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Occupational Therapists' Perceptions on Addressing Spirituality: A Cross Sectional Survey

Shannon Metzger

Grand Valley State University - USA, metzgesh@mail.gvsu.edu

Jeanine Beasley

Grand Valley State University - USA, beasleyj@gvsu.edu

Jordan Marheineke

Grand Valley State University - USA, marheinj@mail.gvsu.edu

Amy Stites

Grand Valley State University - USA, stitesa@mail.gvsu.edu

Amy Riley

Grand Valley State University - USA, rileyam@mail.gvsu.edu

See next page for additional authors

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Occupational Therapists' Perceptions on Addressing Spirituality: A Cross Sectional Survey

Abstract

Background: Occupational Therapy (OT) was founded as a holistic profession that addresses the mind, body, and spirit. Research indicates that occupational therapists feel uncomfortable incorporating spirituality into practice. **Method:** This study aimed to identify perceptions of occupational therapists in addressing the spiritual needs of their clients. A cross-sectional Qualtrics survey was adapted from the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS). The survey was electronically sent out by several professional OT organizations. It was sent to occupational therapists and OT assistants to obtain their perspective of incorporating spirituality in practice. Quantitative and qualitative data analysis was completed. **Results:** Of the 52 participants that completed the Likert scale items on the survey, 46 were open to learning about spiritual beliefs that differ from their own. Ninety-seven percent of the participants believed incorporating spirituality can improve client outcomes and achieve goals; 95% could address unfamiliar beliefs; and > 90% said that it was essential to address clients' spiritual beliefs. Qualitative themes involving barriers to spiritual implementation included: too little time, lack of education, and workplace integration complications. **Conclusion:** Although spirituality is accepted as part of the OT process, there are a multitude of barriers that impact the feasibility and inclusion of spirituality in practice, including time, workplace integration, and education.

Comments

The authors declare that they have no competing financial, professional, or personal interest that might have influenced the performance or presentation of the work described in this manuscript.

Keywords

occupational therapy, perception, spirituality

Complete Author List

Shannon Metzger, Jeanine Beasley, Jordan Marheineke, Amy Stites, Amy Riley, Christine Byam, Diane Maodush-Pitzer, and Dawn R. DeVries

Credentials Display

Shannon Metzger, BS Psychology, BS Clinical Exercise Science; Jeanine Beasley, EdD, OTRL, CHT, FAOTA; Christine Byam, BS Recreational Therapy; Jordan Marheineke, BS Recreational Therapy; Amy Riley, BA Communication Studies; Amy Stites, BS Pre-Physical Therapy; Diane Maodush-Pitzer, DHA, MPA, CTRS; Dawn DeVries, B.S., M. Div, M.A., PhD

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Occupational Therapy (OT) has historically encompassed all aspects of the person, including the mind, body, and spirit, treating clients with a holistic view (Hemphill, 2015; Taylor et al., 2000). Seventy-five percent of United States adults claim they are spiritual (Lipka & Gecewicz, 2017), and 80% of Americans believe in God (Pew Research Center, 2018). There is a disconnect between OT theory and practice in that occupational therapists receive inadequate guidance to address spirituality (Farrar, 2001; Milliken, 2020; Morris, 2013). Although the first edition of the *Occupational Therapy Practice Framework: Domain and Process* (OTPF) included spirituality (American Occupational Therapy Association [AOTA], 2002), throughout the following decades, occupational therapists continued to feel uncomfortable incorporating spirituality into their practice (Egan & Swedersky, 2003; Engquist et al., 1997; Farrar, 2001; Morris et al., 2014; Thompson & Gee, 2018). This study aimed to investigate further the perceptions of occupational therapists addressing the spiritual needs of their clients.

