantitative research where terms such as reliability, validity and generalizability, are commonly applied. Qualitative researchers are divided in relation to whether these terms, which are primarily associated with the quantitative research paradigm, can be applied to qualitative research which has vastly different epistemological and ontological assumption. Others have argued that each study is unique and therefore that it is futile to try to assess studies against any predetermined criteria. Reflective and reflexive accounts seek to strengthen the quality of qualitative research studies (Rolfe, 2006). Despite the debate surrounding terms for establishing quality, the terms reliability, validity and generalizability, have been widely accepted and applied to ethnographic research methods (Brewer, 2000; Hammersley & Atkinson, 2007). For the purpose of this thesis the commonly used terms reliability, validity, and generalizability have been used to outline the strategies adopted to enhance the credibility of the findings and interpretations. Ethnography has been criticised for a perceived lack of rigour, being high in validity and low in reliability, due to subjectivity in the collection and reporting of data. The position of the researcher as a key player in the research activity may reduce the objectivity of the presentation of the findings and interpretations

(Brewer, 2000; Lewis, Ritchie, Ormston & Morrell, 2014). The following sections will present the measures undertaken to achieve the reliability, validity and generalizability of this study.

7.2 Validity

Validity in qualitative research relates to the precision of the research *processes* that confirm the trustworthiness of the findings and inferences made (Lewis et al., 2014). Key to achieving the validity of ethnographic research is the ability to accurately and authentically reflect the phenomenon being explored (in this case spirituality). Accuracy and authenticity are strengthened by using rich and detailed data extracts that reflected the language and meanings assigned by the participants (Brewer, 2000; Lewis et al., 2014). Improving the validity of the study related to whether the methods facilitated a detailed exploration of the way occupational therapists embedded spirituality in occupational therapy practice. Additionally, validity related to whether the findings were presented in a way that illuminated the phenomenon as applied to practice. A range of strategies were used throughout the study to ensure the findings were valid:

- The participants were recruited from a setting that was representative of the daily practice of occupational therapists. A gatekeeper (the service manager) contacted the occupational therapists to ensure they were not coerced into participating;
- The period of observation in the '*field*' added in capturing the occupational therapists delivering a wide range of care, which facilitated opportunities to observe spiritual dimensions of care;
- In the absence of co-researchers, the role of the supervisory team was to critically question the validity of the study, by challenging my decisions and assumptions throughout the data collection and analysis.

First, in terms of plausibility, the findings support the constructs of spirituality articulated in the literature and presented in Chapter Two (Concept Analysis). The study found that spirituality was central to person-centred occupational therapy practice and a concern for occupational therapists, in particular embedding spiritual care in their everyday practice. The existing body of knowledge was enhanced by the application of an ethnographic study design and

observation of practice. Previous studies have explored what occupational therapists say they do to embed spirituality in their practice. The strength of the present study lies with the rich observations of practice, combined with discussion of the experiences with participants. The study environment for observing occupational therapy practice was the participants' familiar practice setting, and supported examining how they embedded spirituality in their usual practice (Ritchie & Lewis, 2013).

Second, validity is concerned with the accuracy of the claims made by the researcher and how these are reported and justified. Spirituality is a nebulous construct, difficult to define and locate in healthcare practice. This presents a challenge for ensuring the validity of the findings and inferences made. The validity of the findings and inferences were strengthened by contextualising the findings with the constructs of spirituality, as reported in occupational therapy practice in the wider literature.

The circumstances of the research and the characteristics of the researcher were explored using reflection and reflexivity; these are integral skills to the practice of ethnography. Reflexivity and reflection differ: the former involves critically acknowledging personal values and accounting for preconceived assumptions that may have led to the conclusions presented, whilst the latter concerns the evaluation of the research methods and processes and how they could have been improved (Brewer, 2000; Finlay & Gough, 2003; Hammersley & Atkinson, 2007). Reflection and reflexivity were supported by maintaining three subjective reflective diaries throughout this PhD, detailed as follows:

- A record of research activities from the initial conception of the study through to practicalities in relation to the research processes - for example, recruitment of participants, development of the study plans and protocol, and accounts of supervision sessions;
- A '*subjective*' diary was maintained to record thought processes, preconceived ideas and impressions of the data collection process from participant observations to interviews;

- A diary to detail the progress of writing up this PhD thesis and the issues encountered. This notebook was used to inform the section on reflection on the research process and thesis development. These entries will ultimately contribute to my personal development planning and continuing professional development portfolio. The reflective entries supported the complexity of observing practice, and the challenge of processing incoming information.

Thirdly, the rigour of the data analysis strengthens the accuracy of the inferences made to support the findings. The reality of how occupational therapists embedded spirituality in their practice was captured by the rigorous application of the framework approach to data analysis (Ritchie & Lewis, 2013), and reported in Chapter Four. The strength of the framework approach in supporting the validity of the study related to retaining continuity with the original data throughout the analytical processes. Additionally, the audit trail offered transparency to the decision-making processes throughout data analysis, such as the development of themes and core concepts, further enhancing the rigour of the findings. One of the strengths of the framework approach is that the processes are aimed at ensuring transparency between participant's accounts (and in this study observed practice), and the research interpretations (Ritchie & Lewis, 2013). Ensuring deviant or contrasting extracts were actively sought when reporting the findings strengthened the validity of the inferences from the data (Ritchie & Lewis, 2013).

7.3 Reliability

Reliability, in the context of qualitative research, is concerned with the robustness of the study design, its relevance to the phenomenon being explored and the rigorous process of data collection and analysis (Brewer, 2000; Lewis et al., 2014). Traditionally, in quantitative research, reliability is considered to be concerned with the replication of the study in another setting (or re-test in the same setting). However, the epistemological and ontological underpinning of qualitative research where the aim is to value and represent the perceptions and experiences of participants, as well as the uniqueness of the context is incongruent with the concept of replicability and the dynamic nature of qualitative research (Ritchie & Lewis,

2013). The strength of ensuring the reliability of the study reported in this thesis was the internal checks on procedures. These internal checks were applied to ensure reliability:

- Audio-recording and verbatim transcription of interviews;
- Checking of the interview transcripts by the participants;
- Management of voluminous amounts of unstructured data required a comprehensive process of record keeping - a data analysis notebook was used to record all decisions and provides an audit trail of the process;
- The rigorous application of the framework approach to data analysis;
- The role of the supervisory team in confirming the labels attached to the themes and core concepts strengthened the reliability of the findings (Lewis & Ritchie, 2014).

Additional measures to strengthen reliability when interpreting the data occurred during debates and discussions at supervision meetings. The purpose of regular supervision meetings during the data analysis stage of the study was to challenge each stage of the process. Agreement was reached in relation to the key features that emerged from the findings about embedding spirituality in occupational therapy practice. The supervisors discussed the interpretation and labelling of the themes and core concepts to ensure meaningful '*labels*' were applied. A further notebook was kept during data analysis, strengthening the audit trail by demonstrating the reasoning behind the analysis process and decisions made (Ritchie & Lewis, 2013). The reliability of the study findings was enhanced by applying the process of crystallisation using the observations, follow up interviews, subjective diary entries, reflection and reflexivity. A reflexive account is presented later in this chapter, in section 7.5, and reflective account, in section 7.6.

A feature of ethnographic study designs is the variety of data collected from different sources. The study reported in this thesis collected data from fieldwork notes of observations, interview transcripts, subjective diary entries for reflexive practice and reflections on the study processes. Each perspective revealed something different about the reality of spirituality in the occupational therapists' practice (Brewer, 2000). The processes outlined for strengthening the reliability of the study findings are triangulation and crystallisation (Sandelowski, 1995).

Triangulation is concerned with exploring the complexity of the phenomenon under investigation, justifying study findings and substantiation of inferences. Data sets are combined from the different sources to reveal a *'true picture'* of perceived reality. Data triangulation confirms the reliability of the findings by analytically comparing two or more data sets (Sandelowski, 1995; Brewer, 2000). However, the value of triangulation has been debated in qualitative research, criticised as being a means for widening understanding of the data through multiple readings rather than confirming its reliability (Denzin & Lincoln, 2003). Equally, the metaphor of a triangle is considered inadequate to represent the complexity of the multifaceted nature of data collected. In contrast, the term crystallisation uses the metaphor of the multi-faceted crystal to reflect the complexity of the process. Crystallisation serves a similar purpose to triangulation, but is often used to represent the complexity of the varied dimensions of a phenomenon and the multiple combinations of data sources for analysis (Sandelowski, 1995; Denzin & Lincoln, 2003; Ritchie & Lewis, 2013). Therefore, the term crystallization was the term applied to this study in terms of justifying the reliability of the data.

The strength of crystallisation for the qualitative research reported in this thesis lay with the opportunity to consider the diverse experiences of spirituality by the occupational therapists, comparing the differing qualitative accounts. The diverse nature of data collection from four occupational therapists working in different contexts, observation of their practice and follow up interviews to discuss spirituality in more depth enabled the process of crystallisation to consider the many facets of the phenomenon (Denzin & Lincoln, 2003). Through this process, the participant observation provided a background for the in-depth open-ended conversational interviews where the specific issues that emerged from the observations were investigated further. The two inherently different processes for exploring spirituality in occupational therapy practice strengthened the findings because the two methods complemented each other. The observations sought to explore what the four occupational therapists did to embed spirituality in their practice. The interviews sought to illuminate what was observed (Sandelowski, 1995;

Morse & Field, 1996). The authenticity of the participant's voices was retained by rigorously applying the data analysis process to both the fieldwork notes and the interview transcripts. The process increased the reliability and strength of the interpretive potential of the study, thus decreasing investigator biases and providing a range of perspectives (Denzin & Lincoln, 2003).

Member checking of the data is a contentious method of ensuring the reliability of the data. The benefits and good practice of further consideration of data by research participants are acknowledged. However, in practice, member checking is fraught with problems that could potentially bias and compromise the significance of the findings (Mays & Pope, 2000; Thorne & Darbyshire, 2005; Streubert & Carpenter, 2011; Green & Thorogood, 2014). Member checking, in the case of reporting participant's experiences, is considered questionable, particularly where the analysis concerns a group of participants (Thorne & Darbyshire, 2005; Robson, 2011; Green & Thorogood, 2014). Ascertaining '*reality*' from ethnographic data is challenging and member checking is also limited in confirming findings (Polit & Beck, 2014; Gray, 2014; Green & Thorogood, 2014; Lewis et al., 2014). The aim of the study was to explore how occupational therapists embed spirituality in their day-to-day practice, and therefore to report the participants' experiences. The following process of checking the participants' reports against alternative evidence were adopted:

- Impressions from observation of practice were discussed with the participants during de-briefing;
- Themes and impressions by the researcher were generated during the observation of individual occupational therapists' practice;
- Themes and impressions from observations discussed with supervisors;
- Themes and impressions from observation of individual occupational therapists' practice were discussed during their individual interview;
- Interview transcript returned to the occupational therapist for checking and removal of any data considered misleading or personally controversial for the occupational therapist.

The five stages outlined above provide evidence that the interpretations were authentic and ensured that misinterpretation and omission was reduced (Streubert & Carpenter, 2011)

Returning findings to the participants for confirmation was not carried out during the reported study. One reason for this was concern not to overburden busy occupational therapists who had already given up to five days of their time to be observed (Streubert & Carpenter, 2011). The strategy presented above was also deemed to provide the occupational therapists with feedback to support their own continuing professional development and understanding of how they embed spirituality in their practice. Additionally, the process of analysis employed the framework approach which combined all the data and was not limited to individual representations. Thus, the confidentiality of the participants was maintained (Green & Thorogood, 2014).

7.4 Generalizability

Generalization in research term refers to the relevance and reliability of the study findings to the wider population of occupational therapists, and is primarily associated with quantitative research. Generalizability is dependent on the processes adopted to ensure the reliability and validity of the study findings. In qualitative research the term generalization is often used interchangeably with transferability and relates to the application of findings to others contexts, and the contribution to existing knowledge. In this study, generalizability related to how observing four occupational therapists in diverse settings in one NHS Trust was likely to be applicable to the wider occupational therapy community. There are no commonly agreed principles for achieving the generalizing of qualitative research data. Indeed, the concept of generalizability in qualitative research has been criticised for its attempts to interpret reality, and make inferences for its significance beyond the context where it was derived (Lewis & Ritchie, 2013; Lewis et al., 2014). The generalization of ethnographic data is problematic, with accounts and inferences challenged as introspective, and therefore not impartial or neutral.

