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The Utilization of Spirituality in Occupational Therapy: Beliefs, Practices, and Barriers

Jennifer S. Collins

Western Michigan University

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THE UTILIZATION OF SPIRITUALITY IN OCCUPATIONAL THERAPY:
BELIEFS, PRACTICES, AND BARRIERS

by

Jennifer S. Collins

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Science
Department of Occupational Therapy

Western Michigan University
Kalamazoo, Michigan
December 2000
ACKNOWLEDGMENTS

First, thanks to my committee members. Dr. Stanley Paul, Dr. Cindiee Peterson, and Dr. Thomas Holmes have provided me with guidance and support throughout this process. Thanks also to Jaclyn West-Frasier, my “fourth reader”, who gave freely of her time and provided value input on this project.

Thanks also to my mom, Polly Collins, who promised me that we would manage my education. Even though it looked doubtful a few times, we made it. I haven’t told her enough times how much I appreciate how much she sacrificed to help me reach this point.

Several other people have kept me going throughout my graduate education and the writing of this thesis. Becky Heffner has endured a page-by-page description over ten months, and has kept on asking “How many pages?” She has been with me in laughter and tears, and has kept reminding me the outcome was worth the effort. Eliza Enstine has kept me laughing with her many interesting stories and thoughts, and has been there on a daily basis as I have rejoiced and complained. Her daily email was one of the most eagerly anticipated parts of my day. Warren Throckmorton has also contributed humor, bits of sage advice, the voice of experience, and always a willingness to listen. Without these people I never would have completed this.

Finally, thanks to God the Father Almighty, whose grace and love have guided me and whose strength has carried me through.

Jennifer S. Collins
THE UTILIZATION OF SPIRITUALITY IN OCCUPATIONAL THERAPY: BELIEFS, PRACTICES, AND BARRIERS

Jennifer S. Collins, M.S.
Western Michigan University

Spirituality has become an increasingly important topic in healthcare and specifically in occupational therapy. Previous studies of spirituality in occupational therapy indicated that while therapists believed spirituality was important to health and rehabilitation potential, few therapists reported incorporating spirituality into treatment (Engquist, Short-DeGraff, Gliner, & Oltjenbruns, 1997; Howe, 1996; Rose, 1999). This study utilized a survey design to examine occupational therapists’ current beliefs and practices regarding spirituality, as well as asking therapists to identify barriers to the use of spirituality in treatment.

The results of this study indicate that beliefs and practices regarding spirituality in occupational therapy may be changing. Therapists reported that they believed that spirituality is important to health and well-being. Therapists reported discussing spiritual issues with clients more frequently than in previous studies. Only one barrier, lack of education or experience in taking a spiritual history, was reported by a majority of respondents as impeding their ability to incorporate spirituality into their practice.
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CHAPTER I

THE UTILIZATION OF SPIRITUALITY IN OCCUPATIONAL THERAPY: BELIEFS, PRACTICES, AND BARRIERS

Introduction

The Problem

Spirituality permeates human existence. It gives meaning to life, provides motivation for human activity, unifies mind and body, allows a relationship with a Higher Being, creates connections with other people and with the world, and provides intrinsic worth to each person (Egan & Delaat, 1994; Ellison, 1983; Urbanowski & Vargo, 1994). Although spirituality has long been recognized as an essential part of the human being, during the twentieth century medical advances focused attention upon only the biological side of illness and disability. Within recent years, medical professionals have begun to re-investigate the relationship of spirituality and health, resulting in a new integration of spirituality into health care (O’Brien, 1999; Thoreson, 1999).

Background

Occupational therapy is a holistic profession that considers the role of the body, mind, and spirit in illness and disability. Several studies within the past ten years have found that occupational therapists do not intentionally assess or utilize spirituality in treatment (Engquist, Short-Degraff, Gliner & Oltjenbrus, 1997; Howe, 1996; Rose, 1999). However, it has been argued that spirituality is implicitly part of
the philosophy of occupational therapy and is actually incorporated into all that occupational therapists do (Egan & Delaat, 1997).

Spirituality has often been ignored in research because it is difficult to define. Spirituality and religion are often used interchangeably, which might alter some people's perceptions of spirituality. In fact, religion and spirituality are separate entities. Religion may be a way some people choose to express spirituality, but not all people are religious, while spirituality is a universal characteristic of humans. Previous attempts to study spirituality in occupational therapy may have been hampered by this difficulty. Several authors have attempted to increase practitioners' awareness of the meaning of spirituality. Egan and Delaat (1997) incorporated several proposed definitions of spirituality and decided that spirituality "relates to our thoughts, feelings, and actions concerning the meaning that we make of our daily lives" (p.116). This definition was used in the present study.

Numerous studies of spirituality have found that spirituality and health impact one another. Spiritual issues can negatively impact health while health issues can negatively impact spirituality (Urbanowski & Vargo, 1994). Spiritual beliefs can help an individual cope with illness or disability. Many spiritual issues may arise for individuals who are forced to confront their own mortality because of potentially fatal illness (Fryback & Reinert, 1999). Spiritual beliefs help individuals to claim responsibility for their actions, cope with death or loss (O'Brien, 1999), and establish value systems that can influence lifestyle choices (Hill & Butler, 1995).

Studies examining the explicit use of spirituality in occupational therapy have indicated that therapists believe that spirituality is important to health and rehabilitation and that spiritual issues can affect rehabilitation potential (Engquist et al., 1997; Rose, 1999). Spirituality is often an important aspect of therapist's
personal lives (Howe, 1996), yet few therapists intentionally assess spirituality or incorporate it into treatment (Engquist et al., 1997; Howe, 1996; Rose, 1999).

**Purpose**

Occupational therapists who responded to surveys about their intentional utilization of spirituality in the mid-1990s believed that spirituality was important to health and rehabilitation, yet they rarely incorporated spirituality into treatment (Engquist et al., 1997; Howe, 1996). Since those studies were completed, more attention has been given to spirituality within the occupational therapy literature, including special issues devoted to the topic in both the *American Journal of Occupational Therapy* and the *Canadian Journal of Occupational Therapy*. The previous studies resulted in a proposed definition of spirituality for occupational therapy. The lack of an accepted definition for spirituality within the profession may have affected the results of these studies.

The current study reviewed definitions of spirituality from occupational therapy and other literature and discussed literature related to the impact of spirituality on health. This study sought to determine occupational therapists’ current beliefs and practices about spirituality by surveying therapists about these issues. A definition of spirituality was included in an attempt to avoid confusion regarding the numerous definitions of spirituality. It also sought to find perceived barriers to the incorporation of spirituality into occupational therapy treatment.

The purpose of this research was informative; however, it is believed that generalizations can be made from this study that can benefit the field of occupational therapy. The quantitative data obtained from this study will contribute to the profession’s knowledge of spirituality and might draw attention to the increasing
importance of this aspect of health care in general and specifically in occupational therapy. Increased attention to spirituality in treatment might lessen the gap between practitioner’s explicit use of spirituality and the intrinsically spiritual nature of occupational therapy.

Objectives

The objectives of this study were to determine the frequency with which occupational therapists intentionally incorporate spirituality in treatment, discover occupational therapists’ beliefs about the role of spirituality in occupational therapy treatment, and identify perceived barriers to the utilization of spirituality in occupational therapy treatment.
CHAPTER II

LITERATURE REVIEW

Defining Spirituality

Spirituality is a concept that has proven difficult to define within the health professions. Spirituality is the expression of one's spirit, which the Merriam-Webster dictionary (1966) defines as "the breath of life: an animating or vital principle giving life to physical organisms" (p.2198). It is considered a characteristic of all people and motivates humans to find purpose and meaning in life (Ellison, 1983).

Spirituality is distinct from religion. Religion is a way that spirituality can be expressed, but not every spiritual person is religious (Emblen, 1992; Seaward, 1994; Stoll, 1989). Instead, religion is one way that a person may choose to express or enhance his or her spirituality (Dombeck, 1998; Seaward, 1994). Religion is generally accepted to be a system of symbols that direct beliefs and behaviors and provide a sense of order in life (Geertz, 1995). Emblen (1992) found that within the nursing literature, faith, beliefs, and practices related to a Higher Being, Force, or Power were considered to be aspects of religion. Spirituality was defined as a "dynamic, principle, or an aspect of the person that related to God or god, other persons, or aspects of personal being or material nature" (p.43).

