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Spirituality and Occupation in Living (SOiL) Model: Conceptualizing Occupational Performance Through the lens of Spirituality

Abstract

Spirituality is a multi-faceted concept that includes varied personal, societal, and cultural informers. Despite a relatively high volume of analysis there is significant and ongoing debate about the concept of spirituality in occupational therapy. In particular, this discourse includes questions of relevance, how spirituality might be defined, and what its clinical application might entail.

To date, several models have connected spirituality with occupation but none have supported clinicians in framing occupational performance and occupational performance change in day-to-day clinical practice via a spirituality lens.

This paper describes the Spirituality and Occupation in Living (SOiL) model. This model is designed for day-to-day clinical application in the consideration and analysis of occupational performance. It supports clinicians in partnering with clients, families, and caregivers in framing, analyzing, and respectfully discussing occupational performance through a spirituality lens. It is a model that can be responsive to multi-factorial informers across the care paradigm, is culturally accountable, and supports the integration of co-occupation.

Comments

The author declares that he has no competing financial, professional, or personal interest that might have influenced the development or presentation of the work described in this manuscript.

Keywords

spirituality, model, theory, occupational therapy

Cover Page Footnote

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Spirituality is a compelling concept in consideration of occupation and occupational performance. It is complex and multi-faceted, with varied personal, societal, and cultural informers. Despite a relatively high volume of discussion and analysis of the the topic, there has been limited agreement on the role of spirituality in the profession or in the provision of occupational therapy care. The conceptualization and application of spirituality concepts vary widely from jurisdiction to jurisdiction, facility to facility, and clinician to clinician (Mthembu et al., 2016; Newbigging et al., 2017). Maley et al. (2016) describe three primary research foci in the profession related to spirituality: the use of spirituality when dealing with a significant life event, the benefits of spirituality associated with engagement in select occupations, and the meaning of lived experiences where spirituality is identified as an integral element of that experience.

To date, several occupational therapy models have conceptually connected spirituality with the concept of occupation, but no theory, framework, or conceptual model has supported occupational therapists in practically framing and defining occupational performance in day-to-day clinical practice via a spirituality lens (Newbigging et al., 2017). Of this, Morris et al. (2014) note: “a gap exists between what is stated in theory and what is actually assessed and practiced by occupational therapy clinicians” (p. 29). Wallace (2018) also speaks to the disparity between theory and practice noting that “although there has been interest in including spirituality into OT interventions, to date, the spirituality aspect has remained largely an academic discussion” (p. 7). Newbigging et al. (2017) state plainly that: “In order to bridge the gap between theory and practice, a more detailed practice model illustrating spirituality’s place in occupational therapy would provide evidenced-base guidance in this practice area” (p. 15).

Despite this apparent lack of applicable day-to-day clinical practice models, spirituality continues to occupy an evolving centrality in the consciousness of the occupational therapy profession (Hartje et al., 2018; Misiorek & Janus, 2018). This paper critically considers occupational performance through the lens of spirituality and offers, in response, the SOiL model (Spirituality and Occupation in Living). This practice model is designed for day-to-day clinical application in the analysis of occupational performance. It supports clinicians partnering with clients, families, and caregivers in framing, analyzing, and respectfully discussing occupational performance through a spirituality lens. It is a model that can be responsive to multi-factorial informers across the care paradigm, is culturally accountable, and supports the integration of co-occupation and community participation. At the same time, the SOiL model enables clinician agency to support a spirituality-focused narration and analysis of occupational performance and occupational performance change. In practical terms, the SOiL model, as presented in this paper, enables clinicians to describe or consider occupational performance in the moment and across the lifespan via the lens of spirituality.

Review of the Literature – The Complexity of Spirituality in Occupational Therapy

The occupational therapy profession is rich in consideration of how the concept of spirituality can inform our practice. Indeed, spirituality has long occupied an interesting place of debate and discussion as the profession grappled with the concept and its application. Urbanowski (1990) references multiple Canadian Health and Welfare Task Forces from 1983, 1986, and 1987, where the concept of spirituality was formally considered. The outcome of those task forces was the identification of spirituality as one of the key components defining the Model of Occupational Performance (CAOT, 1991) and several later revisions of the Canadian Model of Occupational Performance (Townsend, 1997; Townsend & Polatajko, 2007). Townsend and Brintnell (1990) reference these same task forces and identify an earlier start, 1979, marking a more than 5-decade journey in the formal discussion of spirituality concepts informing occupational therapy practice.

In the original conceptual framework of the Model of Occupational Performance (CAOT, 1991), spirituality was weighted equally with an individual's physical, sociocultural, and mental status. It reciprocally informed and was informed by each individual's participation in self-care, productivity, and leisure. Similarly, it influenced and was influenced by the social, physical, and cultural environments in which people participated. The move to formally include spirituality in the *Occupational Therapy Guidelines for Client-Centred Practice* (CAOT, 1991) and specifically in the development of the Model of Occupational Performance was significant as the authors noted: "This component has rarely been identified in the previously cited American occupational therapy literature but has been one of the fundamental elements in conceptualizing Canadian Occupational Therapy practice" (p. 18).

