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The Use of Spirituality in Occupational Therapy Practice: An Appreciative Inquiry

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DECLARATION

I, Raashmi Balbadhur (p4149211), hereby declare that the work in this research study is my own. Acknowledgement was given to any work cited from other sources. The work completed in this research study has not been previously submitted at another university for degree purposes.

Name and Signature

Date:

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ABSTRACT

Spirituality has been identified as vital to client-centred, holistic occupational therapy (OT) practice. Attending to mind, body and spirit are essential for health and wellbeing. Spiritual beliefs have a significant impact on everyday routines and habits and give meaning and an additional dimension to everyday activities. Occupational therapists recognise the potential to make spirituality tangible through the use of deeply meaningful occupations.

Many occupational therapists avow that they are unclear on how to integrate spirituality into treatment. They lack the confidence, knowledge and skill to address spirituality. Many argue that preparation for such a role should be embedded in the curricula.

This study aimed to explore how spirituality is being addressed in OT practice by educators and clinicians in Gauteng, South Africa. A qualitative, descriptive, explorative research design using Appreciative Inquiry (AI) as an approach was conducted. The participants' understanding of spirituality, their current successes, and their wishes concerning spirituality, as well as recommendations on how to address spirituality in OT were investigated. Purposive sampling resulted in a total of 24 participants. Data was collected by means of an AI workshop that consisted of self-report, AI interview schedules and focus group inquiries. Data was analysed through thematic analysis.

Four major themes emerged from this study, namely 1) understanding spirituality as a construct, 2) client-centred practice/approach, 3) envisioned practice enablers of spirituality, and 4) nurturing spirituality within the therapist. Participants clearly articulated how spirituality is defined and understood in their practice. Current successes in spirituality were attributed to client-centred practice. Strategies to address, sustain and implement spirituality in education and practice were identified.

These findings may contribute to the current discussion on spirituality in OT. Literature on the utilisation of the AI approach in OT and in healthcare is limited, thus this study may also serve to contribute to the existing body of knowledge.

Keywords: Occupational therapy, spirituality, Appreciative Inquiry, religion, client-centred practice.

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LIST OF ABBREVIATIONS AND ACRONYMS

ADL	Activities of Daily Living
AI	Appreciative Inquiry
AIDS	Acquired Immune Deficiency Syndrome
AOTA	American Occupational Therapy Association
CAOT	Canadian Association of Occupational Therapy
CMOP	Canadian Model of Occupational Performance
COHSASA	Council for the Accreditation of Health Services in South Africa
CPD	Continuing Professional Development
FICA	Faith, Importance/Influence, Community, Action/Address
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
IADL	Instrumental Activities of Daily Living
ICF	International Classification of Functioning, Disability and Health
OT	Occupational Therapy
OTASA	South African Association of Occupational Therapy
OTPF	Occupational Therapy Practice Framework
PEOP	Person Environmental Occupational Performance
SAJOT	South African Journal of Occupational Therapy
VdTMoCA	Vona du Toit Model of Creative Ability
WFOT	World Federation of Occupational Therapists
WHO	World Health Organisation

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CHAPTER 1: ORIENTATION TO THE STUDY

1.1. INTRODUCTION

As a profession rooted in holism, humanism, and client-centred practice, occupational therapy (OT) possesses the unique opportunity to assist clients in restoring meaning to their lives – a crucially significant and spiritual task.[1-2]

Engaging in meaningful occupations is a common mechanism to express spirituality tangibly. Occupation has been a foundational construct of OT since the 1970s.[1] In OT, occupation means “everyday activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to, and are expected to do”.[3] Occupations can be categorised as activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure and social participation.[3]

The Occupational Therapy Practice Framework (OTPF), based on the International Classification of Functioning, Disability and Health (ICF),[4] is a framework that guides and defines OT practice.[3,5] This framework highlights that engagement in occupation is facilitated through the scientific application of all appropriate client factors.[3] In the presence of disability, illness, and/or any other distressing life experience, different client factors may be affected.[3] Spirituality is included as a client factor in the OTPF, implying that it is a specific ability and characteristic within a person. Highlighting the significance of spirituality even further in OT, the third edition of the OTPF includes spiritual activities and religious activities as an IADL occupation. Thus, spirituality may be the golden thread that links all OT intervention.[3] While occupational therapists identify spirituality as an essential aspect of life, integration of spirituality into OT practice proves challenging, the lack of which then limits OT goals of providing holistic occupation-based and client- centred care.[1,6,7]

Due to the complex and multifaceted nature of spirituality, it defies a simple definition. However, recurring themes associated with spirituality within OT literature are hope, faith, coping, and self-transcendence.[1] Likewise, literature indicates that concepts such as meaning and purpose, connectedness, peacefulness, personal wellbeing, and

happiness have also been used to explain spirituality.[8] Often religion is associated with spirituality and can inform an individual's understanding and experience of meaning.[1]

To study this multifaceted client factor, it was decided to conduct research to facilitate an understanding of spirituality by providing OT clinicians and educators the opportunity to share their stories using the Appreciative Inquiry (AI) approach. The use of this approach enabled participants to propose recommendations to address spirituality in practice and education.[9]

1.2. RATIONALE AND BACKGROUND

Spirituality has been a topic of interest amongst occupational therapists since the beginning of the profession in the early 20th century. The founders of OT advocated for moral treatment and recognised that treating body, mind and spirit through occupation facilitated meaning to life and supported health.[1] In the early 20th century, spirituality was overshadowed by technological advances in diagnosis and treatment, and the need for more evidence-based practice and reductionist models was recognised.[1,10] The late 20th century saw the resurgence of spirituality, where the Canadian Association of Occupational Therapy (CAOT) placed spirituality at the centre of its theoretical construct of occupation that guided OT practice.[1] Spirituality was again recognised as an essential aspect of the concept of holism, and confirmed that it should be assessed as part of therapy and be addressed in therapy.[11]

Many therapists affirm that spirituality is critical for the health and rehabilitation of their clients.[12] Several studies report a positive correlation between spirituality and quality of life, self-esteem, reduced anxiety, increased hope and the ability to cope.[7,12-16] Conversely, negative spiritual (e.g. feelings of meaninglessness or hopelessness) or religious (feelings of being abandoned by God) philosophies may translate to an increase in the burden of illness.[14,17] Scientific studies on spirituality have, for example, been linked to extended life expectancy, lower blood pressure, lower rates of death from coronary artery disease, increased longevity in the aged, and reduced mortality after cardiac surgery.[12]

Literature abounds with definitions of spirituality.[18] Previous studies of spirituality in OT, as well as amongst other healthcare professionals, reveal that there is no consensus

or a consistent voice on the definition of spirituality.[1,6,12,18,19] The OTPF (2014) defines spirituality as “the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and the significant or the sacred”.[3,14] Another definition for spirituality in recent OT literature is “Spirituality is the essence of the self and a source of meaning and will. It is what helps human beings experience a meaningful connection to their core selves, other beings, the world and/or greater power, as expressed through their reflections, narratives, and actions, within the context of space and time”.[20]

Highlighting spirituality’s association with humanness and volition has been included as a central construct in the Canadian Model of Occupational Therapy (CMOP).[20-21] Spirituality’s central placement in the CMOP is justified, however, the lack of a consistent definition and direction regarding the role of the occupational therapist with respect to this construct continue to spark debate and pose a challenge for occupational therapists.[6,20,22] The Person Environment Occupation Performance Model (PEOP) presents spirituality in a similar way to the CMOP, as it remains an integral component in human experience.[21-22]

It is clear that, internationally, occupational therapists and other health care professionals have seen a Renaissance in spirituality over the past several decades.[1,23] However, they continue to contend with this topic. They are apprehensive and unclear on how to meet the spiritual needs of clients and still lack expertise in this area, therefore their knowledge and skill is lacking.[6,18-20,24] It is suggested that inclusion of spirituality as a client factor in OT should be embedded in the university curricula.[18] Many assert that educational curricula on this topic are lacking or absent.[6,8,13,19,23,25-27]. A recent mixed-method study conducted by Morris et al. revealed that there is a significant gap between OT education, theory, and practice. Assessment instruments from an OT perspective are also lacking. The on-going confusion in the implementation of spirituality in everyday OT practice needs to be addressed.[6]

Within the South African context, there is limited literature on spirituality in OT. However, attention to this topic is on the increase.[20,28] This could be attributed to many factors, namely the concept of ‘holistic’ intervention and the growing awareness of the relationship between health and spirituality.[20,28] It is uncertain whether courses

regarding spirituality and spiritual care exists in the South African OT education.[29] Further probable barriers identified in literature to the integration of spirituality by South African occupational therapists are a) spirituality is under-represented within OT training, b) OT practice lacks integration of spirituality, and c) health facilities have limited practice guidelines for spirituality.[27] Nevertheless, the role of the South African occupational therapist in spirituality has emerged and should be further developed.

Therefore, this study aimed to explore perceptions and understanding of spirituality amongst OT educators and OT clinicians. Using AI as an approach, this research sheds light on their wishes concerning spirituality, as well as recommendations on how to address spirituality in OT.

The essence of AI is encapsulated in the following definition by Cooperrider et al.:[30]

"Appreciate: a) To value, recognise the best in people or the world around us, affirm past and present strengths, successes, and potentials, to perceive things that give life (health, vitality, excellence) to living systems.

b) To increase in value. Synonyms: value, prize, esteem, and honour.

Inquire: a) To explore and discover.

b) To ask questions, to be open to seeing new potentials and possibilities. Synonyms: discover, search, systematically explore and study."[30]

Appreciative Inquiry is a change process that has its roots in Action Research. It was developed primarily from the doctoral studies of David Cooperrider in 1980.[9] AI focuses on the necessity for change. However, it is grounded on a positive approach to change and is expressed clearly in the analogy of seeing the glass as half full rather than it being half empty. Consequently, this approach takes on a relational constructionist view centred on affirmation, appreciation, and dialogue.[9] This approach is a cooperative, co-evolutionary exploration for the best in people, their organisations, and the world around them. It involves the systematic discovery of what gives life to an organisation or a community when it is most effective and functioning at its best, while actively recognising and celebrating their successes.[30-31]

The AI approach advocates for a move away from the traditional problem-solving methods towards viewing organisations as a mystery to be embraced.[30] Problem-orientated approaches tend to drain energy and focus on the negative. Whereas emphasis on successes, achievements, strengths, positive choices, resources, assets,

and energy can enable discovery of what is actually working and be a catalyst for further positive development and sustaining of existing strengths.[31] Appreciative Inquiry holds the potential to bring about a significant transformation and can make a difference in a single person or with any collective human system.[30-31]

The underpinning assumptions of this approach are as follows: There are aspects that works well in all groups, societies or organisations. Our reality is based on things that we focus on, and our reality is influenced by language and dialogue, while multiple realities exist and these can be created in a moment. Appreciating differences is essential and once individuals have enhanced confidence, they will take forward positive aspects of the past.[31]

Appreciative Inquiry has the potential to improve effective practice. To generate this positive change, AI uses a process known as the 4D cycle that includes four phases namely Discovery, Dream, Design, and Destiny. In the Discovery phase, the emphasis is not on the problem but the “best of what is” and “has been”. Dreaming relates to what might be, Design focuses on working together to design what should be the ideal. Finally, the Destiny phase relates to what will be and how to sustain this.[31] This cyclical non-linear process is not prescriptive. Rather, it is a map of a journey of engagement between participants and organisational change.[9] Thus, the researcher decided to combine the design and destiny phase.

Literature on the benefits of AI is prevalent. It is viewed as a catalyst for positive change as it adopts a view based on affirmation, appreciation, and dialogue.[31] The application of this approach to this study is further detailed in Chapter 3.

1.3. PROBLEM STATEMENT

Attention to spirituality in OT is imperative to rendering true holistic intervention. However, the role as well as the practice of spirituality amongst occupational therapists remains unclear and undefined.[20] Research has indicated that the topic of spirituality in educational curricula also needs further attention.[6]

South Africa is a rainbow nation with diverse religions and cultures.[32-34] South Africans are renowned for their religious involvement by people and communities.[35] In South

Africa, the right to enjoy and freedom to engage in one's culture and religion is enshrined in the Constitution of the Republic of South Africa.[27]

The seven predominant religious traditions in South Africa are as follows: African traditionalists, Bahai, Buddhism, Christianity, Hinduism, Islam, and Judaism. In the Apartheid era, occupational therapists and other health care professionals, in different settings, encountered different religious groups. In the formerly 'white' institutions, predominantly Christians and Jews were found, whereas in 'non-white' institutions, there was a mixture of African traditionalists, Hindus, Muslims, and Christians. Since the early nineties, the integration of health facilities resulted in occupational therapists and other health care professionals having to embrace patients with different religious and spiritual traditions in all institutions.[33]

In order to render culturally sensitive and relevant interventions, the occupational therapist needs to consider the patient's religion.[34] Deeply meaningful religious occupations, in other words, those that are spiritual, should be included in therapy to facilitate the client-centred approach. However, many therapists feel uncomfortable with integrating this into intervention.[1]

Spirituality embraces secular, philosophical, religious and cultural beliefs and practices.[10] It is, thus, deemed necessary that within a multicultural and multireligious context there should exist practice guidelines on addressing spirituality, however, this has not yet been formulated.[32] A fundamental aspect that this research considered was: Within the context of a diverse religious South African society, how should spirituality be addressed in occupational therapy practice and training?

1.4. RESEARCH QUESTION

Therefore, the primary research question is:

- How is spirituality being defined, experienced, and addressed in OT practice by clinicians and educators?

1.5. RESEARCH AIM AND OBJECTIVES

1.5.1. Aim

To explore how spirituality is being addressed in OT practice by clinicians and educators.

1.5.2. Objectives

Based on the AI approach, the following objectives were formulated:

1. Discover Phase*: (the best of what is)*

- To explore and describe spirituality in OT practice through the generation of experienced successes in spirituality.

2. Dream Phase*: (what might be?)*

- To explore the aspirations and wishes of OT clinicians and educators regarding spirituality in OT practice.

3. Design and Destiny Phase*: (What should be and will be)*

- To develop strategies on how to implement, sustain and address spirituality in daily OT practice.

1.6. CONCEPT CLARIFICATION

Concepts relevant to this study are:

- Appreciative Inquiry: “Appreciative Inquiry (AI) is a theoretical research perspective, an emerging research methodology and a world view that builds on action research, organisational learning and organisational change.” AI adopts a relational constructionist view based on affirmation, appreciation and dialogue.[31]

- Occupational Therapy: The World Federation of Occupational Therapists (WFOT) describes OT as “a health discipline which is concerned with people who are physically and/or mentally impaired, disabled and/or handicapped, either temporarily or

permanently. The professional qualified occupational therapist involves the patients in activities designed to promote the restoration and maximum use of function with the aim of helping such people meet the demands of their working, social, personal and domestic environment, and to participate in life in its fullest sense".[22]

- Spirituality: The OTPF defines spirituality as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or the sacred".[3]

- Client-centred: Client-centred practice/approach, very broadly, can be defined as embracing a philosophy of respect and partnership with people receiving services.[22]

- Client factors: A specific ability and characteristic within the person. In the presence of disability, illness, and/or any other distressing life experience, different client factors may be affected.[3]

- Occupation: Occupation means "everyday activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to, and are expected to do." Occupations can be categorised as activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure and social participation.[3]

- Occupational Therapy Practice Framework: The Occupational Therapy Practice Framework (OTPF), based on the International Classification of Functioning (ICF), is a framework that guides and defines OT practice.[4]

- Patient/client: Recipients of service may include individuals and other people relevant to the individual's life. This term has been used interchangeably in the document.

1.7. SIGNIFICANCE

In light of an increase in patient dissatisfaction and clinician burnout, broaching the topic of spirituality is both relevant and timely. Furthermore, it has been found that healthcare practitioners feel ill-equipped in the face of complicated medical and social issues associated with care for patients with chronic complex problems. All too often, patients visiting health care facilities are seen as agents of disease, whereby their problems need to be fixed quickly and cheaply. Spiritual needs are annulled, and the client does not find their inner resources of health and healing, reducing patient health outcomes.[14]

South African healthcare embraces many challenges, such as skills and human resource shortages, poor staff attitudes, and patient dissatisfaction.[35] The Council for Health Service Accreditation in South Africa (COHSASA) was developed to ensure delivery of quality healthcare to clients. The COHSASA Hospice Palliative Care Standards include a standard for spiritual care. However, the COHSASA Hospital Standards at present do not include a standard for spirituality. Spirituality is vital in the provision of holistic client-centred healthcare.[35] The findings of this study will, in essence, enhance patient care. Study findings are envisioned to be presented at any national conferences involving healthcare standards and OT practice, so that spirituality may possibly gain inclusion into the COHSASA hospital standards.

As mentioned earlier, a review of international and national literature on OT and spirituality reveals the ongoing confusion in the integration of spirituality in OT. Occupational therapists continue to grapple with the nature of this concept.[6,20] This study aimed to address the challenges prevalent in OT literature on spirituality, thereby contributing to the body of knowledge in theory and practice. The findings of this study will shed light on a South African OT perspective of spirituality, how this is translated into practice, and it could possibly inform what curricula should entail regarding spirituality. Gaps in the theoretical basis could be addressed, thereby improving patient care. This may lead to the development of possible practice guidelines for the role of spirituality in OT clinical practice. Knowledge acquired from this study could also contribute towards creating OT educational standards in spirituality.

Methodological benefits of this study include that this study will add richness and greater depth to current literature due to the use of a qualitative research design.[6] There

also exits a gap in literature with respect to methodological approaches commonly used to implement the 4D cycle in the healthcare context, and this research, once published, will also shed light on this aspect.[31]

1.8. OUTLINE OF CHAPTERS

Chapter 2 discusses applicable literature related to spirituality. Chapter 3 provides details regarding the research design, methodology, trustworthiness as well as ethical considerations of the study. Chapter 4 presents the results of the study according to the AI phases of the study. Chapter 5 describes and discusses the relevant themes of the research in relation to pertinent literature. Chapter 6 entails the conclusion and implications of the study, the limitations of the study, and the recommendations emanating from the study are outlined. Refer to Figure 1.1. below for a diagrammatic presentation of the forthcoming chapters.

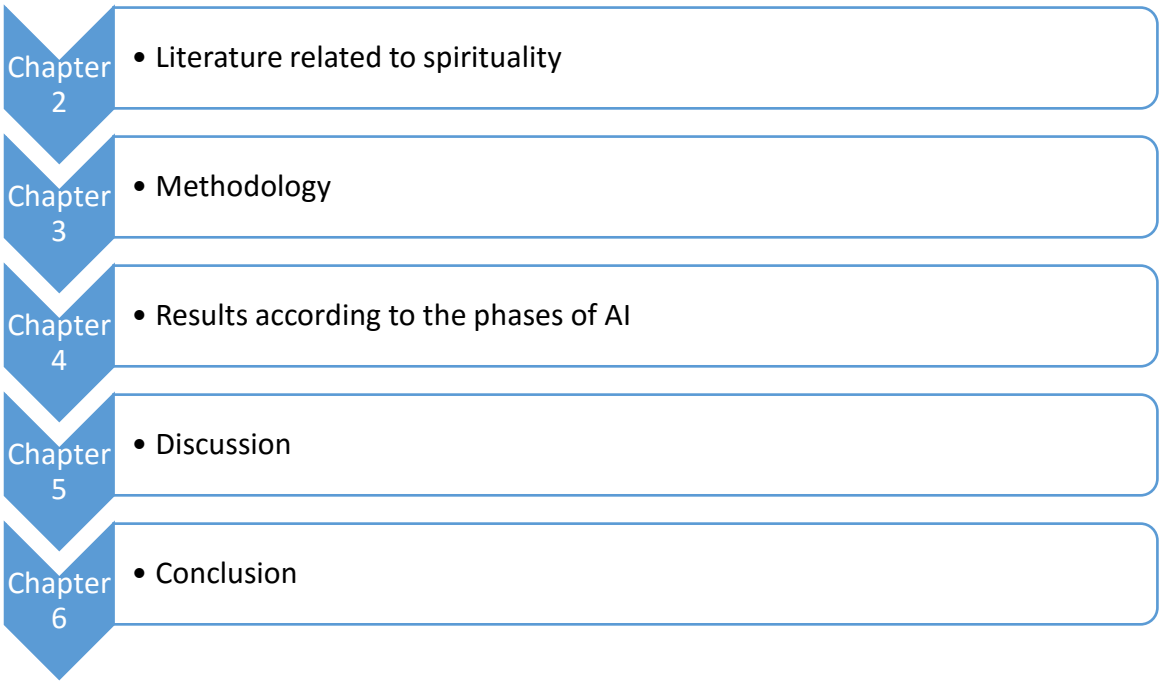

Figure 1.1. Diagrammatic presentation of chapters

1.9. CONCLUSION

Chapter 1 described the background that culminated in the aim and objectives of this study. The methodological approach to the study was briefly introduced and the significance of this study was explained. Chapter 2 further explores relevant literature.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

The purpose of this chapter is to provide the reader with current literature concerning the topic of spirituality. The history of spirituality is discussed first, followed by the relationship between spirituality and religion. Hereafter spirituality is defined. It will subsequently review literature on culture and Ubuntu. This is followed by the benefits of integrating spirituality in practice. Then literature on spirituality in Occupational Therapy (OT) practice is reviewed. Finally, the chapter concludes by reviewing pertinent models describing spirituality.

