Attitudes of Occupational Therapists Toward Spirituality in Practice

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Key Words: education • research

Objective. This study examined (a) occupational therapists’ attitudes about spirituality in practice on the basis of whether they identified themselves as religious, (b) whether their personal definition of spirituality related to their religiousness, (c) whether their definition related to their attitude about spirituality in practice, and (d) the methods they used to address the spiritual needs of clients.

Method. An attitude questionnaire was developed and mailed to 396 American occupational therapists. Fifty-two percent (n = 206) of the mailed questionnaires were analyzed.

Results. Overall, participants indicated a slightly positive attitude toward spirituality in occupational therapy practice. Participants who considered themselves to be religious indicated a more positive view toward spirituality in practice than those who did not consider themselves to be religious. Religiousness accounted for only 28% of the variance in choice of spirituality definition, indicating that additional variables account for what determines therapists’ definitions of spirituality. No relationship was found between personal definition choice and attitude regarding spirituality in practice. The three methods most commonly used to address the spiritual needs of their clients were to (a) pray for a client, (b) use spiritual language or concepts with a client, and (c) discuss with clients ways that their religious beliefs were helpful.

Conclusion. Therapists’ conceptualization of spirituality and attitudes about spirituality in occupational therapy practice are quite diverse.


Spirituality is increasingly recognized as influencing people’s overall health and rehabilitation (Hemphill-Pearson & Hunter, 1997; Krippner, 1995; Levin, 1994; Ross, 1995). Lukoff, Lu, & Turner (1992) concluded that religion and spirituality were “among the most important factors that structure human experience, beliefs, values, behavior, and illness patterns” (p. 673). Nursing studies have suggested that there is a spiritual dimension in humans that is linked to meaning, purpose, hope, the will to live, and an ability to improve one’s health (Clark, Cross, Deane, & Lowry, 1991; Goddard, 1995; Ross, 1995). Based on an understanding of the influential role spiritual beliefs and behaviors play on human experience, psychologists have noted the importance of addressing spiritual issues in practice (Jones, 1994; Shafranske & Malony, 1990). In keeping with the trends in nursing and mental health, Bullis (1996) stressed the importance of addressing spirituality in clinical social work practice. From the patients’ perspective, King and Bushwick (1994) found
that 98% of hospital inpatients believed in God, 77% indicated that physicians should consider their patients' spiritual needs; and 48% said that they would like their physicians to pray with them. Some researchers have suggested that since clinical professions (e.g., medicine, nursing, social work) address such cultural issues as gender, ethnicity, and race, the same consideration should be given to religious and spiritual factors (Bergin & Jensen, 1990; Lukoff et al., 1992).

Despite the inclusion of spirituality in the nursing, mental health, and social work literature and its link with psychological well-being, meaning, and purpose in life, many health care providers continue to ignore spirituality when treating clients (Christiansen, 1997; King & Bushwick, 1994; Lukoff et al., 1992). The ignoring of spirituality in practice may be due to several reasons:

• Training for health care providers in ways to address the spiritual needs of clients is limited or absent (Engquist, Short-DeGraff, Gliner, & Oltjenbruns, 1997; King & Bushwick, 1994; Lukoff et al., 1992).

• Some health care providers may not see themselves as the appropriate persons to address clients' spiritual needs (Kroeker, 1997).

• Some providers may not see the relevance of spirituality to their practice (Bergin & Jensen, 1990).

Other than in a recent issue of *The American Journal of Occupational Therapy* (March 1997), spirituality has largely been ignored in the American occupational therapy literature, treatment models, and discussions among practitioners (Christiansen, 1997). Explanations for this absence include (a) the lack of a clear definition of spirituality (Christiansen, 1997; Egan & DeLaat, 1997), (b) the unclear relationship between religion and spirituality (Kroeker, 1997), and (c) the emphasis on objective rather than subjective practice (Christiansen, 1997). Conversely, the Canadian Association of Occupational Therapists (1991) included spirituality as a core component of the Canadian Occupational Performance Model. Consequently, the bulk of the current literature about spirituality in occupational therapy practice has been published in Canadian journals (Egan & DeLaat, 1994, 1997; Kirsch, 1996; Kroeker, 1997; Unruh, 1997; Urbanowski & Vargo, 1994).