Spirituality can be conceptualized in a number of ways. Jung (as cited in Collins, 1998) discussed life and spirit as interdependent components of the person. Spirit gives meaning to life, and life gives expression to spirit. In some definitions, spirituality is related to connectedness with others and the world (Egan & Delaat,
Spirituality is partially expressed through the way a person lives his or her life (Egan & Delaat, 1994; Ellison, 1983; Urbanowski & Vargo, 1994). The spirit unites the personality with body and psyche and creates a whole and unique individual (Ellison, 1983). Some define spirituality as a motivating force in the search for meaning and purpose in life (Ellison, 1983). Maslow (1968) said “we have, each one of us, an essential inner nature which is instinctoid, intrinsic, given, ‘natural’…which tends to strongly persist” (p. 190). Some characteristics are shared with other people, while some are unique to the individual (Maslow, 1968; Seaward, 1994). Spirituality can also be defined in a more religious way as those things that comprise a relationship between a person and his God or gods (Piles, 1990; Reed, 1992).

Stoll (1989) discussed a vertical and a horizontal component to spirituality. The vertical dimension is related to transcendence, or a relationship beyond and above the self, and a relationship with a Higher Being, who may or may not be accepted by formal religions. The Higher Being may be a god, or it may be a set of values that become the supreme focus of life. Maslow (1968) described this need for a vertical relationship: “The human being needs a framework of values, a philosophy of life, a religion or religion-surrogate to live by and understand by, in about the same sense that he needs sunlight, calcium, or love” (p. 206). The horizontal aspect complements the vertical. This is the person’s relationships with self and others, and is expressed through love, forgiveness, and trust (Stoll, 1989).

Spirituality has entered the occupational therapy literature in the past decade. Most authors who have written about or studied spirituality in occupational therapy have discussed the difficulty in defining the term. Christiansen (1997) attributed this difficulty to the “quintessence” of spirituality, meaning that it is an essence that
extends beyond earth, air, fire and water. Urbanowski and Vargo (1994) proposed that occupational therapists should define spirituality as “the experience of meaning in everyday life” (p.89). Urbanowski (1997) further expanded upon this definition:

If a phenomenon is to have meaning for someone, and if that meaning will have a lasting value, it must be experienced. When that occurs, meaning has a spiritual dimension. When it is committed to the past through memory, a spiritual ‘tag’ recalling the experience of the meaning is attached to it. When it is recalled to the present, this spiritual tag is brought with it. Thus, the mundane, daily life events that people experience in the course of their lives provide the fundamental source of spirituality. (p. 20)

Egan and Delaat (1994) conceptualized a person’s spirit not as a part of the person, but as the core characteristic that defines the person. Thus, the spirit gives each person intrinsic worth. The spirit is expressed through engagement in activities of daily living. The spirit allows connection to the rest of creation, and “allows us to unite those essential aspects of our true selves with the greater whole of all being” (p. 96). Howe (1996) surveyed occupational therapists to develop a definition of spirituality. Based on the results of her study, she proposed that spirituality includes thoughts, behaviors and beliefs that relate to self, other people and a higher power and that structure a person’s values and beliefs. Howard and Howard (1997) stated that spirituality is that which provides us with meaning and gives us motivation for daily life. All human activities come from spirituality. Egan and Delaat (1997) attempted to synthesize several definitions proposed by occupational therapists, resulting in the following definition of spirituality: “Spirituality relates to our thoughts, feelings, and actions concerning the meaning that we make of our daily lives”(p.116). According to their definition, meaning is derived through relationships with ourselves, other people, other creatures, the earth, and for those who choose, a relationship with a Higher Being.
Occupational therapy is concerned with the ability of people to perform occupations. Occupations fall into the categories of work, activities of daily living, and leisure. Occupations are goal-directed, occur over time, involve the completion of multiple tasks, and must be meaningful to the person performing them. In the course of human existence, an individual must fulfill roles, or combinations of occupations. Occupational therapists provide services when there is a discrepancy between the occupations a person wants to accomplish in order to fulfill roles and what they are capable of doing independently. The goal of therapy is to increase the individual's ability to independently perform or control the performance of meaningful activities and fulfill roles (Moyers, 1999).

Occupational therapy definitions of spirituality have suggested spirituality is the experience of meaning within. This definition implies that any activity that has meaning to an individual can be an expression of his or her spirituality. Since occupations are meaningful to the client, occupations can be an expression of spirituality. Egan and Delaat (1994) suggested an individual might express spirituality by contributing to the world through using gifts such as music, writing, art, sports, or cooking. Collins (1998) gave an example of how a writing exercise in an occupational therapy group helped a client to begin to find a reason for living, which ultimately helped him recover from depression and suicidal ideation. Unruh (1997) suggested that gardening is an activity that encourages spiritual reflections and allows the gardener to participate in an act of homage and devotion. She said that gardening can help people cope with illness or stress, provides solace or harmony, brings hope and expectation to life, and encourages reflection about life and one's place in it. Urbanowski (1997) gave an example of an occupational therapist who
patiently allowed a client with a history of psychosis an opportunity to become accustomed to the therapist holding her hand prior to doing passive range of motion, which the client had previously resisted. The relationship with the therapist became important to the client and made the sessions meaningful to her so that she became willing to do the exercises and awaited the therapist’s daily visit.

Christiansen (1997) suggested that spirituality could be expressed through rituals or symbols. In a discussion of the spirituality implicit in the daily life of four orthodox Jewish couples, Frank et al. (1997) found that the ritual of observing the Sabbath provided the couples with time to nurture their relationships and gave the couples a sense of meaningfulness. The ritual of studying Jewish writings was inspirational to the subjects and helped them to develop a stronger sense of self. Gibbs and Barnitt (1999) interviewed Hindu elders to find ways in which Hindu spirituality impacted activities of daily living. They found that the Hindu elders interviewed in the study expressed their spirituality through obeying dietary restrictions and following guidelines for the preparation of food. Some subjects ritually fasted on specific days. Some subjects followed rituals related to bathing and the use of separate hands for eating and toileting. Several subjects followed guidelines for traditional dress, and were unwilling to be seen without clothing. Several respondents expressed an unwillingness to be treated or assisted by a health care professional of the opposite sex.

Since the definition of spirituality includes connectedness to other people, spirituality can be a quality of a group of people or can be shared between two individuals. Egan and Delaat (1994) gave an example of a client with Alzheimer’s disease that expressed caring for a neighbor in her nursing home who was crying. She tried to comfort the resident but was unable to do so due to language deficits, so
she found a staff person and remembered that her mission was to get help for the
crying resident. Townsend (1997) discussed community dimensions of spirituality
within a mental health setting. Her study included observing and interviewing
subjects at seven adult mental health day programs over a six-month period. She
referred to each program as a "mental health community" where activities were done
through consensus between professionals and community members with a goal of
including as many people as possible. Community programming allows individuals
to become connected with others through making meaningful contributions to a
common goal. Algado, Gregori and Egan (1997) wrote of the spirituality they
witnessed within the daily lives of the inhabitants of a refugee camp in Guatemala
and described how they utilized this spirituality in developing a program to assist the
families in re-establishing themselves within their culture. The individuals that made
up the community described by the authors had been displaced from their native
Guatemala to Mexico, and were returning to a new community in Guatemala from the
refugee camps. The authors worked within the spiritual beliefs of the people to assist
them with the transition. Part of the intervention program involved teaching the
children and adolescents how to function within their native culture, and assisting the
adults in transitioning back to their previous roles in their spiritual lives. Spirituality
was particularly addressed with the elders, whose role is to serve as guardians and to
pass on ancient wisdom.

Spirituality and Health

Over the past 25 years, the relationship between spirituality and physical and
mental health have been increasingly recognized, in both scientific and popular
literature (Ellison & Levin, 1998; Hill & Butler, 1995; Levin, 1994). Thoreson
(1999) pointed out that this is not unprecedented; at the beginning of the 20th century researchers were interested in how religious experiences could impact health. The interest in spirituality at that time was soon lost in favor of interest in germ theory and advances in medicine. The recent increase in research in this area reflects changes in the medical professions, and Thoreson suggested that this knowledge requires so much clarification that "developmentally, empirical research in the area may be at the toddler level, with some almost balanced movement forward, but falls aplenty" (p.298).

Health itself is a multi-dimensional construct which is evidenced by an overall well-being (Reed, 1992). Health includes physical, psychological and spiritual components. It is possible to have a healthy attitude about life even during the terminal stages of physical illness. Although the spiritual aspect of health was neglected throughout much of the 20th century, recent changes have brought spirituality back into healthcare as part of a holistic outlook (O'Brien, 1999). Spirituality can have multiple effects on health. It can help people to claim responsibility for their actions, confront death or loss, and provides values that guide decisions (Canadian Association of Occupational Therapists, 1998; Hill & Butler, 1995). Reed (1992) states that spirituality is an integral part of health because it is "an ever-present, sometimes dominant, part of human experience" (p.351). Health and spirituality have reciprocal effects upon one another; spiritual issues can negatively impact health and health issues can negatively impact spirituality (Reed, 1992; Urbanowski & Vargo, 1994).