The relationship between the researcher, participants and the fieldwork setting have been criticised as producing autobiographical data that is unscientific (Brewer, 2000).

There are three linked elements in relation to generalization; representational, inferential and theoretical (Lewis & Ritchie, 2013). They are described and applied to the study reported in this thesis as follows:

- Representational generalization refers to how the occupational therapists who took part in the study are similar to, and represent others in order to generate similar findings from other study settings. The occupational therapists who participated in the study reported in this thesis were similarly qualified to the participants in previous studies. For instance, two qualitative studies selected occupational therapists with experience of practice as opposed to newly qualified graduates, in order to explore spirituality from the breadth of their experience (Udell & Chandler, 2000; Began & Kumas-Tan, 2005; Hoyland & Mayers, 2005). The strategy to achieve validity in relation to choice of setting and sampling has been articulated earlier in the section regarding validity (Lewis and Ritchie, 2003);
- Inferential generalization (also sometimes described as transferability or external validity), is a principle which suggests that study findings can be inferred to other samples or settings. By considering the research setting in greater depth and acknowledging the unique features of that setting, the better the judgements about generalization to other settings that can be made (Lewis & Ritchie, 2013; Lewis et al, 2014). This was achieved by description of the setting as outlined in Chapter Four. The participants' characteristics were described in Chapter Five, and included verbatim quotes of each participant describing the impact of taking part in the study. These rich descriptions are likely to be familiar to the day-to-day practice of occupational therapists in similar contexts, thus strengthening the generalizability of the findings to other settings and inferential generalization. The application of the findings to the wider occupational therapy profession were strengthened by the rich descriptions from the text contained in the fieldwork notes and interviews that illuminate the core concepts in Chapter Five (Lewis et al., 2014). Additionally, the findings are supported by the presence of several similar instances representing the phenomenon of spirituality between the participants. For example, '*valuing the individual*' was a commonly held attribute of the occupational therapists supported by the findings presented in Chapter Five. In summary, inferences made from the findings of this study and the wider

occupational therapy community are supported by the sharing of themes between different study participants working in different well-described settings. Further support is offered by the similarity of some of the themes with those found in previous occupational therapy studies reviewed in Chapter Two;

- Theoretical generalization refers to the opportunities created by the study findings to inform and influence wider policy, research and existing theories (Lewis and Ritchie, 2003). The issues relating to theoretical generalization will be covered in Chapter Eight.

In summary, the generalizability of a study's findings is strengthened by the central concepts of reliability and validity. As interpreted for qualitative research, reliability and validity are factors assuring the authenticity and credibility of the research, confirming the sustainability of any wider generalization (Lewis et al., 2014).

7.5 Reflexivity

Reflection and reflexivity are integral to ethnographic research, acknowledging and avoiding bias in the study design as the researcher adopts a position of "*empathetic neutrality*" (Ormston, Spencer, Barnard & Snape, 2014, p.22). They both serve distinctly different purposes, and are explored in relation to the study reported in this thesis in separate sections. Reflexivity is positioned in this chapter as an acknowledged method of substantiating the reliability of a study. Following on from the reflexive account, a critical reflection considers the completed study and my personal and professional journey. Critical suggestions are offered for improving the study, and further developments for practice, education and research.

Reflexivity is the process of critically interrogating the personal and professional practices of a study, from its inception, design, analysis and presentation of findings processes. The process of reflexivity is concerned with the critical impact of the researcher on the study, enhancing the transparency and the reliability of the findings presented. Needless to say, reflexivity is a challenging process and there are a range of methods suggested to achieve transparency. Reflexivity has been criticised for encouraging an overly introspective position

by the researcher that loses sight of the aims and objectives of the research (Brewer, 2000; Finlay & Gough, 2003; Gray, 2014). For the purposes of this study, and in order to counteract the criticisms of the value of a reflexive approach, a personal approach to reflexivity has been applied. A personal reflexive approach was achieved by acknowledging my presence as integral to the study and reporting how my personal values, attitudes and beliefs have impacted on relationships between participants, and the setting, and thus impacted on the study (Brewer, 2000). The evidence used to create this account was found in the daily research notebook which outlined the progress of the study and decisions taken, including notes of meetings with supervisors. In addition, a subjective diary was kept throughout the data collection and analysis process recording details of impressions, emotions, thoughts and feelings during this process. Relevant extracts will be offered to illuminate points made which are relevant to reflexivity (Brewer, 2000; Gray, 2014, Ormston et al., 2014). The following issues will be considered in relation to reflexivity and the study presented in this thesis:

- The position of the researcher as a lecturer, novice researcher, experienced occupational therapist, and the impact of this on the study design;
- The perceived power relationship between the occupational therapists and the researcher;
- The position of the researcher as an *'insider'* researcher on data collection and analysis, known to all the participants and familiar with the settings.

To strengthen reflexive analysis, the process of *'bracketing'* can be adopted. This seeks to recognise and attempt to isolate potential research bias. Potential sources of bias include the researcher's pre-conceived assumptions about the phenomenon under investigation, and the impact of their own values, culture, personality and socioeconomic status on the study. These potential sources of bias are recognised and *"put on one side"* or *"bracketed"* in order to enhance efforts to report participants' experiences accurately (Ahern, 1999). The process of bracketing is contentious but bracketing has been adopted in this thesis, whilst acknowledging the challenges inherent in *'holding in abeyance'* previous experiences of practice, academic study and research. Applying a reflexive approach to the study strengthens how my tacit

knowledge and experiences of spirituality in occupational therapy practice have been a benefit to the classification of the phenomenon, and as the motivation for the study to progress. Areas where bracketing was considered important in the progress of the study are discussed in the sections that follow.

7.5.1 Impact of the researcher on the study from design to final presentation

Ethnographic research demands that the researcher is actively involved in all stages of the study design and processes. Reflexivity is an important aspect of the study design from developing the ideas for the study, through to the analysis and presentation of the findings (Band-Winterstein, Doron & Naim, 2014). This section presents the reflexive processes associated with my personal impact on the study as a researcher. The section is structured as follows: pre-research, study design, data collection and data analysis, acknowledging that there is no agreed method of operationalizing reflexivity, or ensuring a neutral approach to representing the data (Brewer, 2000; Mauthner & Doucet, 2003).

In terms of the pre-research stage, the first phase of planning the study involved discussions with my supervisory team around my previous study of student perceptions of addressing spirituality, and how they had been prepared for this during their academic studies. There was no neutral or objective stance since, as an experienced occupational therapist and university lecturer responsible for the students' development of the core values and philosophies of the profession; I had a breadth of understanding of the concept of spirituality and occupational therapy practice (Brewer, 2000; Ormston et al., 2014). Bracketing was important at this stage, since previous research about students' perceptions of spirituality in occupational therapy practice provided some insights into the background understanding of the issues. The following pre-conceived ideas supporting the process of bracketing were recorded following preparatory supervision discussions:

Spirituality is not defined adequately enough for occupational therapists to aid their practice

Spirituality is seen in practice as client centred practice

Models, such as the Canadian model of occupational performance, helped understanding of how to put spirituality in practice

Discharge planning is significant for addressing spirituality by occupational therapists, patients discharged to place of spiritual well-being

Applying cultural competency to practice, particularly when religious issues need to be considered for housing adaptations

Not sure students are fully prepared to address spirituality in practice, and they are not sure that it is articulated by their supervisors

Suggestion made by the supervisory team that the researcher should do observation of practice as that appears to be the missing link. The question was - what is spirituality and will it be observed in practice? Extracts from research notebook and supervision accounts

The extracts above illustrate how I ensured my prior knowledge and experiences as an occupational therapist were explicit, and was conscious this might induce bias in how the findings were reported. As a novice researcher, the experience of the supervisory team was acknowledged and, referring to the literature, it was conceded that if occupational therapists talked about spirituality in their practice, then it must be possible to see it.

Reflexive analysis is crucial at this stage in order to manage any specific problems with the process. For instance, impressions of how the rapport between myself and the occupational therapist was developing aided the opportunity to adopt an appropriate level of involvement with each situation during observation (Ormston et al., 21014) The following diary extract illustrates this issue:

Mark is a very experienced occupational therapist, working at a senior level. He walked onto the ward and was immediately greeted by a nursing colleague who asked for his opinion on a complex trauma case to be available for a consultation later that day. I felt uncomfortable impinging on his time to do my research when he had matters of life and death at his door. We discussed the plan for the morning's observation and his work load. We considered the patients he was going to see and made the decision that with the complex trauma patient, although interesting, my presence would be adding to the complexity of the issues he had to deal with. It was decided that the issues of complex trauma and his practice addressing spirituality would be discussed at a later date, perhaps a topic for the interview. Reflective diary entry.

The previous diary entry highlights the need to be pragmatic and flexible in approaching the observation of occupational therapists in their day-to-day practice. There were situations that

arose where it was not appropriate; however interesting and rich the data would have been, to compromise my participants' developing therapeutic relationship with patients.

Reflections before and after each observation and interview provided the opportunity to explore in more depth the issues that appeared to be emerging, noting down key words or ideas next to the fieldwork notes, applying the process of bracketing. The ideas and key words were discussed with the occupational therapists at the de-briefing session held after each period of observation, and developed further during the interviews. The following extracts seek to illuminate this process.

Mark: acute ward context appears chaotic. Within this practice embracing the core principles of occupational therapy are evident. A very skilled practitioner, focussed on discharge planning. Themes emerging from these observations were - connection, safety and place of peace. Fieldwork notes

Patsy: very controlled context in the community; variety of interventions observed; overarching themes of practice were: meaning, purpose, journey, giving a person hope, dignity, respect and the importance of the therapeutic relationship. Fieldwork notes

Phoebe: calm and controlled context in the community; the importance of developing a therapeutic relationship, impact of not being able to find a solution for the patient and thus not provide any hope. Fieldwork notes

Julie: busy acute ward context; struck by how Julie created a calming and peaceful environment for all her patients; deep respect for patient's wishes and aspirations; how patients get their lives back after trauma. Fieldwork notes

Applying a consistent reflexive approach to data analysis is important for positioning the data in its context, and not introducing pre-conceived ideas about what the data might be saying. Bracketing again was important in this process. After every interview, a reflection was written to establish what I thought was emerging. Each recorded interview was listened to, and then again with the transcript. I noted initial thoughts about what was emerging from the data, and considered whether these thoughts linked to my pre-conceived ideas and personal perspectives. A data analysis notebook was kept to record issues occurring during the data

analysis. Reflexivity was strengthened by the application of a framework approach to the data analysis process. The framework approach retained consistently strong links with the original data, thus keeping the analysis focussed on the integrity of the participants' voices and reducing the introduction of personal bias (Brewer, 2000; Mays & Pope, 2000).

7.5.2 Relationships with participants

An essential element of reflexivity is to articulate how relationships within the field work were developed, acknowledging any issues of power and how this was addressed (Brewer, 2000). Acknowledging any issues of power was a concern because I had personal knowledge and experience of occupational therapy, and my own views about spirituality both personally and professionally. Acknowledging and managing the power relationships within the study demanded a dynamic and subjective self-awareness, strengthened by a reflexive approach throughout the data collection and analysis processes (Finlay, 2002). The researcher was known to the participants and also an occupational therapy academic. There was the potential for participants to consider me to be an expert. In order to address this and encourage recruitment, the information letter was constructed to acknowledge these power differentials. The participant's expertise in their speciality of occupational therapy practice was acknowledged, and the purpose of observation to explore elements of practice constituted as addressing spirituality was reiterated. Any concerns were openly discussed at the pre-observation session. However, all the participants revealed that their motivation to take part was as a continuing professional development opportunity to learn more about spirituality and their practice.