**Arguments for and Against Inclusion of Spirituality in Occupational Therapy Practice**

Throughout the history of occupational therapy, several persons have suggested the need for spirituality in practice. Meyer (1922) described the unity of the spirit and occupation as resulting in “a new sense of the sacredness of moment” (p. 9) in which the proper use of time and meaningful occupation allows the person to fit “rightly into the rhythms of individual and social and cosmic nature” (p. 9). Barton (1920), one of the founders of the Society for the Promotion of Occupational Therapy, described occupational therapy as the process of making a person stronger physically, mentally, and spiritually. Early occupational therapy philosophy viewed the person as “a unified body, mind, and spirit that were interdependent and inseparable. Curing the diseased individual, then, required several approaches that addressed all aspects of the person” (Quiroga, 1995, p. 104). More contemporary practitioners have suggested that therapy can be practiced in ways that convey the spiritual aspects of occupation (Christiansen, 1997; Egan & DeLaat, 1997; Urbanowski & Vargo, 1994).

The influence on occupational therapy of the scientific method, which espouses objectivity, has resulted in less focus on clients’ subjective experiences, such as their spirituality (Mattingly & Fleming, 1994; Quiroga, 1995). Additionally, spirituality has come to be viewed as a private, often religious, matter (Kroeker, 1997). Because spirituality is frequently associated with religion, it has been considered “off limits” in the secular aspects of our society because of the legal mandate in the United States to keep church and state separate (Engquist et al., 1997; Howard & Howard, 1997). Spiritual experiences are considered to be within the realm of nonmedical professionals, such as clergy or other spiritual leaders (Kroeker, 1997).

Engquist et al. (1997) found that 37% of the 270 occupational therapists in their survey believed spirituality was a valid concern of occupational therapy; 27% did not; and 36% were undecided. According to the authors, possible reasons for the diverse responses were: (a) the varied definitions of spirituality used by respondents and (b) the question of appropriateness of including spirituality in the secular practice of occupational therapy. The researchers intentionally omitted a definition of spirituality, expecting respondents to use their own personal definitions. However, several respondents indicated that the lack of a definition rendered them unable to answer the questionnaire or made it difficult to respond to specific items. Engquist et al. concluded that the lack of a definition was ultimately a limitation of their study and may have influenced their results.

The current study was conducted to extend the work of Engquist et al. (1997) by including three definitions of spirituality and examining the specific methods clinicians use to address clients’ spiritual needs (Furman, 1997). The purposes of this study were to determine (a) therapists’ attitudes regarding spirituality in practice on the basis of whether they considered themselves to be religious, (b) whether there was a relationship between therapists’ choice of a definition of spirituality and their self-appraisal of religiousness, (c) whether there was a relationship between therapists’ choice of definition and attitude about spirituality in practice, and (d) how spirituality may be manifested in occupational therapy practice.

**Method**

**Participants and Procedures**

Three hundred and ninety-six therapists were randomly selected from the American Occupational Therapy
Association (AOTA) member data bank as potential participants. After receiving Institutional Review Board approval, researcher-developed questionnaires with cover letters and complimentary tea bags were mailed to the participants. A follow-up postcard was mailed to nonresponders 3 weeks later. Return of the questionnaire was considered informed consent to participate. Of the 396 questionnaires sent, 210 (53%) were returned, 4 of these were not usable, leaving 206 (52%) for analysis.

**Instrument**

The researcher-developed questionnaire used in the study was based on a review of the literature (Bullis, 1996; Clark et al., 1991; Furman, 1997; Shafranske & Malony, 1990) and discussions among the authors. Participants were first asked to select one of two definitions of spirituality that most closely matched their personal beliefs: (a) a global definition, “Spirituality refers to the animating principle of humans and other animals, their vital power or energy, and that which gives meaning to life,” or (b) a religious definition, “Spirituality refers to having a personal relationship with God or other deities, that inspires and gives meaning and purpose to life.” If neither definition was suitable, participants were asked to write their own definition in a provided space. On the basis of their definition of choice, participants were asked to respond to 15 items about their attitude about spirituality in occupational therapy practice (e.g., “disease and disability affect clients’ spirituality,” “good occupational therapy practice must address the spiritual needs of patients”) using a five-point Likert scale.

Participants were also asked to indicate yes or no to 19 items regarding whether they (a) had personally used given methods to address spiritual needs in occupational therapy practice (e.g., “recommend spiritual readings to your patients”, “pray for a client”) and (b) deemed the given methods as appropriate for occupational therapy practice. Next, participants were asked about their (a) education on spirituality while in occupational therapy school, (b) frequency of religious practice (Likert scale from 1 = daily to 5 = never), (c) frequency of spiritual practice (Likert scale from 1 = daily to 5 = never), (d) identification as a religious person or not, (e) level of education attained, (f) gender, (g) years of occupational therapy experience, and (h) current practice area. An optional comment section followed. The instrument was pilot tested with 12 occupational therapists whose feedback was used to refine the questionnaire.