Religious behaviors have been particularly studied for their impact on health. Thoreson (1999) summarized the results of a number of studies on the religion-health connection. In general, most, but not all, studies showed that religious individuals
had reduced heart disease, lower blood pressure, fewer strokes and cancers, and lower overall morbidity and mortality. In relation to mental health, studies have found that individuals who are religiously or spiritually involved in some way have higher rates of general well-being and greater life satisfaction, less depression and suicide, less divorce and greater marital satisfaction, and lower rates of drug and alcohol abuse. These results usually were consistent despite differing definitions of religion and across ethnic backgrounds. However, Thoreson reminded readers that correlation does not imply causation, and that there are many unanswered questions in these studies. Most studies of religion and health have found positive effects, which can partially be attributed to restrictions religions may impose upon diet and lifestyles. Participation in religious activities allows the development of social support, a sense of belonging, and provides a faith system that provides answers, coping mechanisms, optimism, healing, assurance, and the potential for supernatural intervention (Hill & Butler, 1995; Stolley & Koenig, 1997).

Spiritual issues can create health issues. Alcoholics Anonymous views alcoholism as a physical, psychological, and spiritual disease. According to Alcoholics Anonymous, the most serious problem resulting from the abuse of alcohol is the spiritual decay that comes from believing the self is at the center of life, rather than believing in a higher power (Moyers, 1997; Seaward, 1994). Before the alcoholic begins the recovery process, he or she is experiencing negative spirituality characterized by low self-esteem, mistreatment of others, and a life without pleasure. The alcoholic seeks the experience of a life with positive spirituality through the abuse of alcohol (Warfield & Goldstein, 1996). The development of a relationship with a Higher Power is a central component of the Twelve-Step Program. As the alcoholic progresses through the steps he or she begins to develop positive
spirituality, which provides a feeling of unconditional love, acceptance, and trust in relationships with themselves, others, and their Higher Power. This ultimately grows into loving, accepting, and trusting the world. The alcoholic learns to find meaning in life. Those who develop stronger spirituality tend to be happier and to have more success in remaining sober (Warfield & Goldstein, 1996).

Health issues may contribute to spiritual issues (Koenig et al., 1992; Sumner, 1998). “Spiritual distress” and “potential for enhanced spiritual well-being” are nursing diagnoses recognized by the North American Nursing Diagnosis Association (Stoll, 1989). Spiritual distress is “disruption in the life principle that pervades a person’s entire being and that integrates and transcends one’s biological and psychosocial nature” (Kim, McFarland, & McLane, 1997, p. 81). Potential for enhanced spiritual well-being is used to indicate that there is potential for further development of the patient’s knowledge of his or her “inner strengths, a sense of awareness, self consciousness, sacred source, unifying force, inner core, and transcendence” (Kim et al., 1997, p. 82-83). These diagnoses are given when the patient expresses concern with or anger about the meaning of life and death or expresses needs resulting from questions about belief systems (Kim et al., 1997; Sumner, 1998). These diagnoses are often used with terminally ill patients, such as those coping with a diagnosis of cancer or AIDS. These patients are forced to confront spiritual issues, such as finding meaning in life in the context of the illness, facing guilt related to the illness, and a sense of loss (O’Neill & Kenny, 1998; Sumner, 1998). Sumner (1998) pointed out “the onset of serious illness brings the nonphysical aspects of life into the conscious mind” (p.28).
Spirituality and Coping

One of the benefits of having spiritual beliefs is that spirituality can provide coping skills (Hill & Butler, 1995; Seaward, 1994; Stoll, 1989; Stolley & Koenig, 1997). Stoll (1989) stated "a person's perception of and experience with the transcendent will in great measure influence how that person views life and copes with life's crises of illness, suffering, and loss" (p. 7). Alcoholics Anonymous again serves as an example. As the alcoholic progresses through the program, he or she develops spirituality, and in doing so learns better ways to deal with the world. The new coping strategies replace alcohol, which is an unhealthy way to cope (Warfield & Goldstein, 1996). Spirituality can be used by patients and caregivers to provide hope and methods of coping such as comfort, strength, and connection to others (O’Neill & Kenny, 1998).

Spirituality is a crucial issue for patients dealing with potentially fatal illnesses. When the diagnosis is made, patients are faced with their own mortality. They must make decisions about the future and prepare their affairs. Fryback and Reinert (1999) studied the spiritual concerns of patients diagnosed with cancer or HIV/AIDS. All the subjects in their study stated that spirituality was a dimension of health. The subjects identified the following main concepts related to spirituality: belief in a higher power, recognition of mortality, and self-actualization. Belief in a higher power included church attendance and religion, spiritual beliefs, and transcendence. Religion was associated with both satisfaction and conflict, particularly for the men with HIV/AIDS. Recognition of mortality included appreciating life and nature and living in the now. Self-actualization involved loving and accepting the self and finding meaning or purpose in life and the illness. Some subjects expressed anger at God for their illness. The subjects felt that their illnesses
had improved their spiritual health by making them more aware of a guiding force in their lives that made them feel loved. The subjects did not give up on life, but they did become aware that they were not immortal, and this led to a greater appreciation of life and nature. Illness also brought self-awareness. The subjects made changes in their lives based upon the belief that to be healthy they had to know themselves, improve their lives, and reach their potentials.

Religious beliefs can produce guidance in how to deal with difficult situations or provide relief from burdens. Christians are reminded “I can do everything through Him who gives me strength” (Philippians 4:13) and are told “Therefore we do not lose heart. Though outwardly we are wasting away, yet inwardly we are being renewed day by day. For our light and momentary troubles are achieving for us an eternal glory that far outweighs them all” (2 Corinthians 4:16-17). Buddhism teaches that the purpose of suffering is to lead to spiritual enlightenment. Suffering is the fundamental problem in life and is encountered by everyone at some point in life. Buddhist teachings provide guidance in dealing with suffering through teachings on conduct, meditation, and the cessation of suffering (Gethin, 1998). Hinduism teaches that suffering is due to the result of bad acts by the sufferer. Some acts have consequences in the present life; other consequences follow the person through reincarnation. God is the karmaphaladata, or the giver of the fruits of action, and as such is not responsible for suffering nor happiness (Bhaskarananda, 1994). Followers of Judaism see themselves as God’s chosen people, and believe that God punishes those He loves, but will ultimately will take away suffering because He loves His followers (Solomon, 1996).
Occupational Therapy as a Holistic Profession

Occupational therapy claims to be a holistic profession. As such, it believes that all aspects of human experience, including physical, psychological, social, and spiritual arenas, are important aspects of health (Hubbard, 1991; McColl, 1994). Disruption in one area impairs functioning in all areas (Canadian Association of Occupational Therapists, 1998). However, occupational therapy has often been criticized for not being as holistic as it claims to be (McColl, 1994; Schkade & Schultz, 1992).

The ambiguity regarding occupational therapy as a holistic profession has its roots in the history of the profession. When occupational therapy was developed, it was created with a holistic view of health. Purposeful activities were used to enhance spiritual, mental, and physical functioning (Hubbard, 1991; Kielhofner, 1997). An early book on occupational therapy stated:

When [the patient] gets down to honest work with her hands she makes discoveries. She finds her way along new pathways. She learns something of the dignity and satisfaction of work and gets an altogether simpler and more wholesome notion of living. This in itself is good, but better still, the open mind is apt to see new visions, new hope and faith. There is something about simple, effective work with the hands that makes [humans]...creators in a very real sense makes them kin with the great creative forces of the world. From such a basis of dignity and simplicity anything is possible. Many a poor starved nature becomes rich and full. All this is aside from the actual physical gains that may come from new muscular activities. (Hall & Buck, 1915, as cited in Kielhofner, 1997, p. 29)

In the 1940s and 1950s, occupational therapy underwent what Kielhofner (1997) termed a “crisis” based upon pressure from the medical profession to subscribe to more reductionistic, biomedical views of illness and disability. Hubbard (1991) and Kielhofner agreed that this reductionistic model was not compatible with the holistic view of occupational therapy. Hubbard suggested that this incompatibility is the
reason that occupational therapy does not enjoy the same status and acceptance as physical therapy, which by nature follows a more reductionistic model and is more in keeping with Western medicine. Although occupational therapists adopted more mechanistic theories based upon kinesiology, neurology, and psychodynamic theories, Hubbard suggested that the profession never felt entirely comfortable with these theories. Kielhofner suggested that the adoption of mechanistic theories changed occupational therapy and removed the focus from occupation. In the 1960s Mary Reilly and other therapists began to attempt to restore occupation to occupational therapy. By the 1980s this had resulted in what Kielhofner referred to as an “emerging paradigm” which once again focused on occupation. This has brought occupational therapy back to a more holistic outlook.

