3-10-2008

Addressing spirituality for clients with physical disabilities

Laura Feeney
Moss Rehabilitation Hospital, feeneyl@einstein.edu

Susan Toth-Cohen
Thomas Jefferson University, susan.toth-cohen@jefferson.edu

Addressing *Spirituality* for Clients With Physical Disabilities

LAURA FEENEY
SUSAN TOTH-COHEN

How occupational therapy practitioners can use spirituality to enhance interventions for adults with physical disabilities, regardless of the setting.

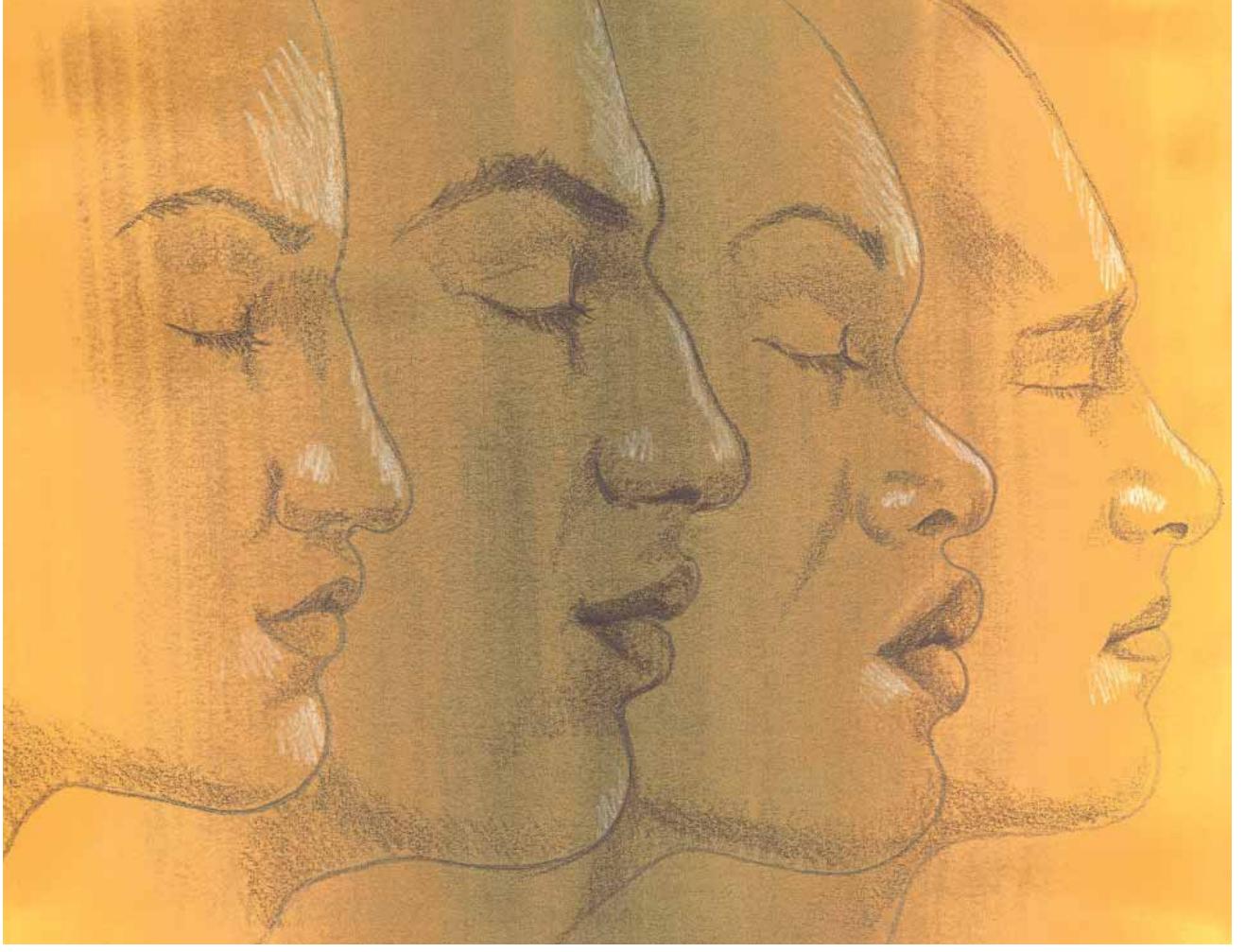
"[OTs] don't shy away from any issues: You know, sexual issues, employment issues, relationship issues. I am surprised that in my own education, [spirituality] was not addressed more directly. There are so many facets to a person. And our role as OTs is to help them relearn or learn for the first time to adapt those roles and habits and the things they value. Why would we leave out one part? I think [addressing spirituality] is a very critical role."