2.2. HISTORY OF SPIRITUALITY

Traditionally, no separation between spirituality and religion could be found, and these two concepts have been interwoven in their cultural meaning. Spirituality, when distinguished from religion, does not have an extensive history. The need to distinguish spirituality from religion only became evident with the rise of secularism in the 19th century.[36]

Since the beginning of documented history, religion, medicine and healthcare have been connected.[37-38] The enduring nature of the role of religion in human life is evident from 500 000 years ago during the Chinese Palaeolithic period, when ritual treatment of skulls took place.[37] Religion, medicine and healthcare only separated in the 19th century, especially in the West in highly developed nations. Developing countries did not embrace this separation. Historically, religious organisations in the West were instrumental in building the first hospitals to care for the sick, and these were staffed by religious orders. Through the middle ages and the French revolution, physicians were often clergies. Religious institutions were accountable for authorising physicians to practice medicine. Similarly, the care of those with mental health care needs occurred within monasteries and religious communities. The work of psychiatrist, Sigmund Freud, in modern times led to religion and psychiatry parting ways.[38]

Puchalski et al.[14] reiterate that while the close link between spirituality and health has been recognised for many eras, the prominence of science in medical practice triggered the dismissal of spirituality's potential therapeutic effects. However, since the early 1990s, literature reflects heightened interest in the debate about this topic, especially in palliative care.[14]

Reviewing the historical roots of OT affirms the presence of traces of spirituality from the profession's founding. In the early 20th century, the founders of OT were influenced by moral treatment. This led to the advocacy of holism, humanism and an acknowledgement that to engage the mind, body and spirit through occupation is a means of promoting health and bringing meaning to life. However, at this time OT was criticised for its limited theory based on scientific principles. Consequently, the profession adopted reductionist models through the 1950s, thus reducing the importance of the human spirit as expressed through occupation. In 1962 there was concern that the profession's reductionist view did not make explicit the role that occupation could play in facilitating health. Hence, the recurrence of holism and valuing spirituality as a central concept in OT. In the latter part of the 20th century, the Canadian Association of Occupational Therapy (CAOT) incorporated spirituality into theories about client-centred practice and occupational performance. In 1997 the American Journal of Occupational Therapy dedicated an entire issue to the topic of spirituality. In 2002 the Occupational Therapy Practice Framework (OTPF) included spirituality as a context for occupation. This led to the official acknowledgement of the importance of spirituality to OT in the United States.[1]

In the second edition of the OTPF (2008), spirituality is expressed as a client factor. Client factors are based on specific abilities, characteristics, or beliefs that reside within the client and may affect performance in areas of occupation. This edition defines spirituality as "the personal quest for understanding answers to ultimate questions about life, about meaning and the relationship with the sacred and transcendent, which may (or may not) lead to or arise from development of religious rituals and the formation of community".[5]

Evolution of this framework led to the development of the third edition of the OTPF (2014), whereby spirituality still remains a client factor, but is defined differently. This edition also includes religious and spiritual activities as an instrumental activity of daily

living (IADL). Nevertheless, this document fails to describe how this occupation should be integrated in OT practice.[3,39]

The International Classification of Functioning, Disability and Health (ICF) has a special category for defining religion and spirituality (d930), which emphasises engagement in activities and practices for finding meaning and establishing connections with a divine power. On a more direct and practical level, the ICF focuses on the activities associated with religious and spiritual practice, such as attending places of worship or praying and chanting. These activities lend themselves to purposeful assessment and occupational therapists can assist clients to conduct the occupations associated with their spiritual needs.[40]

Following international trends, the Occupational Therapy Association of South Africa (OTASA) recently included in their South African Journal of Occupational Therapy (SAJOT) a position statement on spirituality to express how it relates to education and practice in South Africa.[27]

2.3. THE INTERFACE BETWEEN SPIRITUALITY AND RELIGION

Since the twentieth century, the ambiguity in the definitions of the terms ‘spirituality’ and ‘religion’ has been deliberated.[41] Religion is often associated with spirituality, and can inform a person’s understanding and experience of meaning.[1] Religion can be perceived as a “formal system of beliefs held by groups of people who share certain perspectives on the nature of the world”.[12] Internationally, many working in the field of healthcare have come to distinguish these as separate but connected entities.[12] Spirituality should, thus, not be equated to religion, as it is a much broader concept. However, spiritual needs can be expressed through participation in organised religion.[42] Puchalski et al.[43] concur that religion is one’s expression of spirituality, and it is “a set of organized beliefs about God shared within a community of people”.[43]

Similarly, Becker[44] mentions that several people still consider spirituality and religion as ‘married’ rather than ‘friends’, even though there is a mounting awareness of the difference between these two concepts. This author indicates that, in some cultures, spirituality is understood within the constructs of ordered doctrine. From another

viewpoint, religion may be described “as one way to meet the inherent spiritual needs of humanity.”[44]

Misiorek and Janus[11] define and describe religion more elaborately by stating that religion “involve(s) beliefs, practices, and rituals related to the sacred. The sacred as that which relates to the numinous (mystical, supernatural) or God, and in Eastern religious traditions, to Ultimate Truth or Reality.”[11] Furthermore, religion may also encompass beliefs about spirits, angels, or demons. Specific beliefs about life after death and directions about behaviour that guide life within a social group are also inherent within religion. As much as religion can be practiced and experienced alone and in private, it is often organised and practiced within a community. However, fundamentally, religion is entrenched “in an established tradition that arises out of a group of people with common beliefs and practices concerning the sacred”.[11] Likewise, Mathisen et al.[45] mention that religion is agreed to be about organised “beliefs, practices and rituals related to the transcendent”[45] and is predominantly based upon community expressions of a defined religious theology.[45]

Gall et al.’s[46] study explored the perspectives of 234 participants from various nationalities on the definition of spirituality and religiousness. Their phenomenological analysis revealed that religiousness is an external tool through which individuals can access their spirituality and relationship to the divine. Some participants were of the opinion that religiousness was a pathway to spirituality. Participating in the mission work and life of a religious community led to spiritual experiences for these respondents. These authors concluded that factors such as religious heritage, culture, generation, and nationality impact on how spirituality and religion are defined. The connection between these concepts is dynamic and shifting.[46]

Ultimately, literature highlights the difficulty in unravelling or implicitly distinguishing between religion and spiritual practices and, thus, many studies tend to explore spiritual and/or religious practices with participants.[35,39,47]

2.4. DEFINING SPIRITUALITY

The term spirituality is derived from the Latin word *spiritus*, meaning ‘breath or life’. ‘The word spirit can be synonymous with the ‘living soul.’ Additionally, it could mean

courage, determination, and energy.[8] Historically, as mentioned in 2.2, spirituality was reflected as a phenomenon or concept that develops within a religious context. In recent times, spirituality has been separated from religion as a distinct construct. Over time, definitions of spirituality have evolved from language solely referring to higher power to language more largely incorporating the search for the 'significant,' 'sacred,' or that which holds ultimate meaning or purpose (e.g. relationships with others, the transcendent, nature, or the self).[48]

For the purpose of research and the need to demarcate spirituality and religion, Mathisen et al.[45] cite that Koenig et al., in their handbook, recently expressed a three-part definition along a continuum. "Firstly, there are those individuals who are religious and spiritual (religious/spiritual). Secondly, there are those who are not religious but for whom religion may be part of their lives (religious but not spiritual) and, thirdly, there are those who are not religious or spiritual but humanistic or secular".[45] Research reveals that there is a myriad of definitions of spirituality. There exists no universal definition of spirituality. It is rather generally understood to be a continuous journey people take to discern and understand their own essential selves and higher-order aspirations.[49] Viewed broadly, it is defined as that which gives meaning and purpose to one's life and connectedness to the significant or sacred.[50]

Defined colloquially, Smith and Suto[47] mention that "spirituality is personally and communally defined, based on the values, beliefs, experiences, and practices emerging from individuals' cultures, families, and, for some, their religious communities." [47] Furthermore, the word 'religious' and/or 'spiritual' is used to refer to the everyday language of spirituality that is sometimes separate, overlapping, or synonymous with religion.[47]

Similarly, in palliative care, spirituality is defined as a broader construct, inclusive of religious and non-religious forms. The literature in nursing defines spirituality as "the most human of experiences that seeks to transcend self and find meaning and purpose through connection with others, nature, and/or a Supreme Being, which may or may not involve religious structures or traditions".[51] From a psychology perspective, spirituality is defined "as the search for the sacred".[51] From a social work perspective, Canda and Furman reflected this diversity of meaning in their pluralist description of spirituality as "a universal quality of human beings and their cultures related to the quest

for meaning, purpose, morality, transcendence, well-being, and profound relationships with ourselves, others, and ultimate reality".[52]

Puchalski et al.[10] defines spirituality as "a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices".[10] This definition has been adopted by other studies, the OTASA position statement, and the third edition of the OTPF.[3,27,29]

Framing spirituality from an OT perspective, it becomes evident that spirituality can be described differently and subjectively, and this leads to an emergence of a multitude of definitions, including religious and secular definitions. Therapists individually adopt their own definition that conforms to their understanding of spirituality. Moreover, one's culture and traditions are unquestionably linked to how spirituality is understood.[11] This aspect of spirituality being defined differently and subjectively resonates with the findings of another qualitative study in which the theme of spirituality being unique to every individual emerged.[28]

Similarly, spirituality is highlighted as a metaphysical and an individual experienced phenomenon. Hope, coping, faith and self-transcendence are recurring themes within OT literature. Spirituality can be defined as "a deep experience of meaning brought about by engaging in occupations that involve enacting of personal ideologies, reflection, and intention within a supportive contextual environment".[1]

Spirituality can be expressed outside of occupations, as not all occupations are spiritual. However, every occupation holds the potential to be spiritual. Participating in meaningful occupation is a common effective mechanism to express spirituality tangibly. Spiritual experiences through occupation are reliant on contextual factors (inclusive of the physical and social world). Symbolism is an influential nexus of meaning-making, rooted within these contextual factors. Several people express the experience of spirituality through occupations in nature, like a walk on the beach, a hike in the mountains, or fly fishing in the stream. As meaning is both personally and socially constructed, the social world can considerably influence the spiritual experience. Thus, understanding the spiritual experiences entails viewing the doer of the occupation in reference to the social and cultural worlds of engagement. Co-occupation, which is

engaging in occupations with others, has the probability of being a spiritual experience. Communal religious activities are an example of this, whereby believers receive mutual support and affirmations of their beliefs.[1]

Other communal occupations that have the likelihood to be potential spiritual experiences are occupations such as attending sporting events, concerts, together with family celebrations such as weddings and graduations. As mentioned previously, not all occupations are spiritual, but occupations that hold the greatest potential for a spiritual experience are those that are deeply meaningful to the person imbued with personal reflection and intention.[1]

Spirituality, thus, is a multifaceted and multidimensional construct with which occupational therapists continue to struggle to integrate in everyday practice.[6] Smith and Suto[47] confirm this by stating that the incorporation of spirituality into practice challenges the personal understanding of spirituality by occupational therapists and the language they use to discuss spirituality with clients.[47] Similarly, Mthembu et al.[29] argue that the paucity of a suitable definition of spirituality proves challenging for practicing occupational therapists and students.[29]

2.4.1. Spiritual Care

At this juncture it is imperative to understand and define spiritual care. Broadly perceived, spiritual care is understood as “the foundation of whole person, patient-centred care”.[50] Spiritual care, as defined in a paper by Roman et al.[25], is described as “the care that is embodied in the health professional’s respect for patient’s dignity, display of unconditional acceptance and love, honest health professional-patient relationship, and the fostering of hope and peace”.[25] Another recent definition cited in literature is that spiritual care is “the connection between healthcare professionals and their clients, thereby listening to their fears, dreams, and pain; collaborate with their clients as partners in their care; and provide, through the therapeutic relationship”.[53] Similarly, an article by Piret et al.[54] expands on this definition of spiritual care as “person-centred care which seeks to help people (re)discover hope, resilience and inner strength in times of illness, injury, transition and loss.”[54]

2.4.2. Spiritual wellbeing and spiritual distress

Research shows that attention to spirituality heightens healthcare outcomes, resulting in better quality of life. Conversely, negative spiritual and religious beliefs can be a source of distress that may intensify the burden of illness.[14]

Spiritual wellbeing is “the ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature and/or a power greater than oneself that can be strengthened”.[51] Spiritual distress is “common, normal feelings of vulnerability, sadness, and fear, to problems that become disabling, such as depression, anxiety, despair, and existential spiritual crises”.[51] Illustrations of spiritual distress may include “lack of meaning and purpose, despair/hopelessness, not being remembered, guilt/shame, anger at God/others, abandonment by God/others, feeling out of control, spiritual or existential suffering, reconciliation, and grief/loss”.[43]

Hemphill[8] suggests that, in the face of illness or disease, the loss of meaning is conceivably the greatest crisis a person experiences. Intense physical and emotional trauma can possibly be endured, but clients are unable to withstand a sense of meaninglessness. Medical illness or imminent death can possibly prompt spiritual distress in clients and family members. When there are signs of spiritual crisis, Hemphill mentions that it is vital that the occupational therapist carries out a spiritual assessment.[8]

2.5. CULTURE AND UBUNTU

South Africa is a nation with vibrant diversity of language groups and cultures. Culture is defined broadly “as the behaviour, customs, and the way of life of a group of people passed on from one generation to another, from parents to children”. How we behave, live our lives and how we fit into our family nucleus and community has been influenced by our culture. The South African Bill of Rights, as mentioned by Euvrard et al.,[55] stipulates that everyone has the “right of freedom of religion, belief and opinion”.[55]

Culturally sensitive practice entails that the therapist be familiar with the values and dispositions of certain cultural groups. Furthermore, culturally sensitive practice assists therapist in understanding the meanings that individuals and groups attach to situations

and how clients find consolation and comfort through their cultural practices, rituals and traditions.

African cultures embody the philosophy of Ubuntu. Ubuntu is an integral principle within the South African Constitution. Connectedness, relatedness, and interdependence in relation through other people, the earth and one's ancestors, are core constructs of Ubuntu.[34] Ubuntu is central to the African way of life and simply means "I am because we are." We have to encounter the collective 'we' before we encounter the collective 'I'. I am only through others. Inherent values of Ubuntu are "morality, respect, human dignity, humaneness, compassion, care and understanding." Ubuntu involves one to respect others if one is to respect themselves. The good of the community is valued above self-interest. Wellness of the individual is determined by wellness of the community. In the face of illness, Ubuntu values are more prominent, and respect, honesty and trustworthiness play an important role in care.[35]

2.6. CULTURE AND RELIGION

Religion is a key element of culture. Occupational therapists progressively encounter clients from various cultural backgrounds. The professional obligation of rendering culturally competent practice is hence highlighted.[56] As already mentioned, religion can permeate people's experiences of spirituality. This can be seen through people's daily occupations such as meditation, attending religious services and prayer.[1] Thus, it is necessary to mention and shortly describe the link to spirituality and health in each of the seven main religious groups in South Africa.

2.6.1. African religion

The oldest form of religion in South Africa is the African religion. This can be traced directly to the religious activities of the San and Khoi. Historically, many schools and hospitals in rural Africa have been run by Christian church-related organisations, and the method of cross-fertilisation between African ethos and Christianity in South Africa has led to the creation of the so-called African Indigenous Churches. One of the main characteristics of this religion is faith in the Supreme Being, a God who created the earth. According to African traditions, only through intermediaries (i.e. in the form of

ancestral spirits) can one obtain connections to the Supreme Creator. It is every family's duty to honour their own ancestors. Ancestors are relied on for security and prosperity.[33]

In African belief, health equates to life. Being good implies having an unhindered life flow in all dimensions of one's being. Therefore, disease in African belief is one of the greatest opponents of human existence. It is a sign that life's existence is at risk. It is represented as a reduction in life and an impairment of wholeness. Therefore, it hampers the community's vibrant and creative life.[33,35] Death is not seen as an end of existence, but as a manner to join the company of the deceased or a collective mortality state.[34]

In this religion it is believed that unless the cause of illness is ascertained, treatment will be superficial. In African society there are those that receive a calling from ancestors to become traditional healers. These chosen, trained healers are then referred to as diviners and should not be referred to as 'witch doctors'. Their expertise lies in diagnosing the causes of illness. Consequently, ritual solutions are ascribed to the disturbance. Diviners treat the problems either in terms of medication or a ritual that involves animals, such as a fowl, goat or cow. At times biomedical drugs are supplemented with traditional medicine, and in these cases it is imperative that the healthcare professional is aware of the ingredients in the traditional medicines as well as the method of its application. Traditional medicines usually consist of holy water and herbs. If and when medicinal properties clash with the traditional medicine, a discussion with patient, family and medical practitioner should occur.[33]

2.6.2. The Bahia Faith

The Bahia Faith is the youngest of the world's independent religions. It was founded by Baha' u' llah, a messenger of God. The crucial message of Baha' u' llah is one of unity. The three basic doctrines of the Bahai Faith are as follows: a) there is only one God, b) all divine religions come from the same God, and c) all humanity is one race and come from the same family.[33]

Within this religion there is no clergy, however, the sacred scriptures of the Bahai are read morning and evening. Every 19 days community meetings occur, and these are

called feasts. The Bahia community are overseen by designated councils called Spiritual Assemblies.[33]

In Bahia faith humans are seen as spiritual beings. It is believed that good health is the greatest gift. The founder, Baha' u' llah, expressed that religion and science could be seen as two wings of a bird, thus, healing consists of both spiritual and material processes. Alcohol, intoxicants and smoking are strongly discouraged and prohibited. No dietary restrictions are implemented, however, moderation in whatever is eaten is encouraged. It is believed that the soul is eternal, and the physical body should be treated with respect. Cremation and embalming are forbidden.[33]

2.6.3. Buddhism

Buddhism exists since 500 BC. This religion is derived from the teachings of the enlightened North-eastern Indian Prince Siddartha Gautama, also known as the Buddha. His route emphasised the middle way, encouraging all supporters to keep a neutral and balanced perspective of the globe and avoiding the limits of human asceticism or hedonism. Every individual is suffering and needs to be cured, according to Buddhism. [33] The healing in Buddhism is instituted by the discovery of the four noble truths by Buddha: 1) there is suffering, 2) the reason of suffering is desire, 3) you surrender desire and you will stop suffering, and 4) the eightfold route leads to the cessation of suffering. [33] The eightfold path is described as possessing good and kind thoughts, abstaining from saying unkind things and lying, always being thoughtful and kind to others, work should not infringe on a person's freedom and happiness, and work should not harm others or the environment. Additionally, one should be determined to do well and achieve set goals, as well as being always mindful of your words and deeds, and, finally, one should acquire the right concentration by focusing on something with inner tranquillity.[33]

Buddhist healing practice involves maintaining a balanced world view, practicing the eightfold path, as well as practicing meditation and tantra. Tantric practices, which evolved later in both Buddhism and Hinduism, consist of four stages that shift from outer ritual action to complete spiritual attainment through meditation. A Buddhist's ultimate goal is to achieve Nirvana (enlightenment).[57]

2.6.4. Christianity

Christianity is based on the miraculous event of the birth of Jesus of Nazareth, who rose from the dead after his crucifixion 2000 years ago. He is the Trinity God incarnate and worshiped as the Lord and Saviour by Christians. Christians will worship God by going to church on Sundays and regularly reading the Bible. The Christian doctrines demonstrate that Jesus was commonly regarded as a healer. The New Testament shows many cases where healing of possessed people was achieved by casting out evil spirits, as well as other healing. The numerous healings performed by Jesus in Christianity, depicted in the Bible and used throughout the centuries by ministers/priests, include exorcism, distance prayer, and mystical acts or gestures e.g. miracles. Finally, a unitary view of the person is taken in Christianity i.e. the body, mind and spirit are one, yet distinct. Many individuals, therefore, believe that the disease influencing the body/spirit may be cured by spiritual means, and that, even though the body dies, the spirit is eternal.[33,57]

2.6.5. Hinduism

Hinduism is one of the earliest religions, dating back to 3000 BC. Liberation through oneness with the supreme Reality, also referred to as Brahman or the higher Self, is the premise on which this religion is built. Healing techniques practiced by Hindus throughout history include yoga practices, meditative techniques and prayers. Ayurvedic medicine intends to treat the body and mind together and uses a consumption of plants or herbs, massage therapy and lifestyle changes.[57]

Within this religion are principles of reincarnation and the law of Karma or Action. It is assumed that when a person dies, the soul is eternal and is reborn in a new physical body. This process of rebirth is referred to as reincarnation. The Law of Karma governs this cycle of birth, death and rebirth and is understood colloquially to be that every action has an equal reaction. Thus, good actions take you closer to liberation and wrong actions take you further away. God is represented as Brahma, Vishnu and Shiva. A communal worship place is known as a Mandir (temple) and at home Hindus conduct worship at a shrine. Daily rituals entail having a shower prior to the morning prayer, and then offerings of water, milk and fruits at the shrine. Most Hindus prefer to have showers instead of baths, as daily cleansing occurs with the pouring of water over the body.