Many people use spirituality to find their purpose, meaning, and motivation in life, and these values then guide their actions (AOTA, 2020a). Lukoff et al. (1992) concurred that religion and spirituality (R/S) are important factors that influence clients' experiences, habits, principles, and disease course. Because OT practice is driven to aid clients in finding motivation and meaning in life, spirituality fits well as a core component of its holistic care. Pham et al. (2020) claimed that additional research is needed to explore how best to implement spirituality to provide holistic care. Morris (2013) suggested that future research could focus on more specifics of the occupational therapists' background and current practice. The purpose of this current study was to expand on the work of Morris and Pham et al. regarding the current perceptions of occupational therapists addressing their clients' spiritual needs.

Literature Review

Spirituality is integral to the holistic foundations of OT (AOTA, 2020a; Morris, 2013; Mthembu et al., 2015; Wengerd, 2022). However, spirituality does not currently hold a significant place in OT practice (Collins et al., 2002; Milliken, 2020; Morris, 2013; Morris et al., 2014; Thompson & Gee, 2018; Wengerd, 2022).

It is common for people to gravitate toward spirituality when recovering from illness (Milliken, 2020; Mthembu et al., 2015). Research found that implementing spirituality in practice improved recovery, including increased energy levels, quality of life, a stronger sense of meaning in life, and better coping strategies for those who value religiousness and spirituality (Hinkel et al., 2020; Kelly & Eddie, 2020; Mthembu, 2015; Thompson & Gee, 2018). In addition, Engquist et al. (1997) found that 84% of occupational therapists agreed that a client's health and rehabilitation benefit by including spiritual practices in the intervention.

There is supporting evidence of the inclusion and acceptance of spirituality in assessments used by physicians, mental health professionals, and licensed clinical social workers (Dimmick et al., 2021; Hinkel et al., 2020; Kelly & Eddie, 2020; Oxhandler et al., 2019). Attitudes toward spiritual inclusion are mixed in the occupational therapy practice research. Engquist et al. (1997) reported that 37% of surveyed occupational therapists felt spirituality was not within their scope of practice, and over 90% viewed clergy/pastoral staff as responsible for their clients' spiritual needs. Concurrently, while some occupational therapists believed that spirituality was part of their practice domain (Collins et al., 2002; Farrar, 2001), Morris (2013) found that nearly 70% of surveyed occupational therapists felt their education did not prepare them to address their clients' spiritual needs in practice. Further research affirmed that education may be a limitation (Morris et al., 2014; Mthembu et al., 2015; and Mthembu et al., 2016), as certain topics, such as spirituality and sexuality, are rarely addressed in academia. As such, occupational

therapists may need to seek out their own continuing education on these two topics (Engquist et al., 1997; Morris et al., 2014).

The current health care landscape prioritizes measurable and functional goals, which fail to consider psychosocial and spiritual aspects that can profoundly impact health outcomes (Pham et al., 2020). Insurance companies may not support spiritual outcomes and goals (Engquist et al., 1997), and therapists may perceive that there is an increased time commitment to deliberate and evaluate higher thought-provoking issues, such as spirituality (Egan & Swedersky, 2003; Misiorek & Janus, 2019). In addition, the ambiguity of the definition of spirituality (Morris et al., 2014; Egan & Swedersky, 2003; Misiorek & Janus, 2019; Morris, 2013; Taylor et al., 2000) greatly inhibits occupational therapists' confidence in addressing the topic. Some therapists believe the topic of spirituality aligns too closely with religion, which they may feel is unprofessional to discuss in settings such as public schools that may differentiate religion from the state (Engquist et al., 1997; Thompson & Gee, 2018). Further, there is a lack of knowledge and use of spiritual assessments (Morris et al., 2014) and a lack of diversity in previously surveyed samples (Dimmick et al., 2021; Hinkel et al., 2020; Misiorek & Janus, 2019; Morris, 2014) that restricts overall information from patients and occupational therapists alike.

This study aimed to expand on previous studies and answer the following research question: What are the current perceptions of occupational therapists in addressing the spiritual needs of their clients?