Occupational therapy organizations have responded to these changes by re-structuring occupational therapy’s view of the person to reflect mind, body, and spirit. The American Occupational Therapy Association has addressed each of these areas within the Uniform Terminology for Occupational Therapy (3rd edition) (1994) by establishing parameters for the domain of treatment. Performance areas include the areas of activities of daily living, work, and leisure, which categorize the occupations of daily life. Performance components are the skills that are used to accomplish tasks in each of the performance areas. Performance contexts are the variables apart from performance components that influence a person’s ability to function in a performance area. Performance contexts include temporal aspects, such as the person’s age, developmental stage, and health status, and environmental aspects, including the physical, social, and cultural issues surrounding the client while he or she carries out occupations. Although spirituality is not directly addressed in the American practice guidelines, meaning, values, and rituals are all part of the cultural
environment (Schkade & Schultz, 1992). The Canadian Occupational Therapy included spirituality in Occupational Therapy Guidelines for Client-Centred Practice (1998). This document stated that spirituality is an essential component of the mind-body-spirit triad which “the therapist must come to understand and accept what is at the centre of the client’s being (spirit) in order to develop a therapeutic relationship, examine motivation, and finally engage the client in therapeutic activity” (p.58). The Canadian system considers an understanding of each client’s spirituality to be a critical predecessor of treatment planning or intervention.

McColl (1994) suggested four principles that occupational therapists must follow in order to be truly holistic. The first principle is that the client is equipped with knowledge of what a balance or an imbalance in the occupational areas feels like and at some level the client knows how to restore the balance. The therapist is not the expert guiding treatment, but a resource to help empower clients to change the imbalance in their lives. Second, the experience of function or dysfunction is subjective and is not observable. Only the client can determine if there is dysfunction present in his or her life. McColl’s third principle is an understanding of dysfunction in a client’s life comes from looking at the individual in their environment, and not from breaking the client down into subsystems. Finally, McColl’s fourth principle is that a therapeutic relationship is based upon the view that illness offers an opportunity for learning and achieving greater self-awareness. These principles incorporate spirituality in several ways. First, if a client is to be the person who determines when imbalance is present, if the client feels that spiritual issues are a component of the problem then the therapist must be prepared to help the client face those issues. Second, the third principle suggests that it is not possible to separate a client from his or her spirituality, just as it is not possible to separate the client from his physical
body. Finally, the fourth principle implies that the role of the therapist is to assist the client in finding meaning in illness and in developing increased self-awareness, which are spiritual areas of life.

The Role of Spirituality in Occupational Therapy

The question of the appropriateness of including spirituality in different health professions has been asked repeatedly. Dombeck (1998) listed several reasons health care professionals avoid spiritual care. Many professionals have expressed feelings that all spiritual care is the responsibility of pastoral counselors or perhaps nurses. Professionals may feel that spirituality is private and sacred and therefore feel uncomfortable touching upon this area with clients. Some professionals might be uncomfortable with aspects of their own spiritual life, which leads to discomfort discussing similar issues with clients. Finally, there is a traditional separation between the mind and the body in Western medicine. This has promoted the belief that health care workers did not need to consider the mind or spirit when treating a client's physical problems. However, in recent years there has been a trend in health care toward a more holistic view of the client which envisions a person as more than the sum of mind, body and spirit (O'Brien, 1999). As this integrated view of the person has become more accepted, most healthcare professions have come to the conclusion that spirituality is an integral part of holistic health care. As such, it becomes a consideration for all health care professionals who profess to treat holistically (Burnard, 1988).

One of the many questions raised in several professions has addressed the ethicality of discussing spirituality with clients. Jamison (1995) pointed out that most illnesses are the result of lifestyle choices that are based upon culture and personal
values, which fall under the rubric of spirituality. Therefore ignoring spirituality in treating patients is ignoring part of the illness or injury. Furthermore, Jamison believed that ethical decisions are a function of spirituality, and therefore when we make ethical decisions we are guided by our own beliefs and values, so refusing to discuss spirituality on ethical grounds is actually a spiritual decision. Lukoff and Lu (1999) postulated that being knowledgeable about and comfortable with spiritual and religious issues is a matter of cultural competence for psychiatrists. Cultural competence is also a responsibility of occupational therapists (Moyers, 1999), and as such ignoring spiritual issues rather than addressing them is unethical. Dombeck (1998) believed that although it might be appropriate to refer religious issues to clergy or pastoral counselors, spirituality is relevant to health and this makes it part of all healthcare professions.

Several studies have evaluated occupational therapists' intentional use of spirituality in assessment and treatment. The results of studies in the United States and Great Britain have indicated that although a majority of occupational therapists believe that spirituality is an important part of health and can impact the outcome of therapy, most were not actively assessing spirituality or incorporating it into treatment. One factor that may have affected the results of these studies was continuing ambiguity regarding the definition of spirituality (Howe, 1996; Engquist et al., 1997; Rose, 1999).

Engquist et al. (1997) surveyed 298 occupational therapists in the United States about their beliefs, opinions, and practices related to spirituality in treatment. Approximately 79% of subjects agreed that the survey adequately measured these items. Most strongly agreed or agreed that spirituality is an important part of their own lives, spirituality is a very important part of health and rehabilitation, spirituality
could affect a client’s rehabilitation potential, and that illness, disability, or crisis could affect the spiritual lives of people. In contrast, approximately one-third felt that addressing spiritual issues was within the scope of occupational therapy practice. Most felt that they did not have adequate training to meet client’s spiritual needs. Slightly less than one-third of respondents wanted more training in dealing with spiritual issues, while a fourth of respondents felt that clients did not require assistance from their occupational therapists in dealing with spiritual issues. Most subjects agreed that assessment or treatment of spiritual needs would not be reimbursable. About half of the subjects thought that treatment planning should include opportunities for clients to express spiritual needs. Most respondents felt that referrals should be made whenever spiritual concerns came up in occupational therapy. About one third of the respondents felt confused about their role as an occupational therapist in regard to clients’ spirituality. Less than 10% of respondents consistently assessed spiritual issues of clients or felt that occupational therapists should spend more time addressing spiritual needs of their clients. Most respondents felt it was appropriate to discuss spiritual issues with a client only if the client brought up the issue. Twelve subjects in this study commented on the lack of a definition of spirituality in the questionnaire. The authors noted that the lack of a definition of spirituality on the survey instrument might have created difficulties for the respondents if they had an unclear idea of what spirituality is or if they interpreted spirituality in terms of religion.

Rose (1999) used a modified version of Engquist et al.’s (1997) survey in Great Britain. He restricted his study to occupational therapists working in palliative care, specifically in the areas of HIV/AIDS and oncology palliative care. Rose included two definitions of spirituality from the literature in order to assist subjects in
responding. Most respondents agreed that the survey reflected their beliefs adequately. Rose found that most respondents felt spirituality was an important part of their lives, was helpful in their careers, and was an important aspect of health and rehabilitation. Nearly all respondents felt that spirituality could influence a client’s response to treatment. About one-fifth felt that occupational therapists should not address spiritual issues. More than half of the subjects agreed that assisting clients with spiritual needs was within the scope of occupational therapy. Most felt that clients should be referred to other professionals when spiritual issues were brought up. Most respondents would only discuss spirituality with the client if the client initiated the discussion. A majority of respondents thought that therapists should include activities that allowed clients to express their spirituality in treatment.