Most Hindus follow a strict vegetarian diet, however, in South Africa some Hindus only abstain from pork and beef and consume lamb and chicken.[33]

2.6.6. Islam

Islam, the Muslim religion, originated from the teachings of the Prophet Muhammad, who received the Quran (God's speech) from Allah. In the early Islamic era, it was believed that Allah had appointed a particular therapy or solution for every disease or issue. Honey, cupping and cautery were the three most prevalent techniques for treatment according to Prophet Muhammad's teachings. These procedures have been termed 'Prophet Medicine.'[57]

Illness is not merely somatic, but should be seen in a psychosomatic context. In addition, repeated emphasis is placed on the fact that suffering, particularly illness, cancels sins. Following death, Muslim people believe in an afterlife. Therefore, the death of a loved one is often seen as a temporary separation, as well as that actual death is the will of God. Devoted and devout Muslims think that pain and death are part of the plan of God and should be accepted. Therefore, excessive mourning at death is frowned upon. In hospitals clients will follow a halaal menu. Muslims do not eat pork or its by-products. Alcohol is strictly prohibited, even in medical constituents. The fasting month of Ramadan is of significance to all Muslims, as it is a time of spiritual renewal. The basic rule for the elderly and those in poor health is to not fast throughout the month, but as much as they can manage to fast. Special arrangements should be made to accommodate these clients in this month. For example, they need a meal before dawn and another after sunset.[33]

2.6.7. Judaism

Judaism, the religion of the Jewish people, emerged nearly 4000 years ago in the Middle East and also has a lengthy tradition of healing. Rabbis were renowned for their healing abilities.[57] Among the Jews there is a strong sense of community and a sense of loyalty and mutual support. When God chose Abraham and his descendants to be His people, God entered into a covenant with Abraham. Jews may choose to worship alone, but they usually pray in a synagogue with other Jews. There are three times of prayer a day – night, morning and afternoon. Sabbath is one of the holy days of greatest

importance. Sabbath begins at sunset on Friday and ends on Saturday evening at sunset. Generally, Jews adhere to a kosher diet. Milk should not be mixed with meat, and pork and shellfish are forbidden foods. Eating meat of mammals with split hooves as well as fish with scales and fins are allowed.[33]

2.7. SPIRITUAL BENEFITS

There is a wide range of evidence showing a connection between the outcomes of spirituality, religion, and health care.[10,12,14,39] Clinical studies report that religious people are healthier and require less healthcare services.[39] Spirituality and religion are also powerful sources used by individuals to deal with ailments and distress. Patients as well as the healthcare system gain from providing for spiritual and religious requirements.[58]

The positive impact of spirituality on physical and psychological health, relationships and overall wellbeing has progressively been reported in recent research.[44,59] Some psychological outcomes include improved quality of life, increased ability to cope, increased self-esteem, a greater sense of hope and a greater ability to find meaning in their situations.[13] This concurs with the benefits of spirituality for clients with psychiatric disability; spirituality for these clients was highlighted as a form of coping with stressful events, source of support, and enhanced the self-esteem of these individuals.[60]

According to Moreira et al.[60], a systematic review of more than 3000 empirical studies found that, in general, individuals who are more religious or spiritual experience less depression, anxiety, suicide attempts, and substance use/abuse, and enjoy a better quality of life, faster remission of depressive symptoms, and better psychiatric outcomes.[60] Scientific research confirms the benefits of spirituality, for example, spirituality has been associated with extended life expectancy, lower blood pressure, lower rates of death from coronary artery disease, reduction in myocardial infarction, increased success in heart transplants, reduced serum cholesterol levels, reduced level of pain in cancer suffers, reduced mortality amongst those who attend church and worship services, increased longevity among the elderly and reduced mortality after cardiac surgery.[12]

A qualitative study exploring the views, attitudes and practices of family physicians towards integrating patient spirituality into clinical care found that these doctors believed that being open to a spirituality discussion with clients would contribute to better health and physician-patient interactions.[13] This is consistent with the finding of a study conducted by Misiorek and Janus[11], whereby most of their participants, who were postgraduate OT students, considered spirituality as essential in establishing a therapeutic relationship.[11]

Framing the benefits of spirituality for palliative care clients, Puchalski et al.[43] comment that having a solid sense of spirituality may assist patients to adjust to and deal with a disease, identify wellness throughout cancer treatment and survivorship despite exhaustion or pain, and can help patients find a sense of health in the midst of disease. Spiritual wellbeing in people with cancer is as well associated with lower depression levels and better quality of life near death. Additionally, spiritual wellbeing has been related to protecting against end-of-life despair and a desire for hastened death. Cancer patients describe their spirituality as assisting them to discover hope, appreciation, and positivity in their cancer encounter, and that their spirituality is a source of power that enables them to cope, discover meaning in their life, and make sense of their cancer experience.[43] Similar spiritual benefits were mentioned in a study with clients living with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).[28]

Religion provides individuals with spiritual suffering a historical understanding of suffering and ways to reconstruct their distress. Spirituality also influences medical decision-making for patients with cancer. For example, clients mention that a belief in God is an imperative factor in decision-making about treatment, often more so than the effectiveness of treatment.[43]

Likewise, Rafferty et al.[61] mention the benefits of spirituality and/or religion for people coping with chronic illness. Most individuals report being more spiritual or religious after the onset of a chronic illness. In other chronic illnesses, spirituality was linked with lower anxiety and depression. In diabetic clients, improvement in glycaemic control and self-management behaviours was, likewise, associated with spirituality.[61]Additionally, in seriously ill patients, spirituality acts as a buffer against spiritual pain and spiritual distress. Thus, attending to this crucial aspect is imperative.[50]

According to Mthembu et al.[28] spirituality can be interwoven with experiences of social support. The social support benefits were expressed as communication with a supportive friend and spiritual communication practices such as daily prayer and meditation to calm stress and rejuvenate their mood.[28]

Participants in a study by Gall et al.[46] were asked to describe the function of spirituality in coping with life stress. Findings revealed that spirituality was utilised to cope with a range of stressful situations, as well as with the demands of everyday life. In these participants, their spirituality supported coping, provided meaning and emotional support, created positive emotions, attitude, and boosted self (e.g. inner strength, self-esteem).[46] This is consistent with the findings of a study by Misiorek and Janus[11] and Mthembu et al.[28] The participants in these studies noted the influence of spirituality on their ability to cope with stress, motivation and satisfaction with life. The majority of the participants in Misiorek and Janus's[11] study recognised the influence of their personal spirituality on how they treat others and on their acceptance of their clients.[11]

The benefits of spiritual and religious activities on health is well documented. However, the mechanism by which these activities accomplish or achieve such changes are a debatable mystery. Some evidence proposes that the effect of spiritual healing could be comparable to a placebo effect.[57]

2.8. SPIRITUALITY IN OT PRACTICE

A profession that espouses client-centred practice, holism and humanism warrants integration of spirituality. Within the domain of OT, spirituality has emerged as a key client factor over the past two decades.[1,28] According to Misiorek and Janus[11], the recent attention to spirituality in contemporary OT is an attempt for the return to its origins.[11]

For the client as well as their families, integrating spirituality in practice seems to enhance health, wellbeing and quality of life, according to the World Health Organization (WHO) in 2015.[62] WHO defines health as a "dynamic state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity". [43] Hence, focus on intervention without attention to spirituality does not promote holism or client-centred practice.[43]

Client-centred practice accentuates the significance of meaningful occupation in practice. It is essential that occupational therapists understand the personal values, interests and needs of their clients in order to provide meaningful occupations in their treatment of these clients.[39]

Misiorek and Janus[11] and Jones et al.[26] note that the spiritual dimension has an influence on the individual's rehabilitation and treatment.[11,26] OT essentially aims to make available a choice of meaningful activities/occupations to clients. The use of these client-centred therapeutic occupations integrates the mind, body and spirit of clients and has long since been promoted by occupational therapsts.[39] Engaging in- and control over these activities/occupations fulfil human needs and promote quality of life.[11,28] Spiritual and religious activities and/or occupations fall within the domain of OT as evident in the third edition of the OTPF. [39] However, guidelines to implement these aspects in practice is lacking.[39]

Hemphill[8] argues that to address the client's spiritual needs, the occupational therapist must distinguish whether the client expresses spirituality through traditional religious realms or through unconventional practices.[8] According to Wilson's[40] opinion paper, practical activities connected with religious and spiritual practice are activities such as attending places of worship, praying and chanting. The occupational therapist can carry out purposeful assessment with respect to these activities and, hence, assist clients to fulfil these occupations associated with their spiritual needs. However, the introspective and intangible aspects of recognising a power beyond the human is not easily accessed.[40]

A systematic review by Maley et al.[63] explored the construct of spirituality with people who are experiencing major life events or transitions. Some of the activities that were identified had either a direct connection with spirituality, while other activities supported spirituality or were interrelated with it. Activities where spirituality is associated with religion included conversing with religious authorities and carrying out prayer and other religious rituals and routines. Other activities mentioned were engaging in coping mechanisms and activities that fostered some sense of emotional or physical release. Activities that involve relationships, whereby the connection with others could bring about personal transformation or has the potential to fulfil a spiritual quest to give back to others, were also included. These findings imply that spirituality is expressed in

diverse and complex ways that are interconnected within occupations, client factors, contexts and rituals, however the description of spirituality within in the OTPF (2014) does not reflect this.[63]

Misiorek and Janus[11] mention that spiritual and/or religious beliefs have a significant impact on everyday routines and habits, and give meaning and an additional dimension to everyday activities. Spirituality strongly impacts on the recovery process. This is highlighted in the work of Jones et al., as cited by Misiorek and Janus,[11] which concluded that "occupational therapists respond to a disruption in wellbeing and quality of life by mobilizing patients' spiritual coping strategies in order to support and restore the patient's sense of meaning and purpose".[11]

The understanding of a spiritual experience as a co-occupation, as described in 2.4., was confirmed in a study by Mthembu et al.[64], where spirituality was explored in a community fieldwork setting. On a daily basis, community members will engage in collective spiritual activities prior to meeting with the participants. These activities entailed singing hymns and praying, which were perceived to enable social interactions among the community members as well as connections with God.[64]

Literature reveals that occupational therapists acknowledge the importance of spirituality in practice.[6,39] A study by Bremault et al.[50] on health care professionals, which included occupational therapists, discovered that attending to spiritual needs of patients facilitated a better connection with patients, enhanced person-centred care, and heightened their sense of job satisfaction when meeting patient needs.[50]

A study exploring the perceptions of how young postgraduate occupational therapists define spirituality as well as apply it to their practice, found that the majority of therapists stated that "spirituality affects the quality of the patient's day, his or her choice of everyday activities, as well as motivation, selection of goals, the sense of self-fulfilment, readiness to make important decisions and the sense of agency."[11] The study participants also expressed that considering the client's spirituality is crucial for developing a therapeutic relationship based on partnership. Acceptance and respect for a patient's beliefs were highlighted as vital for collaboration, and participants articulated that this attitude from the therapist facilitates the client opening up and revealing their true aims and motivations.[11]

Mthembu et al.[62] also mentioned that addressing spirituality in practice is fear-provoking in that "the occupational therapists feared intruding on their patients beliefs and imposing their own beliefs".[62] This is in line with Hemphill[8], who mentions that when therapists have firmly-held beliefs and values, there is a risk of imposing them on the clients.[8] Conceptual ambiguity of spirituality has also influenced the implementation of spirituality in OT practice. Research identifies extensive confusion about the definition and meaning of the word spirituality. It is a multifaceted, multidimensional concept.[6,39,62]

Lambie et al.[13] argue that in increasingly multicultural populations, an understanding of spirituality is essential for culturally competent healthcare.[13] Spirituality has varying meanings for different people, thus, consideration of a client's spirituality is a subjective rather than an objective assessment.[6] Spirituality is informed by beliefs, values, traditions, and practices. The values and beliefs may be in conflict with those of the healthcare practitioner. Spiritual care encompasses acceptance of this diversity.[51] This has led to the development of various definitions, both religious and secular. Additionally, understanding of spirituality, inarguably, is associated with the client's culture and traditions.[11]

Integrating spirituality into mental health care settings displays an added challenge. Reasons to elucidate the neglect of religious/spiritual issues by mental health professionals are due to a lack of awareness of the available research; insufficient education on how to deal with religiosity/spirituality in clinical practice; influence and the impact of authors and dogmas that dismiss or pathologise religiosity/spirituality; historical myths of a recurrent conflict between science, medicine and religion; the religiosity gap (mental health professionals being less religious than general and clinical populations); and institutional rivalry between medicine and religion, since both deal with human suffering. The suggestion of religion being an expression of neurosis and a form of hysteria during the 19th century enhanced the above-mentioned impediments. Thus, during the clinical encounter if and when religion emerged, it was frequently either disregarded or treated as a fragment of the pathology.[60]

Smith and Suto[47] argue that this challenge is exacerbated by mental health care users being afraid of the fact that disclosure of their commitment in certain practices will be seen erroneously and contribute towards aspects of their mental health diagnosis.[47]

Hess et al.[20] explains that the expression of religion or spirituality in mental health can be difficult to differentiate from its symptoms.[20]

Bremault's[49] editorial in the Canadian Journal of Occupational Therapy highlights that additional clarity on the role of occupational therapists in engaging clients with reference to spirituality and religion is necessary. Ascertaining how explicitly the therapist discusses these aspects with clients and the competencies thereof is also required.[49]

2.8.1. Spirituality assessment

Hemphill[8], in her article on spiritual assessments in OT, attempted to develop guidelines for occupational therapists to effectively address the spirituality of clients. Richards and Bergin (cited by Hemphill) suggest that spiritual assessment should include eight dimensions, namely a) metaphysical worldview, b) religious affiliation or denomination c) religious problem-solving style (self-directing involves only the self; deferring is giving it to God), d) collaborating involves others, such as medical healers, e) spiritual identity and tradition, f) God image, value and lifestyle congruence; g) doctrinal knowledge i.e. the patient's knowledge of the sacred texts of his or her faith; and h) religious and spiritual health and maturity.[8] Obtaining these eight dimensions, the information should then be understood, organised, assimilated with theory, and made meaningful by the therapist.[8]

At times, spiritual assessments can raise concerns. However, maintaining a balance between treatment goals and focus on building the spiritual strength of clients is necessary. The primary focus should always be on OT intervention. Taking on the role of a spiritual expert should be avoided, rather referrals to the client's own spiritual or religious healer will be required.[8]

Questions included in the spiritual history taking should entail if the client is drawing on religion or spirituality as a method of dealing with their illness, whether clients have a supportive spiritual community, are there any spiritual questions of concern, and are there any spiritual beliefs that affect their medical condition? Likewise, questions that should be integrated into the clinical setting during therapy are as follows: does the client practice their religion in the present, is there a belief in God or another higher power, and does the client engage in certain practices on a regular basis? To evaluate

'sense of meaning', questions like what gives meaning and purpose to the client and what is important to the client may be asked.[8]

Another well-documented tool for spiritual history taking is the Faith, Importance/Influence, Community, Action/Address (FICA).[8,50,58] Concepts integrated in this tool are:

- Questions *about patients' faith (F) are explored,*
- *the importance(I) of their beliefs are discovered, whether the client belongs to*
- *a spiritual community (C), and if there are spiritual practices the client wishes to develop, thus*
- *Action/Address (A) in care are also explored.*

Through the process of the spiritual assessment, the therapist discovers the uniqueness of each person, as well as the contexts that support or hinder occupational performance. Stemming from the spiritual assessment, the therapist can now develop a treatment founded on wishes and experiences of the client.[8]

2.8.2. OT intervention practice guidelines

OT intervention approaches that endorse holism through occupation-based and client-centred techniques will likely promote spiritual health and wellbeing, as spirituality is a deep experience of meaning effectively experienced through occupational engagement. It is also mentioned that integrating spirituality in practice should begin with the practitioners considering their own spirituality and how their spirituality is expressed in their own occupations and experiences. Additionally, these self-reflective processes will bring to light therapists' personal biases and beliefs that could impact negatively on the therapeutic relationship and the therapeutic intervention with clients.[2]

A spiritual approach to therapeutic interaction entails therapists who practice therapeutic use of self through active listening, empathy, tolerance, unconditional acceptance, and flexibility towards the client's desires and needs.[1-2] This agrees with the findings of Misiorek and Janus's[11] study, whereby therapists claimed that, in practice, taking spirituality into consideration involves "tolerating beliefs," "accepting beliefs," "respecting the patient's religion," [11] as well as "respecting traditions followed by the patient".[11] Finally, literature mentions that by honouring the subjective

experience of clients throughout the OT process, the therapist moves towards integrating spirituality into practice and subsequently increasing the client's motivation.[1-2]

2.9. SPIRITUALITY IN OT EDUCATION

Many healthcare professionals report that they still lack the expertise in applying spirituality in practice, thus their knowledge and skill is lacking.[6,18,20] It is suggested that preparation for this role should be embedded in the curricula.[18] It is clearly indicated that healthcare professionals need to enhance their knowledge and confidence in addressing spiritual concerns of their clients, thus facilitating a holistic approach to health.[50,65]

Research indicates that spirituality has been ignored within education. As societal needs continue to evolve, it is suggested that medical schools educate their students in line with societal and health system needs to provide a conducive environment that engenders compassionate caregiving.[29] Nevertheless, incorporating spirituality and spiritual care in education proves to be a difficult matter due to various challenges.[62]

Associated with the need to modify existing education to include spirituality is the aligned requirement for spirituality to be included in OT exit-level outcomes.[28] Likewise, Bhagwan et al.[52] argue that even though exit level outcomes for social work do not include spirituality and religion, references to culture, diversity and ethnicity are made, and this suggests that spirituality should not be neglected in education.[52]

Though occupational therapists accept that spirituality is integral to the client's wellbeing, many do not always feel prepared to engage patients on spiritual issues. A number of studies have shown that a significant barrier to integrating spirituality into OT practice is due to a lack of knowledge, as it has not been formally taught or else emphasised in education, and, thus, the practitioner is left with little preparation to engage the spiritual needs of clients.[6,39,47,62]

Morris et al.[6] mention that a lack of training in the therapist's formal education results in the therapist imposing much of their own religious beliefs in therapy with disregard for the client's beliefs.[6] Educational challenges concerning the teaching of spirituality

are complex and comprise of the lack of consensus about the definition of spirituality, lack of training, lack of knowledge, lack of time and inconsistency in teaching spiritual care.[25]

In the United States, Puchalski in 1991 introduced the first formal spirituality course for medical students at the George Washington University Medical School.[13] Since then, a study conducted in 2010 found that American and British medical schools have taken the lead in this regard with 66,6% and 57% respectively of their medical schools running such a course.[66] A South African research study indicates that spirituality should be included in undergraduate as well as postgraduate psychiatric medical training.[67] Yet many assert that educational curricula on this topic is still lacking or totally absent.[6,13,19,23]

A recent mixed method study conducted by Morris et al.[6] revealed that there is a significant gap between OT education, theory and practice. The OT community surveyed also indicated a significant openness to participating in continuing education workshops or seminars towards the integration of spirituality in practice.[6]