The following extract, was drawn from the observation of an occupational therapist known well to me, from the reflective diary highlights how relationships were managed. There was a change in relationship from being a colleague to being the researcher. The potential power was addressed by openly acknowledging concerns about the observation. The construction of the data became a mutual collaboration with Patsy:

I felt nervous of the whole process, and how I was going to achieve the observation-things going through my head like what if I don't see anything. Patsy will be so disappointed; she prides herself on her holistic practice. Trying to understand the community context with fresh eyes will also be important. Observing the practice of someone well known to me will be a challenge. Talking to Patsy before the day started, she identified similar concerns, so we agreed to just get on with it, see what happens and not worry about the detail. I was nervous about all the paperwork to complete to achieve ethical coverage of the study. Would I get the consent forms all signed off? How would I be perceived by the patients?

Once we were inside the first patient's house I relaxed and the familiar OT practices were all there for me to observe. I felt very privileged to observe someone I knew well and whose practice and experience I respected. I could clearly see the links between practice and spirituality intricately woven into each step of the intervention. The opportunities for discussion and debrief in the car were very rich. There was a sense of mutually engaging with the research process as we discussed what I had seen and Patsy's perceptions as well. (Reflective diary entry)

A further extract illustrates how an interview situation was managed when questioning Mark about the importance of a personal interpretation of spirituality to support occupational therapy practice. My knowledge of underpinning evidence, which identified the need for occupational therapists' to acknowledge their personal experiences and expression of spirituality, was driving my questioning during the interview. However, Mark was only going to explore what he considered to influence his professional practice.

Interviewing Mark was an interesting experience. He was totally committed to the core philosophies and values of the profession, using every opportunity to highlight these in his practice and his descriptions of issues raised by the observations. I thought the question about his personal experiences of spirituality and how this helped his practice and awareness was going to be a great answer and would really add to the richness of my data. I knew from my study of the literature that this was perceived to be an important aspect of addressing spirituality in occupational therapy practice. To my surprise I got the same stock answer to this as other questions, i.e. it's all about the core values and philosophy of the profession. I probed again trying to ask the question in a different way - maybe he hadn't understood me. Then I explicitly quoted the literature and asked about his personal experiences of spirituality. Eventually the penny dropped. This was his answer to this question and what I was trying to do was get the answer I wanted. (Reflective diary entry)

One of the strengths of this study was the researcher's "insider" position. Central to being an insider is the reflexivity of the researcher. It was essential to recognise my tacit knowledge and relationships to both the setting and the phenomenon of spirituality in occupational

therapy. The necessity to be accepted by the host culture or community was deemed essential in order to immerse myself fully in the context. However, this can be problematic. Bias can be heightened as the researcher observes and interprets data through their own cultural lens; this can include gender, age, ethnicity and class, requiring skills in self-awareness throughout the research process which can be challenging (Kawulich, 2005). The following extract shows how the tacit knowledge of the researcher impacted on the collection of data, and the richness of the observations highlighting spirituality embedded in occupational therapy practice in comparison with the experience of interviewing.

During the interview with Julie I was struck by how different her articulation of practice was. Observing her practice had given me a really rich sense of how she addressed spirituality through day to day interventions. I remembered the dressing practice assessment with the elderly woman on the trauma ward - how she had attended to her needs with respect and dignity. She had explored issues that were meaningful to her and how being in hospital had impacted on this. My expectations for her interview were high. I had a number of issues to follow up with her and we had just started when I seemingly hit a brick wall. Her answers were short and lacked the depth I was expecting. I kept on probing but nothing was coming back. In the end she told me that, 'spirituality and everything to do with it was just part and parcel of what I do as an OT', and that was that. The interview encounter shocked me because I was excitedly expecting this to be a really good description of spirituality in practice. Julie was the type of OT I would have been very happy to have for my family, however my expectation of a deeper understanding of spirituality was not forthcoming. (Reflective diary entry)

7.6 Critical reflection

Critical reflection is an essential attribute of healthcare professionals' learning. Reflection is important in practice and research including qualitative research. Reflection is seen as a transformational learning process, valuing and improving practice whilst integrating theory and evidence (Ghaye, 2000; Finlay, 2008; Mann, Gordon & MacLeod, 2009; Ghaye & Lillyman, 2014). Reflective practice is a professional requirement of the Health and Care Professions Council (HCPC) (HCPC, 2013). As a novice researcher and experienced occupational

therapist the understanding of my personal beliefs, attitudes and values was essential to self-monitor and regulate to minimise bias in the research process. To structure this section, I have used the reflective model '*Learning by Doing*' (Gibbs, 1988). Gibbs reflective cycle has the following components: description of what happened, feelings, evaluation of the experience, analysis, conclusion and action plan. This model was selected because it recommends a cyclical process that enriches the application of theory to practice (Finlay, 2008). This reflective model compliments the aim and objectives of this study, which was seeking to explore how the theoretical construct of spirituality was embedded in occupational therapy practice. The following issues will be covered in this reflective section:

- Tensions related to my professional perspectives and strategies to reduce potential bias;
- Methodological issues, including observation of practice and data analysis;
- Opportunities to engage with researchers and a research community.

7.6.1 Tensions, professional perspectives: strategies to reduce bias

Bias is inevitable in qualitative research that involves subjectivity in the process of collecting the data. In terms of qualitative research bias is defined as, any influence that threatens the rigour of the research or the claims made from the analysis of the data (Polit & Beck, 2010). This is particularly pertinent to the study reported here, where observation of occupational therapy practice was undertaken by an experienced occupational therapist immersed in the context (Whitmore, Chase & Mandle, 2001). My preconceptions about how spirituality was embedded in occupational therapy practice had the potential to strengthen or threaten the observation and interpretation of the phenomenon. Additionally, the mixed roles of researcher, senior lecturer and professional colleague had the potential to create tensions and bias. Applying a reflective approach to the experiences throughout this study strengthened my understanding of and capacity to allow for personal bias. Spirituality embedded in occupational therapy practice reflects the core values and philosophies of professional practice held by me as essential for competent, professional and ethical practice. The impact of me as the

researcher has already been outlined in Section 7.5.1 to strengthen the rigorous presentation of the study. Reflective entries in my research journal were used to illuminate the issue of my professional presence in the observations of practice.

Professional perspective and tensions between being a researcher, professional and teacher were notable throughout the observations of practice. These involved my ability to remain focussed on the task in hand of observing and extracting the spiritual dimensions of the occupational therapists' practice, balanced with my interest in their practice. The patients and occupational therapists were all informed of my role in the observation, and I attempted to remain objective in my stance as a participant-as-observer. However, tensions arose when the occupational therapists attempted to engage me in a conversation to ask my perspective on their decision making in front of the patients or other members of the multi-disciplinary team, highlighted in the diary extracts below:

We were sitting in the patient's living room having just measured his bathroom to establish whether there was space for a riser toilet seat and frame to be installed. It was obvious from the conversation that preceded our measurements that this was going to be a potentially tricky subject to approach. Phoebe had told me that this was the last possible option for the patient and that hoisting had been firmly rejected by him. I could see that Phoebe was anxious to make sure that everything was thoroughly explored and she had all the facts to hand as she flicked through the patient's therapy notes again. As she started to explain to the patient what we had found out by measuring his bathroom i.e. that the equipment would not fit in there. Phoebe turned to me and asked if I had any other ideas, telling the patient that I was an expert occupational therapist and a lecturer. I really wasn't expecting this and felt very uncomfortable not wishing to upset the relationship that Phoebe had with the patient. So I politely said that I didn't have anything to add to her evaluation and smiled reassuringly at the patient. Reflective diary: Observations of Phoebe

We were in a side ward and preparing to carry out a washing and dressing assessment with a patient. As we waited for the patient to return from the toilet Julie turned to me and asked if she was showing enough about spirituality and did I know what I was looking for. Reflective diary: Observations of Julie

There was nothing that could have prepared me for this encounter, and indeed it was not an isolated occurrence which is why I have included it as a significant critical event for reflection.

A positive outcome of this type of encounter was that it highlighted the depth of the data

collected, and the relationship of trust that occurred between me and my participants. A mutual exploration of the encounter occurred deeper during researcher –participant debriefing sessions that were undertaken following each period of observation. Issues were explored as to the reasons the occupational therapist had felt it necessary to draw me in the decision making process. This detailed post observation encounter added considerable richness to the data collected. The second extract shows that the participants considered me to be the expert and thought I might already know what I was looking for in their practice in terms of the spiritual dimensions.

One type of research bias related to participant's desires to please the researcher (Polit & Beck, 2014). At times this was evident in the observations of practice, for example when occupational therapists sought my confirmation that they had made the right judgements when working with patients. By reflecting on these situations during de-briefing with participants and remaining neutral in my response, I attempted to minimise bias. I used these opportunities as a means of exploring the observed practice in more depth. In addition, these encounters positively impacted on the participants' confidence in exploring complex situation as they articulated their thoughts and feelings during de-briefing sessions. Being asked my opinion of a patient's situation and the decision the occupational therapist was making with them could have occurred because of being perceived as the expert on spirituality. Undoubtedly I had formulated ideas about what I might observe that would confirm the presence of spirituality in occupational therapists' practice. However, in practice, the observations were a complex process of observing what was happening, what I thought was happening and what my participants thought was happening.

Acting as a researcher and also being an experienced professional in the field was a complex process. Lessons learned from the experience were embedded in the research process as it developed over the period of observations. This included the use of the de- briefing sessions to explore salient issues with the occupational therapists. The power of being perceived as an expert, by nature of my position as a researcher, experienced occupational therapist and

senior lecturer was an issue that on reflection I might have explored further with my participants during the introductory sessions. However, this in itself, might have introduced bias.

7.6.2 Methodological issues

Methodological issues worthy of reflection related to the processes of observation, writing up fieldwork notes and completing data analysis.

7.6.3 Observation of practice

Observation of occupational therapists' practice strengthened the in-depth nature of exploring how occupational therapists embedded spirituality in their daily practice. The following reflection considers how the context of a busy acute in-patient ward affected my ability to observe the occupational therapist's practice.

While occupational therapy practice was familiar to me, and the community visits resonated with my previous practice experience, walking onto the trauma and orthopaedic ward for the first time was different. This experience took me some time to adjust to and to develop my style of observation. There were a number of issues to contend with, not least where to stand or sit during the observations to remain as unobtrusive as possible and not create an additional obstacle for other members of the multi-disciplinary team to negotiate. The following extract from my reflective diary explained the impact on me following my first encounter with a busy acute in-patient ward, highlighted in the diary exact below:

I had just applied gel to my hands and was immediately aware of the extremely busy environment I had entered. Immediate responses were asked of my participant, all around were hustling and bustle. I froze, pinned to the wall. This is so much faster moving than my community experience. I felt a bit like a spare part until we started to see patients, then I was very at ease. Some very in-depth conversations, how will I remember everything? The participant seems to be able to develop a therapeutic relationship very quickly amongst what seems like chaos. Very quickly we were off again, up and down stairs, along very long corridors in and out of lifts and to another ward. This time much quieter Reflective diary: Observations of Mark

The extract highlighted the unexpected nature of observation and how the setting impacted on the research process. The study design did not allow for any practice observations or pilot study for me to prepare myself. Notably the participant was able to practice in a person-centred manner regardless of the interruptions and busy setting. The context also impacted on my own confidence to remember the important aspects of observations.

It is unclear how I would have benefitted from preparation to observe the occupational therapists in the acute in-patient setting. In fact, the context provided valuable rich data to support how they managed to embed spirituality in their practice. My own concerns were related to how I ensured that I achieved the observations of practice without disrupting the care on the ward. An additional issue was developing a strategy to take fieldwork notes unobtrusively in order to retain the information as accurately as possible.

The setting impacted on my perceived ability to observe the occupational therapist's practice and extract the spiritual dimensions. However, in practice what was clear from the Findings and Discussion (Chapters Five and Six respectfully) was that rich data was collected from the acute settings, that supported how the occupational therapists did embed spirituality in their practice and despite the constraints of the setting they developed strategies to manage. It is difficult to say that more preparation would have helped me to cope with the demands of observing such a busy setting, certainly a pilot study would have been beneficial, however pragmatically this was not possible given the time constraints of the study and concerns regarding over burdening participants who were already working under considerable pressure.