Howe (1996) surveyed occupational therapists about their personal religious practices as well as addressing questions related to the views of occupational therapists about spirituality, how it was being assessed, and of whether spirituality was being used in treatment. Howe sought to create a composite definition of spirituality based upon responding therapists’ personal definitions of spirituality. She found that most therapists felt at least somewhat strongly religious or spiritually oriented and most included the appreciation of nature and prayer or meditation in their personal spirituality. Slightly fewer than half attended spiritual meetings or read spiritual literature. Slightly more than one third shared their spiritual experiences with others. Over 90% believed in God or a Higher Power. Three-fourths spent time daily or weekly on some spiritual practice and the same number felt close or extremely close to God or a Higher Power. The most common spiritual practices of occupational therapists were attending spiritual meetings, reading spiritual literature, prayer and meditation, and sharing spirituality with others. The subjects rated their
conservancy; those who were more conservative were more likely to feel that spirituality was important to recovery, that spirituality should be part of all that an occupational therapist does, and that there is a connection between spiritual beliefs and service delivery. Most therapists did not assess spirituality. When spirituality was assessed it was usually after the client expressed a spiritual need. None of the subjects reported actively using spirituality in treatment. There was discrepancy among therapist’s beliefs about when spirituality should be addressed in treatment. About one-third of the respondents thought spirituality be addressed as part of the deepening therapeutic relationship, while another third thought that it should be part of all that the therapist does. Most therapists felt that spirituality was important to recovery and that there was a connection between their personal beliefs and service delivery. More than half felt that the use of personal beliefs regarding spirituality in treatment should depend upon the context. Therapists were asked to rank order items from a list of terms commonly used to describe spirituality in order to develop a definition of spirituality. The definition compiled from the results was as follows:

Spirituality is those thoughts, behaviors, and beliefs dealing with self, others and a higher power that relate to the meaning of life and structure our values and beliefs. This experience is unique to each individual. The spirit itself is the essence of life and provides peace of mind, a separate piece of the whole individual suggesting integration with other parts of the individual. (p. 43)

Spirituality is implicitly addressed through the fundamental principles of occupational therapy. The American Occupational Therapy Association’s The Guide to Practice (1999) defines occupational therapy’s domain of concern as “the engagement by persons in meaningful and purposeful occupations in the performance areas of ADL [activities of daily living], work and productive activities, and play/leisure” (p.258). Since the definition of spirituality includes “the experience of meaning in everyday life” (Urbanowski & Vargo, 1994, p. 89), then spirituality is an
inherent part of occupational therapy. Several authors have argued this point in the literature. Collins (1998) suggested that occupational therapists address spirituality when they consider the quality of the experiences of their clients because quality of life affects spiritual well-being. Thus, working with clients to improve their quality of life can improve their spiritual well-being without ever specifically working on a spiritual goal. Egan and Delaat (1997) discussed the implicit spirituality of occupational therapy. They suggested three requirements that should be met for a profession to say that it incorporates spirituality into treatment. The first requirement is recognition that people have both physical and spiritual needs. The second requirement is a belief in the value of all beings. Finally, to be spiritually aware, the occupational therapist must reflect upon the interconnectedness of all people and the impact of one life upon another. The *Core Values and Attitudes of Occupational Therapy Practice*, published by the American Occupational Therapy Association (1993), addressed the first and second issues under the heading of dignity:

Dignity emphasizes the importance of valuing the inherent worth and uniqueness of each person. This value is demonstrated by an attitude of empathy and respect for self and others. We believe that each individual is a unique combination of biologic endowment, sociocultural heritage, and life experiences. We view human beings holistically, respecting the unique interaction of the mind, body, and physical and social environment. We believe the dignity is nurtured and grows from the sense of competence and self-worth that is integrally linked to the person’s ability to perform valued and relevant activities. In occupational therapy we emphasize the importance of dignity by helping the individual build on his or her unique attributes and resources. (p. 1086)

Connectedness is addressed in the *Uniform Terminology for Occupational Therapy* (1994) as a performance area in caring for others, as a performance component in psychosocial skills, and in performance contexts as an aspect of the social environment. Therefore, according to Egan and Delaat’s criteria, occupational
therapy in the United States does consider the spiritual dimension, although it is not expressly stated.

The current study sought to determine if there have been changes in the beliefs and practices of occupational therapists in the past few years, as well as seeking to determine those factors perceived by occupational therapists to act as barriers to the integration of spirituality into their assessment and treatment.
CHAPTER III

METHODOLOGY

Research Design

The purpose of this study was to gather information about beliefs, practices, and perceived barriers to the utilization of spirituality in occupational therapy assessment and treatment. A survey instrument was used to acquire information about participants’ beliefs regarding spirituality and the use of spirituality in occupational therapy treatment. Subjects were also asked to report the frequency of the utilization of several spiritual practices within their practice and the frequency with which they make referrals to spiritual professionals. Finally, subjects were asked to indicate which possible barriers to the use of spirituality in treatment kept them from incorporating it into assessment or treatment. The survey “Occupational Therapists’ Spiritual Assessment Survey” is included in Appendix A.

The Survey Instrument

The survey used in this study was adapted with permission (see Appendix B) from the “Physicians’ Spiritual Assessment Survey” developed by Ellis, Vinson, and Ewigman (1999). Changes were made to the survey to reflect the practice of occupational therapy, and a definition of spirituality was added based on recommendations by Engquist et al. (1997). The survey was submitted to two occupational therapists in order to establish face validity, and revisions were made to increase the clarity of the instrument.
Selection of Subjects

The subjects included 250 randomly selected members of the American Occupational Therapy Association. The sample was not a true random sample because some occupational therapists are not members of the organization. Subjects were sent a cover letter, survey, and self-addressed stamped envelope. The cover letter provided documentation of assumed consent.

Instrumentation

The survey consisted of 43 questions, arranged in six sections. These sections included demographics, beliefs about spirituality, perceived barriers to including spirituality in practice, the frequency with which various spiritual topics are discussed with clients, the frequency of referrals to professionals in fields related to spirituality, and a final section gave subjects the opportunity to make comments about the study.

Data Collection and Analysis of Results

As each survey was returned, it was sequentially entered into a spreadsheet. Data were analyzed using SPSS Version 6.1. The frequencies for each response were calculated. Pearson's Chi-Square analysis was used to look for any interrelationships between subjects' beliefs and practices regarding spirituality and their demographic information.
CHAPTER IV

RESULTS

Population Demographics/General Information

One hundred twelve of the original 250 surveys were returned, yielding a response rate of 45%. The characteristics of respondents are shown in Table 1.

Table 1

General Characteristics of Respondents

<table>
<thead>
<tr>
<th>Question*</th>
<th>Choices**</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>95.5%</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>4.5%</td>
</tr>
<tr>
<td>Practice Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td>16.1%</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td>17.9%</td>
</tr>
<tr>
<td>Community Based Care</td>
<td></td>
<td>4.5%</td>
</tr>
<tr>
<td>Nursing Home</td>
<td></td>
<td>8.0%</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td>6.3%</td>
</tr>
<tr>
<td>Home Health</td>
<td></td>
<td>8.9%</td>
</tr>
<tr>
<td>School systems</td>
<td></td>
<td>14.3%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>17.9%</td>
</tr>
<tr>
<td>Practice Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural (less than 10,000)</td>
<td></td>
<td>9.8%</td>
</tr>
<tr>
<td>Medium-sized town ((10,000-50,000)</td>
<td></td>
<td>29.5%</td>
</tr>
<tr>
<td>City or metropolitan area</td>
<td></td>
<td>58.9%</td>
</tr>
</tbody>
</table>

*Question refers to question from survey instrument
**Choices refers to forced choice answers on survey instrument

The respondents were predominantly female (95.5%). Most had a bachelor’s degree
in occupational therapy (64.3%), while 29.5% had a master’s degree in occupational therapy and 4.5% had a certificate in occupational therapy. Less than 2% had a doctorate in occupational therapy or another field. The respondents worked in multiple practice areas (see Table 1). The three most common areas of practice identified by therapists as best describing their job were: outpatient (17.9%), other areas (17.9%), which included retired therapists, educators, hand therapists, industrial rehabilitation, and those respondents who worked in multiple practice areas or in non-traditional occupational therapy jobs, and inpatient (16.1%). The respondents had been practicing occupational therapists between one and 43 years, with a mean of 12.69 years experience. The majority practiced in cities or metropolitan areas (58.9%), while 29.5% practiced in medium-sized towns and 9.8% practiced in rural areas.

Respondents’ Views About Spirituality in Occupational Therapy Practice

A majority of respondents (95.6%) believed that spiritual well-being is an important component of good health. Nearly half (45.5%) agreed or strongly agreed that occupational therapists should address spiritual concerns with clients. More than a third (34.8%) felt that inpatients with spiritual concerns should be referred to a hospital chaplain or other spiritual leader and that occupational therapists in this setting should not address spiritual concerns. Nearly the same number (35.8%) felt that clients in the community should be referred to a spiritual leader and the occupational therapists in this situation should not address the clients’ concerns.
Perceived Barriers to the Inclusion of Spirituality in Occupational Therapy Treatment

The responses of subjects when asked to identify barriers to the utilization of spirituality in occupational therapy treatment are shown in Table 2.