This is consistent with another study where health care professionals expressed that additional education is necessary so that they can competently, confidently and intentionally attend to the spiritual needs of their clients. Educational opportunities included "(a) enhance self-awareness; (b) improve the ability to differentiate patient distress from one's own spiritual discomfort; (c) develop competencies and skills in spiritual history taking, interviewing and interventions; (d) explore ways to adhere to professional boundaries; and (e) practice responding to and reflecting on spiritual issues using a team-based, collaborative approach." [50] These authors also suggested that these educational opportunities should be present in undergraduate, postgraduate and as continuous education course content.[50]

Likewise, a qualitative study on occupational therapy students and their perceptions regarding spirituality in their training found that spirituality is addressed minimally in their course. This was obvious from participants' lack of understanding on the topic of spirituality, as well as from participants who stated that no specific lectures were received on the topic. Spirituality was rather discussed as part of other lecture content.[28] It is mentioned in OT literature that OT students require assessment/interviewing tools that can assist them in understanding the spirituality of

their clients. Thus, OT curricula should facilitate this knowledge in order to deliver holistic OT intervention.[28]

A review of South African literature concerning spirituality in OT education makes known that irrespective of spirituality being regarded as a significant component of human beings and holism, it is notably absent from South African literature with few exclusions.[28,62] Additionally, a reason for the non-inclusion of spirituality in South African OT curricula is that it has been minimally researched. Thus, a study exploring the barriers at one OT educational institution in a South African context indicated that the barriers to spirituality and spiritual care included barriers to teaching spirituality in the classroom, barriers to spirituality in fieldwork practice and barriers to spirituality at personal level.[62] Hence, health care educators are challenged to be innovative and adapt education and practice to integrate spirituality into curricula. Integrative, transformative, collaborative and interdisciplinary education is proposed to integrate spirituality in health science education**.**[29]

A systematic review of literature from 2000 to 2013 concerning the content knowledge and teaching strategies employed to teach spirituality and spiritual care in health sciences education**,** recommend that the content knowledge may include "concept analysis, self-awareness, cultural beliefs, diversity and social justice, ethics, spiritual competence, person-centred attributes and barriers, evidence-based practice and possible areas where spirituality and spiritual care may be covered." [25] Furthermore, this review identified learning objectives that consisted of knowledge-based, skills-based learning as well as attitudes-based learning. Teaching strategies should entail educator's teaching strategies in the classroom, collaborative learning and practice learning. This systematic review provides a framework for designing and developing guidelines for integrating spirituality and spiritual care in health sciences education.[25]

A recent South African OT study in a community fieldwork placement found that both self-reflection and critical reflection through journaling were vital in facilitating students' self-awareness and learning about spirituality in the community.[64] This is consistent with the findings of an earlier study in the UK, where directed study and reflection improved OT students' confidence in integrating spirituality and spiritual care in practice.[29,41]

A qualitative study exploring educators' and students' needs regarding teaching and learning strategies for integrating spirituality and spiritual care in one of the South African OT training institutions found that transformative learning theories could be a vehicle to integrate spirituality into OT education. The study supports the concept that teaching and learning strategies for spirituality should include critical reflection and consciousness raising.[53]

This finding aligns with several studies that shows that learning and teaching strategies of transformative learning could be used in class to integrate spirituality into health sciences education. This may be through group and individual activities that may nurture students' capabilities, skills and learning styles. Various teaching and learning styles included in these studies are self-awareness, self-reflection, role-playing, self-study, exposing students to literature on spirituality, journaling and reflection, small group discussions, and case studies.[53]

2.10. OTASA POSITION STATEMENT ON SPIRITUALITY IN OT

Following in the footsteps of the CAOT and the American Occupational Therapy Association (AOTA),[2] OTASA developed and published a position statement entitled 'Spirituality in Occupational Therapy' in the later part of 2018. This statement ushered in the official recognition of the importance of spirituality in OT in South Africa.[27] The statement presented strategies for implementation of spirituality in education and training, as well as in practice, the aim of which was to raise awareness of the importance of spiritualty at this current time.[27]

As mentioned earlier in this chapter, South Africa is home to a diversity of cultures, thus the position statement mentions that understanding spirituality from the perspective of the individual and community is imperative. The therapist should be non-judgmental and show respect to clients and their communities, as this is inherently spiritual. Spirituality should be considered within the routine history assessment of individuals, families and communities. Practical spiritual needs as identified by clients should always be met. These needs could include scriptural texts, prayer beads or clothing, or time for prayer. Addressing spirituality should be a multidisciplinary team approach, as this improves the relationship between institution-based practitioners, traditional

healers and faith-based organisations and clergy, consequently promoting holistic quality of life, health and wellbeing.[27]

Strategies for implementation advocated by OTASA include that spirituality should be merged across OT curricula. Teaching and learning strategies should include "cultural sensitivity and social interaction across diverse backgrounds, self-reflection, reflective and critical thinking, good communication skills and active listening within the classroom".[27] Continuous Professional Development (CPD) programmes that address personal growth, cultural sensitivity and how to integrate spirituality into OT practice should be made available.[27] Ultimately, the minimum standards for training of occupational therapists should be appraised to cover the integration of spirituality as part of person-centred and holistic treatment approaches.[27]

2.11. MODELS USED IN OT

Occupational therapists use models to guide assessment and intervention that consider the whole person, which include the physical, social, psychological, and spiritual needs of clients.[39] Models of relevance to spirituality will now be discussed.

2.11.1. Bio-psycho-social-spiritual model

The bio-psycho-social-spiritual model of care recognises that there is more to the care of the patient than the physical. This model accepts that all dimensions of a person influence their presentation of symptoms as well as their treatment.[12,68]

Literature speaks of 'total pain', which is explained as to where patient's pain may be – physical, social, emotional or spiritual. Emphasis within this model is on the totality of the patient's experience in the context of their illness. Hence, the clinician's assessment and treatment of patients should entail the physical signs and symptoms of the patient's illness, as well as the patient's emotional responses to the illness, the social ramifications of the illness on the client and their family and friends, and the spiritual concerns that may arise from the illness. In instances where the healthcare professional chooses not to discuss spiritual needs with their clients, they are unable to ascertain how clients define wellness and quality of life, this detail is essential for effective

individualised diagnosis and treatment.[12] Literature shows that when a client's values and beliefs are integrated into treatment plans, healthcare outcomes are enhanced, including shorter average 'in-hospital' stay, lower cost per case, and higher overall client satisfaction scores.[12]

2.11.2. The Canadian Model of Occupational Performance (CMOP)

This model was first circulated as practice guidelines in 1983. Several subsequent editions of this conceptual basis of practice have been published.[69] This is a social model that positions the person in a social/environmental context, rather than locating the environment outside of the person. Occupational performance is, thus, a consequence of the interaction and interdependence between the person, environment and occupation.[21-22]

Fundamental features of the CMOP when first published included: [69]

- Occupation as the core domain of OT
- Spirituality as the central core of a person
- The experiential nature of occupation
- Client-centred practice as a foundational principle of practice
- Environment (cultural, institutional, physical, social) as an important determinant of occupational performance
- Enablement as a core competency of occupational therapists

The three main components of the model are occupation, performance, and the environment. Occupations consist of self-care, productivity and leisure. Self-care is defined by the CAOT as "occupations for looking after the self". Productivity is referred to as "occupations that make social or economic contribution or that provide for economic sustenance", and leisure is explained as "occupations for enjoyment".[22]

The performance components of the model are the a) affective (feeling) – this aspect encompasses all social and emotional functions, including interpersonal and intrapersonal factors, b) physical (doing) – this comprises of the sensory, motor and sensorimotor components, and c) cognitive (thinking) – this entails all mental functions.[22]

The environment component comprises of the cultural, physical, social and institutional environment. The cultural, physical and social environments are familiar to occupational therapists. However, the institutional environments include economical, legal and political environment.[22]

Spirituality is located centrally in the model, implying that spirituality "resides in persons, is shaped by the environment and gives meaning to occupation." [22] In essence, spirituality is part of all constituents of the model and is crucial to maintain life.[22]

Occupational therapists are acquainted with the affective, physical, and cognitive domains, however, spirituality still poses challenges, as it lacks a consistent definition, and the debate around the role of the occupational therapist is evident. There is discussion of whether occupation or spirituality should be the therapist's primary concern. Nevertheless, Duncan[22] advocates that the position of spirituality in the model is justified.[20,22,64] Conversely, Barry and Gibbens[41] mention that acceptance of spirituality as a core concept has led to deliberation about whether spirituality falls within the domain of OT.[41]

In 2007, the model was revised to include 'engagement' and is currently known as the Canadian Model of Occupational Performance and Engagement (CMOP-E). Emphasis has now been placed on engagement. Occupation has been represented as the core domain of interest.[22]

2.11.2.1. The Canadian Occupational Performance Measure

This is an outcome measure that was intended for use with the CMOP. This is a multifunctional tool and has been developed for use with people of all ages and across all impairments.[22] It is probably the best example of a client-centred outcome measure, developed to notice a change in the client's occupational performance over time from the client's perspective.[70] The client is asked to score their performance and satisfaction, as well as perceived difficulties in the area of self-care, productivity and leisure. Thus, occupational performance is perceived individually and assessed subjectively.[22]

Literature concerning the CMOP makes known that the impact and recognition of this model goes beyond Canadian OT to include educators and academics internationally.[69] A study that took place in the United Kingdom applied the CMOP in their daily practice.

These participants reported that the use of the CMOP heightened their understanding of daily practice, they also acknowledged the client-centred and occupational nature of their practice, reflection on practice was enhanced, and positively impacted their organisation's understanding of OT.[69]

2.11.3. The Person- Environment-occupational Performance (PEOP) Model

The underlying characteristic of this model is that occupational performance is not merely determined by the nature of the activity, task or role linked to its performance. Characteristics of the person or client (referred to as intrinsic factors) and the environment (referred to as extrinsic factors) determine occupational performance.[22]

Intrinsic factors depicted by this model are physiological, cognitive, spiritual, neurological, behavioural, and psychological. Extrinsic factors include social support, social and economic systems, culture and values, built environment and technology, and the natural environment. Dependent on the context or situation, applicability or significance of the intrinsic and extrinsic factors will vary. However, the model presumes that consideration of each of the factors is necessary for a comprehensive assessment that informs intervention.[22]

Pertinent tenets of the model are that it values collaboration, it adopts a systems perspective and it is client-centred. Occupational Performance is defined as "the complex interaction between the person and the environments in which they carry out activities, tasks and roles that are meaningful or required of them".[22] 'Spiritual', in this model, is defined as that which gives meaning. The model, however, makes no further mention of spirituality and its reference to occupational performance.[22]

PEOP and CMOP are essentially client-centred models used nationally and internationally. Another client-centred model of particular relevance in South Africa is the Vona du Toit Model of Creative Ability

2.11.4. The Vona du Toit Model of Creative Ability (VdTMoCA)

This model is a client-centred practice model that guides OT service delivery in South Africa and the United Kingdom. Research and publications concerning this model are limited.

Entrenched in this model is the postulation that a client's occupational performance is in accordance to their level of motivation and action.[70] The connection of spirituality within this model is not explicit, however, du Toit[71] mentions that Creative Ability "will reflect the individual as a totality of the psyche and soma vitalised by the spirit".[71]

A client's level of motivation and action needs to be determined by the occupational therapist. Descriptive terms coined for each level of motivation and action are positive tone, self-differentiation, self-presentation, passive participation, imitative participation, active participation, competitive participation, contribution, and competitive contribution.[71]

Once the client's level of motivation and action has been established, the clinician's intervention is then personalised to the client's abilities on the specific identified level. This ensures client-centredness and individuality in the intervention. Furthermore, the uniqueness of the individual and the continuous interaction amongst the therapist and the client in this model are strongly accentuated.[70]

2.12. CONCLUSION

This chapter reviewed pertinent literature in relation to spirituality. It provided the reader with literature on spirituality in OT and its accompanying challenges of integrating spirituality into OT education and practice. The following chapter will discuss the methodology used in this study.

CHAPTER 3: METHODOLOGY

3.1. INTRODUCTION

This chapter discusses the research design and methods used to explore how occupational therapists use spirituality in occupational therapy (OT) practice. The reader is reminded of the aims and objectives of this study, as well as the qualitative social constructionism approach that has been employed to address the objectives of this study. The Appreciative Inquiry (AI) approach focusing on the 4D phases of Discovery, Dream, Design and Destiny is also described. The population, sampling, data collection and data analysis are discussed. Methods to ensure trustworthiness as well as ethical considerations are elaborated upon.

3.2. PURPOSE AND OBJECTIVES OF THIS STUDY

The purpose of this study was to explore how spirituality is being addressed in OT practice by clinicians and educators in Gauteng. This facilitated practical strategies on how to address and sustain spirituality in OT practice. The Design and Destiny phases were combined for the purpose of this study.

Based on the AI approach, the following objectives were formulated:

1. *Discover Phase: (the best of what is)*

- To explore and describe spirituality in OT practice through the generation of experienced successes in spirituality.

2. *Dream Phase: (what might be)*

- To explore the aspirations and wishes of OT clinicians and educators regarding spirituality in OT practice.

3. *Design and Destiny Phase (What should be and will be)*

- To develop strategies on how to implement, sustain and address spirituality in daily OT practice.

Figure 3.1. is a diagrammatic representation of the AI phases applied in the study.

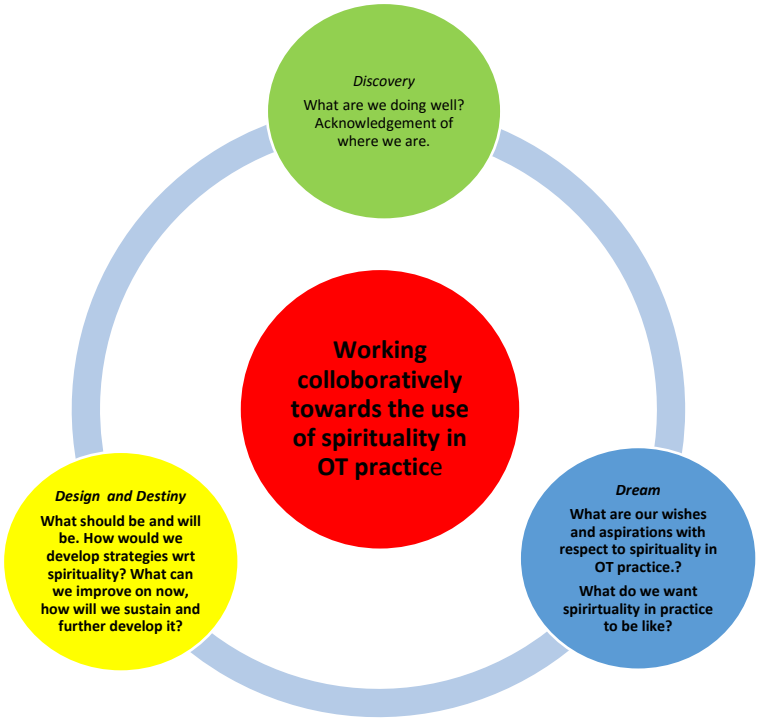

Figure 3.1. Application of AI phases as applied to the study

3.3. RESEARCH DESIGN

The research design denotes the overall strategy employed by the researcher to address the research problem. It has also been referred to as strategies of inquiry[72] and provides a framework for the collection and analysis of data, thus enhancing the trustworthiness of the research.[73]

A qualitative exploratory descriptive design was used for this study. The researcher was concerned with understanding rather than explanation.[74] Imperative to this then "is the meaning individuals or groups ascribe to a social or human problem".[72] Subsequently, the subjective reality from the perspective of insiders was explored.[74] In the context of this research, an appreciative inquiry (AI), via the use of an AI workshop, was conducted to generate an in-depth understanding of the use of spirituality in OT practice.[30,31,75,76]

3.4. RESEARCH PARADIGM

A paradigm is defined as a "basic set of beliefs that guide action".[72,73] It dictates what should be studied, the process of research, and in what manner results should be interpreted.[73] As mentioned, AI underpins all activities of this study, and, thus, the social constructionist/constructivist paradigm has been adopted. Multiple realities were co-constructed between the researcher and study participants based on the AI constructivist view.[30,31,77] To elaborate on this, the philosophical assumptions will now be discussed.

3.4.1. Philosophical assumptions

3.4.1.1. Ontological assumptions

This relates to the nature of reality and its characteristics. In social constructionism, realities are multiple as seen through many views.[77] One embraces multiple realities (views) of spirituality. In this study, spirituality was viewed from a clinician/practice as well as an educator/theory perspective. The researcher assumed that the way participants addressed and experienced spirituality was relative[78], therefore emanating into multiple realities constructed through the clinician and educators lived experience of spirituality, and their interaction with others.[77]

Social Constructionism is often also referred to as constructivism.[73,74] In social constructionism, the social nature of knowledge is emphasised. Therefore, knowledge is seen as a product of social interaction and communication. Language is, therefore, of integral importance in this process.[79] AI focuses on affirmation, appreciation and dialogue and, thus, adopts a social constructionist or constructivist view.[31,80]

This research was further guided by the following five AI principles:[9,30,81]

- The constructionist principle: Individuals constantly negotiate and interact with others around them, therefore, resulting in organisational change. Consequently, knowledge has a collective basis. The researcher believes that the dynamic interactions within the workshop facilitated insight in experience of spirituality in OT. The constructionist would claim that change is inherent in the initial questions posed. These questions then conceive/construct the future. Questioning was positive in

nature, therefore, facilitating strategies amongst occupational therapists on addressing spirituality.

- The simultaneity principle: Simultaneously, inquiry and change occur. Inquiry is therefore intervention. This suggests that questioning facilitates thinking and is resultant in change. The researcher used carefully designed open-ended questions to facilitate change in a positive direction. The researcher envisaged that utilising positive questions, in essence, allowed participants to address spirituality in OT.
- The poetic principle: This relates to organisations being open systems. The past, present and future are open to change from different interpretations from different people. Facilitating knowledge amongst participants in the 4D phases allowed the above to emerge.
- Anticipatory principle: This relates to positive transitions embedded in positive images of the future. The researcher facilitated this in the Dream phase.
- Positive principle: Focus should be on the positive and uplifting. The researcher utilised only positively framed open-ended questions in the workshop, therefore, inquiry was conducted appreciatively.

The researcher reported the various views based on emerging themes that developed during data collection.[31]

3.4.1.2. Epistemological assumptions

This refers to what counts as knowledge, how it is justified, and what is the relationship between that which is being researched and the researcher.[77] In this study, understanding and addressing spiritualty in OT practice and training was co-constructed between the researcher and participants. It was shaped by individual experiences and interactions in the workshop. To justify knowledge claims, the researcher used direct quotes that occurred in the workshop.[77] Participants were allowed to talk freely and the researcher listened attentively and with empathy.[9]

The interactive process between the researcher and participants has, therefore, yielded research findings. Essentially, the researcher was part of the research process and not independent from the research participants. Views of research participants were, therefore, constructed within the relationship with the researcher, consequently adopting the constructionist paradigm.[77]

3.4.1.3. Methodological assumptions

This refers to the process of research and how the evidence is best attained.[77] The researcher made use of the inductive method of emergent themes to yield findings about addressing spirituality in OT by utilising AI to obtain research findings. In AI, a change process has its roots in Action Research that was developed by David Cooperrider in the 1980s.[9] Focus is on discovering the best possible outcomes by utilising the 4D cycle of Discovery, Dream, Design and Destiny. The researcher assumed that by focusing on the positive aspects of addressing spirituality in practice, AI reduced defensiveness amongst participants and facilitated collaboration.[9] The 4D cycle, as well as its application to this study, is described in detail later in this chapter.

3.5. POPULATION AND SAMPLE

3.5.1. Population in context

This study took place within the Gauteng Province. Occupational therapy educators from three universities within this region, as well as OT clinicians from private and public settings working in this region were invited to attend an ethics continuous professional development (CPD) AI workshop. Therefore, the population for this study consisted of OT educators employed in the three respective Universities in Gauteng, namely University of Pretoria, University of Witwatersrand and Sefako Makgatho Health Sciences University, and practicing OT clinicians from various fields of practice who were registered with the Health Professionals Council of South Africa (HPCSA).

3.5.2. Sampling

Purposive, convenience sampling, also known as judgmental sampling, has been employed in this research.[73,74,82] This is a sampling method where selection is based on those who are most informative regarding the topic of research. Consequently, in relevance to the research question being posed, only OT educators and clinicians from various public and private practices in and around Gauteng were purposively invited to attend the data-gathering workshop.