Method

Research Design

A cross-sectional survey was selected as the research design to obtain occupational therapists' perspectives of spirituality in practice. An electronic survey was determined to be the most efficient way to obtain the largest number of responses in the timeframe. The Grand Valley State University Institutional Review Board approved this study. The researchers contacted several organizations through their social media, websites, and email correspondence to obtain permission for survey distributions. This included AOTA, Canadian Association of OT, Michigan OT Association (MiOTA), and various Facebook Groups: OT New Grads and Students and OT Community. Inclusion criteria included individuals who were current or retired registered occupational therapists (OTR) or current or retired certified OT assistants (COTA). Exclusion criteria included participants who were not OTRs/COTAs. These details were self-disclosed in the demographics of the survey. Electronic consent was obtained from the participants.

Instrument

The present survey was adapted from the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) from Oxhandler (2019). The original survey consisted of a 40-item RSIPAS with established face, content, criterion, discriminant, and factorial validity. All subsections have been found to be reliable ($\alpha = .84-.91$), as was the overall 40-item scale ($\alpha = .95$) (Oxhandler, 2019). Survey questions are divided into four subsections: (a) Self-Efficacy Regarding Spirituality in Practice, (b) Attitudes Regarding Spirituality in Practice, (c) Feasibility of Integrating Spirituality into Your Practice, and (d) Including Spirituality in Your Practice. Questions unrelated to the present research question were excluded, and some were combined to reduce redundancy. The present survey contains 24 questions: 20 of the original 40 Likert scale questions and one open-ended question added to each of the four subsections for the participants to add comments. The participant responses in the 2014 RSIPAS and the present survey were collected through a 5-point Likert scale ranging from *strongly disagree* to *strongly agree* (Oxhandler, 2019). The following instructions and definition of spirituality from the OTPF were fixed at the top of each survey page to reduce any ambiguity in the meaning:

According to the OTPF, spirituality is a “deep experience of meaning brought about by engaging in occupations that involve the enacting of personal values and beliefs, reflection, and intention within a supportive contextual environment” (Billock, 2005, as cited in AOTA, 2020a, p.15). Please keep this definition in mind as you fill out this survey. Please complete this survey in regard to your most recent practice setting.

A demographic questionnaire adapted from Wurm (2004) was used to gather information on the participants (see Table 1).

Table 1
Demographic Questions

Question	Type of response
“Please indicate your gender”	Free response
“Please indicate your age”	Free response
“Please check the area of practice that best describes your current or most recent work setting”	Multiple choice (could select more than one) with option to free response “other”: “school-based,” “home-health,” “inpatient rehab,” “inpatient acute,” “residential care home,” “memory care,” “private practice,” “community-based care,” “hospice care,” “mental health,” “outpatient,” “other (please specify)”
“Please check all that apply”	Multiple choice (could select more than one) with option to free response “specialty certification” or “other”: “associates degree in OT,” “bachelor’s degree in OT,” “master’s degree in OT,” “doctorate in OT,” “certificate in OT,” “doctoral in other field,” “Specialty certification (please specify),” “other (please specify)”
“Please check one of the following”	Pick either: “currently practicing,” “not currently practicing,” or “retired”
“Years of practice”	Free response
“Practice location (population)”	Pick either: “Rural (<10,000),” “Medium-size town (10,000-50,000),” or “City or metropolitan area (>50,000)”
“The majority of the people I treat are between this age”	Pick either: “0-17,” “18-30,” “31-55,” “56-70,” “71+”
“Are you a”	Pick either “OTR*,” “COTA*,” or “Other (please specify)”
“Is there a religious/spiritual affiliation at your workplace?”	Pick either “Yes,” or “No”
“What university did you obtain your degree from?”	Free response
“Are you comfortable with your spiritual/nonspiritual identity?”	“Yes,” “No,” or “unsure”

Note: Registered Occupational Therapist = OTR; Certified Occupational Therapy Assistant = COTA.