<table>
<thead>
<tr>
<th>Potential Barrier</th>
<th>Respondents who Agreed or Strongly Agreed</th>
<th>Respondents who Were Neutral</th>
<th>Respondents who Disagreed or Strongly Disagreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discomfort with the subject matter</td>
<td>17%</td>
<td>21.4%</td>
<td>61.6%</td>
</tr>
<tr>
<td>Belief that expressing spiritual concerns is not appropriate to the occupational therapists' role</td>
<td>26.8%</td>
<td>17.9%</td>
<td>55.4%</td>
</tr>
<tr>
<td>Concern that I will project my own beliefs onto clients</td>
<td>44.6%</td>
<td>12.5%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Lack of experience or training in taking a spiritual history</td>
<td>55.7%</td>
<td>21.4%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Uncertainty about how to manage spiritual issues raised by clients</td>
<td>46.5%</td>
<td>20.5%</td>
<td>32.2%</td>
</tr>
<tr>
<td>Potential Barrier</td>
<td>Respondents who Agreed or Strongly Agreed</td>
<td>Respondents who Were Neutral</td>
<td>Respondents who Disagreed or Strongly Disagreed</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Lack of time</td>
<td>41.9%</td>
<td>17.9%</td>
<td>32.2%</td>
</tr>
<tr>
<td>Belief that spiritual issues must take a lower priority than more acute issues</td>
<td>15.2%</td>
<td>21.4%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Belief that clients do not want to share spiritual concerns with their occupational therapist</td>
<td>16.1%</td>
<td>36.6%</td>
<td>46.5%</td>
</tr>
<tr>
<td>Uncertainty about how to identify clients who desire a discussion of spiritual issues</td>
<td>31.3%</td>
<td>27.7%</td>
<td>41.1%</td>
</tr>
<tr>
<td>Lack of continuity in relationship with clients</td>
<td>31.3%</td>
<td>17.0%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Difficulty in using appropriately-understood language in discussion of spiritual issues</td>
<td>26.8%</td>
<td>23.2%</td>
<td>49.2%</td>
</tr>
<tr>
<td>Negative attitudes of peers</td>
<td>17.0%</td>
<td>32.1%</td>
<td>49.1%</td>
</tr>
<tr>
<td>Lack of financial reimbursement</td>
<td>32.2%</td>
<td>24.1%</td>
<td>41.1%</td>
</tr>
</tbody>
</table>
The most frequently reported barriers to the incorporation of spirituality into occupational therapy treatment were lack of experience or training in taking a spiritual history (55.7%), concern that the therapist would project personal beliefs onto clients (44.6%), uncertainty how to handle spiritual issues raised by clients (46.5%), and lack of time (41.9%). The barriers that were disagreed with most frequently were belief that spiritual issues should take a lower priority than more acute issues (62.5%), discomfort with the subject matter (61.6%), belief that spirituality is not the concern of occupational therapy (55.4%), and lack of continuity in the relationship with clients (51.8%).

Reported Use of Spirituality in Treatment

Therapists were asked to report the frequency with which they discussed specific topics related to spirituality with clients. The results are shown in Table 3. The most commonly discussed spiritual topic reported by therapists was the meaning or purpose of illness. Most therapists also addressed belief, faith, and religious views occasionally or frequently, attitudes about giving or receiving love, meditation or quiet reflection, and fears of death and dying. A majority of therapists reported rarely or never addressing the role of God in illness, attitudes about forgiveness, and prayer (see table 3 for specific percentages).

Frequency of Referrals to Spiritual Leaders

A minority of therapists occasionally (18.8%) or frequently (15.2%) referred clients to a chaplain, or requested the services of a client’s spiritual leader (21.4% and 13.4%, respectively).
Table 3
Frequency of Discussion of Spiritual Topics

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The meaning or purpose of illness</td>
<td>7.1%</td>
<td>26.8%</td>
<td>37.5%</td>
<td>25.9%</td>
</tr>
<tr>
<td>The role of God in illness</td>
<td>24.1%</td>
<td>33.9%</td>
<td>33.0%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Belief and faith, religious values</td>
<td>11.6%</td>
<td>24.1%</td>
<td>47.3%</td>
<td>16.1%</td>
</tr>
<tr>
<td>Attitudes about giving and receiving love</td>
<td>13.4%</td>
<td>25.0%</td>
<td>40.2%</td>
<td>21.4%</td>
</tr>
<tr>
<td>Attitudes about forgiveness</td>
<td>18.8%</td>
<td>33.0%</td>
<td>34.8%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Prayer</td>
<td>23.2%</td>
<td>25.0%</td>
<td>38.4%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Meditation or quiet reflection</td>
<td>20.5%</td>
<td>17.9%</td>
<td>44.6%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Fears of death or dying</td>
<td>17.9%</td>
<td>18.8%</td>
<td>45.5%</td>
<td>17.9%</td>
</tr>
</tbody>
</table>
CHAPTER V

DISCUSSION AND CONCLUSIONS

Summary of Results

When compared to previous studies of spirituality in occupational therapy, this study indicated that beliefs and behaviors of occupational therapists regarding this topic might be changing. The results of this study make it obvious that therapists are divided about many aspects of spirituality. Previous studies indicated that therapists felt that spirituality was important to health and rehabilitation potential, that clients with spiritual concerns should be referred to spiritual leaders, and that few therapists addressed spirituality in treatment (Engquist et al., 1997; Howe, 1996; Rose, 1999). This study found that therapists continue to agree that spirituality is important in health and rehabilitation, but also indicated that therapists seem to be integrating spirituality into occupational therapy more frequently. Further, some therapists seem to be beginning to see spirituality as part of the domain of occupational therapy. It was evident from the results of this study that spirituality continues to be a controversial topic among therapists, as shown by numerous items with which therapists equally agreed and disagreed. Numerous comments stated both that spirituality is very important to occupational therapy and while many other respondents commented that occupational therapists should avoid spirituality.

Defining Spirituality

Although a definition of spirituality was provided on the survey instrument, it
appeared that many occupational therapists associate spirituality with religion. The definition used for this study was taken from a Canadian publication, and American occupational therapists might have a different working definition of the term. Many of the comments written by respondents referred to “religion” as opposed to spirituality. Three respondents felt that the survey reflected a religious bias that was more specific than the provided definition. This was particularly a problem in a question that referred to God; this question might have been more revealing if it had referenced God or a Higher Power. The tendency to interpret spirituality as religion may have affected the results, as therapists might be less willing to discuss specifically religious issues than issues relating to spirituality. One respondent wrote, “There seems to be a real taboo about discussing religious issues...[sic] possibly due in part to equal rights issues.”

Beliefs Regarding Spirituality

Nearly all (95.6%) of the respondents believed that spirituality is an important component of good health. This is slightly more than in previous studies. Engquist et al. (1997) found that 84% of subjects felt spirituality was important to health and rehabilitation. Rose (1999) used the survey developed by Engquist et al. to question occupational therapists working in palliative care in the United Kingdom. Among that population, 88% of respondents agreed. Howe (1996) found that 77% of therapists agreed that spirituality was important in recovery. The increased agreement to this concept may indicate differences in therapists’ feelings about spirituality. Several respondents commented on their feelings about the importance of spirituality. One respondent wrote, “my patients with a strong spirituality seem to ‘heal’ [sic] faster.”
Therapists were divided about whether occupational therapists should address spiritual issues. Nearly half (45.5%) of the respondents selected the “neutral” choice. This seemed to be related to a general feeling that the appropriateness of addressing spiritual issues depended upon the situation. Many respondents commented that spirituality should only be addressed if the client brings it up. Other concerns were that the appropriateness depended on the particular client/therapist relationship, that therapists were not trained to deal with spirituality, and that practice area is important in determining the appropriateness of such a discussion. Many therapists who worked with children felt that spiritual discussions were inappropriate for the population. This might also have been affected by therapists’ religiously oriented definitions of spirituality. One respondent commented “Religion plays no role in a school environment.”

Therapists were divided about whether spiritual concerns should always be referred to spiritual leaders. This was true in regard to both inpatients and outpatients. For both groups, approximately one-third of respondents agreed or strongly agreed that spiritual concerns should be referred, another one-third disagreed or strongly disagreed, and another third was neutral. Again, the appropriateness of referral seemed to be specific to an individual situation.

Perceived Barriers to the Inclusion of Spirituality in Occupational Therapy Treatment

Therapists were asked to identify barriers that they believe inhibit them from incorporating spirituality into treatment. Of the 13 possible barriers, there was only one that a majority identified as a barrier. The barriers selected by a respondent may have been affected by the therapists’ feelings about spirituality; if the therapist felt spirituality had no place in occupational therapy, he or she would be less likely to
perceive barriers.