To determine the internal consistency of the questionnaire, a Cronbach alpha was computed using the 19 items about spiritual methods and the 15 attitude items. Responses to the 34 items were converted to standardized $z$ scores, producing an alpha of .90 (see Table 1). To measure internal consistency, two items were removed, which produced an alpha of .92, indicating high internal consistency (Mueller, 1986), and thereby strengthening the findings associated with the instrument. The possible range of the Total scale scores was from 32 to 103. Two sub-scales were constructed from the Total (32-item) scale on the basis of the researchers’ categorization of items as indicating spiritual Belief or Behavior (methods deemed appropriate for practice). The Belief subscale consisted of 10 attitude items and 3 method items, with possible scores ranging from 13 to 53 points ($M = 39.6, SD = 6.6$ [n = 205],

<table>
<thead>
<tr>
<th>Attitude Items</th>
<th>Overall *</th>
<th>(R, NR)</th>
<th>Overall</th>
<th>Overall (R, NR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spirituality is a fundamental aspect of being human.</td>
<td>5 (2.7)</td>
<td>9 (5.17)</td>
<td>86 (93.76)</td>
<td></td>
</tr>
<tr>
<td>2. One’s spirituality influences his or her health.</td>
<td>3 (1.6)</td>
<td>6 (1.16)</td>
<td>91 (98.78)</td>
<td></td>
</tr>
<tr>
<td>3. Disease and disability affect clients’ spirituality.</td>
<td>14 (14, 17)</td>
<td>17 (14, 21)</td>
<td>69 (72, 62)</td>
<td></td>
</tr>
<tr>
<td>4. Knowledge of spiritual beliefs and practices is essential when working with patients as an occupational therapist.</td>
<td>14 (10, 20)</td>
<td>26 (27, 26)</td>
<td>60 (63, 54)</td>
<td></td>
</tr>
<tr>
<td>5. Holistic treatment should include the mind, body, and spirit, and not just the mind and body.</td>
<td>3 (1.6)</td>
<td>17 (15, 19)</td>
<td>80 (84, 75)</td>
<td></td>
</tr>
<tr>
<td>6. Occupational therapy education should prepare therapists to address the spiritual needs of their clients.</td>
<td>19 (14, 25)</td>
<td>27 (30, 24)</td>
<td>54 (56, 51)</td>
<td></td>
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<tr>
<td>7. The constitutional principle of separation of church and state prevents occupational therapists from addressing the spiritual needs of their clients.*</td>
<td>62 (60, 63)</td>
<td>19 (18, 21)</td>
<td>19 (22, 16)</td>
<td></td>
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<tr>
<td>8. Occupational therapists possess the knowledge and skills needed to assist clients in spiritual matters.</td>
<td>51 (49, 52)</td>
<td>36 (36, 38)</td>
<td>13 (15, 10)</td>
<td></td>
</tr>
<tr>
<td>9. Gathering spiritual information about a client should be a part of an occupational therapy assessment.</td>
<td>29 (26, 31)</td>
<td>33 (33, 33)</td>
<td>38 (41, 36)</td>
<td></td>
</tr>
<tr>
<td>10. Good occupational therapy practice must address the spiritual needs of clients.</td>
<td>27 (34, 31)</td>
<td>36 (36, 37)</td>
<td>37 (40, 32)</td>
<td></td>
</tr>
<tr>
<td>11. It is appropriate for an occupational therapist to raise the topic of spirituality with a client.</td>
<td>26 (25, 29)</td>
<td>36 (37, 34)</td>
<td>38 (37, 34)</td>
<td></td>
</tr>
<tr>
<td>12. Occupational therapists should address spirituality only if the client expresses interest first.*</td>
<td>20 (19, 25)</td>
<td>21 (20, 21)</td>
<td>39 (61, 54)</td>
<td></td>
</tr>
<tr>
<td>13. My spirituality assists me in performing my daily job responsibilities.</td>
<td>8 (3, 13)</td>
<td>11 (5, 21)</td>
<td>81 (92, 66)</td>
<td></td>
</tr>
<tr>
<td>14. My spirituality is an essential part of my life.</td>
<td>5 (1, 12)</td>
<td>8 (4, 13)</td>
<td>87 (95, 75)</td>
<td></td>
</tr>
<tr>
<td>15. My occupational therapy education covered the topic of spirituality.</td>
<td>84 (81, 90)</td>
<td>6 (8, 3)</td>
<td>10 (11, 7)</td>
<td></td>
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Note. $n = 132$ for religious participants; $n = 74$ for nonreligious participants.

