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Spiritual Assessments in Occupational Therapy

Abstract

Spirituality is recognized as an important concept in the study and practice of medicine, including occupational therapy. This aligns with occupational therapy's core value of treating people holistically—mind, body, and spirit. Currently, the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) requires that a spiritual assessment be given to patients on admission. To conduct effective spiritual assessments, occupational therapists must distinguish between religion and spirituality. They also must be aware of their own spiritual beliefs and practices and how those might influence their clinical interactions. This article presents spiritual assessment tools that occupational therapists can use in clinical practice; they range from history taking, to questionnaires, to observation scales. Guidelines are presented for selecting among several spiritual assessments. A case study is presented in which a patient's faith tradition is being challenged, which could affect the outcome of therapy. Finally, treatment and intervention planning and ethical considerations are discussed.

Keywords

spirituality, religion, wellness, spiritual crisis, spiritual distress, medical schools, spiritual history

Cover Page Footnote

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Credentials Display

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Based on the assumption that there is an ontological drive to make sense of life, particularly in the presence of tragedy, individuals face the task of redefining the meaning of their existence within the reality of the threat of nonbeing.

(Sorajjakool, 2006, p. 83)

Historically, occupational therapists have been concerned with the care of the whole person—body, mind, and spirit—and have a professional commitment to treat individuals from a holistic perspective. Illness, by its very nature, is a spiritual encounter as well as a physical and emotional experience. But the spiritual is the least visible aspect of the whole. How can occupational therapists effectively address the spirituality of their patients in their daily practice?

The term spirituality comes from the Latin word *spiritus*, meaning breath or life. The word spirit can be a synonym for the living soul. It can mean courage, determination, and energy. Nelson (2011) stated:

> the term "spiritual" is generally applied to any human essence connecting us to an unseen world that defies scientific measurement but which we nonetheless believe and feel exists, leaving traces here and there. It can refer to anything transcendent or something that deeply moves us or connects us in one way or another to something larger than ourselves." (p. 17)

It is something beyond the human being. Nelson defined spiritual as a "direct personal experience, regardless of social context" (p. 26), and, quoting William James (1982), what makes a personal experience spiritual is "'the feelings, acts, and experiences' of individual people who in their solitude understand they have touched 'whatever they may consider the divine'" (p. 26). This definition is both inclusive and expansive. It means many things to many people and includes concepts such as meaning and purpose, connectedness, peacefulness, personal well-being, and happiness.

Spirituality, Religion, and Health Care

The study and practice of medicine recognizes spirituality as an important concept. Hospitals and health care organizations seem to be listening to what the research says. Since 2000, the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) has required "that a spiritual history be taken on every patient admitted to an acute care hospital or a nursing home, or seen by a home health agency, and that spiritual history must be documented in the medical record" (Koenig, 2007, p. 4). According to Davis (1997), "we are morally obliged to act in certain ways that reflect what it means to be professional, to respond to fellow human beings who place trust in us because of their vulnerability in times of need" (p. 24). Medical students are educated to understand that taking a patient's spiritual history is as relevant as taking a family history (Spencer, 2004).

In the specific context of occupational therapy, spirituality is viewed as part of the concept of holism and needs to be assessed (American Occupational Therapy Association, 2014). Therapists need to recognize whether their patients relate to spirituality through a traditional religious

discipline or through unconventional practices, and then assist them in their spiritual process.

According to Hodge (2001), in order to accomplish this, therapists must distinguish between religion and spirituality. Religion is an institutionalized form of spirit, expressed subjectively through rituals, beliefs, and practices.

> Spirituality is definitely a part of religion, but religion may not be a part of spirituality.

Spirituality contains the domains of religion, but a person can be spiritual without following religious ideology. Hodge (2001) defined spirituality "as a relationship with God, or whatever is held to be the Ultimate (for example, a set of sacred texts for Buddhists) that fosters a sense of meaning, purpose, and mission in life" (p. 204). This relationship results in concepts such as altruism, love, or forgiveness, which, in turn, affect a person's relationship to the self, nature, others, and the ultimate being (Carroll, 1997; Sermabeikian, 1994).