The results of the barrier section indicate that when occupational therapists consider the utilization of spirituality in treatment, they are most likely to be concerned about their lack of experience or training in taking a spiritual history. The therapist is also likely to feel that uncertainty about how to manage spiritual issues, fear of projecting personal beliefs onto clients, and a lack of time are barriers to the inclusion of spirituality into treatment. They are least likely to be concerned with the belief that spiritual issues should take a lower priority than more acute issues, a belief that clients do not want to discuss spiritual issues with their occupational therapist, negative attitudes of peers toward spiritual assessment, or discomfort with the subject matter. They also are unlikely to see uncertainty of how to identify clients who wish to talk about spiritual issues, lack of continuity in relationship with clients, difficulty in using appropriate language in a spiritual discussion or lack of financial reimbursement as barriers.

The most commonly reported barrier was lack of experience or education in taking a spiritual history, cited by 55.7% of respondents. This is in agreement with Engquist et al. (1997), who found that 82% of subjects felt they did not have adequate academic training to deal with clients’ spiritual needs and 67% did not feel that their on-the-job training had provided them with preparation to meet client’s spiritual needs. However, Engquist et al. found that only 36% of respondents wanted more education in this area. Again, there was a decline in the percentage of therapists who felt untrained to cope with spirituality between the study by Engquist et al. and the present study.

Several of the most commonly reported barriers had nearly equivalent numbers of respondents who agreed with or disagreed with the statement. The third
most commonly reported barrier was concern that the therapist would project his or her own beliefs onto clients (44.6%). However, 42.9% of respondents disagreed with this statement. The fourth most commonly reported barrier was lack of time (41.9%). Again, nearly the same number of respondents (39.3%) disagreed. This even distribution may reflect opposing opinions. This might be attributable to differences in the work environment. One respondent shared the following story:

A patient recently wanted to pray in her OT session, so we both silently expressed our thoughts/prayers. Unfortunately my beeper did its thing ruining the moment, and I saw this as a sad commentary of how “medicine” can interfere with a person’s “health”.

In a different setting this may not have occurred.

The least commonly reported barrier to the use of spirituality in treatment was the belief that spiritual issues must take a lower priority than more acute issues (15.2%). This seems to indicate that occupational therapists feel that spiritual issues are as important as physical or mental health issues. Only 16% of respondents felt that clients do not want to share spiritual concerns with their occupational therapist. Only 17% of the respondents felt that negative attitudes of peers toward spiritual assessment was a barrier. The same number cited discomfort with the subject matter. Other barriers with which more therapists disagreed than agreed were belief that expressing spiritual concerns is not appropriate to the occupational therapists’ role, uncertainty about how to identify clients who desire a discussion of spiritual issues, lack of continuity in relationship with clients, and lack of financial reimbursement. It is interesting to note that only 32% of therapists cited lack of financial reimbursement for spiritual assessment as a barrier, since Engquist et al. (1997) found that 81% of respondents felt it would be difficult to be reimbursed for spiritual assessment or treatment.
Most occupational therapists reported discussing each of the eight spiritual topics with between 1 and 10% of clients. This is an increase from reports of spiritual activities by occupational therapists reported in previous studies. Howe (1996) found that none of the therapists surveyed reported addressing spirituality in treatment. Engquist et al. (1997) showed that 76% of respondents believed that all spiritual issues should be referred to other professionals. However, this seeming discrepancy might be accounted for by the lack of a definition of spirituality on the Engquist et al. survey instrument. It is impossible to determine if therapists were responding to issues other than those suggested on the current survey instrument. Fears of death and dying, the meaning or purpose of illness and belief, faith, and religious views were discussed most frequently. These topics were discussed with clients occasionally or frequently by 63.4% of respondents. However, although a majority of therapists discussed these topics at least occasionally with clients, there was still some disagreement about whether the topics were relevant. One respondent indicated that she did not feel there was a purpose to illness. Attitudes about giving and receiving love and meditation and quiet reflection were the second most frequently discussed topics. These topics were addressed by 61.6% of therapists occasionally or frequently. More than half (51.8%) of respondents addressed prayer occasionally or frequently. Forgiveness was addressed by 48.2% of respondents. The least commonly discussed topic was the role of God in illness (41%). However, this may be due to the wording of the statement; if the question had referred to God or a higher power, it may have received a different response.
Referrals to Spiritual Professionals

This section asked respondents to identify the frequency with which they refer clients to spiritual leaders. Approximately one-third (34%) utilized the services of a chaplain occasionally or frequently. Nearly the same proportion (34.8%) occasionally or frequently referred clients to their pastor, rabbi or other spiritual leader.

Comparison to Family Practice Physicians

The survey instrument used for this study was originally developed for use with family practice physicians. This allows comparison between occupational therapists' and family practice physicians' views and practice related to spirituality. Ellis et al. (1999) found 96% of family physicians felt that spirituality was an important component of good health. This is the same proportion as occupational therapists. Physicians were more likely to believe that inpatients should be referred to spiritual leaders (86% compared to 34.8% of occupational therapists). However, more physicians (58%) believed that they should address spiritual concerns with patients than did occupational therapists (45.5%). The most frequently reported barriers to assessment or treatment of spiritual issues as cited by family practice physicians were lack of time (71%), lack of training (59%), difficulty in identifying patients who want to discuss spiritual issues (56%), and concerns about projecting beliefs onto patients (53%). Three of these were also top issues commonly cited by occupational therapists: lack of time (41.9%), lack of training (55.7%), and concerns about projecting beliefs onto clients (44.6%). The fourth issue cited by physicians, difficulty in identifying patients who wish to discuss spiritual issues, was cited by only 31.3% of occupational therapists, indicating that therapists feel more
comfortable identifying clients with spiritual concerns. The least commonly cited barriers by physicians were negative attitudes of peers toward spiritual assessment (23%) and lack of reimbursement (11%). These were also among the least frequently reported barriers for occupational therapists. Physicians appeared to be much less divided in opinions about barriers than were occupational therapists. This may reflect more uniform beliefs about the role of spirituality in medicine. Physicians saw more barriers than occupational therapists, which might explain the greater diversity of occupational therapists’ views. When family physicians were asked about the frequency with which they discuss spiritual topics with patients, the most frequently addressed issue was fear of death and dying. This was also the most frequently reported topic for occupational therapists. Occupational therapists were more likely to report discussing the meaning or purpose of illness, and attitudes about giving or receiving love frequently. Family practice physicians were more likely than occupational therapists to refer patients to a chaplain or another spiritual leader, although only 22% reported doing so frequently. This compared to 15.2% of occupational therapists that frequently referred inpatients to a chaplain and 13.4% of occupational therapists that frequently referred clients to a pastor, rabbi, or other spiritual leader.

Although family practice physicians are more likely than occupational therapists to state they should address spiritual concerns of patients, occupational therapists actually do so more frequently. Physicians see more barriers than occupational therapists and are more likely to make referrals. There seems to be more agreement among physicians about their beliefs and practices regarding spirituality than among occupational therapists.
Limitations of the Current Study

This study was limited by its survey design. Survey research has limitations by nature. Since the researcher is not present while the survey is being filled out, it is impossible to know the conditions under which the respondent is working. Respondents may interpret items differently, affecting results.

The instrument used for this study had several limitations. First, there were two errors. The first was the omission of item 12 in section three. The second was the use of the word "patents" rather than "clients" in the instructions for section five. Secondly, the survey may have reflected a bias toward religion. Several respondents commented upon a perceived discrepancy between the definition given and several questions. The use of the word "God" in section four, question two might also have impacted results. This should have been stated as God, gods, or a higher power. Finally, the survey instrument did not include indirect ways a therapist might address a client's spiritual needs.

The response rate to this survey was 45%. This rate is typical for surveys that only are mailed to respondents once. However, response rates increase to approximately 70% when surveys are mailed to respondents more than once (Weisberg, Krosnik, & Bowen, 1996). This study did not include a second mailing to remind respondents to return the surveys. A higher response rate might have been possible if this had been done. A higher response rate would have allowed for more statistical analysis of possible correlations between demographic information and responses.

This study looked for changes in occupational therapists' opinions about spirituality and treatment. It was believed that these opinions might have changed since previous studies were completed since therapists may have had more exposure
to the topic of spirituality due to the publication of the results of previous studies. This effect may have been heightened because of the publication of an article (Rosenfeld, 2000) in an issue of OT Practice. The issue in which the Rosenfeld article was published was distributed to all members of the American Occupational Therapy Association shortly before the surveys for this study were mailed to subjects selected from the membership list of that organization. The effects of this article are unknown; it is possible that therapists felt more positively or more negatively about spirituality based on this article. One respondent commented that the article had increased her interest in the topic.