This formal inclusion of spirituality as a clinical practice informer has markedly influenced the profession over the years. It has also opened a series of fissures and debates among students, clinicians, faculty, and regulatory organizations that have not abated (Keiter Humbert, 2016). In particular, concepts of relevance, definitional uncertainty, and practice application have been, and continue to be, debated and discussed. Those issues, interestingly, were highlighted in early work by Egan and DeLaat (1994), who, only a few years after the CAOT publication, noted rather presciently that "the exact role of spirituality in occupational therapy has been difficult to delineate" (p. 95).

In his doctoral dissertation, Lem (1986) provided some insight into co-occurring early consideration of spirituality in the American context. Lem, interestingly, frames occupational therapy interest in spirituality at that time as a move away from the perceived reductionism of the biomedical model and toward a conception of "wholistic health care" and "whole person medicine" (p. 4). Lem also drew some attention to the kind of debate then occurring in the profession related to the concept of spirituality. In particular, he highlighted theorist Gary Kielhofner's (1983) position "that though he agrees that a transcendental (spiritual) level exists, he omitted the discussion of it because he was unable to speculate on its implications for occupation" (p. 4).

In the years that have followed the initial 1991 inclusion of spirituality as a performance component in the *Occupational Therapy Guidelines for Client-Centred Practice*, there has been significant and ongoing analysis, discussion, debate, and disagreement about the application of spirituality in the profession (Barry & Gibbens, 2011). This content seems to fall into two broadly related thematic areas considered below.

Spirituality and the Demand for Definition

It is evident that, over the past several decades, the concept of spirituality has taken on an enhanced centrality in the occupational therapy profession (Milliken, 2020). It also appears that there is remarkably little agreement on what spirituality might encompass and/or how it might more practically apply in day-to-day care provision (Newbigging et al., 2017; Wallace, 2018). One area that has been notably debated is that of definition.

Lem (1986) initially tackled the definition question in capturing spirituality via a religion-focused lens. He noted that "spirituality is defined, in this study, as the sensitivity or attachment to religious values or beliefs" (p. 7). Lem's focus, in a modern and potentially more secular worldview, may appear somewhat reductionist in nature. However, it is notable that the narration of spirituality accounting in a religious context does remain a somewhat common inclusion in the literature (Brémault-Phillips, 2018; Hemphill, 2020; Howard & Howard, 1997; Hume, 1999). Other authors have grappled with the relationship between religion and spirituality, notably Neill (1997), who perceived spirituality as "different from, but not exclusive of, the definition of religion" (p. 26). Hemphill (2020), on this subject, notes:

> a distinction must be made among religion, spirituality, and soul. Spirituality is definitely a part of religion, but religion may not be a part of spirituality. Spirituality contains the domains of religion but need not adhere to a religious ideology. (p. 3)

Urbanowski (1990) identified some of the challenges the profession faces in seeking to define and understand spirituality as a practice informer. Noting the previously referenced Canadian Health and Welfare Federal Task Forces (1983, 1986, and 1987), he posits: "the definition offered in these cited documents considers spirituality as a state of wellbeing. Furthermore, spirituality is regarded as the prime l'elan vital (life force) of human beings" (p. 29). Potentially unaware of Lem's (1986) dissertation, Urbanowski goes on to state, "there are no other clear, concise references to spirituality in occupational therapy literature" (p. 29). This kind of broad and philosophical narration of spirituality ("l'elan vital") appears fairly common over the years. Speaking to concepts involved in the Model of Occupational Performance, including spirituality, Urbanowski noted that: "Existing literature does not define these tenets well, hence their existence cannot be readily demonstrated. It is a responsibility of the profession to define these constructs, prior to engaging in research activities that are premised on the model" (p. 8).

This viewpoint, endorsing the responsibility of the profession to provide definitional clarity related to spirituality, seems to have colored much of the literature and dialogue in the years that have followed. Accordingly, as a result, researchers have forwarded, and continue to forward, a wide range of competing definitions in the occupational therapy context. Despite this critical attention, it does not seem that the desired definitional clarity in the profession has been achieved. A brief sample of some of this definitional tension over time is noted in Table 1 immediately below.

Table 1

Spirituality and the Demand of Definition

Definition	Author
CAOT (1991)	As spiritual beings, individuals are concerned with nature, the meaning of life, and their purpose in the universe (p. 18).
Egan & DeLaat (1994)	For the purposes of this paper, the spirit is seen more simply as our truest selves, which we attempt to express in all of our actions (p. 96).
Egan & DeLaat (1997)	Spirituality relates to our thoughts, feelings, and actions concerning the meaning we make of our daily lives (p. 116).
Hammel (2000)	Occupational therapists demonstrate difficulties in clearly defining a shared meaning of this word and thereafter in identifying how spirituality can and should be addressed in practice (p. 187).
Tse (2005)	Spirituality relates to the acknowledgement of an individual's sense of meaning and purpose in life, which may or may not be expressed through religious doctrine, beliefs and practices. Spirituality involves a unity of body, mind and spirit and relationship with someone or something beyond ourselves that sustains and comforts us (p. 181).
Barry & Gibbens (2011)	On the current understanding of spiritual care, it is nearly impossible to make the assumption that any single view of spiritual care will be agreeable to all (p. 68).
Gray (2015)	Most struggle to define spirituality (p. 54).