7.6.4 Writing up fieldwork notes

Fieldwork notes were an essential component of the data collection strategy when I undertook observation of practice. There are a range of suggestions in the literature as to how they can be constructed (Brewer, 2000; Green & Thorogood, 2014). However, essentially the method has to be supportive of the context where the observations are taking place, and the style of the researcher. In this study a notebook and handwritten fieldwork notes were kept. The

fieldwork notes were written contemporaneously, and further reflective entries were written at the end of each day. When these notes were reviewed it became apparent that the first visits of the day were recorded more as impressions than the “*thick description*” expected and described as necessary to capture “*the essence of a situation*” (Brewer, 2000, p.67). To address these issue future observations were recorded contemporaneously after the interaction had been observed and away from the patient. The ward based setting provided the natural opportunity for this as the occupational therapist normally documented their interaction immediately after the session with each patient. The notes were written as a narrative description of the events, avoiding as much as possible any interpretation of what was happening with each encounter. This was challenging and the subjective diary entries helped in noting and acknowledging any preconceived ideas about what was occurring. These ideas were followed up during the interviews with the participants to gain clarification highlighted in the diary extracts below:

Over the period of the last few months I have observed four occupational therapists and their practice and have endeavoured to capture what I have seen in fieldwork notes, handwritten to expedite their construction. I think I have got better at how to write these fieldwork notes, however there are some formats that I could have used. My memory has been challenged as I used the option of writing up after the event and not noting down anything during the observed interactions between occupational therapists and patients. Reflective diary: Summary of experience

The issues highlighted by this reflection of constructing fieldwork notes are helpful in understanding how future studies would be approached. The use of fieldwork notes and separate reflective diary supported the separation of direct observations and interpretative data. The writing of fieldwork notes was a skill that developed over the period of observations.

The fieldwork notes were written without using a structure and were free flowing narrative style. This was my preferred style and supported the recording of the observations of practice. I have acknowledged the challenges encountered, and how I developed appropriate styles for each context and participant. The two methods of recording i.e. fieldwork notes and subjective reflective diary supported this study, and enabled me as the novice researcher to avoid

confusing the two accounts and influencing the rich data from the participants with my own impressions.

On reflection the style adopted for writing up fieldwork notes and supporting them with a subjective reflective diary was an effective strategy. However, in future opportunities to record fieldwork notes some further consideration of frameworks might be useful to develop recording skills and reduce the need for multiple notebooks.

7.6.5 Data analysis

Application of the framework approach (outlined in Chapter Four) was both challenging and illuminating, and the most time consuming element of this study. In order to ensure that decisions were recorded, and could be defended as changes were made throughout the process, a data analysis notebook was kept. The purpose of this notebook was to record the process of data analysis, decisions made and the rationale. In keeping with the reflective nature of the study some reflective accounts were noted to illuminate the impact of the process on the researcher, and how changes to future uses of the framework approach might be developed.

The decision to adopt the framework approach to analyse the data was made in collaboration with my supervisory team. It was clear that the voluminous unstructured nature of the data I had collected needed a rigorous, structured method to create order and a coherent analysis. The framework approach was followed according to Smith and Firth (2011) and Ritchie et al (2013). As each stage of the processes described were carried out confirmation of the codes, themes, categories and the final core concepts were debated and discussed with my supervisory team, until agreement was reached. Changes to the wording of the final core concepts was an iterative process with adaptation and amendments made, until the final version of the ESpiOT model presented in Chapter Five and discussed in Chapter Six. I had not accounted for the time commitment necessary to undertake rigorous data analysis. The process required exceptional organisational skills in meticulously keeping track of the charts

created, ensuring the correct version was applied. The data analysis notebook was an effective way of support the process of data analysis. The following extract illuminates how daunting the process appeared from the outset, and the need for organisation to avoid 'getting lost' as highlighted in the diary exact below:

I'm all set to go. I've read the relevant chapters, made meticulous notes and flow diagrams to help me on my way. I feel like I have the A to Z of Framework Approach but no idea what will happen. It's like having all the maps and no sense of direction. The whole approach feels very daunting but I plan to take it step by step and see where it takes me. Some terms seem familiar and I think I know what they mean, need to develop a glossary to keep by my desk. Data Analysis notebook

There is a pattern of spirituality emerging and it's exciting to see. I have developed a 'coding index' and can see themes of spirituality in practice emerging. This is taking a long time and requires dedicated time, I must make sure that I block out plenty of time to do justice to this. Data analysis notebook

The issues highlighted by the data analysis process provide a valuable insight in how a future study utilising the framework approach would be structured. There was a need to develop meticulous structures for managing the data analysis process, including a data analysis notebook and a computer generated filing system. The experience for me as a novice researcher was supported and strengthened by an experienced supervisory team, including one supervisor who had published papers applying the framework approach to studies (Smith & Firth, 2011).

The application of the framework approach supported my pragmatic approach to a task that could have been overwhelming with the volume of data. The clear systematic and rigorous stages of analysis appealed to my logical thought processes, and enabled me to have confidence in the outcomes of the analysis. I was able to see clearly how the final core constructs could be traced back to the original data. This strengthened the presentation of Chapter Five.

Reflecting on the data analysis process one of the key messages to embed in any future study employing the framework approach is to ensure that sufficient time is afforded to ensure each

step of the process can be completed coherently. In addition to the time factors are the organisation of the data and the analytical frameworks produced. Each stage provides a justification to progress to the next, and requires a robust filing system to enable changes to be made whilst retaining the original documents.

7.6.6 Opportunities to engage with researchers and a research community

The opportunities to engage with other researchers and the research community during the study reported in this thesis, and the development of the thesis, enhanced my experience as a novice researcher. These opportunities were as follows:

- PhD research supervision team;
- School of Human and Health Sciences Research conferences for example; Equinox Conference July 2012;
- School of Human and Health Sciences Spirituality Special Interest Group.

Monthly supervision meetings were held throughout the length of my PhD studies from 2009 - 2015. These meetings were supportive and challenging as the study was developed and progressed. A supervision notebook was kept throughout recording the issues discussed, decisions made and actions to progress the study. For a novice researcher the opportunity to discuss and debate the progress of the study was essential for developing research skills, and in particular for confirming key elements of the study i.e. data analysis. My supervisory team was made up of individuals who were experienced in research and publications. Their unique individual strengths complimented the supervisory team, and matched my needs as a novice researcher. A tension could have arisen when a new Director of Studies was required following the departure of one of the team. However, this change was embraced positively as an opportunity to learn from a different approach. In fact, the pragmatic approach of my new director of studies has expedited the completion of this thesis.

Engaging with an active research community and gaining feedback from both peers and experienced researchers was essential in the development of my skills presenting my research. The Equinox conference in 2012 provided me with the opportunity to present and

discuss the findings of the concept analysis (Jones, 2012), which is presented as a chapter in this thesis (Chapter Two). The subsequent article based on Chapter Two has been submitted for publication to the British Journal for the Study of Spirituality. The outcome of presenting at the Equinox conference was to develop a broader understanding of the constructs of spirituality presented by Kang (2003) which had been used as a framework for the study, and consider what these constructs looked like for individuals in practice.

The Spirituality Special Interest Group (SSIG), of which I was a founder member, has provided further opportunity to engage with researchers from a broader background than just health and social care academics. The purpose of the group was to draw together individuals who were researching, or have an interest in, aspects of spirituality within the university. The benefit of presenting my PhD study as it progressed was to gain feedback from individuals who were not closely associated with the study, and who could challenge my assumptions objectively. Presentations prepared for national and international conferences were delivered to the group to gain feedback on the content and delivery. Additionally, I have engaged in the opportunity to take part in research supported by the SSIG to explore perceptions of healthcare lecturers' experiences of addressing spirituality (Prentis et al., 2014)

The opportunities outlined above contributed to my personal development as a novice researcher, and provided constructive feedback throughout the study.

7.6.7 Summary of reflections

In summary, my approach to this study was strengthened by the reflective approach adopted. The meticulous recording of critical incidents in reflective summaries has provided an audit trail to support the decision making throughout the process. Some of these recordings were used to substantiate the reflexive section in this chapter, which supports the rigorous application of reflection to the research process in this study. The lessons learnt from analysing and synthesising the reflective accounts strengthens the transparency of the study, providing areas for my future development as a researcher.

7.7 Study strengths and limitations

The strength of this study was the small group of occupational therapists who agreed to take part in the study were known to the researcher. The small sample supported in-depth observations to be carried out over an extended period of time, and facilitated the observation of a full range of practice events in the settings. The strength of the extended periods of observation was the production of rich thick description, recorded in the fieldwork notes of how the occupational therapists embedded spirituality in their day to day practice. Close involvement with the setting was acknowledged as an opportunity to strengthen the internal validity of the study (Brewer, 2000; Gray, 2014). The occupational therapists were all known and there was a previous professional working relationship with each one of them. This strengthened the opportunities to be an *'insider'* researcher. However, a fine balance was needed to retain the critical stance whilst fully engaging in the observations of practice. This was strengthened by the use of reflective diary entries and critical reflexivity, continually refining the approaches to observation and interviews as the setting or occupational therapist required.

A limitation of the study reported in this thesis was the lack of the active voice of the patient; they were the silent participants in the observations since no data about them was recorded. Involvement of patients or service users in research has developed over recent years, acknowledging their valuable contribution in shaping the healthcare services (COT, 2011). Not involving the patients' voice in the data collection strategy limited the potential for the crystallisation of data. Crystallisation could have occurred between the occupational therapist's observations and interviews, and the experiences of the patient as recipients of their interventions. The omission of the patient voice limited the richness of the data. Although inclusion of patient data would have added a further interesting dimension, it was not feasible for ethical and practical reasons within the limitations of this PhD study. The absence of a patient voice has not compromised meeting the study aim and objectives, but does point to a need for further research.

7.8 Summary

Assuring quality in ethnographic research was a challenge. All methods of validating qualitative research have limitations, therefore it was impossible to claim a completely reliable account of reality (Ormston et al., 2014). The critique offered in this chapter has sought to address the quality of the research and findings in the context of this study. The critique aimed to enable the reader to judge the validity of the findings against the adequacy of the evidence provided to support the study design, processes of data collection and analysis. In addition, this critique aimed to authenticate how the description of spirituality found in the core concepts were embedded in occupational therapists' practice. This chapter has also reported the strategies undertaken to enhance the credibility of the study findings. The final chapter which follows concludes this thesis, presenting the key findings, dissemination strategy, and drawing implications for future occupational therapy practice, education and research.

Chapter Eight

Key findings and future recommendations for practice, education and policy

8. Introduction

The final chapter of this thesis draws the study to a conclusion. A summary of the key findings is presented from the concept analysis (Chapter 2), and the observation study outlined in Chapters Three, Four and Five. Four key issues emerging from the key findings are presented. The potential impacts of the study on occupational therapy practice, policy, education and future research are considered. Suggestions are offered for how this study can inform the evidence base relating to spirituality and occupational therapy practice. Finally, a strategy for dissemination and a conclusion is offered outlining how the findings, conceptual framework and ESpiOT model will be promoted for use in practice, education and research.

8.1 Key findings

This thesis explored how spirituality was embedded in occupational therapy practice by undertaking a: Concept Analysis reported in Chapter Two; Empirical research study was reported in Chapters Five and Six. The empirical study presented in this thesis appears to be the first known study that has observed the way occupational therapist address spirituality in practice. A detailed account of how four occupational therapists embedded spirituality into their daily practice in the challenging context of 21st century healthcare, has provided a unique insight into practice and an invaluable contribution to the body of knowledge for the occupational therapy profession. By understanding the diverse factors that impact on a patients emotional well-being, occupational therapists embed spirituality in their practice by placing the patient central to the therapeutic encounter. Often seemingly simple interventions were delivered in the context of complex factors impacting on the patient's lives and well-being, for example patients home circumstances, mental health issues, anxiety, fatigue and grief. Working collaboratively with patients enabled the occupational therapist to embed spirituality into their daily practice. Defining spirituality appeared to create tensions between

theory and in both the concept analysis and empirical study, supporting the notion that describing as opposed to theoretical defining spirituality being more useful to occupational therapy practitioners. The key issues that emerged from this thesis are highlighted in Table 10, which are now explored.