* Items removed from Total score. ** Percent agreement based on all participants. * R = Percent agreement of religious participants (n per item varies from 125–129); NR = percent agreement of nonreligious participants (n per item varies from 66–68).
alpha = .85). The Behavior subscale consisted of 16 method items, with possible scores ranging from 16 to 32 points, \( (M = 23.3, SD = 4.9 \ [n = 203], \alpha = .87) \). The Total, Belief, and Behavior scores for each participant were then used in further analyses.

**Results**

Participants’ number of years of occupational therapy experience ranged from 1 to 41 years \((M = 14.5, SD = 8.14)\). The highest educational degree held by the majority (64%) was a bachelor’s degree, 31% \((n = 64)\) obtained a master’s degree; 3% \((n = 7)\) had doctorates; and 2% \((n = 3)\) had degrees in the “other” category. The participants worked in various practice settings: school (17%), skilled nursing (15%), rehabilitation (6%), outpatient (6%), private practice (6%), general hospital (5%), home health (4%), mental health (3%), multiple settings (25%), and “other” (13%).

Of the 206 participants, 64% \((n = 132)\) considered themselves to be religious, whereas 36% \((n = 74)\) did not. Sixty-seven percent \((n = 134)\) chose the religious definition of spirituality; 25% \((n = 50)\) chose the global definition; and 8% \((n = 16)\) wrote in their personal definition of spirituality. Fifteen percent \((n = 29)\) stated that the topic of spirituality was covered during their occupational therapy education.

Overall, participants had a slightly positive attitude toward addressing spirituality in occupational therapy practice as indicated by a mean Total scale score of 72.9 \((SD = 11.5, N = 205)\), which was greater than the instrument’s expected mean of 67.5.

On the basis of an analysis of variance (ANOVA), religious participants had significantly more positive attitudes about addressing spirituality in occupational therapy practice \((M = 74.3, n = 131)\) than did nonreligious respondents \((M = 70.5, n = 72)\), \( F(1, 202) = 9.28, p = .0026 \), and significantly higher Belief scale scores \((M = 40.6)\) than did the nonreligious group \((M = 37.7)\), \( F(1, 202) = 11.50, p = .0008 \). No significant difference was found between the two groups on the Behavior scale scores. Percent agreement between the two groups on the 15 attitude items are presented in Table 1. Religious participants engaged more often in religious practices \((M = 16)\) than nonreligious participants \((M = 3.4)\), \( F(1, 197) = 130.06, p = .0001 \), and more frequently in spiritual practices \((M = 1.8)\) than nonreligious participants \((M = 2.2)\) on the same scale, \( F(1, 188) = 4.62, p = .0329 \). No significant differences were found between the two groups for the variables of whether spirituality of patient care was covered in their occupational therapy curriculum, highest level of education attained, years of practice, or practice area.

\( X^2 \) analysis used to examine the relationship between participants’ choice of a definition of spirituality and their appraisal of themselves as religious or nonreligious revealed that the religious participants were significantly more likely to select the religious definition of spirituality, whereas the nonreligious participants were more likely to select the global definition of spirituality, \( X^2 (2, N = 178) = 49.6, p < .001 \). A phi correlation coefficient of .53 between participants’ choice of definitions was obtained.

When relationship between chosen definition of spirituality (global vs. religious) and attitude toward spirituality in practice was examined via ANOVA on Total, Belief, and Behavior scores, no significant difference was found between the two definition groups. Because the number of participants who wrote in their own definition of spirituality was small \((n = 16, 8\%)\) it was excluded from this analysis. Global definers had a significantly higher level of education \((M = 1.68)\) than religious definers \((M = 1.37)\), \( F(1, 183) = 8.85, p = .0033 \), and more years of practice \((M = 16.41)\) than the religious definers \((M = 13.81)\), \( F(1, 182) = .97, p = .0479 \).

A frequency ranking of the methods participants used to address the spiritual needs of their clients appears in Table 2. Seventy-two participants (35%) added optional comments. Comments of particular interest to us are discussed in the next section.

**Discussion**

The first purpose of the study was to determine whether attitudes regarding spirituality in practice were based on a view of oneself as being religious. Both religious and nonreligious participants had positive attitudes toward addressing spirituality in occupational therapy practice, with the religious group \((n = 132)\) significantly more positive than the nonreligious group \((n = 74)\). However, the fact that the group means for positive attitudes were only slightly above the instrument’s expected mean suggests that a fair number of participants did not view spirituality in occupational therapy practice as appropriate.