Advertisement of the workshop was distributed via the e-mailing system of the OT Department at the University of Pretoria, as it was an ethics workshop hosted by the department. The researcher also invited therapists on her own database from various settings to try to ensure a heterogonous sample. Taking cognisance of AI principles, by appreciating and valuing the time of participants, the researcher on various occasions contacted personnel from the three stakeholder universities to ensure that the date of workshop was appropriate to ensure possible attendance. Clinicians were informed well in advance to ensure that work commitments were fulfilled, thus permitting their attendance.

The first advertisement was sent eight weeks prior to the workshop (as a save-the-date event) and the final advertisement was emailed four weeks prior to the event. Consent forms (refer to Appendix A), including consent to be audiotaped, were emailed to participants as an attached document to the advertisement of the workshop.

Even though these consent forms were emailed to participants with the invitation to attend the ethics workshop (to ensure familiarity with the nature of the workshop being a data-gathering workshop as well as a CPD activity), participants could decide autonomously to attend the workshop or not. Written consent forms together with demographic details were completed anonymously on the day of the workshop.

The demographic information form (refer to Appendix B) designed by the researcher requested information regarding age, gender and OT experience. The demographic information contributed to the trustworthiness of findings, as it describes the sample for possible repeat studies. This demographic information was completed anonymously to maintain confidentiality, as further discussed under ethics.

3.5.3. Sample size and description

Sample size was dictated by data saturation. Initially the researcher planned to recruit a minimum of 16 participants or until data saturation was achieved.[72] If data saturation was not achieved, another AI workshop would have been conducted later in the year to achieve data saturation. However, at the end of the first workshop, data saturation was declared. There were 24 participants in total. The independent discussion leader (facilitator), supervisors and independent co-coder confirmed that data saturation was

achieved. Data saturation occurred when themes were repeated, and no new information emerged. Therefore, new data revealed redundant information.[72,82]

Thus, a total of 24 participants attended the workshop, of which 21 were female and 3 males. The average age of participants ranged from 28 and 40 years of age. Most participants were employed full time and on average employed for a period of 1 to 20 years. The majority of the participants were clinicians, however, educators were also fairly represented. Participants were from various fields of practice.

3.5.4. Inclusion and Exclusion Criteria

3.5.4.1. Inclusion Criteria

All current Health Professions Council of South Africa (HPCSA) registered OT clinicians and educators from Gauteng that voluntarily accepted the invitation to the AI workshop.

3.5.4.2. Exclusion Criteria

Therapists no longer involved in OT treatment or education were excluded.

3.6. DATA COLLECTION

Data collection refers to the “actual techniques and strategies employed to collect and manipulate data and acquire knowledge”.[83] This research aimed to explore how spirituality is being addressed and used in OT. In order to accomplish this, a data-gathering workshop based on appreciative inquiry principles was conducted.[9,30,31,75,76]

3.6.1 Self-Report AI schedule and the focus group inquiry (small group discussions)

The workshop consisted of self-report interview schedules, as well as small group discussions (focus group inquiry),[30,31,84] facilitating the respective phases of the AI cycle (Discovery, Dream, Design and Destiny phases)[75] (refer to Figure 3.1). In this study, the Design and Destiny phases have been combined. The phases of AI are not prescriptive and, thus, the researcher decided to combine these two phases exploring

how participants develop strategies on how to implement, sustain and address spirituality in daily OT practice.[9]

Prior to the workshop, the primary researcher, together with the valuable support of her supervisors as well as the independent facilitator, carefully crafted a self-report interview schedule based on the AI processes of Discovery and Dream.[30,75,86] For a list of these questions refer to Appendix C. These questions were compiled to be unconditional, positive questions evoking essential aspirations and inspirations. This is based on the AI premise that "the art of inquiry moves in the direction of evoking positive images that lead to positive action" [30], consequently also encouraging creativity within participants.[30]

Focus group inquiry used in AI adopts a culture rich in storytelling, collaboration and creativity.[30] Participants were allowed to share openly and through discussion generate a common understanding of the topic at hand. Lategan[84] highlights further benefits of this type of inquiry, as it is a process that is time- and cost efficient, stimulating the participants' innovation and, consequently, the likelihood that findings are used.[84] This links well to the simultaneity principle of AI, were inquiry relates positively to change.[9,30]

3.6.1.1. Group facilitator

An independent facilitator with the assistance of assistant facilitators (i.e. the researcher and supervisors) facilitated the focus group inquiry within the workshop. The independent facilitator is competent and knowledgeable in facilitating group discussions in AI. She was co-opted to enhance the trustworthiness of the study.[73,74]

The facilitator ensured that each participant who wanted to share their thoughts was heard. The facilitator also utilised communication techniques, like paraphrasing, summarising and questioning, to obtain feedback during the discussion phase. Identified themes could therefore be substantiated.[74]

3.6.1.2. Group facilitation team

De Vos[74] refers to the assistant facilitators as "a recorder, observer, analyst and even consultant". [74] During the workshop, the researcher, accompanied by her supervisor and co–supervisor in the role of assistant facilitators, handled environmental conditions and logistics as well as operated the voice recorders. The researcher was also

responsible for keeping track of the time expended on each activity. Assistant facilitators were tasked with compiling comprehensive notes, which will be described under field notes.[74]

3.6.2. Field notes

Field notes are written accounts of things that the researcher hears, sees, experiences, and thinks in the course of collecting on the data obtained during the study. The assistant facilitators took notes of how participants reacted to questions asked, seating arrangements, as well as the order in which participant's spoke, to assist with voice recognition during transcription. Group dynamics, pertinent themes as well as non-verbal behaviour of participants were noted.[74] When the workshop was adjourned, all parties discussed their notes[74] as it facilitated reflexivity and peer-debriefing[72,83], consequently enhancing trustworthiness.

3.6.3 Preparation of the workshop

The data collection event occurred in a venue that was conducive to the facilitation of the workshop. The venue ensured privacy with the least possibility of disturbance during group discussions. All logistical arrangements, such as booking of the venue as well as parking for participants, were made well in advance. The primary researcher together with the facilitator set up the venue prior to the commencement of the workshop. Tables were arranged to facilitate small group discussions. Each table setting accommodated five participants. At each table, materials to facilitate the group activities were laid out e.g. craft materials, magazines. Participants were also provided with a bottle of water and sweets at each respective table. Each table also received a different coloured pack of sticky notes. A flip chart was positioned centrally in the room.

At the entrance of the venue, a table was positioned to accommodate the sign-in and sign-out register, as well as labels for participant's names. Anonymity was guaranteed outside the workshop, however, participants identified themselves during the workshop to facilitate authentic and open discussion. Throughout the entire workshop no names of participants were documented. Participants were referred to according to numbers allocated to the various tables to simplify transcription.[30]

A table displaying various pictures that may be associated with spirituality was also prepared. The venue was arranged in such a way that it made provision for participants to come together centrally during discussions.

The researcher ensured that recording equipment was in working order and available. Two digital audio recording devices were utilised in case of technical failure.[74] Provisions for refreshments during tea-time were arranged. The duration of the workshop was approximately four hours, with a tea break of approximately 20 minutes.

The workshop comprised of a welcome phase, a data collection phase and a closure phase. The data collection phase facilitated the AI approach. Details of the activities of the workshop facilitating the 4D process, as depicted in Figure 3.2., will now be described. The reader is reminded that this study combines the Design and Destiny phase. Appendix D provides a more detailed flow chart.

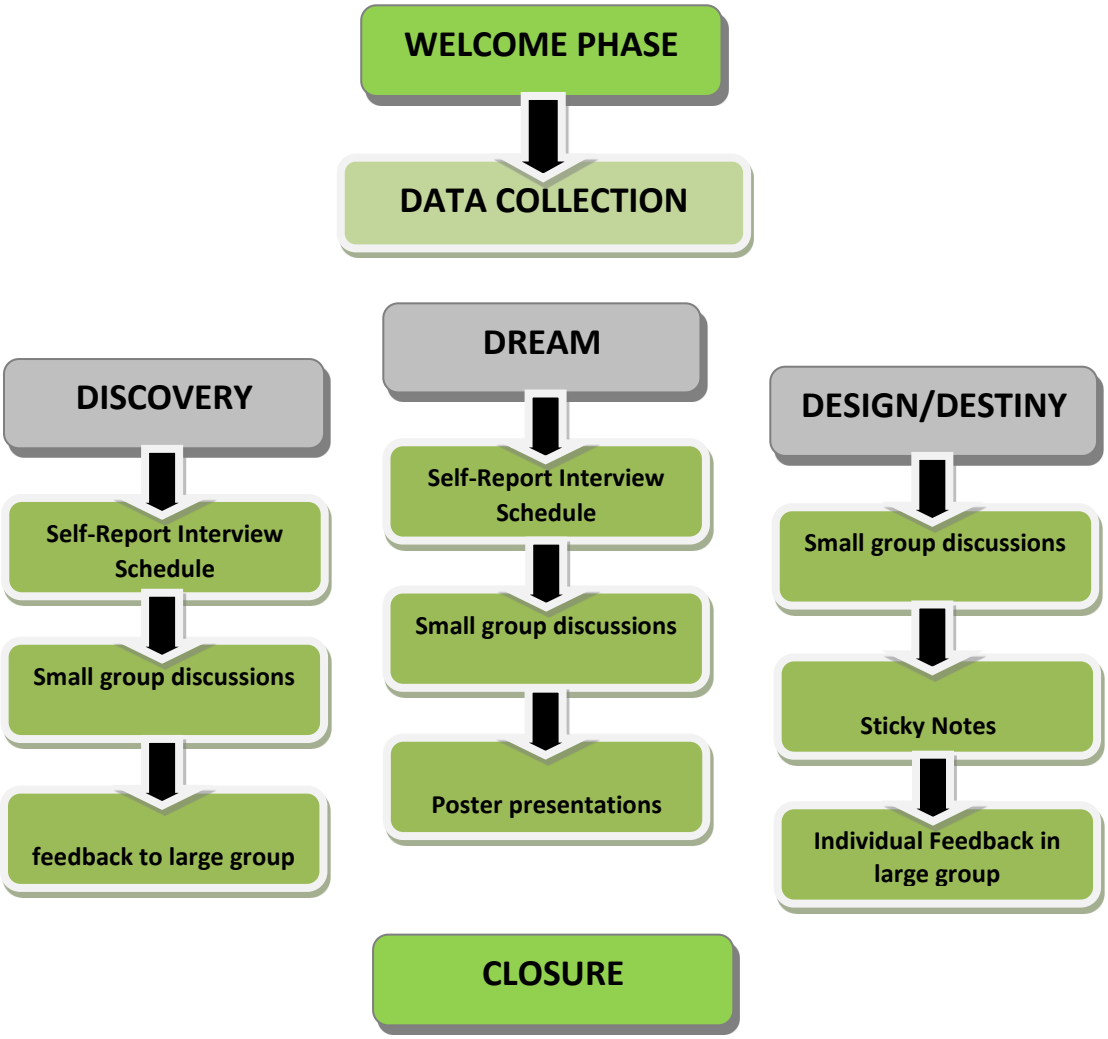

Figure 3.2. Illustration of the data collection process

3.6.4 Phases of the Workshop

3.6.4.1. Welcome Phase

The workshop started with a brief presentation of the overview of the workshop. The researcher briefly introduced AI and clarified the role of participants. Ethical considerations were clarified, and participants were assured of confidentiality. As much as confidentiality was guaranteed outside the workshop, it was difficult to do so within a group setting. Respecting anonymity is vital according to Cooperrider et al.[30] and, therefore, stories and quotes were used annonomously.[30] Participants were then given the opportunity to ask questions if anything was still unclear. Participants completed

printed consent and demographic forms that were made available at registration. The reason for consent forms only being completed at that point was to ensure anonymity, as the researcher would have no record linked to email addresses.

The research team introduced themselves and the facilitator established the ground rules necessary for the session. Some pertinent ground rules were to respect each other, as well as to gain consensus. For other ground rules refer to Appendix E.

In order to create a warm and friendly environment and to set the participants at ease, an 'opening move' was planned.[74] Participants had to select a picture (from the table provided) that represented spirituality to themselves. In a round-robin fashion, participants then introduced themselves, their place of practice, as well as the reason for choosing that particular picture. Thus, the journey of exploring spirituality already began with this exercise. This activity set the tone for the discussion to follow and put participants at ease. Cooperrider et al.[30] reiterates that the facilitator should welcome each participant as though he or she is special. The facilitator adopted a humble stance and took time to listen and value the participants to create an affirmative spirit.[30] Thereafter, participants returned to their seats at their table of preference, with each of the five tables accommodating four to five participants.

3.6.4.2. Data Collection Phase

Discovery Phase (appreciating the best of what is)

Discovery entails conducting interviews, sharing stories and identifying themes that are shared amongst the many high-point experiences and stories.[30] The essential undertaking of this phase is to appreciate and identify the best of what is. This was achieved by focusing on 'peak times' i.e. successful and effective experiences and seeking to comprehend unique factors that made these experiences successful.[30] A methodological review by Trajkovski et al.[31] reveals that the most prevalent approach in this phase is to utilise stories emphasising experienced successes or high points.[31] In this study, these stories were captured by participants when reflecting on question 1 and 2 in the self-report appreciative interview schedule, as seen in Appendix C. The objective here was to explore and describe spirituality in OT practice through the

generation of experienced successes in spirituality. This was facilitated by the first two questions on the self-report interview schedule.[85]

Question 1: Share your ideas about what spirituality in occupational therapy practice is.

Participants seated at each respective table answered the first question individually i.e. participants were asked to write down their ideas about what spirituality in OT practice is and share this in their small group

An extra answer sheet with the above question was placed at each table. The group nominated a scribe at each respective table. Participants then engaged in open discussion in their small group and the scribe wrote down notes of what was shared. If points were similar, the scribe indicated this by a tick for each repetition. This enabled participants to discover their own stories, and to develop a broad understanding of each other's worldview.[31]

Participants were further instructed to actively engage in conversation with other participants while sharing their experiences.[31,75,86] Occupational therapists are knowledgeable and well-trained with respect to communication techniques.[17,22,34,87] It was imperative that participants listened attentively and maintained a caring and affirmative spirit.[30,75] Approximately 20 minutes were allowed for these discussions. Sharing stories has been reported to be an effective approach in gathering rich qualitative data.[31]

According to Cooperrider et al.[30] it was now necessary to make sense of the data. Sense-making is defined as "an umbrella term used to explain how people make sense of conversations and events based on their experiences of the world". [30] Sense-making is discovering the themes and patterns within the discussions. Diverse approaches have been utilised for this step, such as data being reduced and displayed in tables, diagrams, charts, pictures, storybooks and newsletters. There is no established right way to this, however, it is important to find creative ways of listening, understanding and organising the multiple viewpoints.[30]

Emergent common themes from these small groups were recorded on coloured strips of paper to form the themes identified by the group.[30] The facilitator then requested participants to gather centrally with their various coloured strips of paper and discussed the various emerging themes. This emanated into the creation of flow using the various

strips of paper. Data analysis occurred simultaneously with data collection.[30,75,76,86] Thus, the key activities of the discovery phase was encapsulated into collecting the data and identifying the themes when dialogue was initiated in the AI process.[30]

The second question on the self-report interview flowed into the Dream phase and will be discussed later. It is important to take note that the 4D cycle is not fixed and prescriptive, but it maps the journey of engagement amongst participants.[9] Participants had a 15–20 min tea-break and bathroom break. During this time, the research team organised all themes as was agreed by the group of participants.

Dream Phase (what might be)

The Dream phase of data collection entailed addressing the second objective of exploring the wishes of participants regarding addressing spirituality in OT. Here, focus was on what might be, while envisioning the future, and participants visualised what they want spirituality in practice to be like.[31]

The ultimate goal of the Dream phase is twofold, firstly to create energy and enthusiasm and a tool that develops the dream through dialogue. The Dream dialogue was established with questions encompassing wishes, hopes and dreams. The second goal was to allow participants to identify common themes. This phase does not emphasise one common theme or one best idea, but, instead, participants identify broad themes or life-giving forces that underwrite success in the topic at hand.[30]

Thus, in order to accomplish the above goals in this study, the process was facilitated in various ways. On returning from their tea break and returning to their seats, the facilitator asked participants to collectively explore and brainstorm in a single big group discussion what their wishes were with respect to spirituality.[31] To aid this, the facilitator initially presented the group with a possible dream, namely *spirituality in OT.*

This resulted in an active, lively discussion until consensus was reached. The process was facilitated, summarised and recorded on the flip chart, and the discussion also audiotaped. Participants concluded that their overarching dream was as follows: *Spirituality should inform everyday OT practice.*

The participants were then requested to individually reflect on and answer question two and three of the appreciative interview schedule.

Question 2: Describe how you use spirituality in your practice (think about what works well).

Please take note that question two is following from the Discovery phase. The positive energy harnessed in the Discovery phase, as well as question two in the self-report questionnaire, allowed participants to imagine transformed practice, thus eliciting the spirit for question 3.[31]

Question 3: Share your wishes regarding the use of spirituality in everyday practice (think about what we can do more, how we can do better, move towards excellence)

On completion of their individual dreaming reflections (facilitated by question 3), participants were asked to depict their ideas, as reflected upon during the interview schedule, visually on a poster presenting their reality regarding 'what they are doing well' and their wishes 'what they could do better'. The craft materials initially set out at the respective tables were utilised in this activity to aid in this creative process.[30]

According to Cooperrider et al.[30] the "more playful the depictions the better". Time allocated for this was approximately 25 minutes. Hereafter, each small group presented their poster to the entire group. Although each small group had a spokesperson, everyone in the group was included in the presentation. This gave the participants the opportunity to add to the spokesperson's presentation.[30]

After each poster presentation, the bigger group had the opportunity to comment on what they see, feel, hear, and imagine after each poster presentation. This step facilitated creating a collective verbal picture of the envisioned future.[30] Poster presentations, as well as feedback from the rest of the group, were audio recorded.

Destiny and Design Phase (what should be and will be)

The objective for this phase was to develop strategies on how to implement, sustain and address spirituality in daily OT practice.

Question 4: How would we develop strategies with regards to spirituality?

Question 5: What can we improve on now, and how can we sustain and further develop it?

In the Destiny and Design phase of the workshop, participants were asked in their small groups to co-construct strategies on addressing spirituality in practice. Participants also discussed action plans on how the envisioned future might be sustained. Each small group was then presented with sticky notes to develop strategies on how to address spirituality in practice and how they can sustain this. This was depicted on the sticky notes individually and thereafter shared with the entire large group. Each focus group (small group) received different coloured sticky notes. This session was also audiotaped.

3.6.4.3. Closure Phase

Participants shared what they liked most and least about the day, which concluded the workshop. The researcher then wrapped up by summarising the workshop and thanked the participants for their valued input. This phase was also audiotaped.

After completion of the workshop, peer debriefing amongst the research team followed. Reflective notes as well as identified themes were discussed (as mentioned under field notes). The research team reflected on the day and agreed that data saturation was achieved and that it was not necessary to have another workshop.

3.7. DATA MANAGEMENT

All large group feedback sessions, as well as the poster presentation of the workshop, were audiotaped and then transcribed. The narratives of the interview schedules in the Discovery phase and Dream phase were analysed, and, as these were in written format, it was not necessary to transcribe. All self-report interview notes were collected during the workshop for analysis. The digital recording was backed up on computer and played repeatedly to ensure accuracy and clarity of information.[72] The raw data generated is to be stored for 15 years in the OT department at the University of Pretoria.

3.8. DATA ANALYSIS AND INTERPRETATION

The intention of the analysis and interpretation thereof is to make sense of the data.[72] It involves moving deeper into understanding the data through a process of data reduction, data display, conclusion drawing and verification.[83] All qualitative data obtained in this study was analysed by the researcher according to Creswell's steps[28,72], which are:

Step 1 – Organise and prepare the data. Data from the self-report interview narratives of the Discovery and Dream phases were already in written format, therefore transcription was not necessary. However; the researcher manually transcribed the audio-recorded group discussions verbatim.

Step 2 – Read through all the data. This step involves gaining an overall sense of the data and reflecting on its meaning. This relates to general ideas on what participants are saying.