It is interesting that the issues surrounding the definition of spirituality have led some to consider completely reframing the concept or departing from it altogether. Hammell (2001) indicated that the "use of the word spirituality is problematic and potentially ambiguous" (p. 187). Accordingly, Hammell proposed replacing spirituality with a concept called intrinsicality that: "embedded within all aspects of person/environment interactions . . . is a central dimension of the self, is shaped by the environment and gives meaning to the occupations of everyday life" (p. 191). Similarly, Unruh et al. (2002) argued for a concept of occupational identity as a potential replacement for spirituality. While neither of these concepts seemed to gain clinical traction, their emergence speaks to some uncertainty the profession has held and perhaps continues to hold with the concept.

Spirituality in Clinical Application

While the occupational therapy profession has struggled with the seemingly Sisyphean task of defining and understanding spirituality, it has struggled equally with the concept of spirituality in day-to-day clinical application. The CAOT *Guidelines for Client-Centred Practice* (1991) describe some early consideration of practice application noting a dynamic and balanced relationship between the individual's spiritual, physical, sociocultural, and mental self with the "essence of a healthy, functional person . . . [being] . . . the balance integration of these four components to provide a sense of wellbeing" (p. 17). In the included Assessment Guidelines, it was noted that the "abilities and deficits" of each client should be evaluated, accounting for performance components, including "spiritual" (p. 28). In describing how to proceed with intervention, the authors advocated for a thematic approach including exploration of varied concepts including, but not limited to, meaning and purpose, suffering and tragedy, self-esteem and dignity, as well as guilt and forgiveness.

In considering the potential application of spirituality in practice, Egan and DeLaat (1994) offered some revisions to the CAOT (1991) model. They advocated for a somewhat more transactional approach, noting that: "to maintain spiritual well-being the individual must remain connected with self, others, and the rest of creation" (p. 96). Egan and DeLaat, importantly, identify a key change to the CAOT model in noting that spirituality was not merely a component of the person but, rather, "the essence of the person" (p. 101). Given this approach, the other components identified by the CAOT model then act either as supporting or blocking spiritual expression by the person (Egan & DeLaat, 1994). This concept of spirit as the essence of the person appears to have significantly influenced CAOT conceptions of spirituality; notably, the idea of spirituality as the center of the individual has been a key element in the Canadian Model of Occupational Performance and Engagement (Townsend, 1997; Townsend & Polatajko, 2007).

By the latter part of the 1990s and into the new century, the profession continued to struggle with actual day-to-day practice application. Kirsh (1996) noted, "methods of integrating this performance component into daily practice remain elusive, largely due to our limited knowledge in this area as well as a lack of clarity around methods to assess and address spiritual health" (p. 55). Others, like Engquist et al. (1997), identified more practical questions arising from clinicians in considering spirituality, including how reimbursement might be viable. Rose (1999) spoke to the issue of practice application of spirituality that remains present to this date, noting: "respondents considered that their education had not prepared them to deal with clients' spiritual needs" (p. 307). An interesting and powerful sentiment was reflected by Kirsh et al. (2001) speaking to the Canadian educational context noting: "the importance of addressing spirituality in practice was juxtaposed with ambivalence around how to actually deal with such issues" (p. 124).

In the two decades that have followed, it appears that this professional ambivalence is unresolved. The question of how to deal with spirituality in conceptualizing day-to-day practice, let alone share that content with clients, has not really been answered. This does not, however, appear because of a lack of effort or intention by the profession. Indeed, multiple theories or models have been proposed in the intervening period (Kang, 2003; Kang, 2017; Keiter Humbert, 2016; Newbigging et al., 2017). Practically, these models have encouraged clinicians to consider concepts of spirituality but often appear to support more the operationalizing of it as a construct. Kang (2003) refers to this as "enabling spirituality" and notes: "There is a need for an inclusive yet definitive understanding of spirituality and a concrete framework that might assist practitioners in systematically managing spirituality in daily practice" (p. 94). The difficulty with this kind of approach, pragmatically, is that there may be some ethical and/or

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professional tensions for clinicians in "enabling spirituality" and "systematically managing spirituality in daily practice," which would appear to potentially limit client agency in narrating their own personal spiritual worldview. An alternative approach would be to support clients in self-defining their own spiritual worldview and using that narration as a catalyst for consideration of occupational performance. This is the approach that the SOiL model employs, as described below.

SOiL Model

Conceptualizing Spirituality

The occupational therapy profession has spent a remarkable amount of time and energy seeking to come to consensus in defining spirituality. This appears to relate to the idea that the profession requires some level of critical agreement to proceed, as if uniformity is required in a client-centered clinical practice. This assumption is conceptually interesting given the evident lack of consensus in other areas of the profession including, but not limited to, splinting, wheelchair seating, sensory integration, psychotherapy, environmental modification, and cognitive assessment. In those areas, difference of opinion and the absence of consensus has led to the adoption of varied approaches and ongoing innovation in practice.

Perhaps more important than the professional focus on definition would be that spirituality, for each person, family, and client, is uniquely experienced and narrated. At a clinical level, the most important part about each person's spirituality is, plainly, how they choose to define, describe, and experience it. The SOiL model proposes a definition of spirituality consistent with that kind of client-centered approach. Accordingly, the SOiL model posits that spirituality is "the sum of experience that each individual holds personally sacred." In this context, the concept of personally sacred speaks to those "things . . . set apart with special meaning" by the client (Evans, 2003, p. 33). This approach shifts the focus from a clinician or profession-defined spirituality narrative to a client-centered narrative and provides them the autonomy to describe the diversity of experience that they hold "personally sacred."