Morris (2013) suggested that future research should include what university the occupational therapists attended, as this may have a more direct bearing on their attitudes toward spirituality. A demographic question was added regarding comfort with their own spiritual identity, as recommended by Taylor (2000), who reported that individuals who considered themselves religious had a positive view of spirituality in practice. Demographic questions were placed after the survey questionnaire to encourage more responses.

Procedure

The researchers deployed the Qualtrics link to the above-listed forums/emails for the participants to complete anonymously at their convenience. A second link was sent 2 weeks later as a reminder to those who did not complete the survey to increase participation. Once clicking the Qualtrics link, the

participants were presented with an electronic consent form. The participants were then shown the present study's five self-efficacy questions, followed by five attitude questions, five feasibility questions, and five inclusion questions. Each section was presented on its own page. At the bottom of each respected section was a free response block allowing the participants to add any comments to the corresponding section. The participants could view the survey items at their own pace and advance/go back to any page at their leisure. Following the last subsection, the participants were presented with the demographic section.

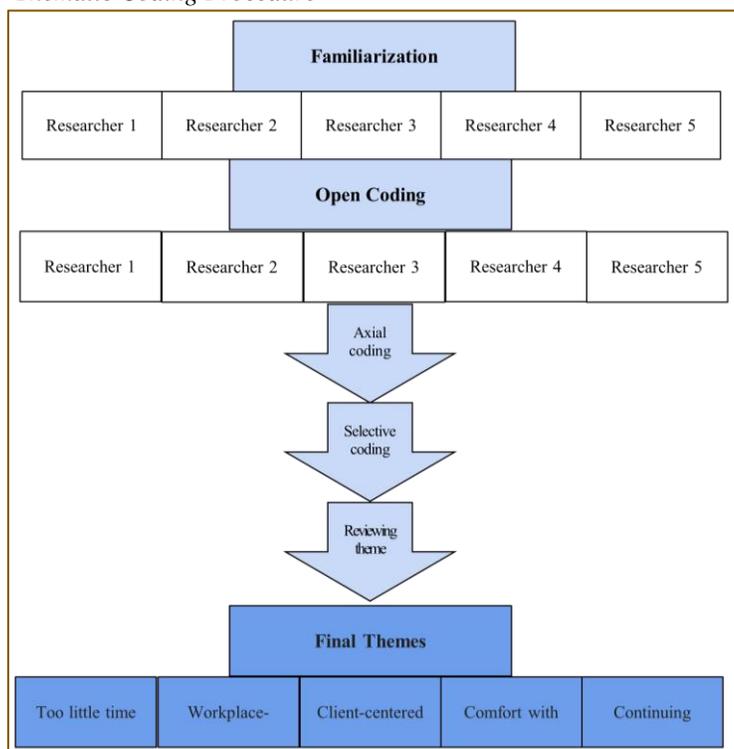
Data Analysis

Demographic questions were analyzed using descriptive statistics. Numeric equivalents (as used with the original RSIPA scores) were assigned Likert responses of *strongly disagree* = 1, *somewhat disagree* = 2, *neither agree nor disagree* = 3, *somewhat agree* = 4, and *strongly agree* = 5. A mean score was obtained for each participant's subscale. Frequency tables were used to analyze participant data. Cronbach's alphas were used to analyze reliability in the subsections, and Pearson correlation coefficients were conducted to analyze relationships between subsections. Significance level probability was set at $p \leq .05$.

Open-ended comments at the end of each subset were coded through qualitative thematic processes by the researchers to categorize these responses into themes. The open-ended comments (see Figure 1) in each subsection were analyzed through a qualitative thematic process that consisted of six steps (Roller & Lavrakas, 2015). This process involved each individual researcher reading and rereading the comments, which provided an orientation to the data. Open coding was then used by each researcher to condense the data into a manageable format for analysis. Then, each researcher individually performed axial coding to consolidate and refine their themes. Next, the researchers collaborated on selective coding, ensuring that the themes formed a logical pattern. Lastly, the researchers defined and named the themes in relation to the research question (Braun & Clarke, 2006).