Many clinical assessments of spirituality are limited by their use of terms that are too narrow. These assessments generally assume that the patient is Christian and do not include other traditions. Therapists must take precautions not to use measures that are based on Christian ideology when assessing people who are not of the Christian faith. Further, some people might be offended by the word God or find it confusing or meaningless. Spirituality is a broader term that can be substituted. Some other examples of alternative words for God could be transcendent being, deity, or higher power.

Thus, the ability of any clinical assessment to capture a patient's spirituality is often limited by the choice of words. Spirituality can be described using words such as higher consciousness, transcendence, self-reliance, love, faith, enlightenment, community, self-actualization, compassion, forgiveness, mysticism, higher power, and grace. Any of these words can be used to describe the personal meaning someone attaches to human life. Spirituality, although often associated with religion, must be distinct from religion. Occupational therapists need to be careful to use words that are consistent with each individual patient's faith tradition.

A loss of meaning is perhaps the greatest crisis a person might experience when faced with illness or disease. People are able to deal with great physical and emotional trauma, but they might be unable to bear a sense of meaninglessness. People can overcome pain, disease, or hardship, but when they believe they are no longer needed, that they can no longer contribute, or that their life has no meaning, they are in spiritual crisis (Hay, 1989; Howard & Howard, 1997; Smucker, 1996). Anandarajah and Hight (2001) added to the discussion about spiritual crises and distress when they wrote:

> Spiritual distress and spiritual crises occur when individuals are unable to find sources of meaning, hope, love, peace, comfort, strength and connection in life or when conflict occurs between their beliefs and what is happening in their life. This distress

> can have a detrimental effect on physical and mental health. Medical illness and impending death can often trigger spiritual distress in patients and family members. (p. 84)

When a patient is in spiritual crisis, as defined by Anandarajah and Hight (2001), it is appropriate for occupational therapists to administer a spiritual assessment, to initiate discussion about spiritual needs, and to refer the patient to appropriate spiritual leaders, if necessary. Spiritual crises and spiritual distress are terms "used to describe a pervasive disruption in a person's spiritual life" (Hasselkus, 2011, p. 146). Spiritual crises are the opposite of spiritual health, spiritual well-being, and spiritual integrity.

Spirituality and the Assessment Process

The context for spiritual assessment includes the patient's spiritual locus of control, which includes well-being, personal beliefs, level of spiritual maturity, and religious traditions and values. Richards and Bergin (1997) proposed five reasons why spiritual assessment is essential in a therapeutic relationship: (a) to understand a patient's worldview so the therapist can become more empathetic and sensitive, (b) to increase the therapist's understanding of how healthy or unhealthy a patient's spiritual orientation is and to what extent it affects the presenting problem, (c) to see whether the patient's beliefs and the community can be used as resources for coping methods and growth, (d) to find out which spiritual interventions may be beneficial for the patient, and (e) to determine whether the patient has unresolved spiritual issues.

Further, Richards and Bergin (1997) proposed eight dimensions that should be included in a spiritual assessment:

- Metaphysical worldview
- Religious affiliation or denomination
- Religious problem-solving style (self-directing involves only the self; deferring is giving it to God; collaborating involves others, such as medical healers)
- Spiritual identity and tradition
- God image
- Value and lifestyle congruence
- Doctrinal knowledge (i.e., the patient's knowledge of the sacred texts of his or her faith)
- Religious and spiritual health and maturity

Of course, gathering data does not constitute an assessment in itself; the information must be interpreted, organized, integrated with theory, and made meaningful.

Spiritual assessments can sometimes raise concerns. Occupational therapists must maintain a balance between using and developing a patient's spiritual strengths and remaining focused on treatment goals. Therapy should always be the primary focus. Occupational therapists need to avoid assuming the role of spiritual expert, and instead refer their patients to their own spiritual or religious healer (Hodge, 2001).