—"Cheryl," occupational therapist working in hand rehabilitation

A major tenet of occupational therapy is to view the person holistically: acknowledging the mind–body–spirit connection. Among the important influences on a person's daily occupations is spirituality.[1–4] One definition of spirituality is "the fundamental orientation of a person's life; that which inspires and motivates that individual" (p. 623).[5] This definition suggests that even if practitioners work in a setting that traditionally does not focus on clients' spirits, people are spiritual beings, and this aspect of them affects how, why, and when they choose to perform occupations. By considering spirituality in occupational therapy practice, we are supporting the client's ability to engage in occupations and participate in life activities.[2]

Current literature reveals that occupational therapy practitioners recognize that their clients have spiritual needs[2,6,7] and see how spirituality provides value and meaning to clients' everyday experiences and occupations.[3,8] Spirituality also gives purpose to an individual's life. Yet although practitioners acknowledge the importance of spirituality, few actually address clients' spirituality in practice.[6,7] Christiansen viewed this discrepancy between theory and practice as a lost opportunity to "understand the full potential of occupation to enhance the health and well-being of clients" (p. 171).[9] Indeed, failing to address clients' spiritual needs is a critical gap, because spirituality is central to many clients' lives. If practitioners ignore spiritual needs, intervention may be ineffective because it fails to take into account what is most relevant and meaningful to clients. Moreover, ignoring clients' spirituality also fails to incorporate factors that may be essential for helping them to regain health. Research findings demonstrate a positive relationship between some aspects of spirituality, such as religious involvement or prayer, and achievement of positive health outcomes.[10–16] And, although illness or disability may disrupt people's experiences and their ability to find meaning in life,[3,8] attending to spiritual needs may help them better manage the challenges of disability and rehabilitation.[17]

Some ways that occupational therapy practitioners address clients' spiritual needs are through open-ended discussion and active listening[18,19]; referral to



pastoral care[20]; and simple encouragement.[21,22] There is little documented on how to address these needs during intervention sessions and how to overcome barriers that may hinder doing so,[4,23] and occupational therapy researchers agree that more information is needed about specific ways to address spirituality to benefit clients.[4,7,18,19,21,22] To begin to address this gap, we conducted a phenomenological study examining the experiences of eight occupational therapists who currently address clients' spiritual needs in their practice. All the therapists in the study believe that it is important to address spirituality and indicated that spirituality is an integral part of their own lives. At the same time, they felt strongly that it is crucial to avoid imposing their beliefs on their clients.

Occupational therapy practitioners are renowned for being resourceful and creative, and our methods of addressing spiritual needs are no exception. All the therapists described ways in which they incorporate their clients' individual experiences of spirituality into intervention. They begin by making critical observations to evaluate each person's spiritual needs or values. They often pick up cues from the client's room, such as religious books, symbols, or cards; and they listen for cues in the client's comments (e.g., referring to God, prayer, or church). "Mary" gave an example of a client who told her, "Well, I'm mad at God right now." These signals from our clients reinforce that they are spiritual beings, they have spiritual needs, and they may be in some spiritual distress.

The eight therapists described their own religious backgrounds as Protestant (3), Jewish (1), Catholic (1), and other (3). The "other" category consisted of Quaker, Armenian Christian, and nondenominational. We interviewed the therapists and also asked them to write about specific experiences in which they addressed clients' spiritual needs.

The therapists in our study described two main strategies for incorporating clients' spiritual needs into their intervention and for providing holistic care (see Table 1 on p. 18). These strategies were: (a) to be a resource for spiritual concerns, and (b) to enable participation in the client's spiritual activities.

BE A RESOURCE FOR SPIRITUAL CONCERNS

"I let it evolve from them, and if [spirituality is] something they want to address, I let them initiate the conversation. Ultimately I feel [that] people heal better when they have that component of spirituality."