Conceptualizing the Person via the Lens of Spirituality

Spiritual Soil

The SOiL model considers each individual via a lens of spirituality. Symbolically, the sum of experience each person holds personally sacred is captured as their spiritual soil (see Figure 1). This soil, like life itself, is cumulative and evolves or changes in its composition over days, weeks, months, and years as new experiences are added. This depth provides a temporal aspect to the SOiL model, while the composition of each individual's spiritual soil is inherently determined by the sum of those experiences that each individual holds personally sacred.

Relational Inputs

Relationships with others can markedly inform each individual's spiritual soil. These are represented visually in the SOiL model using trees, buildings, or structures of different sizes, shapes, or types. Some longer-term, meaningful, and valued relationships (for example, parents, siblings, caregivers, partners, or pets) might be long held and, accordingly, extend deep into the soil. These roots or foundational elements may extend, for parents or caregivers, to the base of the spiritual soil. Other, shorter-term relationships may only extend down a shorter distance. These relational experiences inform and contribute to each individual's spiritual soil. It is notable that even on death or passing, the relationships may continue to influence the individual's spiritual soil. This ongoing influence may be visually represented by the supporting clinician as the maintained presence of a root/foundational structure, a fallen

tree, a collapsed building, or a change in the soil itself. These relational inputs and memories, held personally sacred, continue to inform or influence the individual's spiritual soil.

Occupational Performance

Occupational performance and participation can be represented visually and symbolically in the SOiL model by use of varied crops, plants, grasses, or flowers. Longer-term or recurring participation that individuals describe as meaningful might be represented using a perennial crop or grass, for example. When employing the SOiL model, clinicians have the agency to partner with clients and to enable them to narrate their own participation with those symbols they might find meaningful. Figure 1 provides an example of this approach with a more moderately rooted crop and a shorter seasonal ornamental grass represented. Note, however, that there is no limit in clinical practice to the number or type of grasses, plants, crops, or other inputs that might be chosen in partnership with the client to describe their occupational performance. All occupational performance, as represented by these crops, plants, grasses, or flowers, has a beginning and end point, and those experiences held personally sacred by the client ultimately inform their spiritual soil.

It is notable that some occupational performance may not be personally sacred or, indeed, particularly meaningful for each individual. The SOiL model makes space for this type of perfunctory participation. Clients may describe occupational performance that, for them, feels dutiful, obligatory, or compulsory. This can be described in the model as, for example, a short grass with a limited root structure. This type of participation may not significantly influence the spiritual soil. At the same time, its inclusion supports a more fulsome discussion of each individual's occupational performance. Further, it enables the clinician supporting care to explore the more limited meaning of some occupational performance and how this may be impacting the client.

Illness, Wellness, and Our Spiritual Soil

Each person, through the course of their lifetime, will face varied and unique experiences with illness and wellness. The SOiL model is responsive to these varied factors and enables each clinician, in partnership with their client, to visually narrate and consider these inputs. As noted in Figure 1, illness experiences can be represented in several ways. The first of these involves the use of a fissure. The depth, width, and influence of the fissure can be determined in partnership with the client. This enables each client to describe their illness experience meaningfully as well as how those impacts have influenced their spiritual soil, their relationships, the root and foundational structures, and broader occupational performance. Some illness experiences with an early onset and ongoing symptoms may compel a wider or deeper fissure to be described. Other, more recent and perhaps less impactful illness experiences across the lifespan may compel a smaller fissure. The client is enabled in the SOiL model to support their own narration of their illness experience.

Some lived experiences may significantly impact and cause damage or harm to an individual's spiritual soil. For example, experiences of trauma or abuse may occur and significantly inform an individual's occupational performance and lived experience. These impacts are unique to each individual and may cause a significant impact on their spiritual soil. The SOiL model supports each client to narrate these difficult experiences and their impact on their spiritual soil via the use of a circle or oval. The size of this circle or oval is determined by the client in describing their experience and impacts of the same to their spiritual soil. It is important to note that other experiences may also cause significant damage to a person's spiritual soil. One example may be use of illicit substances. Sometimes less obvious experiences, such as the pain associated with regret, anguish, grief, or separation, may also cause lasting and permanent

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damage to an individual's spiritual soil, and the use of a circle or oval (color filled or devoid of color at client discretion) may speak to these impacts.

Mood/Affect

Mood and affect are constantly changing for each individual. The SOiL model uses the symbolic application of the sun and clouds to symbolize the impacts of an individual's mood on their spiritual soil. The sun may involve a more positive affect, while clouds may speak to mood impacts. These can be graded (i.e., the sun being covered by some clouds, darker clouds symbolizing enhanced mood or affect inputs, rain symbolizing emotional response). Further, the position of the sun and clouds may also speak to the influence of mood on occupational performance or relational status, for example. The use of the sun and clouds in this way enables the agency of the individual in describing and contextualizing their mood and its influence on their spiritual soil to the clinician.

Mood and affect may also be influenced by inputs related to the spiritual soil. Grief, for example, may occur following a relational loss. This may be visually represented using a tree stump or tree devoid of leaves but with a maintained deep root structure. Similarly, illness experience, as described above, may also influence affect significantly. When considering illness experience, trauma, grief, or related concepts, the clinician may also wish to ask about potential mood or affective outcomes.