When practitioners have firmly held values, they risk imposing their own positions on patients. In this case, they should not conduct spiritual assessments with people who hold values different from theirs. Also, some people consider spirituality a private matter and may object to exploring this area in a rehabilitative setting. Still, others do not believe in a higher power, and therapists should respect this. In short, therapists should never administer a spiritual assessment without obtaining consent.

Therapists' Spiritual Self

Anandarajah and Hight (2001) indicated that two factors might increase the likelihood of a successful discussion of spiritual needs: spiritual self-understanding and spiritual self-care. They asserted that a therapist must "understand his or her own spiritual beliefs, values and biases in order to remain patient-centered and nonjudgmental" when dealing with a patient's spiritual concerns (p. 84). This concept is compatible with the relationship-centered care concept, and it is especially relevant when the therapist's and patient's beliefs differ.

Anandarajah and Hight (2001) further stated, "Spiritual self-care is integral to serving the multiple needs and demands of patients in the current health care system" (p. 85). Later, Koenig (2004) described some of the barriers therapists might encounter in obtaining spiritual histories. They included lack of time on the part of the therapist, lack of training, discomfort with the subject, worries about imposing religious beliefs on patients, and lack of interest or awareness. Ultimately, it is important that a therapist first look at his or her spiritual self.

Spiritual Assessment Process

Koenig (2004) suggested four questions that occupational therapists can use when gathering information from patients about their spiritual history:

- Are they drawing on religion or spirituality as a method of coping with their illness?
- Do they have a supporting spiritual community?
- Do they have spiritual questions of concern?
- Do they hold spiritual beliefs that may affect their medical care?

Similarly, Gorsuch and Miller (1999) proposed that therapists integrate three questions into the clinical setting during therapy:

- Do you currently practice your religion?
- Do you believe in God or a higher power?
- Are there certain practices that you engage in on a regular basis?

To assess a sense of meaning, therapists also might ask, "What is important to you, and what gives you meaning and purpose in life?" All of these questions are helpful to consider when conducting a spiritual assessment.

Another spiritual history tool, referred to as the FICA, asks a series of questions about patients' faith, the importance of their beliefs, if they belong to a spiritual community, and if there are spiritual

practices they wish to develop. Through these questions, the FICA examines four concepts: faith or beliefs, importance, community, and address. Puchalski (1999) suggested that therapists use the FICA to explore their own personal spiritual history.

A spiritual history assessment should be administered during the admission process and during the initial occupational therapy evaluation process. Care should be taken that the same questions are not repeated. If a spiritual history is not taken at the time of admission, it is appropriate for the occupational therapist to administer a spiritual history evaluation. Koenig (2007) suggested the best times to conduct an initial spiritual history:

- When taking the medical history during a new patient evaluation. The spiritual history is taken during the initial evaluation process and integrated into the interview; it is part of obtaining the patient's occupational profile.
- When taking the medical history while admitting a patient to a health facility.
- When doing a health maintenance visit as part of a well-person evaluation. This includes obtaining information about the patient's environment and support system, such as family, job, and sources of stress.

The spiritual history assessment can be repeated after several months or years, if appropriate. It needs to be reviewed and updated to reflect the patient's current condition and medical, social, and physical environment. It is important to distinguish between a spiritual history assessment and a spiritual assessment that is intended to reflect the patient's current spirituality and relates to clinical goals and objectives. An example of a question in a spiritual history assessment would be "What was your faith tradition growing up?" A spiritual assessment would ask, "What faith tradition do you currently follow?"