Directions for Future Research

This study indicated that spirituality is a topic about which occupational therapists are divided. There seem to be many therapists who feel that spirituality should be explicitly addressed in occupational therapy, while many others feel that it has no place in therapy. This may be related to the confusion between religion and spirituality. Future research needs to determine whether occupational therapists differentiate between these two topics. This study addressed only explicit, direct ways in which spirituality is addressed in treatment. Since a review of occupational therapy literature indicated that spirituality should implicitly be part of occupational therapy, research to determine if therapists do implicitly include spirituality in their conceptualization of occupational therapy is needed. There are many indirect ways in which therapists might address spirituality, such as helping a client work toward the client’s goal of returning to church. This study did not assess these means of addressing spirituality. Subjects reported feeling untrained in how to address spirituality. As the role of spirituality in occupational therapy is clarified, a study of
how spirituality is addressed in occupational therapy education would be appropriate. Client-centered treatment focuses on what the client feels is important. In the spirit of this, research is needed to determine how clients feel about addressing spirituality with occupational therapists. Studies of therapists’ beliefs are only as relevant as their clients’ opinions about this topic.

Conclusions

Spirituality remains a disputed topic among occupational therapists. There is little agreement about many of the issues related to spirituality and treatment. Therapists appeared to have multiple definitions of spirituality. Some seemed to equate spirituality with religion. Nearly all therapists believe spirituality is important in health and well-being. Beliefs about the appropriateness of the inclusion of spirituality in treatment and identified barriers to inclusion were divided. Most therapists reported addressing spirituality in some way in treatment.

Beliefs about spirituality and occupational therapy seem to be changing. Compared to previous studies of spirituality, this study found more subjects felt spirituality was important and more subjects reported using spirituality in treatment. Previous studies found occupational therapists were concerned with various aspects of spirituality, such as education in dealing with the topic and reimbursement. The current study showed that therapists are less concerned with these areas. Only one barrier, lack of experience or training in taking a spiritual history, was cited by a majority of respondents. Other barriers were considered important by nearly the same proportion that felt that the barrier was not relevant.

Spirituality is a topic that is increasingly becoming relevant to healthcare providers, including occupational therapists. As healthcare continues to become more
client-centered, the topic will increase in importance. The exact role of spirituality in occupational therapy is yet to be defined. It is anticipated that much change in the views and practices of occupational therapists will continue to occur. Further studies to track these changes and to further clarify how spirituality fits into occupational therapy are warranted.
Appendix A

Occupational Therapists’ Spiritual Assessment Survey
Western Michigan University
Department of Occupational Therapy
Principal Investigator Dr. Stanley Paul
Research Associate Jennifer Collins

You are invited to participate in a research project entitled “The utilization of spirituality in occupational therapy: Beliefs, practices, and Barriers.” This survey is intended to study the use of spirituality in occupational therapy, the relationship of occupational therapists’ spirituality to their use of spirituality, and barriers to the use of spirituality in occupational therapy treatment. This project is being conducted as part of the thesis requirements for Jennifer Collins.

This survey contains approximately 30 questions and will take approximately 10 minutes to complete. Your responses will be completely anonymous, so please do not put your name anywhere on the form. You may choose to not answer any question by leaving it blank. If you choose not to participate in this survey, you may return the survey blank or you may discard it. Returning the survey indicates your consent for the use of the answers you submit. If you have any questions you may contact Dr. Stanley Paul at (616) 387-7242, or Jennifer Collins at (616) 353-6039, the Human Subjects Institutional Review Board at (616) 387-8293, or the vice president for research at (616) 387-8298.

This consent documentation has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in this project if the corner does not have a stamped date and signature.

Thank you.

[Signature]
Stanley Paul, OTR, Ph.D.

[Signature]
Jennifer Collins
When answering the following questions, please use the following definition of spirituality: “Spirituality relates to our thoughts, feelings, and actions concerning the meaning that we make of our daily lives” (Egan & Delaat, 1997, p. 116).

I. Practice Setting/Demographics

1. Please check your gender.
   Male _____
   Female _____

2. Please check the area of practice that best describes your job:
   Inpatient _____
   Outpatient _____
   Community Based Care_______
   Nursing Home_______
   Mental health_____
   Home Health_____
   School systems_____
   Other (please specify) ______________

3. Please check all that apply:
   Bachelor’s degree in occupational therapy____
   Master’s degree in occupational therapy_______
   Certificate in occupational therapy__________
   Doctorate in occupational therapy_______
   Doctorate in other field________

4. Years in practice _____

5. Practice location (population):
   _____ Rural (less than 10,000)
   _____ Medium-size town (10,000-50,000)
   _____ City or metropolitan area (greater than 50,000)
II. Please circle the one number in each row that most closely reflects your views.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I believe that spiritual well-being is an important component of good health. 1 2 3 4 5

2. I believe that an occupational therapist should address spiritual concerns with his or her clients. 1 2 3 4 5

3. I believe that inpatients with spiritual questions should be referred to the hospital chaplain or other spiritual leader; these questions should not be addressed by the occupational therapist. 1 2 3 4 5

4. I believe that clients in the community with spiritual questions should be referred to their pastor, rabbi, or other spiritual leader; these questions should not be addressed by the occupational therapist. 1 2 3 4 5

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

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Discomfort with the subject matter. 1 2 3 4 5

2. Belief that expressing spiritual concerns is not appropriate to the occupational therapist’s role. 2 3 4 5

3. Concern that I will project my own beliefs onto clients. 2 3 4 5

4. Lack of experience or training in taking a spiritual history. 1 2 3 4 5

5. Uncertainty about how to manage spiritual issues raised by clients. 1 2 3 4 5

6. Lack of time. 1 2 3 4 5

7. Belief that spiritual issues must take a lower priority than more acute issues. 1 2 3 4 5

8. Belief that clients do not want to share spiritual concerns 1 2 3 4 5
with their occupational therapist.

Section III-continued,

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Uncertainty about how to identify clients who desire a discussion of spiritual issues.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Lack of a continuity relationship with clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>11. Difficulty in using appropriately understood language in discussion of spiritual issues.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. Negative attitudes of peers toward spiritual assessment of clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. Lack of financial reimbursement for spiritual assessment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

IV. Select the response which most closely describes the proportion of clients with whom you discuss the following topics. Circle one letter in each row.

<table>
<thead>
<tr>
<th></th>
<th>Never 0%</th>
<th>Rarely 0%-1%</th>
<th>Occasionally 1%-10%</th>
<th>Frequently &gt;10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The meaning or purpose of illness</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
<tr>
<td>2. The role of God in illness</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
<tr>
<td>3. Belief and faith, religious views</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
<tr>
<td>4. Attitudes about giving and receiving love</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
<tr>
<td>5. Attitudes about forgiveness</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
<tr>
<td>6. Prayer</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
<tr>
<td>7. Meditation or quiet reflection</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
<tr>
<td>8. Fears of death and dying</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
</tbody>
</table>
V. Indicate the frequency with which you do the following for your patents. Circle one letter in each row.

<table>
<thead>
<tr>
<th></th>
<th>Never 0%</th>
<th>Rarely 0%-1%</th>
<th>Occasionally 1%-10%</th>
<th>Frequently &gt;10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Utilize the services of a chaplain</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
<tr>
<td>2. Request the services of client’s pastor, rabbi or other spiritual leader</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
</tr>
</tbody>
</table>

VI. In the space below, please write any comments you have concerning the results of this survey.
Appendix B

Permission to Use and Adapt Physicians Spiritual Assessment Survey
10/25/1999

Ms. Jennifer Collins
5043 Chilsom Trail
Kalamazoo, MI 49009

Dear Jennifer:

I enjoyed our conversation today, and am happy to hear of your interest in researching spirituality as it relates to patient care. I have enclosed a copy of our survey instrument; feel free to use any or all parts of it for your study. I have also enclosed a copy of the letter to the editor I had mentioned and the Family Medicine article I had mentioned.

My best wishes for success with your research. Please let me know if I can be of any further help.

Sincerely,

Mark R. Ellis, MD, MSPH
Faculty Physician, Cox Family Practice Residency
Clinical Assistant Professor, University of Missouri-Columbia
Appendix C

Protocol Clearance From the Human Subjects Institutional Review Board
Date: 20 January 2000

To: Stanley Paul, Principal Investigator
    Jennifer Collins, Student Investigator for thesis

From: Sylvia Culp, Chair

Re: HSIRB Project Number 99-12-09

This letter will serve as confirmation that your research project entitled "The Utilization of Spirituality in Occupational Therapy: Beliefs, Practices, and Barriers" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 20 January 2001
BIBLIOGRAPHY