Figure 1

Thematic Coding Procedure



Results

This study sample included 52 participants, but not every participant answered every question. In response to the demographic questions, 40 identified as female (95.2%), one as male (2.4%), and one person recorded their gender as “spiritual warrior” (2.4%). The mean age of the participants was 46 years (range = 25–63). The mean length of practice was 16 years (range = 0–40). Practice location results were consistent with the AOTA 2019 Workforce Survey regarding practice locations (2020b) (see Table 2). The largest number of the participants worked in outpatient settings (n = 12; 26.1%) (see Table 2). The practice setting percentages are consistent with the AOTA 2019 Workforce Survey (2020b) regarding practice locations, except for the school-based setting, which was underrepresented in this study. The most common education level was a master’s degree (see Table 2). Forty-one (95.3%) of the participants were currently practicing, and 2 (4.7%) were not currently practicing. These demographics are consistent with 2022 OT demographic statistics (Zippia, Inc., 2022), except for male respondents who were underrepresented in these results.

Table 2

Frequencies of Participant Practice location, Practice area, and Educational Degree

		Frequency	Total
Practice Location	City or metropolitan area (>50,000)	25	43
	Medium size town (10,000-50,000)	13	
	Rural area (<10,000)	5	
	Did Not Report	9	
Practice Areas	Community-based Care	4	52
	Home Health	7	
	Inpatient Acute	7	
	Inpatient Rehab	4	
	Mental Health	3	
	Other	2	
	Outpatient	12	
	Private Practice	3	
	Residential Care Home	1	
	School-based	1	
	Skilled Nursing Facility	6	
	Did Not Report	2	
Educational Degree*	Associate’s Degree in OT	5	*63
	Bachelor’s Degree in OT	9	
	Master’s Degree in OT	22	
	Doctorate in OT	7	
	Certificate in OT	2	
	Specialty Certification	9	
	*Did Not Report	9	

**Note: for educational degree, participants were allowed to select more than one option.*

RSIPAS Results

Forty-six of the participants completed the Likert scale questions. Thirty-nine of the participants (90.7%) answered “yes” that they were comfortable with their spiritual/nonspiritual identity; three participants were unsure (6.98%), and one participant said “no” (2.32%). Forty-one of the participants (95%) were currently practicing. The participants somewhat or strongly agreed on many of the questions but were split on two of the questions (see Table 3).

Table 3
Frequencies of Most-Agreed and Split Questions

Question	Strongly/Somewhat disagree	Neither Agree nor Disagree	Somewhat/Strongly agree
I am open to learning about my clients' spiritual beliefs that may differ from mine	0 (0%)	0 (0%)	46 (100%)
Integrating clients' spiritual needs during treatment helps improve client outcomes and goals	0 (0%)	1 (2.1%)	45 (97.8%)
I know what to do when my clients have spiritual beliefs that I am unfamiliar with	1 (2.13%)	1 (2.13%)	44 (95.65%)
Sensitivity to a client's spiritual needs is consistent with the principles of client-centered practice and the occupational therapy code of ethics	1 (2.17%)	1 (2.17%)	44 (95.65%)
I am aware of the spiritual resources if my clients see this as an important aspect to their healing process	2 (4.26%)	2 (4.26%)	42 (91.3%)
It is essential to assess client's spiritual beliefs in practice	1 (2.17%)	3 (6.52%)	42 (91.3%)
I had to take continuing education credits to feel comfortable integrating my clients' spirituality into treatment	20 (43.5%)	6 (13%)	20 (43.5%)

Means were calculated for each section score out of five possible points. A group mean (*M*) and standard deviation (*SD*) were then calculated for each subsection. The *M* and *SD* were as follows: Subsection 1: self-efficacy (*M* = 4.13, *SD* = .68), Subsection 2: attitudes (*M* = 4.57, *SD* = .45), Subsection 3: feasibility (*M* = 3.04, *SD* = .73), and Subsection 4: inclusion (*M* = 3.38, *SD* = .90). The *M* and *SD* for Subsection 1 and Subsection 2 were the greatest, demonstrating higher feelings of self-efficacy and positive attitudes toward spirituality in practice. The *M* and *SD* for Subsection 3 and Subsection 4 had lower mean scores, showing that the participants had less feasibility and inclusion of spirituality in practice (see Table 4).