The second purpose of the study was to determine whether there was a relationship between choice of a definition of spirituality and personal religiousness. Our finding that those who were religious did not necessarily choose the religious definition, and those who were not religious only choose the global definition suggests that religiousness only accounted for about 28% of the variance in definition choice.

The third purpose of this study was to determine whether personal definitions of spirituality were related to attitudes regarding spirituality in occupational therapy practice. No significant difference in attitudes was found between groups on the basis of whether a global or religious definition of spirituality was selected. In addition, our findings about whether spirituality issues should be within the scope of the occupational therapy practice was identical to that obtained by Engquist et al. (1997): 37% agreed, 27% disagreed, and 36% were neutral or undecided. Given that our response rate of 52% was comparable to the 53% in the Engquist et al. study, one may conclude that giving therapists the choice of definitions on spirituality, a major
component of our questionnaire, did not appear to influence their attitudes about addressing spirituality in occupational therapy practice. This finding supports the notion of therapists’ diverse conceptualization of spirituality, which is consistent with the writing of Egan and DeLaat (1997).

The fourth purpose of the study was to determine how spiritual issues may be addressed in occupational therapy practice. The methods participants frequently used to address the spiritual needs of clients are similar to those used by psychologists. Shafranske and Malony (1990) found that 7% of psychologists stated that they prayed with clients, 36% reported recommending that clients participate in religious activities, and 57% stated that they used spiritual language or concepts with clients. Comparable responses by participants in the current study are 23%, 46%, and 57% respectively for the same methods. The finding that participants who chose the global definition of spirituality had a significantly higher level of education and more years of experience than those who chose the religious definition is consistent with the inverse relationship between religiousness and education reported for psychologists by Bergin and Jensen (1990). Of further interest, 15% of our participants indicated that spirituality was addressed during their occupational therapy education, whereas only 5% of psychologists indicated training in spiritual and religious issues (Shafranske & Malony, 1990). This finding indicates that both psychologists and occupational therapists are probably not learning how to address the spiritual needs of their clients through their formal education but are learning it elsewhere (Bergin & Jensen, 1990; Lannert, 1991).

Several participants wrote comments that expressed the view that therapists need to be sensitive to beliefs and values different from their own, as the following examples illustrate:

Spirituality and religion are touchy areas. I think in order to use this therapeutically and to share with coworkers, a person must be non-judgmental of others’ beliefs. I think that if it is important to a patient to return to [spiritual] practices that have been hindered by their condition, then we should address it in therapy.

It is essential to be sensitive to the client’s own beliefs and comfort level when dealing with spiritual and/or religious topics. Respect for client beliefs is of utmost importance.

Of concern to us were comments that indicated intolerance toward views different from one’s own, for example:

I do not feel OT [occupational therapy] schools should teach spirituality. This is taught in the Church.

I disagree OT’s should discuss spirituality with their clients, unless they are of Christian faith. There are too many “religions” out there and they mess up people’s minds. Jesus is the only True God.

If any therapists are encouraging any “spirituality” (i.e., New Age, meditation, Moslem, Jehovah’s Witness, Mormon, etc.) other than Christ, they are walking in Satanic Spirituality and the forces of evil are alive and well, being encouraged by them. Anything other than Christian Spirituality is of the Devil.

Although religious therapists may be more willing to address the spiritual needs of their clients than therapists who do not consider themselves to be religious, they must be able to do so in a manner that shows respect and tolerance for beliefs and practices that are different from their own. Occupational therapy education programs may want to consider ways of further promoting understanding and respect for the cultural diversity that their students may find in their practices.

This study has several limitations. The analysis rate of 52% of the sample was less than ideal for obtaining representative information on attitudes toward spirituality in American occupational therapy practice. Because of the complexity of the topic, our findings can only be seen as a small fraction of what we need to understand about spirituality in practice. The questionnaire presented a list of 16 possible methods that could be used to address the spiritual needs of clients. Because this list was based on a review of the literature of spirituality in health care in general...
(Bullis, 1996; Clark et al., 1991; Furman, 1997; Shafranske & Malony, 1990), it may or may not accurately reflect methods used by occupational therapists.

Future research identifying the methods used specifically by occupational therapists to address clients’ spiritual needs could give a more accurate ranking of methods. Potential methods might also be obtained directly from clients. Establishing construct validity would strengthen the instrument used in this study. By removing specific reference to occupational therapy, the instrument could be used to compare the attitudes on spirituality in practice of a variety of health care providers. The AOTA may want to develop a core definition of spirituality and guidelines for addressing clients’ spiritual needs that could be of use to the profession. This information could, in turn, be used to prepare students to attend to the spiritual aspects of clients’ daily lives. ▲

References