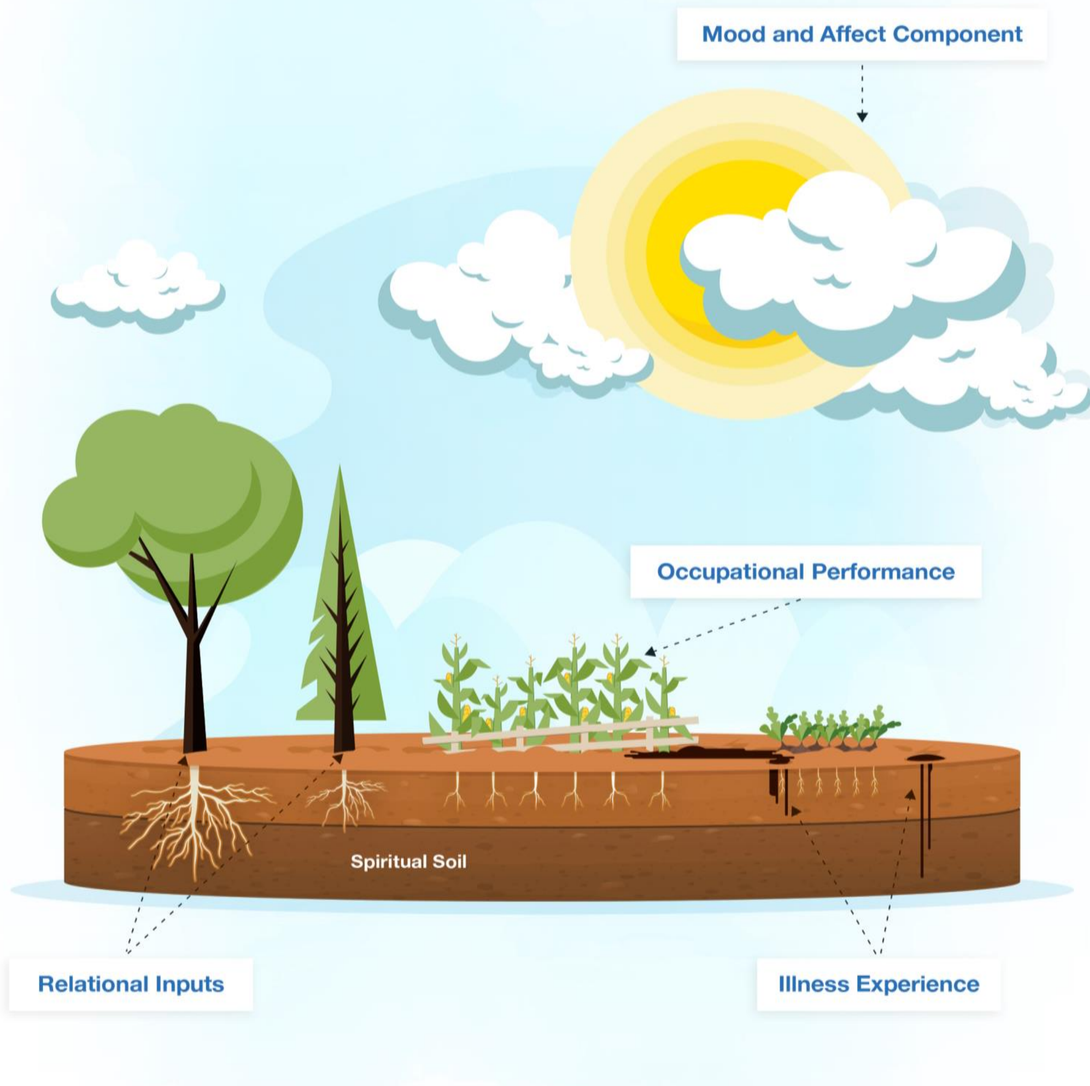
Concepts of Co-Occupation, Community, and the SOiL Model

Concepts of co-occupation speak to an interactive and social aspect of occupational performance wherein "the occupations of one individual and another . . . sequentially shapes the occupations of both persons" (Pierce, 2011, p. 203). The SOiL model supports conceptualization of co-occupation, parallel occupational performance, and the potential for spiritual soil to have shared inputs. The dimensionality of the model, and its flexibility in application, supports partnering with clients or even families to visually represent concepts of co-occupation, as clinically indicated. Every individual, family, and community is unique. The SOiL model enables the therapist and client(s) involved to visually describe and narrate those unique and shared relational inputs that influence co-occupation and inform their spiritual soil.

Using the SOiL model to conceptualize co-occupation might include describing shared occupational performance involving family members, siblings, partners, or caregivers. Concepts of co-occupation could also involve participation with community groups, friend groups, and vocational or work relationships. The potential for co-occupation is as diverse as each client's social and participation choices. The SOiL model offers the potential to describe relational inputs that might influence the spiritual soil of several individuals. Shared occupational performance can be described using various crops supporting the agency of those client(s) involved. The model also offers the potential to describe shared impacts of illness experience, trauma, addiction, loss, or other difficult experiences.

Figure 2, below, practically describes several of these concepts in application using the context of a family. Note that in Figure 2, one family member is specifically impacted by a dark fissure describing some type of illness experience. In using the SOiL model, it is possible to describe how that illness experience might impact the spiritual soil that is collectively shared by the family. In a similar way, an element of loss also impacts the family in Figure 2 and continues to impact the spiritual soil shared by the family members. It is important to note that in this type of familial or community application, the SOiL model supports a visual representation of a highly varied volume of illness impacts or loss impacts. This enables the supporting clinician to meaningfully describe those impacts on the spiritual soil and, as indicated, in day-to-day occupational performance, mood, or affective status.