Adapted RSIPAS

A correlation (CORR) procedure was used to obtain a Cronbach's coefficient alpha (α) to determine the internal consistency of the Likert scale subsections. The participants answered the five items in each section similarly, meaning a participant who agreed to one item in the section was more likely to agree with the remaining items. These correlations ($\alpha = .45-.80$) were lower but related to the positive correlations of the original RSPIA scores ($\alpha = .84-.91$) (Oxhandler, 2019). A Pearson correlation (*r*) was also computed to assess the relationship between the four subsections. These correlations ($r = .40-.61$) related to the RSPIA as they demonstrated moderate positive internal consistency reliability, with each subsection of the survey appearing to measure the same construct.

Table 4
Summary of Means, Standard Deviations, and Correlations of Subsections

(Cronbach's Alpha)	N	Mean	Std Dev	Sum	Min	Max	Subsec 1	Subsec 2	Subsec 3	Subsec 4
Sec 1: Self-efficacy ($\alpha = .69$)	47	4.13	0.68	194.10	2.40	5.00	–	$r = 0.40$ $p = <.05$	$r = 0.61$ $p = <.05$	$r = 0.54$ $p = <.05$
Sec 2: Attitudes ($\alpha = .80$)	46	4.57	0.50	210.40	2.60	5.00	$r = 0.40$ $p = .05$	–	$r = 0.56$ $p = .05$	$r = 0.49$ $p = .05$
Sec 3: Feasibility ($\alpha = .45$)	46	3.04	0.73	139.80	1.20	4.20	$r = 0.61$ $p = .05$	$r = 0.56$ $p = .05$	–	$r = 0.59$ $p = .05$
Sec 4: Inclusion ($\alpha = .78$)	43	3.38	0.90	145.40	1.20	5.00	$r = .54$ $p = 0.00$	$r = 0.49$ $p = 0.00$	$r = .59$ $p = .00$	–

Qualitative Data

Themes were deduced from the open-ended questions. The researchers reflected on the importance of each of the following final themes: too little time, workplace-based, client-centered, comfort with experience, and continuing education (see Table 5). The theme of “too little time” related to issues such as productivity and work demands, limiting the inclusion of spirituality in practice. The theme of “workplace-based” related to how certain practice settings or populations (like pediatrics) may inhibit how and if spirituality is addressed. The theme of client-centered related to how spirituality is personal for each client and that interventions must be individualized. The theme of “comfort with experience” highlighted that the more experience and knowledge an occupational therapist has on the topic of spirituality, the more comfortable they are addressing spirituality in practice. Finally, “continuing education” related to how many occupational therapists were unaware of continuing education that addressed spirituality.

Table 5
Examples of Participants' Responses to Open-Ended Questions Sorted by Theme

Too Little Time
“Unfortunately, in my acute care job, there is little time to incorporate spiritual assessment or concerns due to very brief Eval and dc times.”
“I address what is important for the client, but I do not go out of the way to address spirituality. With productivity issues in SNF, there is really not enough time. It is a disservice to clients, but the real world is so removed from what is considered ‘ideal’ practice that is taught in the classroom.”
Workplace-based
“It is not promoted within my workplace.”
“Difficult to address in pediatrics.”
“I travel to many buildings and the attitude varies regarding spirituality in the workplace. Most of the time it’s important to address the issue in the privacy of their rooms.”
Client-centered
“It aligns well with patient-centered care - we customize care to the needs, wishes and resources of the patient - spirituality is one aspect of that process and should be considered with every patient individually.”
“I think the importance of intervention varies depending on the value the patient places on spirituality.”
“It’s an important part of who they are.”
Comfort with Experience
“It was not covered when I was in my OT program. It has felt awkward to address anything beyond individual goals until recently when I developed a greater comfort level with the topic through my own life experiences.”
“I learned more during an internship for my advanced degree and internship with hospice.”
Continuing education
“What continuing education classes are available for this?”
“I am unaware of any CEU that addresses this.”