Step 3 – Code the data (either manually or computer e.g. the Atlas-Ti program). Data was coded manually, according to the eight steps of Tesch, as cited by Creswell[72] and were applied in the following ways:

i) All transcriptions were read carefully, thus gaining a sense of the 'whole'. Ideas that came to mind were jotted down in one margin.

ii) The researcher then picked one document, tried to establish the underlying meaning, and wrote her thoughts in the margin of the document.

iii) The researcher repeated step ii) for several other participants. Thereafter, a list of topics was identified. Similar topics were then clustered together and formed into columns, namely major, unique and leftover topics.

iv) The list of topics was abbreviated as codes and the codes were written next to the appropriate segment of the text. The researcher then searched for possible new categories and codes that emerged.

v) The researcher found the most descriptive wording for the topic and translated this into categories. She reduced the total list of topics into themes and categories by grouping topics that related to each other.

vi) A final decision on the abbreviation of each category was made and these codes alphabetised.

vii) The data material was assembled in one place where a preliminary analysis was performed

viii) The existing data was recoded, if found necessary.

Step four – From this coding arose the categories and themes for analysis. Themes emergent during the workshop were recorded as well. In the tradition of AI, these themes were identified by the facilitator and the participants.[30,75]

Step five – Interconnected themes were considered. The final step is an interpretation of the themes. The data was interpreted with reference to the main research question, 'How is spirituality in OT being used?' An independent co-coder confirmed the conclusion reached by the research team that data saturation was achieved. The co-coder is from a medical background, has a Master's degree as well as experience in qualitative research. See Appendix G for confidentiality agreement.

3.9. TRUSTWORTHINESS

Trustworthiness has been addressed by looking at the following four constructs, namely:

3.9.1. Credibility

This refers to confidence in the truth of the data i.e. are the findings consistent with that of reality.[74] It is suggested that the technique of triangulation addresses credibility in a qualitative study.[82] Credibility or authenticity is based on the constructivist assumption that there is no single reality, but rather multiple realities.[83]

Data collection triangulation was accomplished in this study by using multiple data sources i.e. using OT educators and clinicians, as well as the use of multiple quotes to corroborate the emerging theme. Method triangulation was included by the use of multiple methods to address the research problem. In this study, narratives from self-report interviews, discussion groups, reflective notes as well as field notes have been

utilised. Member checking has also been used to enhance credibility. During the AI workshop, the participants and the facilitator identified themes.[82]

Peer debriefing has also been used to enhance credibility. As mentioned earlier, the researcher and supervisors together with the independent facilitator reflected on themes identified, as well as the research processes during and after the workshop.[72-74,82]

3.9.2. Transferability

This essentially refers to the generalisability of the data. Here the question arises whether the findings of this study can be transferred to other regions in South Africa. The context of this study is clearly described and detailed. Therefore, it allows other researchers to identify the applicability of the data obtained in this study to other similar contexts. De Vos[74], however, asserts that a research study with multiple informants as well as using more than one data gathering method can greatly strengthen the studies' usefulness for other settings.[73,74]

3.9.3. Dependability

Dependability is the constancy of data over time and in different conditions. To establish dependability, the research process also needs to be logical, well-documented and audited. However, dependability in a qualitative study is difficult to achieve as the social world (i.e. the understanding of spirituality) is constantly being constructed. Therefore, the concept of replication of this study will be problematic. However, the researcher has found that dependability was achieved through following a well-documented audited research plan and by maintaining analysis transparency.[73]

3.9.4. Confirmability

It refers to the neutrality of the data and relates to the concept of objectivity. The result should be that there should be confirmability or agreement on the meaning of data. Peer review (via peer debriefing) as well as the independent co-coder in this study have addressed this aspect of confirmability.[73,74]

3.10. ETHICAL CONSIDERATIONS

Ethical clearance for this study was obtained from the Faculty of Health Sciences Research Ethics Committee (240/2017). Refer to Appendix F.

3.10.1. Autonomy

Autonomy refers to participants being free to make their own choices. Respect has been shown for participants' dreams and their proposed plans and goals during the data collection phase. The decision to attend the workshop was entirely voluntary. Participants signed an informed consent form prior to the commencement of the workshop. Participants were also given the option to withdraw at any time they deem it necessary. Autonomy was further facilitated by the principle of free choice in AI.[73,74]

3.10.2. Beneficence

The processes of AI should result in positive organisational change, therefore, benefiting participants as well as those that they provide a service to.[73,74]

3.10.3. Non-maleficence

Non-maleficence refers to 'do no harm'. If at any stage during data collection a participant felt vulnerable, an independent counsellor was available for counselling or debriefing. However, working from an AI perspective, all research intervention was positively framed[73,74] and at no stage during the data collection of the study did such a need arise.

3.10.4. Confidentiality

As it is not possible to link the data to consent forms, participants will remain anonymous. Confidentiality of transcripts was maintained, as transcripts do not identify participants. As much as confidentiality was guaranteed outside of the workshop, it was difficult to guarantee within the group. The data collection method facilitated interaction and participants were made aware of this before signing consent. Confidentiality

agreements with the independent co-coder was signed (Appendix G) to maintain confidentiality.[73,74]

3.10.5. Compensation

No compensation was given to any participant other than the refreshments provided during the workshop and the CPD points allocated to each participant.

3.11. CONCLUSION

This chapter described the research design and the context of the research. The application of the AI approach in this study has been discussed in detail. Data analysis, trustworthiness and ethical considerations were described. Chapter 4 details the findings of this study.

CHAPTER 4: RESULTS

4.1. INTRODUCTION

Chapter 3 discussed the methodology of this study, and this chapter presents the findings thereof. The results has been conveyed by, firstly, discussing the demographic details of participants, and, secondly, providing an overview of themes, categories and subcategories, which are substantiated by direct quotes from participants.

4.2. DEMOGRAPHIC DETAIL

The demographic details of the participants in this study are provided in the Table 4.1.

Table 4.1. Demographic Profile of Participants

Demographic Information	Gender	Age	Full day/ Part-time	Educator/ Clinician	Experience
Frequency Participants	Female = 21 Male = 3	23-28yrs=10 33-38yrs=6 40-45yrs=3 52-65yrs=5	Full day=19 Part-time=5	Clinicians=16 Educators=6 Educators and Clinicians=2	0-1yrs=3 1-10yrs=12 11-20yrs=4 21-30yrs=2 30yrs+++=3

A total of 24 participants attended the workshop, of which 21 were female and three male. The average age of participants ranged from 28 and 40 years of age. Most participants were employed full time and, on average, employed for a period of between 1 to 20 years.

The majority of the participants were clinicians (n=16), however, educators were also fairly represented (n=6). Participants were from various fields of practice, namely paediatric, psychiatry, physical, vocational rehabilitation and community.

4.3. OVERVIEW OF THE ANALYSIS PROCESS

This research aimed to explore how spirituality is being addressed in occupational therapy (OT) practice by clinicians and educators. To accomplish this, a data-gathering workshop based on Appreciative Inquiry (AI) principles was conducted.[9,30,31,75,84]

The workshop consisted of self-report interview schedules, as well as small group discussions (focus group inquiry),[30,31,84] which facilitated the respective phases of the AI cycle (Discovery, Dream, Design and Destiny). The Design and Destiny phases have been combined in this study and, thus, the findings are presented according to three phases. The results will be presented according to the objectives and questions relevant to each phase. Refer to Table 4.2. for a summary of the phases, questions, and relevant themes of each phase.

Table 4.2. Questions and emerging themes identified for each of the three phases

Phase	Questions	Themes
Discovery	Share your ideas about what spirituality in OT practice is.	Understanding spirituality as a construct
	Describe how you use spirituality in your practice (think about what works well)	Client-centred practice
Dream	Share your wishes regarding the use of spirituality in everyday practice (think about what we can do more, how we can do better, move towards excellence)	Envisioned practice enablers of spirituality
Design and Destiny	How would we develop strategies with regards to spirituality?	Client-centred practice
	What can we improve on now, how we can sustain and further develop it?	Nurturing spirituality within therapist

After identification of the themes for each phase, the categories and subcategories for each theme will be explained. These categories and subcategories are reflected based on the voices and experiences of the participants, supported by direct quotations of participants, which are reflected in italics.

4.4. ANALYSIS OF THE DISCOVERY PHASE (APPRECIATING THE BEST OF WHAT IS)

This phase aimed to explore and describe spirituality in OT practice through the generation of experienced successes in spirituality. Two questions were used to facilitate discussions in the Discovery phase.

Question 1: Share your ideas about what spirituality in OT practice is.

The categories and subcategories for theme 1 in the first phase are reflected in Table 4.3. These categories and subcategories emerged during the workshop and in the tradition of AI were identified by the facilitator and the participants.[30,75]

Table 4.3. Categories and subcategories for theme 1 from phase one

Theme 1	Categories	Subcategories
Understanding spirituality as a construct	a) Meaning of life	• Motivation
		• Hope
	b) Connectedness	• Individual
		• Community

4.4.1. Theme 1: Understanding spirituality as a construct

Understanding spirituality as a construct refers to how participants understood spirituality in OT practice. Participants concurred that spirituality is central to OT practice – it cannot be ignored. It is a truth and has a spirit component, thus being intangible. Participants stated that it influences mind and body and hence guides behaviour. Participants also expressed that it is a concept beyond religion and culture and not just religion and culture. Participants identified that spirituality is expressed through engagement in occupation, with occupation being a foundational tenet to OT practice.

This is expressed in the following quote:

"It's connecting on a deeper level with the patient, included in spirituality is religion but it is not the only aspect, how we perceive and interact with the world is influenced by spirituality… We express our spiritual being through occupation…"

Participants' core ideas of spirituality in OT practice was related to 'greater or deeper' meaning in one's life as well as being connected.

4.4.1.1. Category a) Meaning of life

Meaning was understood to be the purpose and understanding of life leading to the way you give meaning to an experience and its circumstances. This deeper meaning could also get you through adversity. As one participant stated,

"*it is the meaning I give to myself, my world and others."*

Other participants added,

- *"Spirituality is that which roots you and gives you a sense of meaning"*
- *"that which gives you the ability to live through difficult circumstances"*

According to participants, meaning of life correlated with subcategories of motivation and hope in one's circumstances.

- <u>Motivation</u>

According to participants, motivation is a driving force related to "doing, being and becoming". Motivation allows for "growth" and can be expressed through a fluid "journey", as it is a growth process that continues.

- *"Part of volition, it what drives you"*
- *"A means to which to motivate others."*

- <u>Hope</u>

Participants related Hope to *"healing", "strengthens", "peace", "awareness", "in the moment", "inner peace", "nourishing", "sustaining", "enrichment", and "freedom"*. Participants reiterated that hope gives you meaning, strength and awareness in the

moment. Hope can be healing in that it gives you inner peace and harmony, facilitating freedom. This culminates in the nourishment and the sustenance and enrichment of the soul.

4.4.1.2. Category b) Connectedness

Another core idea that was pivotal in understanding spirituality from the perspective of the participants was that of connectedness. Spirituality was also the basis of connecting with the client. Connectedness was understood by participants to be linked to individuals (the client) as well as being linked to their communities.

- *"It's connecting on a deeper level with the patient*"
- *"A way to connect with patients"*
- *"A basis to connect on"*

Connectedness has two subcategories, namely that of the individual and/or community.

- <u>Individual</u>

Here participants felt that spirituality in OT practice can be "*being connected on a deeper level with patients."* Participants stated that every client has their own identity and is unique. Respecting diversity and creating a judgment-free environment allowed for emotional expression. Spirituality was also expressed as the beliefs an individual hold, and how this influences their behaviour and life choices. It also could refer to the client's intimate relationship with their Creator.

- *"Spirituality is about the individual's beliefs and the individual's identity."*
- *"Spirituality is the intimacy and relationship with the Creator"*
- *"Unique to each person"*
- *"Acknowledging the difference of people"*

- <u>Community</u>

Individuals are connected and interlinked to their communities. Within each community there is a certain culture with its specific beliefs and values. Participants suggested

that, at times, this could also include religious beliefs. This association of the individual in the community creates a sense of belonging and consequently safety.

- *"There is a connection between the individual, and the community, you the individual is connected to the community"*
- *"…connected to the community…"*

Participants were in agreement that it is imperative when considering spirituality that the client's connection with their community is deliberated.

Question 2: Describe how you use spirituality in your practice (think about what works well)

This question provided the opportunity for participants to describe their highpoints/peaks with regards to current use of spirituality. In AI these experienced successes act as a catalyst for positive change. The dialogue facilitated discussion that was energising and self-realising.[79] The categories and subcategories that were identified for theme 2 of phase one are reflected in Table 4.4. The tables for each of the themes are represented as a colour-coded representation of themes that repeat themselves in categories and subcategories across all three phases.

Table 4.4. Categories and subcategories for theme 2 from phase one.

Theme 2	Categories	Subcategories
Client-centred Practice/ Approach	a) Spirituality as expressed through the **therapeutic relationship** to the client	• Acknowledge and accept as a spiritual being and their differences/uniqueness
		• Open and non-judgemental to cultures and religion
		• Respect the client's beliefs and values
		• Listen and understand
	b) Spirituality as expressed through **beneficence** to the client	• Instils hope
		• Motivate patients
		• Gives meaning
	c) Spirituality as expressed through **therapeutic intervention**	• Client centred /individualistic intervention
		• Meaningful
		• Creation of a safe space
		• Cultural and God centred intervention

4.4.2. Theme 2: Client-centred practice

Client-centred practice/approach can, very broadly, be defined as embracing a philosophy for respect and partnership with people receiving services.[1,70] When describing spirituality in OT practice through the generation of experienced successes in spirituality, participants highlighted client-centred practice or approaches as being vital to their current OT practice. This finding is supported by the following quotes:

- *"I understand as much about the patient's narratives, beliefs, values and what is meaningful to them so that I am able to invigorate/harness the spirit which better leads to participation and engagement."*
- *"Being client-centred"*
- *"We said that we as OTs supposed [sic] to be client centred and we said that we work client-centred"*

This theme further pertained to the following categories of spirituality as expressed through a) the therapeutic relationship, b) beneficence to the client, and c) therapeutic intervention.

4.4.2.1. Category a) Spirituality as expressed through the therapeutic relationship

The therapeutic relationship refers to the relationship between a healthcare professional and a client (or patient). It is a way in which the therapist and client engage with each other in the hope to bring about beneficial change to the client.[1]

Participants articulated that the therapeutic relationship with their clients was vital when wanting to facilitate spirituality in their current practice successes. The importance of the therapeutic relationship with the client is encapsulated in the following quotes:

- *"We are trying to work towards inner peace and harmony as well as building a life time relationship with your clients"*
- *"I use spiritualty as a common thread to build rapport"*

The category of spirituality as expressed through the therapeutic relationship was made up of the following four subcategories, acknowledgement, being open and non-

judgemental to cultures and religion, respecting clients' beliefs and values, and listening and understanding.

- Acknowledgement

Participants echoed that they work with an array of diverse cultures and religions, and that by acknowledging and accepting their clients as spiritual beings, irrespective of their different beliefs, they facilitated current successful integration of spirituality. Participants also stated that it is important to acknowledge the uniqueness of clients. Participants' successes were also attributed to acknowledging the significance of spirituality in OT.

- *"Acknowledge each client as a spiritual being…incorporate aspects of spirituality in handling".*
- *"By acknowledging the differences of my patient based on their beliefs and/or religion".*
- *"Acknowledge the uniqueness of the individual's beliefs and goals and dreams"*
- *"To accept them and appreciate them unconditionally."*
- *"…..what we are currently doing well in OT is…… we acknowledge the importance of spirituality in OT"*

- Open and non-judgemental to cultures and religion

Participants reiterated that in their current successes with respect to spirituality, one needs to refrain from making judgements on clients' narratives.

- *"My current successes are related to being open and non-judgement [sic] to the client"*
- *"Openness/comfortable to talk about spirituality with your patients (right timing)"*
- *"Openness to cultures and religion"*

- Respect the clients beliefs and values

Respect refers to demonstrating regard for the person's feelings, wishes, views and opinions.[22] Participants expressed respect as another subcategory enabling their current successes in spirituality. Participants articulated that respecting the client

referred to respecting them as an individual with their specific qualities and attributes as well as respecting them within their context (community).

- *"Respecting patient's identity".*
- *"To respect the client's beliefs and values".*
- *"My successes are related to that people/clients spirituality and spiritual experience are differenced".*

- Listen and understand

In the context of this study, participants referred to listening as the process of being attentive and being able to establish what is said and not said. Participants' apparent view was that listening attentively has facilitated a better understanding of the client's spirituality.

- *"Listen to what gives them inner strength."*
- *"We can listen better; ask the right questions so that we can get more information about our clients so that we know where they are spiritually and how does it help them so that we can empower them to use it."*
- *"To be in tune with your patient"*

4.2.2.2. Category b) Spirituality as expressed through beneficence to the client

When describing their current successes of spirituality in their practice, many participants expressed the value its implementation had on their clients. Some participants also expressed spirituality to be 'nourishment' for the soul. This category was conveyed through the subcategories of instilling hope, motivating patients/clients, and giving meaning. .

- Instil hope

'Hope' was articulated as aspirations in their clients. Participants also voiced that this inner hope allowed clients in difficult circumstances to move towards healing and better handling of their situation. Instilling hope in clients was twofold: firstly, participants were of the understanding that by bringing hope to the situation they are addressing

spirituality and, secondly, participants felt that engaging in spiritual activities facilitated hope.

- *"I use spirituality to …instil hope in my clients."*
- *"I have seen it truly lift up and encourage clients who have had their lives destroyed by injury or illness."*
- *"By sharing spiritual moment this leads to inner hope which moves towards healing and a cure."*
- *"And then also with the attitude that we often bring into therapy by bringing hope and strength and connecting people in their community"*

- Motivate patients/clients

Participants also used spirituality as a vehicle to enhance the client's motivation. Here participants voiced this as intrinsic motivation, which refers to behaviour that is determined by internal needs and/or rewards. Participants felt that this was crucial to ensure compliance and adhere to treatment.

- *"Motivate patients to harness positive energy/feelings."*
- *"I use spirituality to motivate and instil hope in my clients."*
- *"We build on the core functioning of spirituality (motivate; hope; connectedness; bring meaning of life)"*

As mentioned previously, participants expressed motivation and hope as a core constructs in understanding spirituality.

- Gives Meaning

Spirituality gives meaning. Meaning was understood by participants as the client making sense of their current situation. It referred to how the clients define and understand their current situation**.**

- *"It give [sic] them purpose and stability when other areas of their lives are broken."*

- *"….we as OTs was supposed to be client-centred...that if we work client-centred, we would consider the beliefs, purpose and meaning, their aspirations, …what gives them meaning and purpose."*
- *"They added survival and you cannot grow if you are focused on that only, that you need to dig deeper into your wellbeing and your spirit to actually be able to come out of that survival mode and live again."*

4.2.2.3. Category c): Spirituality as expressed through therapeutic intervention

Participants were in agreement that current OT practices have the potential to be spiritual. Participants stated that they "sort of" address spirituality through OT but would like to implement it "much better". Participants were of the opinion that occupational therapists already incorporate a lot of spirituality in the work that they do.

"Spirituality is already a core in our treatments, spirituality is the roots from which we work"

This category will now be discussed according to its four subcategories: client-centred/individualistic intervention, meaningful activities/occupations, creation of a safe space, and cultural- and God-centred interventions.

- Client-centred/Individualistic intervention

Here clinicians and educators reiterated that current successes in spirituality can be attributed to focusing on the client as an individual. Participants were also of the view that they should not see clients through their own narrow worldview. It is imperative to move beyond a pure 'medical model' and to incorporate a bio-psycho-social model.

This was encapsulated in the following quote:

"I see the person, it's a good reminder to be client-centred because we so easily want to teach the patient what we want them to be able to know or do before they go home but actually we need to be more client-centred so it's a good reminder."

Other quotes to substantiate the feelings of participants regarding this subcategory include:

- *"Promotes self-choice. Promotes belief in own strengths"*
- *"Assess patient holistically, not just a tick-off list."*
- *"Allowing students to express their spirituality in class."*
- *"Allowing freedom to express who you are (your unique id)."*
- *"By seeing each patient as an individual drawing their meaning and understanding of life from different environments."*

It is apparent from the above that participants echoed words like self-choice, client needs, holistic, and unique identity as being inherent to their current successes in spirituality.

- Meaningful activities/occupations

Here participants conveyed that engaging clients in meaningful occupations and activities is a way of facilitating their successes with respect to spirituality. Participants were also of the opinion that utilising spiritual activities could facilitate meaning for their client's intervention.

- *"By selecting activities that are meaningful to our clients"*
- *"Incorporate aspects of spirituality in handling and treatment of clients: e.g. worth, hope uniqueness, belonging/meaning"*
- *"Treatment programme that is meaningful and purposeful to the patient"*
- *"OT already incorporates a lot of spirituality just in the work that we do. So that by choosing and enabling people to do activities that are meaningful to them err… sort of like being a mum, or whatever gives that person meaning, that's helping to facilitate … … spirituality"*

- Creation of a 'safe space'

Participants did not refer to this in literal terms, however they did feel a necessity to mention that clients should feel that they are in a space with their practitioners that is free from bias, conflict and criticism. By creating this safe space for clients, it allows them the opportunity to be who they really are, facilitating the integration of spirituality.