Table 10: Key issues from the concept analysis and empirical study

1. Spirituality is more meaningfully described than defined for occupational therapy practice
2. Occupational therapists support patients during times of vulnerability due to disruption to their health and well-being
3. Embedding spirituality in occupational therapy practice is explicitly linked to person-centred practice which values the individuality of the patient
4. Organisational and contextual factors influence how occupational therapists embed spirituality in practice

First, occupational therapists are not alone in their quest for a definition of spirituality to support their practice. This amorphous concept is fraught with contentions across healthcare literature (Chapter One). Spirituality is a personal construction, understood and unique to each individual. Therefore, the outcome of the concept analysis in chapter two was that it is more meaningful for occupational therapists to describe spirituality, in terms of its application to practice, than to define it. A description of spiritually competent occupational practice was offered in Chapter Two Section 2.5.2. (page 85). The central attributes of spiritually competent practice contained in the description relate to the occupational therapist's view of the patient as a unique spiritual being; how they engage with them in occupations that provide a sense of meaning and purpose. Additionally, the occupational therapist addresses aspects of the patient's experience such as suffering and helps the patient to develop coping strategies which improve quality of life. Furthermore, attributes relate to the occupational therapist's behaviour in accepting the patients' beliefs, values and cultural influences in order to practice with

spiritual competency. Prior to undertaking this concept analysis, I would have approached the contentious issue of defining spirituality from a pragmatic view point of an occupational therapy educator, seeking to provide a framework for students to grasp the concept for practice. However, the concept analysis findings led me to develop a description, which was then confirmed by my experience observing occupational therapists in practice and discussing with them. The participants in this study identified that spirituality was present in practice despite there not being a congruent definition or current guidelines to practice in the context of 21st century healthcare (Chapters Five and Six). A key message from the findings of this thesis is that spirituality for occupational therapy practice is more usefully described than defined.

Second, occupational therapy is concerned with supporting patients during times of vulnerability due to disruption to their health and well-being. Providing patients with a sense of purpose and hope, that aimed to have a positive impact on their well-being, was consistently found during the observations and discussions of practice in this study. This second issue links to spirituality in the way that the occupational therapists approached their interventions. In order to set collaborative goals with the patients, to provide occupational therapy interventions which would improve their well-being, they acknowledged the uniqueness of each patient's experience. The importance of these findings was the way in which the occupational therapists treated patients as unique individuals, respecting their diverse values, beliefs and cultural issues. Adopting these professional values, the occupational therapists were able to support patients with specific individualised interventions. These interventions included the following:

- Discharge planning to a place of significant connection for the patient
- Helping a patient to adjust to a new disability or deterioration in their condition
- Providing strategies to manage distressing symptoms such as fatigue or anxiety

The importance of supporting patients in relation to embedding spirituality is the way in which occupational therapists intervene with patients at a time of vulnerability to address their issues

in a unique and individual way. This second issue linked closely to the concept of person-centred occupational therapy practice.

Third, embedding spirituality in occupational therapy practice was explicitly linked to valuing the individuality of the patient and providing patient-centred care. Holistic, person-centred care which meets the patient's cultural, religious and spiritual needs was integral to occupational therapy core values and philosophy. Person-centred occupational therapy practice that demonstrated the ideology of valuing the individual by acknowledging their uniqueness and humanity was a predominant theme of this study. The features of person-centred occupational therapy practice found in this study were active listening and effective communication skills. These skills were evident when building a rapport with patients, grounded on mutual trust, respect and partnership to develop a therapeutic relationship. This therapeutic relationship supported embedding spirituality through the therapeutic encounter. An effective therapeutic relationship, which enhanced the interactions between patient and therapist, strengthened how the patient's unique perspective of their concerns and experiences of their health and well-being were shared. Thus spirituality was positively supported by the occupational therapists daily practice, applying the principles of person-centred care. By addressing what was uniquely meaningful and purposeful to the individual the findings of this study demonstrated patients were provided with a sense of hope for their future.

This third issue is important in relation to how occupational therapy practice is viewed in the wider healthcare context. Valuing the individualism of the patient, and providing patient-centred care, link to how occupational therapists apply the policy drivers to change healthcare practice through compassionate care. In relation to occupational therapy practice person-centred care is an essential component of embedding spirituality in daily practice.

Finally, embedding spirituality in practice was influenced by organisational and contextual factors. This study was carried out in the challenging context of 21st century healthcare. The global economic climate, ongoing conflict and natural disasters have led people to consider

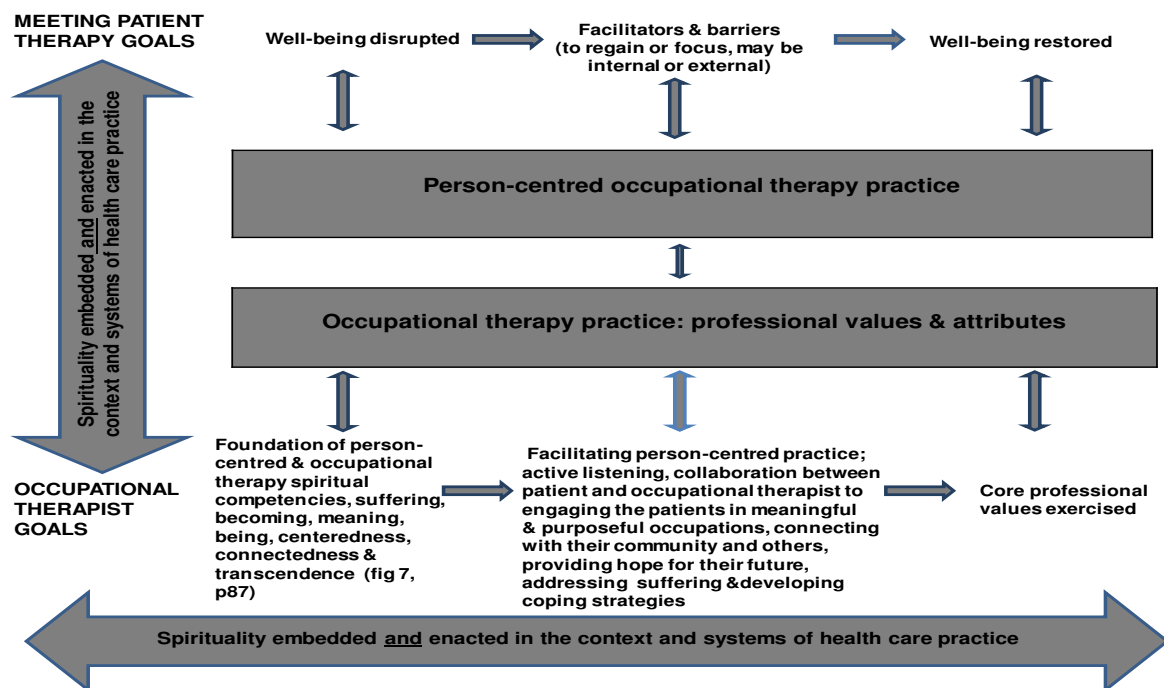
the meaning and purpose of their lives, hence the renewed interest in spirituality from both a religious and secular stance (Chapters One and Two). The impact of the global economic crisis led to a down turn in the UK economy, and to austerity measures being imposed on public services in particular affecting healthcare. The context occupational therapists were working in during this study was challenging. They were tasked with meeting service needs and demands, and compromising the delivery of occupational therapy practice which imbues holistic, person-centred compassionate care. In reality the occupational therapists in this study were challenged by the following barriers to embedding spirituality:

- Time restraints, leading to time limited interventions;
- Organisational targets to increase the throughput of patients on a case load;
- Pressure to adhere to bed management strategies.

The importance of this key issue is how the occupational therapists in this study articulated their strategies to manage these constraints on their practice. They presented the reality of practice, but demonstrated how they continued to practice without compromise of the core values and philosophy of the profession.

The model which has been developed from this study (ESpiOT model), outlined in Chapter Five (Figure 14, page 173), and discussed in Chapter Six, adds to the body of empirical knowledge about occupational therapy practice and how spirituality is embedded.

Figure 14: ESpiOT model



There are a range of definitions and elements of models articulating spirituality for occupational therapy practice. These models have value, however the strength of the ESpiOT model is its contemporary development, grounded in occupational therapy practice and informed by experienced occupational therapists. The model is offered as a guide for the occupational therapist through the processes of practice, using language and constructs which are familiar to them. A further strength of the ESpiOT model is in its applicability to interprofessional working. The model highlights the common ground shared by other healthcare professionals, for instance person-centred practice and develops the unique elements of occupational therapy practice to educate and inform working colleagues. The model serves as a tool for further research, as outlined later in this chapter. Additionally, the model serves as a teaching and learning opportunity for pre and post registration occupational therapy students to guide them through the complex theoretical underpinning knowledge relating to occupational therapy and how spirituality is embedded in practice. To date there appears to be no other study published that has examined spirituality and occupational therapy

practice from the viewpoint of observing what actually happens in practice. The strength of the evidence contained in this thesis is that it is grounded in the context and realities of embedding spirituality in daily occupational therapy practice.

The key findings from both these studies have been mapped to the thesis aim and objectives (Chapter One, section 1.7, and Chapter Three, section 3.1, page 95), and are displayed in Table 11, page 254. The table illuminates how the studies answered the thesis question and achieved the specific objectives.

Table 11: Key findings mapped to the thesis aim and objectives

How do occupational therapists embed spirituality in their day to day practice?	
<p>Thesis objectives were to:</p> <ol style="list-style-type: none"> 1. Investigate therapeutic interventions that occupational therapists considered to be a dimension of spiritual care 2. Observe how opportunities to address dimensions of spirituality were identified and incorporated into occupational therapy practice 3. Explore the facilitators and obstructions to embedding dimensions of the spiritual aspects of care within occupational therapy practice 	
Key findings: Concept Analysis (Chapter Two)	Key findings: Research Findings (Chapters Five and Six)
<ol style="list-style-type: none"> 1. Spirituality is more usefully described than defined for occupational therapy practice (<i>Objective 3</i>) 2. Spirituality in occupational therapy practice involves facilitating patients to: <ol style="list-style-type: none"> 2.1. Engage in occupations that provide a sense of meaning and purpose (<i>Objective 1</i>) 2.2. Connect with their community (<i>Objective 1</i>) 2.3. Develop coping strategies based on their own strengths (<i>Objective 1</i>) 3. Spiritually competent practice involves: <ol style="list-style-type: none"> 3.1. Addressing patient distress and suffering (<i>Objective 1</i>) 3.2. An awareness of own spiritual beliefs and their influence on practice (<i>Objective 3</i>) 3.3. Developing a therapeutic relationship when engaging the patient in therapy (<i>Objective 2</i>) 3.4. Ensuring a person-centred approach to the care; a core domain of the conceptual framework for spiritually competent occupational therapy practice (<i>Objective 2</i>) 4. Well-being and quality of life are restored/adapted when occupational therapist addresses the spiritual needs of patients (<i>Objective 1</i>) 	<ol style="list-style-type: none"> 1. Patients well-being is experienced as a continuum which is disrupted by illness, disability or dysfunction (<i>Objective 2</i>) 2. Spirituality, through authentic and implicit occupational therapy practice, is central to the core values and philosophy of the profession (<i>Objective 2</i>) 3. Person-centred occupational therapy is central to embedding spirituality in practice; valuing the uniqueness of the patient needs (<i>Objective 2</i>) 4. Describing spirituality in terms of application in practice based on the values and philosophy of the profession is more meaningful than defining spirituality (<i>Objective 3</i>) 5. Opportunities to address spirituality by occupational therapy include <ol style="list-style-type: none"> 5.1. Developing a therapeutic relationship based on trust, collaborative decision making, respecting the expertise of the patient (<i>Objective 2</i>) 5.2. Using therapeutic interventions to ameliorate distressing symptoms (<i>Objective 1</i>) 5.3. Exploring the unique meaning of illness with the patient (<i>Objective 1</i>) 5.4. Engaging patients in meaningful and purposeful occupations to progress collaborative goals (<i>Objective 1</i>) 6. Embedding spirituality can be facilitated by the occupational therapist's personal experiences of health issues and suffering. (<i>Objective 3</i>) 7. Barriers to embedding spirituality in practice include organisational and contextual factors such as meeting organisational targets and time constraints (<i>Objective 3</i>) 8. There is a paucity of theoretical models that support embedding spirituality in occupational therapy practice (<i>Objective 3</i>)