—"Martha," occupational therapist working in inpatient rehabilitation

Addressing clients' spiritual concerns directly by creating an open environment was one of the main ways the therapists addressed spirituality in practice. Often, they opened the discussion during the initial evaluation, by asking clients about their religious affiliations and spiritual practices. "Cheryl" routinely asks clients, "How are things going for you, physically, emotionally, and spiritually since your injury?" then follows up with additional questions if the client expresses a spiritual concern. "Larry" pointed out, "[I] tell clients that inherent in our profession is attentiveness to the spiritual dimension of occupation." By including spirituality in how we define occupational therapy, we let our clients know that we are resources for them, and we open the door for

Table 1: Summary of Strategies for Addressing Spiritual Concerns in Adult Physical Disabilities Rehabilitation

Strategy	Examples
Be a Resource for Spiritual Concerns	■ Assist the client with coping strategies ■ Help the client identify resources ■ Identify ways to overcome the effect of the client's condition on the religious or spiritual aspects of his or her life ■ Encourage the client to talk with others (including those undergoing similar experiences)
Enable Participation in Spiritual Activities	
Work directly to improve performance in activities of daily living (ADL) and instrumental activities of daily living (IADL)	*ADL* ■ Self-care (e.g., dressing appropriately before attending religious services) ■ Transfers ■ Energy conservation and rest breaks *IADL* ■ Meal preparation related to religious holidays ■ Community mobility to attend or participate in services ■ Improved standing tolerance to participate in services
Promote relaxation, help client to identify own strengths	■ Progressive relaxation ■ Meditation ■ Humor ■ Stress management
Use spirituality as a medium for therapy	■ Reading the Bible, Torah, Koran, etc. ■ Having therapy in an environment similar to the client's place of worship when spirituality is being addressed

conversation. "Larry" includes spirituality when describing rehabilitation to clients, explaining that, "When a person is engaged in occupation—meaningful activities as part of rehabilitation—the mind, the body, and the spirit are working together, and that's when rehabilitation happens."

After the initial conversation, the therapists follow up to help their clients cope with the impact of changes in their lives, including physical limitations, on important roles. This enables clients to re-engage in valued activities, though possibly in different ways, which helps them regain a sense of meaning and purpose in their lives. The therapists also found it very beneficial to help clients identify and access resources, such as clergy and programs at the treatment facility and in the clients' communities. For example, three of the settings in which the occupational therapists work hold religious services regularly, with special services and programs on holidays. Other facilities, even if they do not offer such services, provide spiritual counseling through pastoral care or chaplain programs.

Facilitate Participation

"I went to a ritual bath with [an Evangelical Jewish patient]. We enabled him to go down the stairs, into the bath, up again, and get dried off. These were some very physical things, but very meaningful for him. If we hadn't addressed the bath he would have accepted not addressing it, but we would have lost opportunities for good rehab within the context of who he is."

—"Larry," occupational therapist working in inpatient rehabilitation

One of the major barriers to addressing spiritual concerns in practice that therapists have reported is reimbursement, because third-party payers do not recognize addressing spiritual concerns as part of the rehabilitation process. The therapists interviewed in this study address spiritual needs with clients while addressing performance goals, so reimbursement is not an issue. For example, the activity of dressing included selecting and donning clothing appropriately, according to the person's cultural or religious traditions. For clients who valued cooking, the therapists incorporated preparing foods traditionally served during religious holidays into the therapy. As "Larry" said, "We made the apple cakes and other things like that for the Seder. Doing this is important to [clients], so it's important to us to help them be able to do [those things]."

To improve functional mobility, therapists helped clients develop standing tolerance. They made this task meaningful by including reading the Bible or Koran while standing, practicing navigating aisles in places of worship with new ambulation devices, and improving or adapting clients' ability to kneel and rise during religious services and prayers.

Promote Relaxation

"She was having a lot of anxiety and fear. She just couldn't progress, so what we talked about was prayer."

—"Donna," occupational therapist working in inpatient rehabilitation

"At the end of the group I ask people what other ways they find to go to a deep place of relaxation or that can really help them deal with stress. At that point some people do say 'my church, my synagogue, music, my pets, my grandchildren, nature,' and I encourage them to do whatever it is that connects them with themselves."

—"Martha," occupational therapist working in inpatient rehabilitation

Often, we interact with clients who are anxious or overwhelmed by their newly acquired disability, and this emotion can interfere with their ability to make progress. The interviewed therapists perceived clients' ability to tap into their existing resources as key to managing spiritual crises that occurred as a result of a severe injury or illness. They acted as facilitators to help their clients regain control by

Envision 08

A multi-disciplinary vision rehabilitation & research conference.