Other Spiritual Assessments

Illness and disability raise fundamental questions about spiritual well-being. Why me? Why do I suffer? Does my suffering have meaning? Maugans (1996) created an assessment examining concepts of meaning and purpose. Maugans drew from the work of Frankl (1984) for the development of a framework for taking a spiritual interview and answering these questions based on the concept of spiritual suffering. Frankl (1984) stated that physical discomfort and deprivation, no matter how extreme or brutal, do not cause suffering. The cause of suffering is the loss of meaning and purpose in life. Maugans' assessment examines the concepts of meaning and purpose.

An assessment rooted in the theory of logotherapy is the Ingleside Skilled Nursing and Rehabilitation Center Assessment Tool developed by Frankl (1984). The underlying premise of this assessment is that people search for meaning in life up until the moment of death. This tool can be used to assess the meaning of a higher power.

An example of a questionnaire form of assessment is the Spiritual Assessment Guidelines by Schnorr (2005). This assessment was initially designed for persons of the Quaker faith. The questions ask about the source of spiritual strength, meaning and purpose, love and relatedness, forgiveness, hope, effects of illness, and religious affiliation.

The Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research is a research instrument available free of charge from the Fetzer Institute (1999). A presentation regarding administration and scoring is available online. The constructs examined that relate to health care are daily activities, spiritual experiences, meaning, values, beliefs, forgiveness, private religious practices, religious/spiritual history, commitment, organizational religiousness, and religious preference. The assessment is available in a short or long form. The entire assessment does not have to be administered to obtain results.

Another spiritual assessment tool that addresses this specifically is the HOPE concept: *H* stands for the patient's sources of hope, strength, comfort, meaning, peace, love, and connection; *O* is the role of organized religion for the patient; *P* represents the patient's personal spirituality and practices; and *E* stands for effects on medical care and end-of-life decisions (Puchalski, 1999). The HOPE questions serve to introduce spiritual content to the interviewing process. The questions have not yet been validated by research, but they allow open-ended inquiry into the patient's spiritual resources and concerns. For example, in the interview process, a therapist can ask, "For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?" If the answer is "yes," the assessment can proceed. If the answer is "no," the clinician can ask, "Was it ever important to you?" If the answer is "yes," the clinician can follow up by asking, "What changed?" This can lead to further inquiry, or the therapist can cease asking questions about spiritual matters.

As this brief survey of possible tools indicates, spiritual assessments come in a variety of formats. There are questionnaires, observational scales, and interview guides. Plus, other types of assessments can be used to reevaluate patients in addition to gathering a spiritual history (see Appendix for a list of recommended assessments).

Guidelines for Selecting Spiritual Assessments

Fitchett (2002) suggested seven issues to consider when selecting a spiritual assessment process or tool:

- "Is the model's concept of spirituality explicit or implicit?" (p. 90). The assessments in this area of occupation are objective and therefore implicit.
- "Is it substantive or functional?" (p. 91). Substantive means that the assessment focuses on the patient's beliefs and values; functional assessments focus on the practice of beliefs and values.

- "Does it include one or more dimensions of spiritual life?" (p. 91). An assessment that asks only one question is one-dimensional (e.g., "What religion do you practice?"). An assessment that asks multiple questions is one that looks at spiritual life from a number of perspectives.
- "Is it static or developmental?" (p. 92). Is change expected and does the assessment measure change? A developmental assessment expects change, such as Fowler's (1981) five stages of spiritual development.
- "Does it have a dynamic perspective?" The therapist needs to "know what people say what they believe and feel as well as observations of unconscious attitudes and emotions that might or might not be consistent with those that are consciously held" (p. 93).
- "Is the context for spiritual assessment holistic?" (p. 93). The patient's religious practices, culture, personality, family, and health should be inter-related. The therapist should be aware of patients' behaviors that may be caused by an infarct on the brain, such as brain injury, medication reaction, or stress.
- "Is the spiritual dimension distinct from the psychosocial one?" (p. 94). Be sure the assessment assesses spirituality and not psychosocial aspects. Do not substitute a psychological test for a spiritual one.