- *"Create a safe space for the client to be."*

- *"Allow for the creation of a safe space where discussion through stages of recovery can occur."*
- *"And actually you are trying to create a safe space for him and giving him individuality, because you are not treating him as an outsider."*
- *"We already giving them a safe place to be and a space to grow, we discover"*

- Cultural- and God-centred intervention

Culture is defined as "*ideas, customs, and social behaviour of a particular people or society*."[1] God can be understood to be the creator and ruler of the universe or Supreme Being. Participants shared that the use of activities based on God and culture enhanced current spiritual intervention.

- *"Put God in centre of all situations."*
- *"Encourage participation in activities that nourish their spirituality e.g. Bible study/devotional as a way to time-out if anxious."*
- *"Diversity to their cultural beliefs-adapting accordingly."*
- *"'We have to accept their ways of life coz [sic] we are dealing with different people and different cultures and their religions as well and in that whole system they (referring to the clients) have what makes their spirit bloom so we need to look at that"*

4.5. ANALYSIS OF THE DREAM PHASE (WHAT MIGHT BE)

The Discovery phase explored the best of what is and participants discussed and identified key factors that contributed to their previous successes in spirituality. This phase aimed to explore the aspirations and wishes of OT clinicians and educators regarding spirituality in OT practice (what might be?). The following question was asked of participants during the focus group inquiry:

Question 3: Share your wishes regarding the use of spirituality in everyday practice (think about what we can do more, how we can do better, move towards excellence)

Categories and subcategories were identified for theme 3 in phase two. These are reflected in Table 4.5.

4.5.1. Theme 3: Envisioned practice enablers of spirituality

When exploring the aspirations of participants regarding the use of spirituality in practice, the theme of 'envisioned practice enablers of spirituality' emerged. This theme encompasses all that participants wished for to enable spirituality in practice and to move towards excellence. This also included what participants could do more and how they could do better. With this being said, there has been a repetition of two categories, namely:

- Maintaining the therapeutic relationship
- Spirituality as expressed through therapeutic intervention

New categories that emerged were:

- Development of spiritual tools
- More consultation time
- Awareness and increased education on the understanding of spirituality

As the first two categories of maintaining the therapeutic relationship and therapeutic intervention were discussed in detail earlier and no new information emerged, the researcher will not discuss these again, and will only discuss the new emerging categories. Participants expressed these subcategories similar to the Discovery phase, however, participants expressed them as aspects they wished they could implement more and perform better in. Here one should take cognisance that, in AI, the Discovery phase is taken as the building blocks for the Dream phase.

Table 4.5. Categories and subcategories for theme 3 from phase two

Theme 3	Categories	Subcategories
Envisioned practice enablers of spirituality	a) Spirituality as expressed through the **therapeutic relationship** with the client	• Not prejudiced and non-judgemental
		• Appreciate and acknowledge
		• Respect
		• Listen better and sensitive
	b) Spirituality as expressed through t**herapeutic intervention**	• Incorporated into activity selection and assessment
	c) Development of Spirituality tool	• Spirituality guide
	d) Consultation time	• Time to address
		• Time for having introspection and reflection.
	e) Awareness and increased education on the understanding of spirituality	• Therapist's spirituality
		• Client's spirituality

4.5.1.1. Category c) Development of a Spirituality Tool

Participants expressed the need for the development of a spirituality tool. As spirituality is expressed as an intangible component of the client's being, participants concurred on the importance of developing such a tool.

- Spirituality Guide

A tool to assess as well as to be used in intervention was the echoed wish of participants. According to one participant, this tool could be a practical vehicle to incorporate spirituality. Participants were of the opinion that a possible tool to be utilised is the Vona du Toit Model of Creative Ability (VdTMoCA).

- *"To have a step-by-step guide on screening a patient's spiritual wellness and be able to detect and help patients uplift spirituality. Being able to tap into the intangible or unseen being of the patient and facilitate healing directed to physical wellness"*
- *"What we also need is the right tools. There's the big question mark, we need to decide which the right tools are and, building blocks, but we should not lose focus on spirituality while we are using our activities to treat our clients so that we can have a happy and healthy individual"*
- *"I see or think tools …. It's in the middle and it's like circle, so it's like very important in this."*
- *"And then we also spoke about the tools and what we can use to embrace spirituality and then we went back to creative ability because we said the client has, err, potential and we want to use the correct activities and challenge and everything to have them grow to their potential (these are leaves growing)."*

4.5.1.2. Category d) Consultation time

Another envisioned dream articulated by participants was that of additional consultation time. Time was expressed as invaluable in the context of the participant practice. Clarity of this category was embedded in the following two subcategories:

- Time to address

Time is essential in establishing an authentic understanding of client's spirituality, their spiritual needs, including their spiritual activities and occupations. However, according to participants, this is apparently hindered by participants' busy schedules and extremely high workload.

Additional time with clients was envisaged by participants to be a possible facilitator to integrate spirituality in practice. Participants echoed the need for additional time to integrate spirituality throughout the entire OT process.

- *"Take time to truly understand what the patient defines as spirituality."*
- *"Time to establish client's needs for treatment with good understanding of his/her spirituality, dreams, values, hopes."*
- *"Need more time with patients- difficult in setting (government- so many patients). Put patients need first."*
- *"But there are barriers which we face…. our schedules and our time constraints…"*

- Time for having introspection and reflection

Introspection and reflection were articulated by participants to be having time for self-analysis, deliberation and contemplation in practice.

These deep thoughts and considerations aid in counteracting the practitioner's narrow worldviews and consequently guides the use of spirituality. Time for having introspection and reflection was also articulated as "*the client having time to reflect and introspect so that the therapist can guarantee the spiritual orientation of client's intervention."*

- *"Allow for more introspection and reflection."*
- *"But we really would like to increase awareness of spirituality and focus on it more intentionally so that looking at it, almost having it as a measurable goal, not that it is. But thinking of it in that way where it becomes a focus… so asking people what spirituality means to them and using it… also doing a lot more introspection and reflection during therapy."*

- *"I am touched by the introspection and reflection because for me that's what we missing. That's why we are not aware, and that we actually embody it so for me the therapists or the practitioners, introspection and reflection that what will guide us into using spirituality."*

4.5.1.3. Category e) Awareness and increased education on the understanding of spirituality

The need for more awareness and increased education was expressed strongly by participants. This was expressed in two different ways: namely the therapist's spirituality and the client's spirituality.

- Therapist's spirituality

Participants felt the need to journey into their own spirituality and become more aware of their own spirituality. This was expressed through strong empowered verbalisations and phrases such as "*your own portrayal of your spirit; focus on finding self in your journey; open the spirituality inside of us."*

Addressing the inherent spirituality of the therapist was seen as a means of preventing burnout amongst practitioners. The need to raise awareness of the importance of spirituality amongst therapist was also seen as essential.

- *"Be aware of your own portrayal of your spirit beliefs and values. "*
- *"Focus on finding self in your journey of spirituality."*
- *"I would appreciate sensitivity/awareness training in this matter. It is important for us to work past our own "spiritual hang-ups" and prejudices before we can effectively listen and share with clients about spirituality. We are good at treating and using what we can see, but the spiritual is a resource we still need to understand so we can use it to a client's benefit."*
- *"Then we all have spirituality inside of us, but we need to open it and make it…give the client the ability to express their own spirituality as well."*
- *"...but we tend to not look at our own spirituality in the process and that's why we get burn out and all those other things, because we as spiritual beings also need to be taken care of in the process and sometimes that what we neglect."*

- *"Create more awareness amongst therapists. Enquire more about the patient's spirituality."*

- Client's Spirituality

Another wish of participants was that of increased education and awareness of clients' spirituality, as this awareness was expressed as nourishment of the client's soul. By addressing this need participants felt they could hone into the spiritual needs of the client better and ultimately bring about growth and healing.

One participant also expressed the need to have additional training in this aspect of spirituality. Thus, facilitating working past therapists' *"spiritual hang-ups and prejudices."*

- *"Be aware of different ways people celebrate their spirituality."*
- *"Discuss what it means to each and every one of them."*
- *"Discuss what it means to each and every one of them."*
- *"We need to be more aware and hone into the client's spirituality in order to see growth and healing and wellness."*
- *"Developing our understanding of spiritual health and well-being. Developing our understanding of the links between spiritual and occupational health. Improve our understanding of spirituality as a mean and end within intervention."*
- *"But we really would like to increase awareness of spirituality and focus on it more intentionally so that looking at it, almost having it as a measurable goal, not that it is."*
- *"We say that it is a nourishment for the soul and you need to be able to walk in some-one shoes to be able to be more aware of how they celebrate their own spiritualty but also more aware of what their spiritual well-being is like."*

4.6. ANALYSIS OF THE DESIGN AND DESTINY PHASE (WHAT SHOULD BE AND WILL BE)

This phase aimed to develop strategies on how to implement, sustain and address spirituality in daily OT practice. The facilitating questions for the group discussion in the Design and Destiny phase were as follows:

Question 4: How would we develop strategies with respect to spirituality?

Question 5: What can we improve on now, how will we sustain and further develop it?

Categories and subcategories identified for themes 4 and 5 of phase three are reflected in Table 4.6.

Table 4.6. Categories and subcategories for theme 4 and 5 from phase three.

Themes 4 and 5	Categories	Sub-Categories
Client-centred Practice	a) Spirituality as expressed through the **therapeutic relationship**	• Respect
		• Listen
		• Acceptance
	b) Spirituality as expressed through **therapeutic intervention**	• Should inform intervention principles
		• Use of creative ability
Nurturing spirituality within the therapist	a) Reflection	• Journaling
		• Discussions
		• Creating time
	b) Awareness and increased education on spirituality	• Therapist's spirituality
		• Education on client's spirituality
		• Understanding the concept in South Africa

4.6.1. Theme 4: Client-Centred Practice

The theme of client-centred practice was, once more, deduced from the two categories, namely spirituality as expressed through the therapeutic relationship and spirituality as expressed through therapeutic intervention.

4.6.1.1. Category a) Spirituality as expressed through the therapeutic relationship

Subcategories of respect, listening/attending, and acceptance re-emerged. These subcategories were now identified by participants as significant factors for bringing a positive change in spirituality. These were definitely skills that participants felt they could and would improve on. Participants expressed listening to be that of 'spiritual listening', implying listening without any internal noise or filters. Internal noise could be subdued by thoughtful attention and consideration.

4.6.1.2. Category b) Spirituality as expressed through therapeutic intervention

Participants were of the opinion that activities included in practice may now be selected with the client's spiritual orientation in mind. This could be facilitated by conversing with clients as to what gives them hope and allowing them time for reflection. The VdTMoCA also re-emerged as a context for addressing the client's spirituality.

4.6.2. Theme 5: Nurturing spirituality within the therapist

Participants also expressed that nurturing their own spirituality is imperative to developing strategies on how to implement, sustain and address spirituality in daily OT practice. This theme was derived from the following two categories, namely reflection and awareness and increased education on spirituality.

4.6.2.1. Category a) Reflection

Reflection was identified in this study as pertinent to sustain and further develop participant's ability to address spirituality. This was expressed in the following three subcategories of journaling, discussions, and creating time for reflection.

- Journaling

Participants were of the opinion that keeping a reflective journal on spirituality would enrich their development of spirituality. Reflections should also be shared weekly to sustain further development.

- *"so I went full blown OT and I said I want to introduce like a reflective journal, that can be written in about spirituality, and shared briefly maybe weekly or so and …then I thought something simple is to make others aware of religious holidays and that allows a space for, err… discussion which can lead to spirituality and then for me personally to engage with others, who I feel I can engage about spirituality with, so be bold to talk about it."*

- Discussions

Participants shared that the practice of conversing about spirituality and exchanging ideas would also facilitate, sustain and further develop their practice of spirituality. Simple and innovative ideas emerged around this aspect. Participants were of the opinion that when various religious holidays are celebrated, this should be communicated as it can bring about awareness. Dialogue with peers around the topic of spirituality was another idea. Sharing thoughts about spirituality with colleagues at practice placements during regular time slots was also identified as a way to develop spirituality.

- *"...I thought something simple is to make others aware of religious holidays and that allows a space for … discussion which can lead to spirituality…"*
- *"…explore spirituality through discussion or having a peer to talk to."*
- *"….to create regular time slots where colleagues are working...I work in a bigger OT setting… can actually reflect on that in a structured way."*

- Creating time

Participants felt that they will need to create time on a regular basis to reflect. This entailed allowing the client to reflect on their own spirituality, as well as having time for the therapists' themselves to reflect on their own spirituality.

- *"And to create regular time slots where colleagues are working…….I work in a bigger OT setting…… can actually reflect on that in a structured way."*
- *"To do daily reflections and introspections with your patient on their journey and then also to reflect on your own spirituality and be aware not to influence or try and change theirs."*

4.6.2.2. Category b) Awareness and increased education of spirituality

Yet again, the category of education and awareness of spirituality emerged. In order to foster the development of spirituality in practice, participants articulated that increased education would allow for implementation of spirituality. This was expressed in the following subcategories:

- Therapists spirituality
- Education on client's spirituality
- Understanding the concept in South Africa

In the Dream phase, the therapist's spirituality and client's spirituality were expressed as a wish, and here participants echoed it as a strategy to enhance spirituality.

- <u>Therapist spirituality</u>

Participants stated that they will feed and enrich their own spirituality. This would be accomplished through various strategies, such as by exploring their own spirituality and creating memories, by reading on their spirituality, spiritual self-empowerment through enquiry, and attaining a comfort level with their own spiritual self.

- *"To feed and enrich my own spirituality"*
- *"The first one create memories about your spirituality ….explore and be in contact with your spirituality."*
- *"The last one is to take care of yourself spiritually then you can take care of others or patients"*
- *"… is to get to know my own spirituality and become comfortable in it so that I can grow."*

- *"Ensuring that as a clinician I also take care of my own spirituality so that I can be able to accommodate and deal with my clients' spirituality"*
- *"… is to read and inform myself about my own spirituality and err take care of my own spirituality and grow spiritually."*
- *"… Is to educate and empower myself so I will have ways to help people express their spirituality."*

- Education on client's spirituality

Education was articulated as a vital empowering strategy to enabling the client's spirituality. These learning strategies were expressed as learning through enquiry (with client), learning through understanding, learning through introspection and reflection with clients, and learning through research.

- *"Mine is to learn a little more about spirituality that is about 'others'."*
- *"Understanding what will give meaning to my client and then work with them to achieve it as far as possible."*
- *"…….to enquire or ask your patient what spirituality means to them in a like a visual or a creative activity so it's more understandable."*
- *"To do daily reflections and introspections with your patient on their journey and then also to reflect on your own spirituality and be aware not to influence or try and change theirs."*
- *"being in spaces that will allow for more understanding and gaining tools ….so I did would do something like research."*

- Understanding the concept in South Africa

Understanding spirituality within the South African context was viewed as an essential strategy to integrate spirituality in practice. This was viewed as therapy having local relevance.

- *"... Also understanding how spirituality is described in South African languages, the meaning might be a little bit different."*

- *"…..I said SA context so understanding spirituality within the SA context then I said in brackets equity, diversity."*

4.7. CONCLUSION

In all three phases there are common categories, which are:

- Spirituality as expressed through the therapeutic relationship, and
- Spirituality informing intervention

The categories of awareness and increased education were mentioned in the Dream and Design phases.

This chapter focused on the presentation of findings. Themes categories and subcategories were substantiated by direct quotes of participants. The findings were presented according to the phases of AI relating to this study's objectives. Participants expressed their understanding of spirituality, as well as their current use of spirituality through recollections of their successes in practice. Wishes regarding the use of spirituality were also shared. Finally, participants articulated strategies to implement and sustain spirituality. The next chapter will expand on the interpretation of these findings and address pertinent literature related to the findings.

CHAPTER 5: DISCUSSION

5.1 INTRODUCTION

The aim of the study was to explore how spiritualty is being defined, experienced and addressed in occupational therapy (OT) practice. Chapter 4 reported on the results of this study. Chapter 5 entails a discussion of these findings in relation to applicable literature, consequently improving the understanding and essence of this study. Study findings will be either conferred or compared with pertinent literature.

There were more female participants in this study than male participants. Similar findings were prevalent in other studies.[28,52] These studies suggest that more females than males tend to study and graduate in health sciences, especially in OT, resulting a greater number of female participants.

When addressing the objectives of the study in the Discovery, Dream and Design/Destiny phases according to the appreciative inquiry (AI) methodology, the following themes emerged:

- understanding spirituality as a construct,
- client-centred practice or approach,
- envisioned practice enablers of spirituality, and
- nurturing spirituality within the therapist.

As stated in Chapter 4, common categories were identified in all three phases namely:

- spirituality as expressed through the therapeutic relationship, and
- spirituality informing intervention.

Another common category was identified in the Dream and Design phases, which was:

- awareness and increased education.

Other categories that were identified in the three phases will also be discussed (refer to Figure 5.1. below).

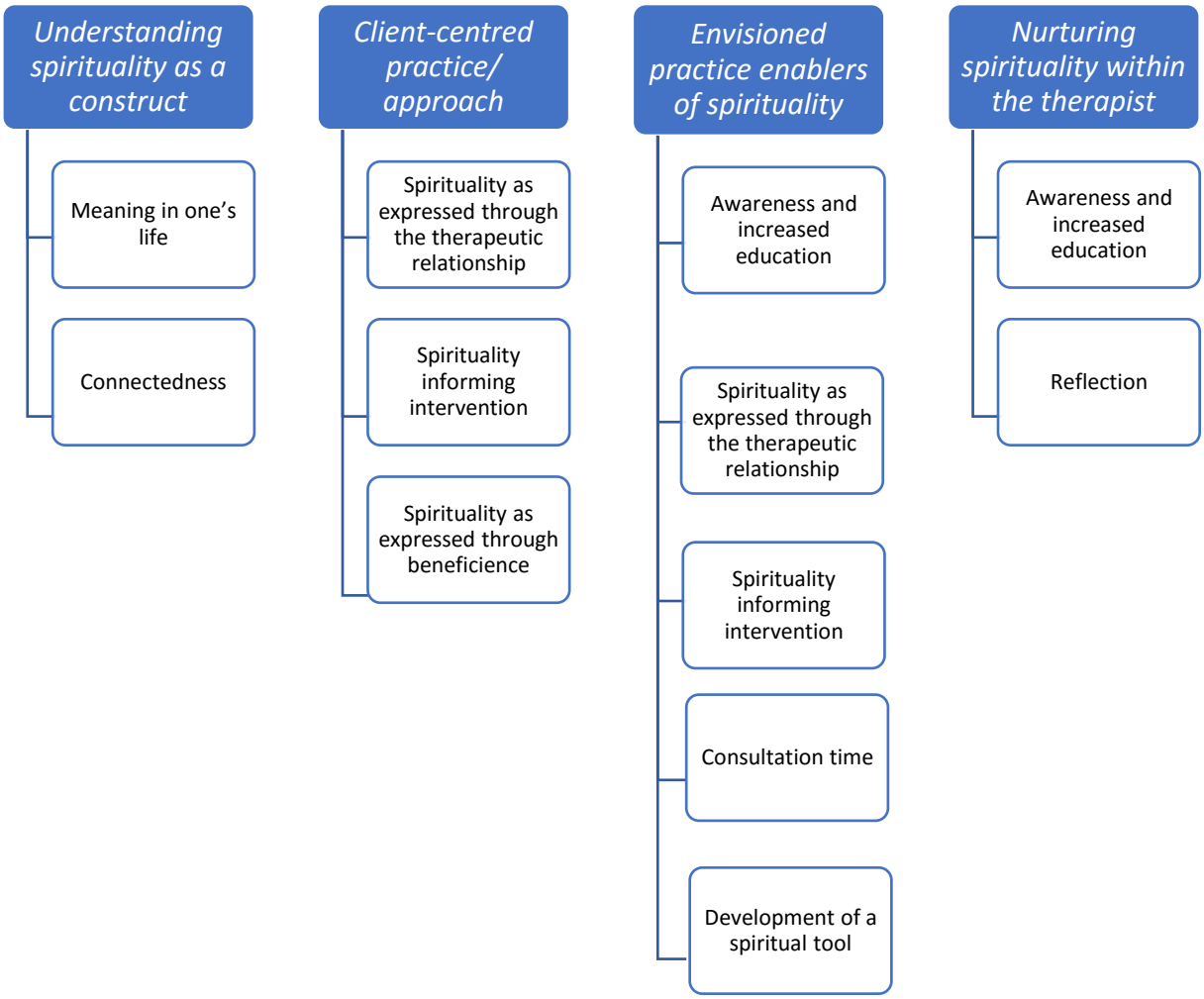

Figure 5.1. Summary of themes and categories

A discussion of each of the themes, their categories and subcategories and the relevance to existing literature will be presented. Common categories will be discussed only once, irrespective of the phase they were identified in, as the available literature remains unchanged.