Figure 1



SOiL Model – Five Keys for Clinical Application

1. Our spirituality (the sum of our experience that we find personally sacred) is dynamic and consistently informs our perception and understanding of occupational performance.
2. Each of us has a spiritual soil or base from which all occupational participation is rooted. Our spiritual soil is the sum of experience, participation, and belief that we hold personally sacred.
3. Occupations grow and evolve from our spiritual soil. They are both informed by our spirituality and concurrently inform our spirituality in an ongoing and reciprocal manner. These occupations can be foundational or deeply rooted over a long term or more temporary in nature. They can be long standing or occur only once.
4. Our spiritual soil is nourished and informed by our occupational performance choices.
5. Occupational performance choices, relationships, and illness experiences can also be non-nourishing, unfulfilling, or even potentially damaging to our spiritual soil.

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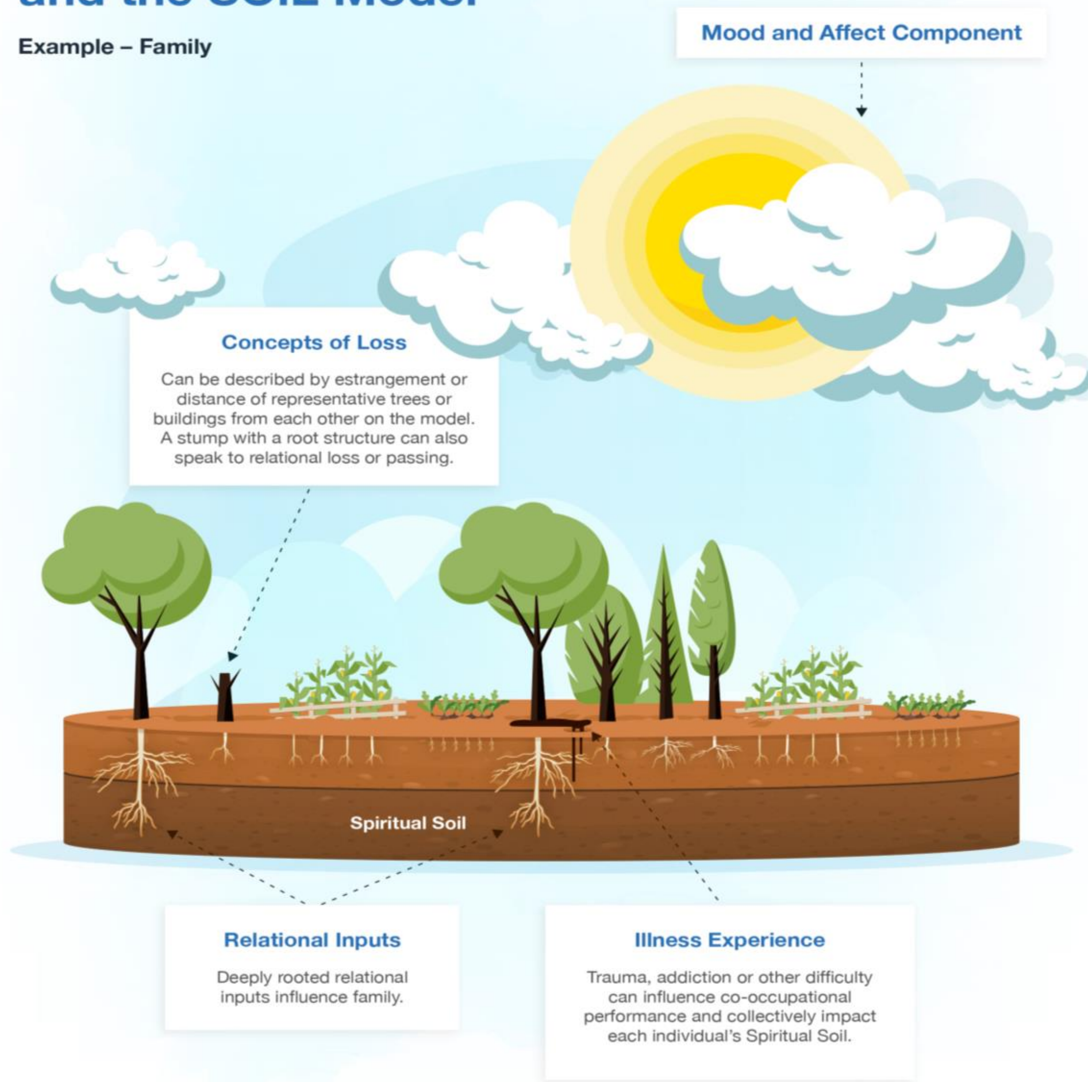
SOiL Model in Application - Case Study

Sam (she/her) is a 34-year-old new Canadian who identifies as female. She is in a longer-term relationship and has one male child, aged 13. Sam has, in recent months, been involved in a serious automobile accident. Outcomes of the accident caused Sam to incur several injuries, including a tibia/fibula fracture requiring internal fixation. Sam is currently participating in outpatient physical therapy and is followed by her surgical team and family medical doctor.