8.2 Implications for occupational therapy practice

Observation of practice confirmed the presence of spiritual constructs embedded in the daily practice of occupational therapists. This was not something extra to practice but embedded in what occupational therapists did and said about their practice. The study confirmed the quest for a definition was futile. The findings confirmed that central to the occupational therapists' practice were the core values and philosophy of person-centred holistic practice. This practice valued the patient's uniqueness, their needs and wishes which embedded spirituality. However, some Occupational Therapist's remained uncertain about spirituality, and this study has attempted to de-mystify what spirituality actually is and what it looks like in practice. The issues being explored changed over the course of undertaking this doctoral thesis study from the *meaning* of spirituality in occupational therapy practice to *how* spirituality is embedded in practice and this is a key distinction. Spirituality and occupational therapy practice is a well explored area, but largely from a theoretical or idealistic perspective and poorly understood in practice. Discussions of spirituality have tended to be over complicated, alienating occupational therapists, in particular the less experienced practitioner (Collins et al 2001). Occupational therapists embed spirituality in every day care when engaging with patients in therapeutic interventions which value their unique humanity and are meaningful and purposeful.

The participants in the study reported in this thesis responded positively to the observation of their practice and follow up debriefing, suggesting that role modelling and mentorship would be beneficial in applying the findings of this study. Occupational therapists should not lose sight of the core values and philosophy of their profession that embeds the constructs of spirituality as authentic occupational therapy practice. Post registration study needs to be constructed coherently to ensure occupational therapists can access opportunities for continuing professional development that will support their development, and resilience in embedding spirituality in a sometimes hostile healthcare environment. Links with the policy agenda for embedding compassionate care into healthcare services will be expanded later in

this chapter (8.3). The strong links between embedding spirituality and compassionate care should be used in order to promote the good practice integral to occupational therapy core values and philosophies. The paucity of application to theoretical models that support embedding spirituality in practice reported in this study suggests a fresh approach is needed for qualified occupational therapists. The proposed workshop for the host NHS trust will include how the ESpiOT model could be used in practice. Pragmatically occupational therapists in practice, challenged by time pressures to publish their good practice, could develop their use of alternative media. For example, using the opportunities afforded by social media through Twitter and Facebook sites: Research4OT, PalliativeRehab and #OTalk.

8.3 Implications for policy

Embedding spirituality in daily practice for occupational therapist's links to the policy agendas (discussed in Chapter 6) surrounding compassionate and person-centred care. Occupational therapists are practicing in context following the investigations reported by Francis (2013) and Keogh (2013) and austerity measures. Health professionals are challenged to practice with compassion whilst making savings, and meeting time limited targets which define episodes of therapeutic interventions. The findings of the study reported in this thesis suggested that occupational therapists are supported to practice with cultural competency by the application of the core values and philosophies of the profession. These underpinning professional attributes also put occupational therapists in a good position to work as role models in embedding the dimensions of spirituality that support those of compassionate care, and are essential elements of healthcare practice. However, healthcare budgets are not finite and therapy managers are faced with the challenges of managing budgets and adhering to policy drivers. They face the issue of how to support the expert practice, which embeds compassionate, person-centred care and meet the demands of commissioners who are concerned with providing value for money. The tension remains to provide services concerned with outcomes as opposed to targets, since in practice occupational therapists reported in this

study were still faced with targets to discharge from acute setting and time limited intervention packages for community settings.

8.4 Implications for education pre and post registration

Occupational therapists felt their educational preparation to embed spirituality in their daily practice was lacking (Udell & Chandler, 2000; Belcham, 2004; Hoyland & Mayers, 2005; Morris, 2013). Studies suggest that, where spirituality is embedded throughout the curriculum, occupational therapy students feel supported in their developing understanding of how spirituality is relevant to their practice (Kirsh et al., 2001; Thompson & MacNeil, 2006). Additionally, students who have had the opportunity to apply spirituality to an academic piece of work, such as a case study feel more confident to address spirituality in their practice (Jones, 2008). The findings of this study suggest that spirituality is integral to *'authentic'* and *'implicit'* occupational therapy practice. Whilst the participants in this study didn't overtly use the term spirituality, they embedded the domains of spirituality in their practice. Clearly the essential construct of spirituality and its support of compassionate care need to be explored within pre-registration curriculums as a standard which is monitored by the approval of courses by the HCPC and accreditation by the COT. The purpose of monitoring would be to exemplify what is integral to occupational therapy values and philosophies. Embedding the ESpiOT model in the teaching of spirituality for occupational therapy students provides them with an evidence based model, which was derived from practice, to apply in their academic and practice placement experiences.

8.5 Future research

The unique contribution of this study to the body of knowledge is to describe how occupational therapists, practicing in the current healthcare context, are embedding spirituality in their daily practice. Additionally, to derive a practice-based model (the ESpiOT model) that has value as a tool for teaching, and a basis for further research. The ESpiOT model requires evaluating in relation to its currency for occupational therapy, and its resonance with patients' expectations

of healthcare. Table 12 outlines the strategy for exploring with occupational therapists how effective the ESpiOT model is in practice. The strategy suggests a qualitative approach adopting a focus group data collection method. An education session is proposed to precede the first focus group. The purpose of the education session is to present the model and how it applies to practice; drawing on the empirical evidence base that underpinned the model's development. The first focus group will aim to explore with the participants their perceptions of implementing the model in practice. Following a period of testing the model in practice a further focus group is proposed, aiming at exploring the perceived effectiveness of the model. The strength of a focus group approach to data collection is the opportunities for the participants to interact and share ideas. Thus, serving the purpose of evaluating the model from practitioner's perspectives and the participants will gain from the discussion (Barbour, 2007).

Previous studies in the UK were all published before the economic down turn and the application of austerity measures to healthcare finances. In addition, this study was carried out in the context of the recent publication of reports finding healthcare unsatisfactory, in particular criticising the lack of compassionate care. This study presents a contemporary view of occupational therapy practice and how occupational therapists embed spirituality, offering recommendations for how occupational therapists and their managers can support their service developments and commissioning. The gap in the research, also highlighted as a limitation of this study, is the lack of the patient's voice in articulating their experiences of occupational therapists embedding spirituality in their practice and how this affected their care. Engaging patients in future research regarding spirituality would support suggestions in previous studies that definitions of spirituality lack congruence. The limitations of previous definitions lie in their development by academics, and not practitioners in collaboration with the patients who are at the receipt of healthcare (Chapter One). Furthermore, this study has focussed solely on the experiences of occupational therapists, and lacked reference to the interprofessional teams in which they were working. A case study exploring how an

interprofessional team embedded spirituality in their practice might illuminate the differences and similarities between professions, and provide further discussion on the essential benefits of interprofessional working. Finally, to strengthen the educational debate regarding embedding spirituality in the curriculum for occupational therapists, a study of the pre-registration courses in the UK could investigate how they currently address spirituality in their curriculum. The following table (Table 12) outlines the suggested future studies and approaches to examine the issues presented.

Table 12: Future research developing how occupational therapists embed spirituality in their daily practice

Issue	Question	Approach
Service users' experiences of occupational therapy practice in relation to embedding spirituality	How do occupational therapists embed spirituality in their practice from the patient's perspective?	A qualitative approach exploring the experiences of patients through individual interviews. This could be developed to include a group of patients in a focus group depending on the setting
Interprofessional teams addressing spirituality in their practice	How does the interprofessional team address spirituality in their care of patients?	A case study approach involving all the members of an interprofessional team in a particular context. This question could be answered by 2 data collection methods: 1. Ethnographic observation of practice with individual patients and follow up interviews with the professionals and the patients 2. Individual interviews with the professionals and the patients
Pre-registration curriculums and how they embed spirituality in the teaching and learning strategy across the course	How do pre-registration occupational therapy course in the UK address spirituality in their curriculums?	Qualitative study and /or quantitative evaluation using a survey supported by an online facility for example, Survey Monkey
Testing the effectiveness of the ESpiOT model in occupational therapy practice	How does the ESpiOT model support occupational therapist embed spirituality in their practice?	A qualitative study employing the following elements: Education/ workshop to promote the ESpiOT model with qualified occupational therapists. Two focus groups: 1. To explore the occupational therapist's perceptions of the model before testing in practice 2. Focus group to explore the occupational therapist's experiences of applying them model in practice

8.6 Dissemination strategy

Disseminating the findings and outcomes of research can be challenging, and requires a strategy to ensure a broad spectrum of outputs ensuring the study achieves maximum readership and influence (Green & Thorogood, 2014). The study reported in this thesis has implications for occupational therapy practice in the following arenas:

- The host NHS trust;
- The wider occupational therapy profession;
 - Practice;
 - Academics;
 - The professional and regulatory bodies (COT & HCPC);
 - Education programme leads.

The following tables represent how this study has already contributed to the debates around spirituality both in occupational therapy practice and the wider interprofessional arena. Table 13, presents the dissemination strategy used during the period of my PhD studies, and the activity related to spirituality and healthcare practice in addition to occupational therapy. Table 14, presents an outline of the proposed publications and conference papers following the submission of this thesis.

Table 13: Publications and conference papers relating to spirituality 2009-2015

Jones, J., Topping, A., Wattis, J., & Smith, J. (2015). Spirituality in occupational therapy: a concept analysis, <i>British Journal for the Study of Spirituality</i> (in press)
Jones, J. (2014). A qualitative study exploring how occupational therapists address spirituality in their practice. In: 16th International Congress of the World Federation of Occupational Therapists., 18th - 21st June 2014, Yokohama, Japan
Prentice, S., Wattis, J., Rogers, M., Stephenson, J. & Jones, J. (2014) Educators' views of "Spirituality in Healthcare". In: Taking Transculturalism and Diversity Beyond Boundaries: Exploring the Experiences of Underrepresented Groups, 7th March 2014, Huddersfield, UK
Prentis, S., Rogers, M., Wattis, J., Jones, J. & Stephenson, J. (2014). Healthcare lecturers' perceptions of spirituality in education. <i>Nursing Standard</i> , 29 (3), pp. 44-52. ISSN 0029-6570
Jones, J. (2012). Spirituality in occupational therapy practice: work in progress. In: Equinox, School of Human and Health Sciences Research Conference
Jones, J. (2012). Spirituality in occupational therapy practice: work in progress. In: College of Occupational Therapists Annual Conference, 2012, 12th - 14th June 2012, Glasgow, UK
Jones, J. & Rogers, M. (2012). Spirituality in healthcare: An interdisciplinary evaluation. In: International Spirituality Conference, 9 th -12 th January 2012, Bangalore, India
Jones, J. & Rogers, M. (2010). Spirituality in Healthcare – An Interdisciplinary approach to education. In: 2 nd European Conference on Religion, Spirituality and Health, 13 th – 15 th May, 2010, Berne, Switzerland.
Jones, J. (2010). Exploring spirituality in occupational therapy practice, a workshop. In: College of Occupational Therapists Annual Conference, 2010, July 2010, Brighton, UK
Jones, J. (2009) The experience of undergraduate occupational therapy students developing the concept of spirituality. In: College of Occupational Therapists Annual Conference, 2009, July 2009, Brighton, UK

Table 14: Proposed publications and conference papers following submission of this thesis