Sept. 5-6, 2008
Westin Riverwalk
San Antonio, Texas

Remember the Alamo.

And remember to earn your CEs in low vision care.

Call for presentations

Share your knowledge of the low vision rehabilitation field. Easy online submission of your presentation at **www.envisionconference.org** by April 30. For more information, contact **michael.epp@envisionus.com**.

Call for abstracts:

Share your research in a platform talk or poster session. Easy online submission of your abstract at **www.envisionconference.org** by June 9. For more information, contact **james.nolan@envisionus.com**.

Call for attendees:

Visit **www.envisionconference.org** to opt in to our online mailing list, learn about the Conference and view previous programs. See why one OT said "Envision 06 was phenomenal because it was multidisciplinary and appropriate for all audiences. I could not wait to share all the knowledge and sense of acceptance of OT with my colleagues."

Last year, attendees earned up to 22.5 AOTA-approved CE units. Make your plans to join us in sunny San Antonio.

APPROVED PROVIDER of CONTINUING EDUCATION by The American Occupational Therapy Association, Inc.

The assignment of AOTA CEUs does not imply endorsement of specific course content, products, or clinical procedures by AOTA.

Meet us at AOTA Conference & Expo in Long Beach:

Visit Michael Epp at Booth 47. Sign up for a chance to win a free Conference registration and other prizes.

P-3007

accessing their own inner resources and strengths through strategies that included progressive relaxation, meditation, humor, and stress management. "Donna" gave the example of a client with a traumatic brain injury who was very anxious and could not focus to organize her finances. Donna did progressive relaxation with the client, then reported that "she felt like she had some control over her life for the first time since her injury. Not only was she able to cognitively reorganize herself a little with the systems that we built, but she was able to manage her anxiety and avoid getting totally overwhelmed with her activities." Thus, techniques designed to promote relaxation or decrease anxiety were seen as a means to an end—participation in occupation. "We would spend some time with each treatment having her get in touch with that part of herself and connect with that place of prayer in herself, so that she could give herself the internal support in order to improve on what she did," said Donna.

Use Spirituality as a Medium for Therapy

"If we're working on standing balance and endurance and mobility, and [clients] are in the middle of their prayers, or if they are in the middle of reading their Bible or the Koran, I ask them to stand up and read it, or say their prayers either silently or out loud, so they can teach me. Then they're more than willing to get up and do it."

—"Jill," occupational therapist working in acute care rehabilitation

Some therapists also take advantage of the environment to conduct meaningful therapy to address clients' spiritual concerns, such as having sessions in chapels housed within the centers where they work; using quiet rooms and dimming the lights; or playing music to aid with relaxation. "Sarah" noted that she helped clients practice tasks related to participating in faith communities, such as navigating through the movable pews in the facility's chapel that she set up just as they were in the client's place of worship. By including spirituality in intervention sessions, rehabilitation goals are being met and the clients are engaged in activities that are meaningful and purposeful.

CONCLUSION

Using a client-centered approach and having a holistic view enables occupational therapy practitioners to evaluate and treat all types of client needs, including spiritual. Incorporating spirituality into our daily practice begins with the evaluation process and continues by using activities embedded with spiritual meaning in our interventions, which may include performance areas directly and indirectly related to spiritual practices. Additionally, we can use relaxation techniques and other ways to help clients tap into their inner resources.

Although every clinical setting is unique, with its own facilitators and barriers, it is our hope that this article demonstrates the feasibility of addressing spiritual needs in practice and provides concrete, easily introduced strategies for use in a variety of settings. The importance of addressing clients' spiritual concerns cannot be underestimated. As "Cheryl" noted, "When we're talking about the essence of someone's life, we're talking to the deep, spiritual part. It might not be concretely verbalized but that's the level that you're speaking to." ■