Figure 2



A referral has been made to the community health team for in-home occupational therapy care by the local community health service. In initially contacting Sam by phone, it is learned that she lives with her partner in a one-floor apartment in a building with an elevator. Sam notes that she is currently able to enter/exit her apartment using crutches and is able to safely transfer in/out of her bed with some difficulty.

While she is able to bathe and shower, she notes that she is not currently able to do so independently and that she and her partner follow the protocols provided by her discharging hospital team. Sam also voices concerns about her currently limited participation in active parenting. She indicates that she finds significant meaning in that role.

Sam reports that she has a relatively lengthy history of anxiety, for which she has benefited from medication. She indicates that she has been feeling somewhat anxious and concerned about her current limitations. Sam is currently away from work as a Personal Support Worker while she recovers and is receiving benefits. She voices some anxiety about how a return to work might look in a few months when cleared by her physician and occupational health staff at her workplace but notes that this concern is not, at present, among her highest priorities.

In meeting with Sam, her therapist learns of her most significant goals as she progresses toward wellness. These include (a) safe bathing and grooming with enhanced independence and (b) renewal of participation in active parenting. Sam voices that she has historically been very self-reliant and that she finds significant meaning in her independence. She also notes that she values personal hygiene and appearance and that these are important inputs to her self-esteem. When asked what she holds personally sacred, Sam notes that aside from her independence in self-care and renewal of her parenting and partnering roles, she is particularly motivated to be able to return to walking her dog, Rubi, with her son on nearby nature trails. Sam indicates that this occupational performance with her child brings her peace and fulfillment.

In using the SOiL model, as a clinician, it is possible to partner with Sam to practically conceptualize her occupational performance via a lens of spirituality. Sam has described her relational inputs, including her long-term partner, her 13-year-old child, and her dog, Rubi. These are visually represented in Figure 3; SOiL model as trees with roots that extend to represent the depth and unique impact of each of those relationships on her spiritual soil. It is notable that these roots somewhat intermingle, and this represents the connection between her son, her partner, and her dog in Sam's spiritual soil.

Sam's illness experiences of tibia/fibula fracture and longer-term anxiety are also represented in Figure 3, the SOiL model. The tibia/fibula fracture is represented as a relatively shallow but somewhat wide impact on the surface of Sam's spiritual soil. In using the SOiL model, it is possible for the clinician to visually describe the impacts of this experience in several ways. First, the width of the illness experience fissure describing Sam's tibia/fibula fracture may interfere with some of those crops that symbolize Sam's occupational performance. This supports narration of those tasks where Sam can participate, such as bathing and grooming, but where she might require some level of support because of illness impacts. Second, the depth of the tibia/fibula illness experience fissure may simply prevent some occupational performance from occurring. It is notable that depth in spiritual soil, and similarly depth of illness experience, describes a temporal impact in the SOiL model. In Sam's case, the depth of her tibia/fibula illness experience relates to several months of impact. These impacts, according to Sam, have mediated her participation in personally sacred occupations, such as independent parenting and/or walking in nature with her dog and her child. Accordingly, these occupations cannot be represented by rows of crops. If desired, the clinician can indicate, above the illness experience fissure, what the impacts may be for Sam in terms of limitation in occupational performance.

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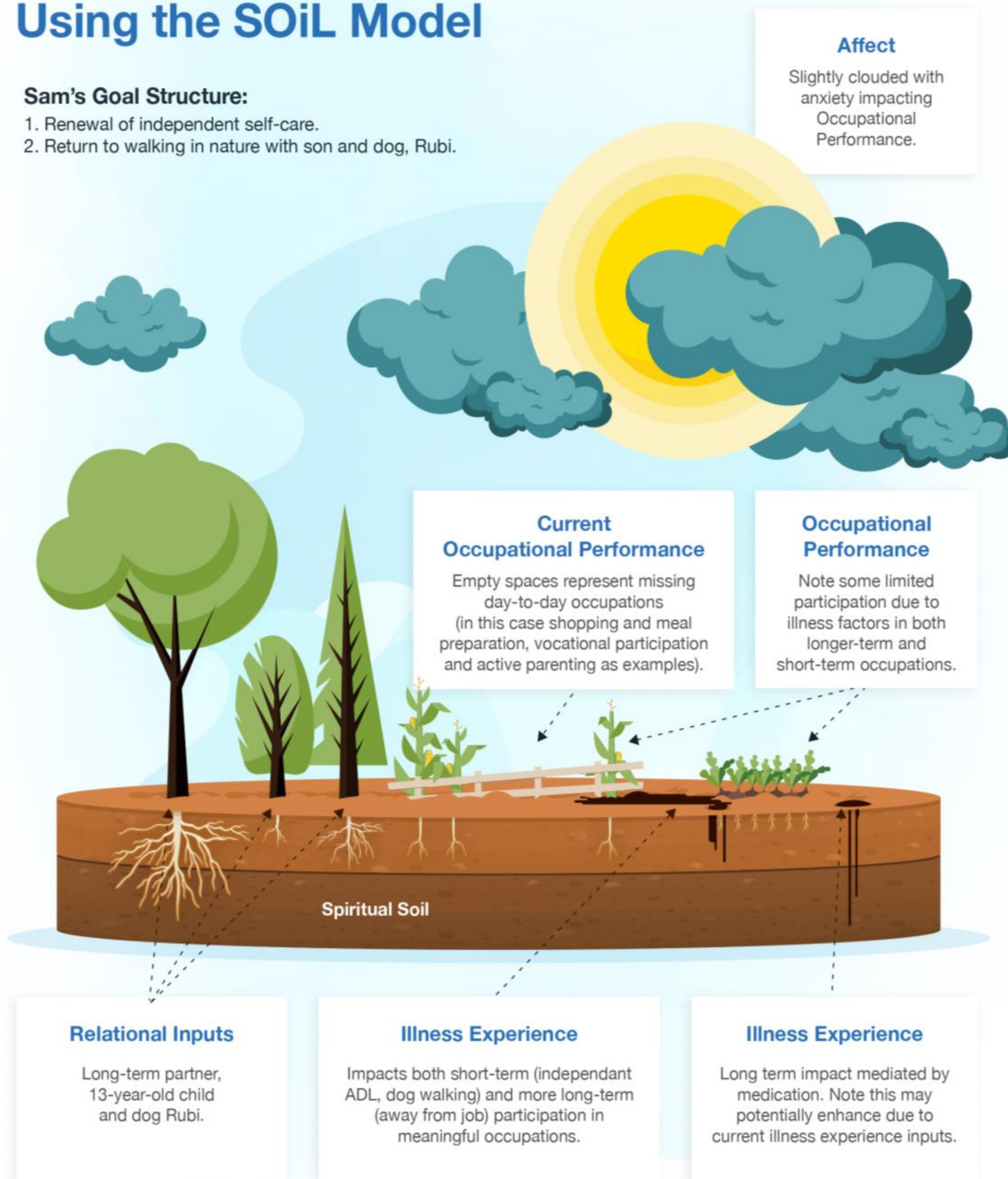
Figure 3