Discussion

This study agreed with the findings presented by Lukoff et al. (1992), who stated that R/S are important factors that influence clients' experiences, habits, principles, and disease course. Other research has explored how spirituality improves recovery and quality of life (Hinkel et al., 2020; Kelly & Eddie, 2020; Thompson & Gee, 2018). The current study also agreed with Pham et al. (2020), who stated the current health care system fails to consider psychosocial and spiritual aspects, preferring measurable and functional goals. The participants in this study agreed that certain settings, such as skilled nursing, acute care, and pediatrics, provide limited time to address spirituality. Perhaps barriers, such as productivity standards and reimbursement conflicts, prevent many therapists from prioritizing spirituality. One participant stated the practice world is removed from the "ideal" practice setting discussed in the classroom.

The participants disagreed with past literature regarding the scope of practice and education on spirituality. This study contradicts Engquist et al. (1997), where 37% reported spirituality was not in their scope of practice, and most of the participants believed that there was a place for spirituality in OT practice. Although Morris (2013) stated most occupational therapists felt their education did not prepare them to address their clients' spiritual needs in practice, this study found that only 40% of the participants stated their education did not prepare them, and an additional 41% stated they were neutral. Previous research claimed a barrier to spiritual inclusion was a lack of confidence and comfort with how to inquire about a client's R/S practice (Morris et al., 2014; Thompson & Gee, 2018).

Similar to Oxhandler (2019), a strength of the current study was its relatively high measure of internal consistency in the survey. The participants' low ratings of feasibility and inclusion agreed with past literature findings that concluded spirituality is challenging to address in OT practice (Collins et al., 2002; Curlin et al., 2006; Milliken, 2020; Morris, 2013; Morris et al., 2014; Thompson & Gee, 2018; Wengerd, 2022). It is the researchers' hope that if feasibility barriers are addressed, spirituality may have the potential to be included in practice. The participants agree with previous research (Collins et al., 2002; Farrar, 2001) that spirituality is in the OT scope of practice, as shown by their high ratings of self-efficacy and attitudes toward integrating spirituality in practice. This research infers occupational therapists value spirituality and are open to including it. However, they may have limited individual experiences with spirituality and have a hard time implementing spirituality in practice because of barriers, such as it not being promoted in the workplace and too little time.

Limitations

The small convenience sampling through an online survey limits the generalizability of the current findings. The participants also had the ability to fill out the survey more than once. Though we submitted our survey to select organizations (AOTA, CAOT, WOTA, IOTA, and various OT-based Facebook groups), not all groups posted the survey. The researchers could not track the participants to specific organizations or specific geographic areas. Also, this study was adapted from the RSIPAS, and additional psychometrics of the modified survey are needed. Re-validating the new version of the survey was not an objective of this current study and is a limitation. Additional research is needed in this area.

Implications for Future Research

The results of this study should be interpreted with caution. Having a larger, more diverse sample size and obtaining the clients' perspectives should aid in further exploration of spirituality incorporation in OT practice. Future research could include exploring the ambiguity and broadness of the definition of

spirituality. This study provided the OTPF's definition at the top of each page of the survey for reference. Another avenue to investigate is how spirituality is interwoven in clients' roles and routines. These practices will challenge the occupational therapist to think outside traditional religious roles (such as the bible and attending church) to things such as individualized practices at mealtimes, food and/or drink exclusions, prayers at different times of the day, refusing therapy on an observed Sabbath, specific seating, order of food consumption, etc. In addition, standard evaluations may be examined to troubleshoot how spirituality may be integrated as a common intake question. Future research could explore how interdisciplinary teams, including social work, hospice care, physical therapy, recreational therapy, and/or chaplains, can work together to include a client's spirituality in their holistic care.