References

1. Egan, M., & DeLaat, D. (1994). Considering spirituality in occupational therapy practice. *Canadian Journal of Occupational Therapy, 61*(2), 95–101.
2. Egan, M., & DeLaat, D. (1997). The implicit spirituality of occupational therapy practice. *Canadian Journal of Occupational Therapy, 64*(3), 115–121.
3. Howard, B. S., & Howard, J. R. (1997). Occupation as spiritual activity. *American Journal of Occupational Therapy, 51*, 181–185.
4. Wilding, C., May, E., & Muir-Cochrane, E. (2005). Experience of spirituality, mental illness, and occupation: A life-sustaining phenomenon. *Australian Occupational Therapy Journal, 52*, 2–9.
5. American Occupational Therapy Association. (2002). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy, 56*, 609–639.
6. Engquist, D. E., Short-DeGraff, M., Gliner, J., & Oltjenbruns, K. (1997). Occupational therapists' beliefs and practices with regard to spirituality and therapy. *American Journal of Occupational Therapy, 51*, 173–180.
7. Johnston, D., & Mayers, C. (2005). Spirituality: A review of how occupational therapists acknowledge, assess, and meet spiritual needs. *British Journal of Occupational Therapy, 68*, 386–392.
8. Urbanowski, R., & Vargo, J. (1994). Spirituality, daily practice, and the occupational performance model. *Canadian Journal of Occupational Ther-apy, 61*(2), 88–94.
9. Christiansen, C. (1997). Nationally Speaking—Acknowledging a spiritual dimension in occupational therapy practice. *American Journal of Occupational Therapy, 51*, 169–171.
10. Koenig, H. G., Larson, D. B., & Larson, S. S. (2001). Religion and coping with serious medical illness. *Annals of Pharmacotherapy, 35*, 352–359.
11. Matthews, D. A., McCullough, M. E., Larson, D. B., Koenig, H. G., Sawyers, J. P., & Milano, M. G. (1998). Religious commitment and health status. *Archives of Family Medicine, 7*, 118–124.
12. Mitchell, L., & Romans, S. (2003). Spiritual beliefs in bipolar affective disorder: Their relevance for illness management. *Journal of Affective Disorders, 75*, 247–257.
13. Mueller, P. S., Plevak, D. J., & Rummans, T. (2001). Religious involvement, spirituality, and medicine: Implications for clinical practice. *Mayo Clinic Proceedings, 76*, 1225–1235.
14. Nelson, C. J., Rosenfeld, B., Breitbart, W., & Galietta, M. (2002). Spirituality, religion, and depression in the terminally ill. *Psychosomatics, 43*, 213–220.
15. Townsend, M., Kladder, V., Ayele, H., & Mulligan, T. (2002). Systematic review of clinical trials examining the effects of religion on health. *Southern Medical Journal, 95*, 1429–1434.
16. Powell, L. H., Shahabi, L., & Thoresen, C. E. (2003). Religion and spirituality: Linkages to physical health. *American Psychologist, 58*(1), 36–52.
17. Faull, K., & Hills, M. (2006). The role of the spiritual dimension of the self as the prime determinant of health. *Disability and Rehabilitation, 28*, 729–740.
18. Hoyland, M., & Mayers, C. (2005). Is meeting spiritual need within the occupational therapy domain? *British Journal of Occupational Therapy, 68*, 177–188.
19. Rose, A. (1999). Spirituality and palliative care: The attitudes of occupational therapists. *British Journal of Occupational Therapy, 62*(7), 307–312.
20. Beagan, B., & Kumas-Tan, Z. (2005). Witnessing spirituality in practice. *British Journal of Occupational Therapy, 68*(1), 17–24.
21. Egan, M., & Swedersky, J. (2003). Spirituality as experienced by occupational therapists in practice. *American Journal of Occupational Therapy, 57*, 525–533.
22. Farrar, J. E. (2001). Addressing spirituality and religious life in occupational therapy practice. *Physical and Occupational Therapy in Geriatrics, 18*(4), 65–85.
23. Belcham, C. (2004). Spirituality in occupational therapy: Theory in practice? *British Journal of Occupational Therapy, 67*(1), 39–46.

Laura Feeney, MS, OTR/L, is a staff level II therapist at Moss Rehab Hospital in Elkins Park, Pennsylvania, and has been a guest lecturer and lab instructor at Thomas Jefferson University in Philadelphia. She can be reached at feeneyl@einstein.edu.

Susan Toth-Cohen, PhD, OTR/L, is director of the Occupational Therapy Doctoral Program and associate professor in the Jefferson College of Health Professions at Thomas Jefferson University in Philadelphia. She can be reached at susan.toth-cohen@jefferson.edu