Sam's longer-term illness experience of anxiety is similarly represented as a fissure. However, in this case, the fissure is significantly deeper and somewhat narrower than the one representing the tibia/fibula fracture. The depth of the fissure symbolizes, temporally, the longer-term impacts of anxiety disorder for Sam. The limiting of width over time speaks to the positive impact that medications and therapeutic care have offered in mediating the impact of her illness. Sam's current affect does, however, also involve some anxiety about both her current occupational performance and her longer-term return to

work. This is represented in Figure 3, the SOiL model by several dark clouds limiting some sunshine and providing a visual representation of Sam's current affective status.

In narrating her occupational performance using the SOiL model, Sam has described a goal structure that speaks to elements held personally sacred to her: (a) renewal of independent self-care and (b) enhanced participation in active parenting (in particular, a return to walking in nature with her son and her dog). In working with her, these are written on the SOiL model and may be revisited in future model applications as Sam's wellness and occupational performance change. In using the SOiL model, it is possible for the clinician to partner with Sam to visually and, over time, narrate the impacts of her illness experience via a lens of spirituality in a manner that is personally meaningful, client-driven, and client-centered.

Implications for Occupational Therapy Practice

It appears that the occupational therapy profession has held a long-term interest in the concept of spirituality. Within that time frame, a significant volume of scholarship has also been developed. This includes current practice guidance from the American Association of Occupational Therapists (2020) identifying spirituality as a client factor representative of "specific capacities, characteristics, or beliefs that reside within the person and that influence performance in occupations" (AOTA, 2020, p. 75).

While professional interest in spirituality has been significant, it also appears that a focus on related professional education has been somewhat more limited. Indeed, it seems that as the profession has grappled with the spirituality concept, it has similarly struggled with how to support clinicians and students in learning about how it might reasonably integrate into day-to-day clinical practice. As early as 1991, the CAOT noted that "the spiritual dimension is largely unplotted territory within our professional practice" (p. 58). In considering academic preparation, Rose (1999) reported: "73% of respondents considered that their educational preparation had not prepared them to deal with client's spiritual needs" (p. 307). Over time these issues with limitations in training and educational preparation supporting spirituality in practice do not seem to have markedly abated (Kirsh et al., 2001; Morris et al., 2014; Taylor et al., 2000). Indeed, as recently as 2016, in the South African educational context, Mthembu et al. (2016) noted: "It is unclear whether any single course on teaching and learning of spirituality and spiritual care exists" (p. 1529).

In accounting for this broader context, it appears that there are significant implications for occupational therapy education and professional development related to spirituality. Given the centrality of spirituality at a professional level, both nationally and internationally, it seems that the inclusion of these concepts into core occupational therapy curricula and professional development modules should be a professional imperative. This academic preparation could focus across the lifespan and account for physical, cognitive, or mental health changes and differences. The SOiL model, as presented, may offer educators and those supporting professional development one avenue to support this essential professional focus.

SOiL Model - Conclusion

It appears that the profession of occupational therapy has struggled with the concept of spirituality for a long time. Indeed, questions of definition, application, and educational preparation have persisted. It also appears that significant professional distractions, including an interesting longer-term desire for definitional consensus, have somewhat limited clinicians in the day-to-day application of spirituality concepts. Further, what seems to be a somewhat limited focus on spirituality in both academic preparation and ongoing professional development, appears to have also potentially contributed to limiting day-to-day clinical application. Finally, it seems that the absence of a practical conceptual model enabling clinicians to frame occupational performance via the lens of spirituality may have also limited the day-to-day application of spirituality concepts in practice. The SOiL model was developed to meet this professional need.

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