The FICA, mentioned previously, is an example of a brief assessment that meets all of these criteria. However, there are other assessments that meet some of these guidelines. In considering the occupational therapy process and conducting a spiritual assessment, occupational therapists must first select a spiritual assessment that is most appropriate for use with an individual patient. Because there are many spiritual assessments available, therapists must choose the assessment(s) they feel will best illuminate their patients' needs and concerns. Next, therapists must clearly and competently understand how to administer and interpret the assessment(s), seeking outside guidance from a colleague or supervisor if there are areas of uncertainty or a lack of understanding. Lastly, therapists must consider how to interpret the data gathered during a spiritual assessment. Consider the case of Lauren and George as an example of the process of conducting a spiritual assessment.

Case Study: Lauren and George

Lauren was an occupational therapist in an outpatient substance abuse treatment clinic and psychosocial clubhouse. George was a 32-year-old, first-generation Mexican American living with his parents. He was caught between the values, beliefs, and religion of his parents—who were Catholic—and his emerging Buddhist beliefs.

When Lauren met George, he had been recently discharged following five years of

incarceration for the manufacturing and sale of methamphetamine. This was George's third incarceration and he now had a felony on his record. While in prison, George received treatment for his addiction and began learning about Buddhism. However, he began using methamphetamine one hour after discharge from prison. He went to the outpatient clinic where Lauren was employed after his parole officer required a random urine screen to ensure he was not using methamphetamine. George, referred to outpatient addictions treatment, had not been able to see his three children for the past five years because his ex-wife had a restraining order against him.

After entering the outpatient treatment environment, George began to question his Catholic upbringing and the beliefs and values his parents appeared to be trying to impose on him. He felt lost, overwhelmed, and did not know what to believe. George's primary motivations for treatment were to be able to see his children and remain out of prison. His parole officer indicated that his primary responsibility was to stay off drugs and get a job—and that this would help him stay out of prison.

Lauren considered herself to be a holistic therapist. Her assessments included reviewing George's medical record, including his family history, personal narrative, life turning points, physical health, nutrition, and social relationships. She administered the HOPE assessment during the interviewing process. She found that George's Buddhist beliefs helped him cope with the ups and downs of being away from his family. Lauren carefully examined George's spiritual environment because this provided a framework in which he was attempting to accept, make sense of, and find meaning in his life; resolve loss and grief issues; solve problems related to employment and life outside of prison; make major life decisions; cope with daily living challenges; embrace joys; adjust to change; and find inner strength, face his fears, and learn how to take appropriate risks.

In the process of her comprehensive assessment, Lauren discovered that many of the issues George was struggling with pertained to Buddhism and his desire to practice this spiritual tradition in all aspects of his life, and his parents' insistence that he return to the Catholic Church. Lauren shared with George, "I think I can assist you in the things you struggle with, but I have limited knowledge of the Buddhist religion. With your permission I would like to consult with a colleague who is a Buddhist. I also may recommend a Buddhist teacher to you to help you clarify some specific beliefs you mentioned earlier. Is this acceptable to you?" George agreed.

In the case of Lauren and George, Lauren needed to understand her own spiritual grounding and then step beyond it. She both reassured George and acknowledged her limitations when she said, "I think I can assist you in the things you struggle with, but I have limited knowledge of the Buddhist religion." She then offered two additional resources/approaches for assistance, after asking his permission.

In addition, Lauren knew enough about Buddhism to understand that she needed to approach George in a mindful way. This approach—a means for interacting with patients from the Buddhist tradition—is, according to Bien (2006), a keen awareness of calm presence. It entails experiencing and accepting reality fully. It is a method of listening reflectively; allowing silence in interactions with patients; and using metaphor, storytelling, and other methods.