Proposed publication	Intended format	Target audience
Executive summary of the findings	Short executive summary relevant to occupational therapy participants and their managers	Host NHS Trust Therapy Manager, participant occupational therapists and patients
Workshop presenting the findings and implications for occupational therapy practice	A two-hour workshop and presentation will be offered to the host NHS trust	Occupational Therapists working in the host NHS trust
PhD thesis	Thesis	Deposit the final thesis in the College of Occupational Therapists library
The Embedding Spirituality in Occupational Therapy (ESpiOT) Model: A 21 st century model for guiding practice	Journal article and conference presentation/poster	British Journal of Occupational Therapists College of Occupational Therapists Annual Conference, 2016
Authentic and implicit occupational therapy practice: how occupational therapists embed spirituality in their daily practice	Journal article and conference presentation	American/Canadian Journal of Occupational Therapy World Federation of Occupational Therapists Congress, 2018
Compassionate care and spirituality: lessons learned from occupational therapy practice	Journal article and/or a conference presentation	British Journal of Occupational Therapists College of Occupational Therapists Annual Conference, 2016
Spirituality embedded in occupational therapy in acute care	Journal article	Occupational Therapy Now
Using an ethnographic study design to explore spirituality embedded in occupational therapy practice	Journal article	Qualitative Health Research Journal
Reflective and reflexive practice: applied to a study exploring occupational therapy practice	Journal article	Reflective Practice Journal
Spirituality in the context of contemporary 21 st century healthcare practice	Conference presentation	British Association for the Study of spirituality Conference 2016

8.7 Conclusion

Spirituality was integral to the founding principles of occupational therapy, albeit primarily from a Christian religious perspective. These principles valued the uniqueness of the individual, their experience of their health and well-being and placed a high position of meaning and purpose in the activities and occupations individuals engaged in (Meyer, 1922, Reilly, 1962). After a period when a reductionist biomedical model dominated practice, the profession has recently developed and responded to the needs of a multi-cultural society and the socio-political and economic contexts (Yerxa, 1990; Clark et al, 1991; Hammell, 2009). Occupational therapy is changing to embrace spiritual constructs of meaning, purpose and direction in life, in a way that is sensitive to different religious and cultural backgrounds. Occupational therapists need to embrace the context, cultural demands and their own philosophy of the profession in order to practice with spiritual competency. This thesis has presented the study exploring how occupational therapists embed spirituality in their daily practice in the context of 21st century healthcare. This study offers a conceptual frameworks and a dynamic model, derived from the study to guide practice, education and research. In the midst of the challenges of 21st century healthcare practice it is timely for occupational therapists to cease the quest for a definition and guidelines for practice. They need to recognise that the underpinning core values and philosophy of their profession supports spiritually competent occupational therapy practice. The conceptual framework for spiritually competent occupational therapy practice and the ESpiOT model provide tools for that purpose.

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Appendix 1: Letter to Therapy Services Director

Date

Dear [Service managers name]

PhD Research Project

A qualitative study exploring how the spiritual aspects of care are addressed in occupational therapy practice

I am writing to you to provide details of a research study I hope to undertake in your organisation and would like to gain your support in accessing experienced occupational therapists (Bands 6 & 7) working in [name of NHS Trust]. This is a post graduate research study and I am studying on a part time basis towards the award of Doctor of Philosophy (PhD). The study has been approved by the School of Human and Health Sciences Research Ethics Panel at the University of Huddersfield, Research Ethics Committee [name] and the research proposal has undergone internal independent assessment. Additionally, I have a red letter of access from [name of NHS Trust].

I wish to explore the work of experienced occupational therapists specifically how they address spirituality in their day to day practice. This ethnographic study involves observation of practice (participant observation) and follow up conversational interviews with each occupational therapist participant. West Yorkshire has a diverse population and I have approached your organisation as one representative of that richness.

I am hoping to recruit up to six qualified occupational therapists working in a variety of practice areas to take part in this study. It is anticipated that the observations of practice will take no more than five working days in each service area. The conversational interviews will be arranged as a follow up from the observations and should take no more than one hour of the participant's time.

I have enclosed a Participant Information Sheet that provides further details of the study. If you would like to ask any further questions at this stage, I would be happy to come and discuss this with you.

If you are happy for me to undertake the study and allow me to approach occupational therapists in your directorate I would be grateful if you could circulate the enclosed Participant Information Sheet and recruitment information to all Band 6 and 7 Occupational Therapists in the Trust. Once they have had two weeks to consider taking part if they could indicate to me their interest. I have attached a contact sheet to the Information sheet and a supply of pre-paid envelopes. I will then follow up interested participants.

There are no financial benefits to taking part and there are no known risks associated with involvement in this research project. However, should the observation of practice and interview raise issues surrounding the participant's experience they are advised to raise through their supervision arrangements. Additionally, I am asking all potential participants to discuss their involvement in this study with their line manager and clinical supervisor.

In the unlikely event that I observe practice considered controversial in relation to the Health Professions Council Standards of Proficiency (2007) or the College of Occupational Therapists Code of Ethics and Professional Standards (2010); then the policies and procedures of the Trust would be followed.

I will be willing to discuss with you the findings of the research at regular stages throughout the period of observation. An executive summary will be available at the end of the period of observations of practice. Additionally, I would be willing to present the findings to an appropriate forum including the participant occupational therapists.

I look forward to hearing from you.

Kind regards

Janice Jones

Senior Lecturer/ Postgraduate Research Student
Course Leader – BSc (Hons) Occupational Therapy
Division of Health and Rehabilitation
Department of Health Sciences
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Queensgate
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Appendix 2: Occupational Therapist participant information letter

Date

INFORMATION ABOUT THE RESEARCH (Occupational Therapists version)

Study title: A qualitative study exploring how the spiritual aspects of care are addressed in occupational therapy practice.

Thank you for taking the time to consider the information about this PhD research project which is taking place in the NHS Trust where you are working. I would like to invite you to take part in this research study. Before you decide I would like you to understand why the research is being done and what it will involve for you. I would be pleased to talk to you about the information provided in this sheet if you are interested in taking part. This could take place over the phone, or I could visit you in your service area whichever is most convenient. This should take no more than about 30 minutes. It is important that you are fully informed in order that you can consent to take part. You should also talk to your line manager and clinical supervisor before deciding whether to agree to take part to ensure they are aware of your involvement and what this entails.

The information sheet is divided into two parts –

Part 1 tells you the purpose of this study and what will happen to you and your service users if you take part.

Part 2 gives more detailed information about how the study will be conducted.

Please do contact me if anything is unclear.

PART ONE

What is the study about and why is it important?

This study will explore how occupational therapists address spirituality in their everyday practice. Spirituality is a frequently misunderstood concept. Traditionally it has been associated with religion and religious practices. However more recently it has been used in a humanistic and secular context, too. It is considered to be concerned with the meaning and purpose of life and is recognised as an important part of holistic care and practice. This study aims to address this area, regardless of whether or not the service user embraces a particular religious faith or philosophy.

Why have you been chosen?

You have been given this information sheet in order to help you decide whether you wish to participate. Your service manager has agreed that I can contact you with an invitation to participate. University of Huddersfield Research Ethics and NHS Research and Governance approval has been given for me to access clinical areas in the Trust where you are working in the capacity as a researcher. I wish to recruit experienced Band 6 or 7 occupational therapists who carry a substantial case load. If a number of occupational therapists from the same service areas wish to participate I will sample volunteers to ensure a range of practice is observed.

Do I have to take part?

It is entirely up to you to decide whether to take part in this research. This Participant Information Sheet describes the project and what you will be asked to do should you agree to take part. I am happy to be contacted if you require any further information; you will find my contact details at the end of this sheet. You should also speak to your line manager and clinical supervisor prior to agreeing to take part. A copy of the information sheet is provided for you to give to them. Once you have read the Participant Information Sheet, had an opportunity to ask questions, and agree to take part you will be asked to sign two consent forms. This asks you to take part in observations of your practice with service users, and participate in a follow up conversational interview. Should for any reason you decide at any time during the study you no longer wish to participate you are free to withdraw and any data collected pertaining to your participation will be destroyed. If a number of occupational therapists offer to take part, I will use a process of purposive sampling and choose between participants to ensure I observe a range of practice.

What would you have to do?

I would like to observe the day to day practice of occupational therapists working with service users, and to talk to you and hear your views about addressing spirituality in your practice. I am interested in the opportunities you have to address spirituality with your patients and what the barriers are.

I will be organising to observe individual occupational therapists in their practice setting carrying out their day to day work for as long as necessary to gather data. It is envisaged this will be for no more than five days with each occupational therapist.

During the period of observation, I will be watching and listening to you working with service users but not participating in care giving. After an episode of observation, I will write up fieldwork notes. These will be written up at the end of the interaction, or at a convenient time during the day, so that the note taking does not interfere with the care that you give to the service users.

When I have completed a sustained period of observation I would like to interview you. This will take about an hour and we will discuss what I have observed. This will take place at a location convenient to you. The interview will be audio recorded, if you consent to audio recording, and I will transcribe the recording. Any information that might identify you, the service user, other staff or the organisation will be removed. You will have the opportunity to check the transcript to make sure it is accurate and to add anything you would like to say at this point. This will take approximately an hour of your time again at a convenient location for you.

I know that you are very busy and I want to reassure you that you do not need to do any extra preparation to take part in the observation of practice or interview. I will be observing your work with service users as a passive participant. This means I will not normally participate in care delivery or your interaction with service users. However, I will act normally with service users and adopt a role similar to that of a student or professional visitor observing practice to avoid embarrassment. You just need to go about your day to day work as an occupational therapist and not plan any interactions that you would not normally do.

All contributions made during the observation of practice, follow up interview and your decision whether to take part or not will be handled anonymously and you will not be identifiable as a participant in this study. Access to the data will be given to me as the researcher and my PhD supervisory team who will supervise the process.

Version 5 (1-2-12) – Information about research (Occupational therapists version)

What will be expected of your service users?

The focus of this study is entirely on the work of occupational therapists practice. The patients are an integral part of that observation although not the primary focus. Prior to observing I will need to ensure that the service user you will be working with understands the research and gives their consent to being observed. The service user will be given an information sheet so they can make an informed decision about whether they wish to

consent to being observed. A copy is attached for you to read for your information. A poster briefly describing the study has been prepared and this will be displayed in the clinical area to inform service users, visitors and staff that I will be observing practice during a given period of time. I will not need to collect any personal service user data or access case notes. Service users will not be quoted in any data collected or identifiable in any fieldwork notes, analysis or writing up of the study

In the event of a service user becoming unwell, or losing their capacity to consent during the observation, I will exclude them from the study. For example, should they become confused or if my presence becomes detrimental to their care or therapeutic intervention then I will withdraw from the situation. In this situation I will be guided by your judgement. Additionally, in the unlikely event distress is caused to the service user, the researcher will withdraw from the situation and the offer to follow up afterwards will be made. Alternatively, the service user will be advised to seek the support of a counselling service through their GP

Are there any benefits to taking part?

This study will not help you but the information I obtain will contribute to better understanding the role of the occupational therapist in addressing aspects of spiritual care. There are no financial benefits from taking part. The findings from this study will be fed back to participants and other occupational therapy staff in the workplace.

Are there any risks?

There is no reason to believe there are any risks associated with taking part in this research. However, should you find any of the issues difficult during the observation of practice then you are advised to seek further discussion with your clinical supervisor. A copy of this information sheet has been included in your pack to give to your clinical supervisor and /or line manager to inform your discussion with them.

In the unlikely event that I observe practice which would be considered controversial in relation to the Health Professions Council Standards of Practice or the College of Occupational Therapists Code of Ethics and Professional Standards (2010) then your employer's policies and procedures would be followed.

It would not be appropriate for me to observe practice while you are also supervising a student on placement to avoid adding further burden on your work load.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2 of this information sheet.

Will my taking part in the study be kept confidential?

All information about you in relation to this research will be kept strictly confidential by the researcher at the University of Huddersfield. The information will be handled in line with the Data Protection Act 1998 and Caldecott Principles. This information includes selection lists, informed consent forms, fieldwork notes, audio tape and transcripts which will be coded, emails and any other correspondence which would lead to identifying you as taking part. All data will be kept for five years at the University of Huddersfield.