Conclusion

Although spirituality is accepted as part of the OT process, there are a multitude of barriers that impact the feasibility and inclusion of spirituality in practice. The therapists in this study agreed that they know what to do when they encounter unfamiliar spiritual beliefs, and they believed it is important to address spirituality when providing client-centered practice. However, issues with too little time, workplace integration complications, and a need for additional education limit the therapist's ability to address spirituality in OT practice.

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QUESTIONNAIRE

J4(25)

Occupational Therapists' Perceptions on Addressing Spirituality

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

Question 1: Seventy-five percent of United States adults claim they are spiritual, many using spirituality to find their purpose, meaning, and motivation in life, and these values then guide their actions.

- A: TRUE
- B: FALSE

Question 2: Occupational therapy has historically encompassed all aspects of the person, including the mind, body, and spirit, treating clients with a holistic view, yet occupational therapists continued to feel uncomfortable incorporating spirituality into their practice.

- A: TRUE
- B: FALSE

Question 3: Research found that implementing spirituality in practice had which of the following three effects?

- A: Improved recovery
- B: Increased dependence on occupational therapists and reduced self-efficacy
- C: Increased energy levels, and better coping strategies
- D: Let to a perceived better quality of and a stronger sense of meaning in life

Question 4: *Engquist et al.* (1997) reported that _____ of surveyed occupational therapists (OTs) felt spirituality was not within their scope of practice, and over _____ viewed clergy/pastoral staff as responsible for their clients' spiritual needs.

- A: 73%; 50%
- B: 23; 95%
- C: 37%; 90%
- D: 90%; 50%

Question 5: The current health care landscape prioritises measurable and functional goals, which fail to consider which of the following that can profoundly impact health outcomes? Select BOTH correct options.

- A: Cognitive functioning
- B: Psychosocial and spiritual aspects
- C: Spiritual aspects
- D: Sleep quality

Question 6: Some OTs believe the topic of spirituality aligns too closely with religion, which they may feel is _____ to discuss in settings such as public schools that may differentiate religion from the state.

- A: Good
- B: Appropriate
- C: Unnecessary
- D: Unprofessional

Question 7: In this study _____ % of OTs strongly agreed that they knew what to do when their clients have spiritual beliefs that they (the OT) are unfamiliar with.

- A: 95%
- B: 43%
- C: 21%
- D: 100%

Question 8: Most of the participants in this study believed that _____?

- A: There was no place for spirituality in OT practice
- B: They were prepared and able to address spirituality
- C: They would not make a difference if they addressed spirituality
- D: There was a place for spirituality in OT practice

Question 9: This study found that _____ of OTs stated their education did not prepare them to address their clients' spiritual needs in practice.

- A: 20%
- B: 80%
- C: 40%
- D: 60%

Question 10: Which of the following limit the OTs ability to address spirituality in OT practice? Select all correct options.

- A: Too little time
- B: Workplace integration complications
- C: A need for additional education
- D: Client's interest in spiritual matters

THE END



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400 Theuns van Niekerk Street

Wierda Park

0157

PO Box 71

Wierda Park

0149

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This activity is accredited for **TWO (2) CLINICAL CEU'S**. You have to achieve 70% to pass this activity.

ANSWER SHEET

J4(25)

Occupational Therapists' Perceptions on Addressing Spirituality

	*Time spent on activity					hour		min				
	A	B	C	D	E			A	B	C	D	E
1						6						
2						7						
3						8						
4						9						
5						10						

How relevant was the content of this activity to your scope of practice?			
			
Not at all	Somewhat	Mostly	Extremely

RETURN ANSWER SHEET TO

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