This case study involves someone with interests in Buddhism, but the same approach can be used whenever the occupational therapist and patient have different spiritual or religious beliefs and/or practices. Successful work with a diverse population necessitates that therapists view spiritual practices as a reciprocal process. Therapists must meet their patients on the patient's own playing field. In the case of this Buddhist patient, the playing field was a therapeutic relationship wrapped in compassion, acceptance, mindfulness, ethical conduct, and wisdom, which might result in the lessening of suffering and thereby contribute to effective habilitation and rehabilitation.

As this case study shows, occupational therapists can contribute to a patient's change, growth, and development by supporting the patient in his or her preferred spiritual environment. By listening to the unique needs and issues shared by the patient—and by critical examination of their own knowledge, ideas, feelings, and beliefs so they are not barriers to understanding the patient's current or previous experiences—therapists can work closely with patients to identify the beliefs and practices that will promote, support, and encourage recovery (Egan & Phillips, 2011).

Treatment Plans and Intervention

During a spiritual assessment occupational therapists can learn about the uniqueness of each person and the contexts that support or hinder his or her occupational performance. Barriers may need to be examined and addressed, as the case of Lauren and George demonstrates. However, by gathering this information, therapists can develop a treatment plan based on the experiences a person most values and wishes to retain.

General Intervention Planning

Galanti (2008) has offered some suggestions that are culturally and spirituality sensitive when developing treatment plans and interventions:

- "Honor patient requests for same-sex providers whenever possible.
- Respect . . . patient's religious beliefs, even when they conflict with your own.
- Allow patients privacy for prayer.
- Be aware that different religions have different holy days. It is Friday for Muslims, Saturday for Jews, and Sunday for Christians.
- Allow patients to make informed choices regarding risks when medical procedures conflict with their religious beliefs.
- Learn what symbols are sacred to those who are treated, and respect them." (p. 78)

Koenig (2007) suggested that a spiritual director should be made available, if possible, although medical centers are cutting budgets and clergy may not be available. Pastoral services may be combined with social services to meet budgetary needs.

Specific Intervention Planning

Ideally, occupational therapists and patients should collaborate, based upon information gathered in the assessment, to develop treatment plans and interventions that value and honor the patient's individual needs (Egan & Phillips, 2011). Just as each spiritual assessment is unique to each patient, each intervention should be planned to address the patient's unique needs, values, and goals.

Through examination of spiritual assessments, occupational therapists can develop interventions to help their patients accept, make sense of, and find meaning in life (Egan & Phillips, 2011). Further, interventions can address grief and loss issues patients may be dealing with that could be hindering their engagement in valued occupations. By examining a patient's spiritual focus, therapists can structure interventions to foster improved problem solving, coping, and decision-making skills. Interventions designed to assist patients in facing fears; adjusting to uncertainty; and addressing change from a physical, mental, or emotional perspective can be addressed (Egan & Phillips, 2011).

Of utmost importance in the area of intervention planning and spiritual assessment is the occupational therapist's role in fostering independence with each patient. Therapists need to plan interventions that promote and enable occupational participation rather than dependency on the therapist or the therapy process (Egan & Phillips, 2011).

At times, a patient may look to the occupational therapist as the keeper of the knowledge when, in fact, the patient is the one who knows themselves better than anyone. Patients should be directly, consistently, and regularly consulted regarding their insights about therapeutic interventions and any perceived benefits, concerns, and outcomes. By engaging in ongoing conversations with their patients, occupational therapists can ascertain if the therapeutic interventions selected are valuing the individual's spiritual being and providing a meaningful connection to his or her world (Schultz, 2011).

In considering intervention planning, implementation, and modification from a spiritual perspective, occupational therapists need to be mindful that individuals' spirituality can evolve, change, and grow as they adapt to life and changes that may occur related to acute illness, chronic illness, or disability (Schultz, 2011). An occupational therapist who provides intervention to a patient for a hand injury in the year 2015, and then sees the same person two years later, cannot rely on previous spiritual assessment data. The individual may have made minor or significant changes from a spiritual perspective. However, that person may not willingly offer this information or perspective to the

therapist; this leads to the importance of conducting ongoing spiritual assessments (Schultz, 2011).