I hope to publish the results of the study during my project as case studies. You, your service users or service area will not be identified in any publication following this research project. An executive summary will be available at the end of the observation of practice stage of the study.

Further details are available in Part 2 of this information sheet.

PART TWO

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time during the process. If you withdraw from the study any data pertaining to your involvement in the study will be destroyed.

What if there is a problem with the research?

If you have a concern about any aspect of this study you should ask to speak to me in the first instance and I will do my best to answer your question. Contact details are at the end of this Information Sheet.

If you remain unhappy and wish to complain formally, you can do this by contacting my PhD Director of Studies Professor Annie Topping email: a.e.topping@hud.ac.uk, telephone 01484 473974

Will taking part in this study be kept confidential?

All data collected for this study will be handled and kept confidentially. Any identifiable data relating to yourself or your patients will be coded to ensure anonymity. The field work notes will be coded, returned to an office immediately after each day of observed practice at the University of Huddersfield and locked in a filing cabinet in a locked office.

The audio recorded interviews will be immediately transferred to a pass coded computer at the University of Huddersfield and deleted from the recording machine. The recording will be transcribed by me to ensure confidentiality. All transcripts will be anonymized using codes to avoid identification of you, your patients, your service area or employing organisation.

Access to the anonymized data collected for this study may be accessed by authorised persons from my supervisory team Professor Annie Topping and Professor John Wattis from the University of Huddersfield. Their role as my supervisory team is to supervise the research project process. They may also be audited by authorised people whose duty it is to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant.

All data will be destroyed by the University of Huddersfield's confidential data management process five years after the end of the study.

Who has reviewed this study?

All research undertaken in the NHS is scrutinised by independent group of people, called a Research Ethics Committee, to protect your interest. This study has been reviewed and given favourable opinion by the following committees: - Research Ethics Committee [name] and The University of Huddersfield School of Human and Health Sciences Research Ethics Panel. The research proposal has undergone internal independent assessment.

If after reading this information letter you would like to take part, please contact me It would be helpful to have an indication of your interest by (date 2 weeks from date of Information Sheet).

If you have any further questions about taking part in this research or would like to discuss it further, please do not hesitate to contact me. My contact details are at the bottom of this Information sheet. If you would like to register your interest in being a participant in this study, please complete the attached contact sheet and return it to me in the pre-paid envelope provided.

Thank you for taking the time to read this Information Sheet.

Janice Jones
Senior Lecturer/ Postgraduate Research Student
Course leader BSc(Hons) Occupational Therapy
Division of Health and Rehabilitation

Department of Health Sciences

School of Human and Health Sciences

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University of Huddersfield Headed Paper

Contact Sheet to register interest in being a participant

Study title: A qualitative study exploring how spiritual aspects of care are addressed in occupational therapy practice

Thank you for taking time to read the attached information letter. If you would now like to find out further details or take part as a participant in the study, please complete the following details and I will contact you.

Name	
Job title and band	
Workplace address	
Preferred method of contact (please provide details) for example email address, mobile number etc	
Preferred time/ day of contact if by phone	

Please delete as appropriate –

I would like to find out more about the study before making a decision to take part. Please contact me as detailed above.

I would like to register my interest in taking part in the study as a participant occupational therapist being observed and in the follow up interview.

Please return this sheet in the pre-paid envelop provided by *(date 2 weeks after circulation by service manager/s)*

Thank you for your time

Janice Jones
Senior Lecturer/ Postgraduate Research Student
Course leader BSc(Hons) Occupational Therapy
Division of Health and Rehabilitation

Department of Health Sciences

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Appendix 3: Informed Consent (Observation of Practice) Occupational Therapist

CONSENT FORM – Observation of practice (Occupational Therapist)

Title of Project: A qualitative study exploring how the spiritual aspects of care are addressed in occupational therapy practice.

Name of Researcher: Janice Jones

Name of Participant:

Please initial box

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 1. I confirm that I have read and understand the information sheet dated.....(version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason. | <input type="checkbox"/> |
| 3. I understand that should I withdraw from the study I can also withdraw any data collected pertaining to my participation in this study. | <input type="checkbox"/> |
| 4. I give permission to verbatim quotes to be used in any write up of this study providing it is anonymized by use of a pseudonym. | <input type="checkbox"/> |
| 5. I understand that the data will be kept in secure conditions at the University of Huddersfield and only accessed by the researcher and her supervisors. | <input type="checkbox"/> |
| 6. I understand that my identity will be protected by the use of a pseudonym in the research report and that no information that could lead to me being identified will be included in any report or publication resulting from this research. | <input type="checkbox"/> |
| 7. In the event of the researcher observing practice that contravenes the Health Professions Council Standards of Proficiency for registrant Occupational Therapists (2007) and The College of Occupational Therapists Code of Ethics and Professional Conduct (2010). I understand the Trust policies will be followed. | <input type="checkbox"/> |
| 8. I understand that my consent to participate over the following days of observation of practice will be checked and recorded in the researchers fieldwork notes | <input type="checkbox"/> |

Name of participant _____ Signature _____ Date _____

Name of
researcher _____ Signature _____ Date _____

Two copies of this consent form should be completed: One copy to be retained by the participant and one copy to be retained by the researcher

Version 4 (01/02/12) Consent form – observation of practice (occupational therapist)

Appendix 4: Patient Information Letter

INFORMATION SHEET FOR SERVICE USERS DURING OBSERVATION OF THE OCCUPATIONAL THERAPIST

Research study: A qualitative study exploring how the spiritual aspects of care are addressed in occupational therapy practice.

Who am I and what am I doing?

My name is Janice Jones and I am a part time post graduate student at the University of Huddersfield studying for a PhD and a registered occupational therapist.

The study is looking at how occupational therapists carry out their day to day work and address spirituality with their service users. Spirituality is described as aspects of our lives that give us meaning, purpose and hope. It is hoped this study will provide useful information that will help to improve the practice of occupational therapists and the care given to service users. To find this out I will be observing your occupational therapist as they go about their work. I will not be actively involved in the care but will just observe.

How are you involved in this study?

[Occupational therapists name] has agreed to take part in this study. S/he will be working with you today and I would be very grateful if you allowed me to observe her practice when she is working with you.

Do you have to take part?

You do not have to agree to take part in this study; you can refuse to allow me to observe [Occupational therapists name] working with you and ask me to leave at any time. If you wish to discuss anything in confidence with her then please feel free to ask me to leave. If you become distressed by me observing, then please also ask me to leave.

Your decision to take part will not affect the treatment or care you receive from [name of NHS Trust] or the Occupational Therapy services.

The focus of the observation is to explore the occupational therapists practice and not your experience. In the unlikely event you become distressed, the researcher will withdraw from the situation and offer a follow up discussion afterwards. Additionally, you can seek the support of a counselling service through your GP.

What will happen to the information I find out?

I will not be using any identifiable personal or clinical information from patients observed during this study. Your details will not be passed onto anyone else. Anything you say to the

Occupational Therapist will also be kept confidential and not used in the study. If you decide during the period of observation, you wish to withdraw then any information relating to your participation will be destroyed.

A summary of the study will be available at the end of the period of observation. Please indicate to me if you would like to receive a copy and I will make arrangements with your occupational therapists.

Who has given me permission to do this study?

I have been given permission to carry out this study by The University of Huddersfield School of Human and Health Ethics Panel, Integrated Research Application System, [name of Service Manager] and the [name of NHS Trust] Research and Governance Department. This permission has been negotiated through [name and title of service manager].

For further information, contact: Janice Jones, Senior Lecturer- Occupational Therapy

University of Huddersfield. Tel: 01484 473350 Email: j.jones@hud.ac.uk

Thank you for assisting me with this study

Appendix 5: Informed Consent, patient

CONSENT FORM – Observation of practice (Service User)

Title of Project: A qualitative study exploring how the spiritual aspects of care are addressed in occupational therapy practice.

Name of Researcher: Janice Jones

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet dated.....(version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason. I can also withdraw any data collected pertaining to my participation in this study
3. I understand that my identity will be protected and that no information could lead to me being identified in any report or publication resulting from this research.
4. I understand that the data will be kept in secure conditions at the University of Huddersfield and only accessed by the researcher and her supervisors.
5. I understand consent will be recorded on this form on subsequent occasions or each day the researcher is present during my occupational therapy sessions
6. I agree to take part in the above study

Name of participant _____ Signature _____ Date _____

Name of researcher _____ Signature _____ Date _____

Record of further contact with service user (process consent)

Date _____ Consent agreed: yes/no (Delete as applicable) Signed _____ (Researcher)

Date _____ Consent agreed: yes/no (Delete as applicable) Signed _____ (Researcher)

Date _____ Consent agreed: yes/no (Delete as applicable) Signed _____ (Researcher)

Two copies of this consent form should be completed: One copy to be retained by the participant at the end of the period of observation and one copy to be retained by the researcher

Version 4 (1/2/12) Consent to observation of practice – service

Appendix 6: Observation guide

Overview of Observation of Practice

Occupational therapist participant _____ (pseudonym)

Location (of interaction) _____

Service users problems (broadly noted, no personal identifying details or clinical details)

1. Introduction (and consent)

Notes –

Becoming	Meaning	Being	Centeredness	Connectedness	Transcendence
Barriers			Facilitators		

Insert observations related to the dimensions observed

Summary and conclusions –

2. Assessment

Notes –

Becoming	Meaning	Being	Centeredness	Connectedness	Transcendence
Barriers			Facilitators		

Insert observations related to the dimensions observed

Summary and conclusions –

3. Problem identification/ formulation in collaboration with the service user

Notes –

Becoming	Meaning	Being	Centeredness	Connectedness	Transcendence
Barriers			Facilitators		

Insert observations related to the dimensions observed

Summary and conclusions –

4. Goal setting

Notes –

Becoming	Meaning	Being	Centeredness	Connectedness	Transcendence
Barriers			Facilitators		

Insert observations related to the dimensions observed

Summary and conclusions –

5. Intervention

Notes *(state nature of the intervention)* -

Becoming	Meaning	Being	Centeredness	Connectedness	Transcendence
Barriers			Facilitators		

Insert observations related to the dimensions observed

Summary and conclusions –

6. Outcome/ measurement

Notes –

Becoming	Meaning	Being	Centeredness	Connectedness	Transcendence
Barriers			Facilitators		

Insert observations related to the dimensions observed

Summary and conclusions –

7. Discharge/ completion of observation

Notes –

Becoming	Meaning	Being	Centeredness	Connectedness	Transcendence
Barriers			Facilitators		

Insert observations related to the dimensions observed

Summary and conclusions –

Appendix 7: Informed Consent (Interview) Occupational Therapist

CONSENT FORM – Interview (Occupational Therapist)

Title of Project: A qualitative study exploring how the spiritual aspects of care are addressed in occupational therapy practice.

Name of Researcher: Janice Jones

Name of Participant:

Please initial box

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 1. I confirm that I have read and understand the information sheet dated.....(version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason. | <input type="checkbox"/> |
| 3. I understand that should I withdraw from the study I can also Withdraw any data collected pertaining to my participation in this study | <input type="checkbox"/> |
| 4. I give permission for the interview to be audio – recorded | <input type="checkbox"/> |
| 5. I give permission to verbatim quotes to be used in any write up of this study providing it is anonymized by use of a pseudonym. | <input type="checkbox"/> |
| 6. I understand that the audio recording and transcript will be kept in secure conditions at the University of Huddersfield. | <input type="checkbox"/> |
| 7. I understand that only the researcher and supervisors will have access to the recording and transcript. | <input type="checkbox"/> |
| 8. I understand that my identity will be protected by the use of a pseudonym in the research report and that no information that could lead to me being identified will be included in any report or publication resulting from this research. | <input type="checkbox"/> |

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of researcher	Date	Signature

Two copies of this consent form should be completed: One copy to be retained by the participant and one copy to be retained by the researcher

Version 4 (01-2-12) – Consent form; Interview occupational therapist participant