Using a valued occupation that patients find meaningful on a daily basis as an orienting force may significantly influence the therapy process in a positive manner. For example, incorporating time in the morning and before bedtime for quiet reflection or meditation may help individuals critically examine goals for the day (a.m. reflection) and progress that has transpired during the day (p.m. reflection). Encouraging patients to engage in meaningful, valued occupations in a consistent fashion also can help them feel a sense of empowerment, stability, and calmness—especially for individuals who may be encountering many areas of their lives over which they feel they have little to no control (e.g., certain medical procedures).

Finally, occupational therapists need to make sure that intervention plans include spiritually meaningful occupations that can help individuals celebrate the joys of change, skill development, and adaptation as they cope with daily challenges.

Ethical Considerations

Incorporating spirituality into the assessment and treatment process can create ethical concerns for occupational therapists. Possible concerns might be imposing one's own religious beliefs on the patient, and/or the need to address a spiritual crisis the patient may be experiencing. To avoid such ethical difficulties, therapists must assess their own spirituality and where they are on their spiritual journey. As previously mentioned, they need to understand how to incorporate their own spirituality into their practice. In addition, therapists need to understand how patients' values and religious beliefs influence their decision making. Some people base their identity (i.e., idiosyncrasies that make a person unique) on what is perceived as right and wrong, and some draw on the spiritual aspect of life, following specific beliefs that have meaning to them.

The following is a set of universal ethics to guide clinicians as they interact with patients who are experiencing a spiritual crisis:

- Be human, be real, be honest.
- Be present and listen, with an emphasis on being with the patient, not doing.
- Include spiritual concerns in treatment planning.
- Respect the patient's belief system, regardless of your own feelings about religion and spirituality.
- Provide access to spiritual resources by referring to spiritual healers, such as chaplains, priests, ministers, rabbis, and imams.
- Be a caring professional; encourage patients and their family members to give voice.
- Explore, but do not probe; help people to feel heard.
- Avoid judging beliefs, practices, or emotional responses; refrain from proselytizing or imposing your own beliefs.

- Be aware of your beliefs and the influence they have on the health care process.
- Be careful if you and a patient share the same religious traditions; beliefs and practices vary widely.
- Avoid discussions of doctrine, dogma, and complicated theological questions. Patients usually do not want or need intellectual discussions; they need comfort and reassurance.
- Avoid clichés, such as "It is God's will" or "God never gives you more than you can bear." Do not use this language unless the patient and family members have used these phrases themselves.
- Respect the patient's and family's spiritual traditions and practices, as well as their privacy in this area.
- Do not initiate participation in the patient's religious observances. Let the family do the inviting.
- Finally, follow the plan for spiritual care agreed upon by the patient, family, and health team.

Conclusion

Spiritual history assessments are an integral part of occupational therapists' holistic practice with their patients. Such assessments generally take the form of interviews, questionnaires, and inventories. Although there are no published articles to date demonstrating the benefits of conducting a spiritual assessment, there is indirect evidence to support this practice. First, spiritual practices are ways in which patients cope with medical illnesses. Second, spiritual beliefs have been found to influence medical decisions. Third, the patient's faith community is a source of support and can be associated with adherence to medical therapy. Finally, patient satisfaction with the emotional aspects of care is high when his or her spiritual needs are recognized and faith traditions are respected (Koenig, 2004).

Spiritual assessments usually focus on health care and end-of-life issues (e.g., one of these is HOPE). Occupational therapists should consider administering a spiritual assessment at the beginning of the evaluation process and again at reevaluation. Prior to the start of clinical practice and on a regular basis (perhaps annually) occupational therapists also should complete a spiritual assessment of themselves to ensure their own values and spiritual ideas do not influence their patient's care in clinical practice or research. Ultimately, spiritual issues can be approached as an aspect of diversity and treated with the same respect as any other personal issue.

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Appendix

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