5.2. LITERATURE CONTROL

5.2.1. Theme 1: Understanding the construct of spirituality

This theme highlights participants' understanding and defining of spirituality in OT practice. In this study, participants' core ideas of spirituality in OT practice were related to 'greater or deeper' meaning in one's life, as well as being connected.

The challenge and confusion about the meaning of spirituality reported in literature was not evident in this study.[6,22,46,62] With that being said, literature also reveals that participants tend to define spirituality individually and subjectively.[62] Hence, it remains as a multidimensional and multifaceted construct.[6] Barry and Gibbens[41] attribute the ambiguous nature of defining spirituality to its various cultural and individual influenced meanings.[41]

Literature reveals that there exists a myriad of definitions of spirituality,[1] as discussed in Chapter 2.4. Participants in the current study echoed a similar ,but also different multi-layered definition. Spirituality was conveyed as meaning to life and connectedness.

5.2.1.1. Category a) Meaning in one's life

Intrinsic to the category meaning to life were the subcategories of motivation and hope. Motivation was expressed as a driving force. This is consistent with the findings of Misiorek and Janus[11], whereby participants in their study expressed spirituality as a "driving force and valued it because of its impact on their and their clients' life in such aspects as coping with stress, a sense of control, motivation, and satisfaction with life".[11] These findings are consistent with the work of Bremault.[49] She mentions the human spirit to be the "essence of self." This is a vital, motivating force directed toward realising higher order goals, dreams, and aspirations that grow out of the essential self. Furthermore, it "organizes life and drives the person forward".[49]

Engagement in spiritual activities by participants in our present study was also articulated as a means of motivating the client. Hess et al.[20] concur that spirituality provokes and nourishes "human volition as a basis for action".[20] This finding was also consistent with that of Mthembu et al.[64] where engaging in spirituality activities in the community were motivating and health promoting.[64] Likewise, this corroborates with

studies on OT student's perceptions on spirituality in training. Most participants in these studies expressed that spiritual occupations are motivating and associated spirituality with coping styles, motivation and satisfaction with life.[11,28] Moreover, in the absence of a conception of a supernatural belief, people tend to perceive spirituality as a motivating force that comprises an integration of mind, body and spirit.[53]

Motivation and purpose are synonymous concepts. Purpose has been communicated as foundational concepts in spirituality definitions, as mentioned previously.[3,14,27,29] Motivation and hope were also highlighted by participants in the category of spirituality as expressed through beneficence.

Hope, faith and coping have been mentioned as recurring themes when defining spirituality.[1] Participants understanding of hope resonates with Cobb et al.'s[12] definition mentioned in their literature that, "Hope is a multidimensional life force for good and considered essential for well-being". Hope correlates with positive experiences of determination, strength, endurance, inspiration, light-heartedness aspirations and positive possibilities. There also ensues a positive correlation between spirituality and Hope.[12 62]

5.2.1.2. Category b) Connectedness

Current findings reveal that connectedness, according to the participants, was related to the therapist being connected to the individual as well as the individual's community. However, literature expresses this connection to be that of the individual's connection with their core self, others, nature, community, and the significant/sacred/transcendent.[14] Participants in the current study conveyed spirituality in OT practice as a deeper engagement with the client and community. This concurs with the position statement by the Occupational Therapy Association of South Africa (OTASA), which states that OT practice with respect to spirituality within a diverse cultural South African context should be understood from the perspective of the individual or community.[27]

Individuality and uniqueness were highlighted as pertinent principles when understanding spirituality in OT practice. This leads to the next theme of client centeredness, which will be discussed in more detail later.

Spirituality is shaped by the environment.[22] In order to understand spirituality in OT practice, findings reveal that a deeper understanding of the individual within their community is imperative. As mentioned earlier in the chapter, beliefs, values, traditions and practices are manifestations of spirituality.[27] According to our participants, these beliefs could also include religious belief. This finding concurs with Ubuntu principles, which remains fundamental to the African way of life.

Community is defined as “sharing of an area, interests and interactions as well as a sense of shared identity”.[1] The importance of the therapist‘s connection with the community and the interplay of spirituality was also articulated by a study conducted by Mthembu et al.[64] Their qualitative study aimed to explore the phenomenon of spirituality in community fieldwork practice. OT educators and students were recruited as participants in this study. A fundamental conclusion of their study was that spirituality appeared as a core element of communities and hence indicates that OT practice should involve awareness of the spiritual needs of communities.[64]

Consistent with other findings in literature, participants explicitly and indisputably acknowledged the importance of spirituality being a foundational/core concept in OT.[1,11,39] Spirituality was expressed as truth and could not be ignored. In contrast, a study by Morris et al.[6] revealed that a small minority of occupational therapists were of the opinion that spirituality should not be addressed by themselves.[6,11]

5.2.1.3. Application to OT

Rooted in the profession’s fundamental principles of OT is the concept of holism, whereby, attending to mind, body and spirit are essential for health and wellbeing.[1,27,62] This resonates with the definition of health by the World health Organization (WHO), whereby health is not just the absence of disease, but engenders physical, mental, social and spiritual wellbeing.[88] However, Balboni et al.[88] and Bremault et al.[50] mention that all too often a reductionist model of care is adopted, and spiritual aspects of care are relegated as nonessential and optional.[50,88]

Participants in the current study likewise voiced spirituality to be a construct that positively influences mind and body and, hence, behaviour. This finding was corroborated in studies by Misiorek and Janus.[11] and Puchalski.et al.[43] Misiorek and Janus[11] mention that spirituality has an effect on the entire OT process.[11] Similarly

Puchalski et al.[43] mention that coping and adjusting to illness is aided by a strong sense of spirituality.[43]

Participants also articulated that spirituality is a concept that can include religion and culture, but is beyond religion and culture. This corroborates with findings of previous studies that highlight spirituality and religion to be connected/related but separate entities.[1,12,52] Consistent to this, Thompson et al.[39] noted that while religious beliefs and practices can permeate one's spirituality, spirituality can be without belief in the transcendent (a higher being, God, a supernatural being).[39] Thus, spirituality does not necessarily emanate from religion. Gall et al.[46] in their study noted that belief in a higher power and connection to mystery are common ties between spirituality and religion.

With that being mentioned, religion is defined broadly as an "integrated system of beliefs with their attendant practices".[1] Cobb et al.[12] offer a more expansive definition explaining "religion to be a formal system of beliefs, held by groups of people who share certain perspectives on the nature of the world." These perceptions entail a particular world view and are communicated through shared narratives, rituals, beliefs and practices.[12] According to Hemphill[8], distinguishing whether spirituality is expressed through traditional religions or unconventional practices are essential to OT practice.[8]

Moreover, participants identified spirituality to be a construct that is expressed through engagement in meaningful occupation, with occupation being a vital tenet to OT practice. Smith and Suto[47] likewise frame spirituality in terms of occupation; these scholars further note that not all occupations are spiritual, however, these have the potential to be spiritual when imbued with meaning.[1,47] Occupation can be seen as an end and as a means in therapy.[39] Generally, literature suggests that occupational therapists tend to use spirituality or spiritual activities as an end goal, whereby the client's participation in this occupation is maintained, as opposed to using this occupation as a means, as advocated by Smith and Suto.[39,47]

5.2.2. Theme 2: Client-centred practice/approach

Client-centred practice/approach, very broadly, can be defined as embracing a philosophy of respect and partnership with people receiving services.[22,70] When describing spirituality in their OT practice through the generation of participants'

experienced successes in spirituality, participants highlighted client-centred practice or approaches as being vital to their current OT practice. Client-centred practice is foundational to OT and clients are rendered as active agents throughout the OT process.[20] Similarly, Duncan[22] mentions that the basis of client-centred practice is "for the therapist to see the world through the client's eyes".[22]

Facilitating spirituality through client-centred practice has, likewise, been highlighted in a study by Hess et al.[20] whereby therapists utilised client-centred practice to facilitate spiritual occupations with mental health users in an environment where spirituality is not stimulated due to concerns of increasing mental illnesses. Additionally, the aforementioned study developed critical checkpoints based on client-centred practice for future occupational therapists when deciding about spiritual occupations in their workplaces. These questions facilitate a therapist's clinical reasoning process and are as follows: [20]

- *What is the meaning experienced in this occupational engagement?*
- *Is the engagement appropriate and consistent with the client's own perspective on spirituality across context and time?*
- *How does the current engagement pattern compare to norms and expectations of the client (for example, premorbid behaviour and values, as well as developmental, familial, and cultural norms)?*
- *What are the implications to the client's and other's health within the immediate environment, as well as to their family and community?*

The importance participants in the current study gave to listening to and reflecting on the client's wishes resonates with client-centeredness, as found in studies by Mthembu et al.[29] and Hess et al.[20]. Similarly, Mathisen et al.[45] found that spirituality should be built-in when this is pertinent for a particular client, because it guarantees client-centred practice that is meaningful, ethical and respectful of the client's wishes.[45] This finding also corroborates with that of Morris et al.[6], whereby data from their study have shown a relationship between spirituality and client-centred practice through subthemes of holism, respect, client-initiated, emotional wellbeing, coping, therapeutic relationship, and motivation.[6]

This theme of client-centred practice further pertained to the following categories of spirituality as expressed through:

- Therapeutic intervention
- Therapeutic relationship
- Beneficence to the client

5.2.2.1. Category a) Spirituality as expressed through therapeutic intervention

In the Discovery phase, the category of spirituality as expressed through therapeutic intervention emerged from four subcategories, namely individualistic intervention, meaningful activities/occupations, creation of a safe space, and cultural and God-centred intervention.

In the Dream phase these subcategories were conveyed holistically and participants articulated that spirituality needs to be incorporated into activity selection and assessment. In the third phase, specifically the Design and Destiny phase, participants were of the opinion that activities included in practice should be selected with the client's spiritual orientation in mind. Additionally, the Vona du Toit Model of Creative ability (VdTMoCA) emerged as a context for addressing the client's spirituality.

Participants were in agreement that current OT practices have the potential to be spiritual. Occupational therapy aims to provide and engage clients in a variety of activities that fulfil human needs, consequently promoting health and wellbeing.[1] Misiorek and Janus[11] report that spirituality relates to the highest level of Maslow's hierarchy of needs. Thus, its inclusion in the OT process of evaluation and treatment of clients will indisputably be related to searching for activities that are significant and give meaning to patient's lives.[11]

The findings of this current study align well with that of Misiorek and Janus[11] who found that more than 60% of their therapists claimed that they addressed spirituality in practice. They also expressed that they utilised the knowledge of the client's spirituality to understand them better. Acknowledgement of the client's spirituality also facilitated a more open conversation, thus clients were more willing to share their thoughts enabling a personalised therapy programme.[11] Another study by Bremault et al.[50] also acknowledged how spirituality facilitates a connection with patients and improves client-centred care. Healthcare professionals expressed that their sense of job satisfaction was enhanced when meeting patient's person-centred spiritual needs.

In contrast, some studies reveal that occupational therapists are of the opinion that spirituality should not be addressed by themselves.[6] Some therapists believe that the patient's spiritual needs should be met by priests, rabbis, and pastoral care workers and that therapists and these experts should liaise to meet the spiritual needs of clients.[11]

Hemphill[8] argues that a balance needs to be maintained between using and developing a patient's spiritual strengths and remaining focused on OT treatment goals. The main focus should always be on therapy.[8] Occupational therapists also need to avoid assuming the role of a spiritual expert, and see benefit in utilising a multidisciplinary team approach, with cooperating traditional healers, clergies and members of faith-based organisations.[1,8,27]

Hemphill[8] mentions that during a spiritual assessment the occupational therapist is able to discover the uniqueness of each individual and the contexts that support or hinder their occupational performance. This fosters the development of a treatment plan that is grounded on the experiences the client most values and wishes to retain.[8] Similarly, the OTASA position statement on spirituality mentions that spirituality should form part of the routine history assessment of individuals and their context.[27]

Participants in this study also expressed VdTMoCA (as described in more detail in Chapter 2 section 2.10.4.) as a context for addressing the client's spirituality in OT. This model is a South African client-centred developmental practice model that guides OT intervention in many health care settings.[70] This model essentially indicates the interrelatedness between motivation and action.[71] It conveys what motivates people and emphasises the uniqueness of the individual and the interface between the therapist and client.[70]

Consistent with these findings, other client-centred models mentioned in literature that engage spirituality are the Person Environment Occupational Performance (PEOP) Model and the Canadian Model of Occupational Performance (CMOP).[21-22,40]
The subcategories relevant to the above-mentioned category will now be discussed.

- <u>Meaningful activities/occupations</u>

Participants attributed their current successes of spirituality in OT practice to engaging clients in meaningful occupations. This concurs with the findings in Maley et al's.[63]

study, where the utilisation of occupations in intervention may elicit meaning and encourage spiritual experiences. The theme of avenues to and through spirituality was identified in their literature review as that which reflects occupation and occupational engagement. These occupations were further reflected in three subthemes namely: spirituality affiliated with religion, coping mechanisms and activities, and relationships. These occupations had either a direct or indirect association with spirituality. Some activities identified either supported or were interconnected with spirituality. Engaging in religious routines, rituals, and speaking to religious leaders were identified as activities with religious affiliation.

As mentioned earlier, occupations imbued with deeper meaning have the potential to be spiritual.[1-2,40,47] Hess et al.[20] view spiritual occupations as "a variety of activities specifically imbued with spiritual meanings and effects that have been performed by human beings over many generations and across all cultures … [which] can be enacted at both individual and community levels".[20]

It is argued that spirituality can be experienced outside occupations, but engagement in deeply meaningful occupations can make spirituality more tangible. Additionally, in order to facilitate a spiritual experience through occupation, these occupations should be permeated with personal reflection and intention and should occur within a supportive contextual environment. Reflection, intention and the ability to find deep meaning in a moment are absent in routine activities. These scholars further report that religious rituals as well as occupations that imbibe ritualised characteristics, such as formalism, tradition, invariance, sacral symbolisation and performance differentiate sacral from mundane occupations.[1-2]

Hemphill[8] reiterates that, on a day to day basis, utilising a valued occupation that is meaningful to clients may significantly impact therapy in an advantageous manner. Additionally, the use of these valued meaningful occupations in a consistent way may assist clients to feel a sense of calmness, stability and empowerment.[8]

Participants in our present study also conveyed that utilising spiritual activities could potentially facilitate meaning for clients in their intervention. This finding is consistent with numerous previous studies citing the benefit of utilising spiritual activities to facilitate meaning.[11,26,49] Misiorek and Janus[11] note that everyday routines and habits are strongly influenced by spiritual and religious beliefs, and that these beliefs elicit

meaning and another dimension to everyday activities.[11] Similarly Jones et al.[26] in their study concluded that a patient's sense of purpose and meaning is restored by the occupational therapist mobilising the patient's spiritual coping strategies.[26] Likewise, Bremault[49] expands on the benefits of spiritual and religious resources to include the "ability to thrive, find meaning and purpose, overcome adversity attain potentials beyond their imaginations".[49]

The OTPF 3rd ed. (2014) highlights religious and spiritual activities as an instrumental activity of daily living.[3,11,39,63] However, this document is presented without specifiers on the OT role as well as how this should be implemented in practice. As mentioned earlier, occupations could be used as a means and an end. The question, thus, arises whether spiritual occupations are incorporated into OT intervention or are therapists merely supporting this occupation indirectly through everyday activities. A recent study conducted by Thompson et al.[39] aimed to explore the attitudes and behaviours of occupational therapists concerning religious observance in clinical practice. The findings revealed that even though therapists were of the opinion that religious observance was an important occupation, they most rarely or never addressed this in intervention. The reasons provided by respondents for not addressing this occupation was that of it not being applicable to the work context as well as the sensitivity of the topic.[39]

Smith and Suto[47] and Hess et al.[20] provided another scenario whereby the use of religious and spiritual practices can be quite challenging. In a mental health setup, the therapist may not be sure if religious and spiritual practices are health promoting or a manifestation of symptoms.[20,47] Smith and Suto[47] note that earlier research findings on the relationship between spirituality and occupation and health in mental health practice are contradictory. Some studies found spirituality to be empowering, enhancing, as well as a coping strategy for people living with schizophrenia. Other research revealed that spirituality is counterproductive for people with psychosis.[47]

Wilson[40] mentions two fundamental points when approaching the use of occupation with a spiritual perspective. These are related to, firstly, the capacity of the client and their willingness or need to participate at a spiritual level, and, secondly, the capacity of the therapist to engage in a client-centred dialogue about spiritual matters. The capacity of the therapist was further explained to include their experience and

confidence and their ability to recognise the appropriateness of utilising spiritual occupations and when not to.[40]

Spiritual occupations also include diverse collective activities that communities engage in. Manifestations of these include, prayer scripture reading, devotional practices such as singing or chanting, meditation, yoga, tai-chi, participation in communities of faith, and expressive arts. The findings of a study by Mthembu et al.[64] revealed that community members tend to partake in devotional practices on a daily basis. These practices appeared to facilitate connection with God as well as enhanced social interactions.[64]

This leads into our next subcategory of God-centred and culture-centred intervention.

- <u>God-centred and culture-centred</u>

Participants shared that the use of activities based on God and culture enhanced current spiritual intervention. Culture can broadly be defined as “ideas, customs, and social behaviour of a particular people or society.” In OT, culture is defined as “customs, beliefs, activity patterns, behaviour standards and expectations accepted by the society of which the individual is a member of”.[1]

Relationship with God and relationship with others have been found in reviewed literature as aspects when defining spirituality.[46] Notably, as mentioned earlier in the chapter, spirituality is expressed through beliefs, values, traditions and practices. Previous literature indicates that spiritual care must reflect a client’s beliefs.[29]

Consistent with this study’s finding, literature advocates that OT that addresses spirituality in practice requires consideration of the client’s culture.[1] Findings from a study in mental health care services by Hess et al.[20] indicate that when viewing the appropriateness of client’s spiritual occupations in mental health care services, it is vital to consider the context. This inevitably addresses cultural factors. The client(s) could be the individual, their family or the community of which the individual is part.[20]

Furthermore, Hemphill[8] suggests that “assistance from a patient’s faith community may be a source of therapeutic aid”.[8,11] Moreover, Fang et al.[89] and Mthembu et al.[62] conveyed that culturally and spiritually sensitive healthcare professionals tend to build

good therapeutic relationships, consequently providing authentic care to clients and their family members.[62,89]

Hemphill[8] made some suggestions on how to ensure that treatment plans are spiritually and culturally sensitive. These are as follows: patient's requests for same-sex providers whenever possible should be honoured; respect for patient's religious beliefs should always be maintained, even when they conflict with your own; privacy for patient's prayer should be allowed; therapist should have an awareness of the different religions and their respective holy days (e.g. Friday for Muslims, Saturday for Jews, and Sunday for Christians); patients should be allowed to make informed choices regarding risks when medical procedures conflict with their religious beliefs; therapist should learn what symbols are sacred to those who are treated, and these should be respected.[8] Similarly, The OTASA Position Statement on spirituality reiterates the need for therapists to adhere to the practical needs of clients, namely, that of access to scriptural texts, prayer beads, or clothing as well as time for prayer.[27]

It is evident from literature that occupational therapists are at times apprehensive about integrating religious occupations into practice, however, these authors further argue that if it is deemed as important occupations of the client's daily life, it can be incorporated as deeply meaningful occupations. Integration of culture might require the therapist to learn more about the rituals and religious traditions of their clients.[1]

In contradiction to our results, a study by Thompson et al.[39] on religious observance by occupational therapists found that, while the majority of the respondents acknowledged the importance of this occupation, they almost never or hardly ever implement religious observance in clinical practice. Respondents in their study reported that the reason for their non-application of this occupation was that it was not relevant in their work context and the sensitivity of the topic prevented integration in practice.[39] This corroborates with the findings of a study by Mthembu et al.[28] whereby most participants articulated that spirituality is a very sensitive topic in practice as you encounter various clients from diverse religions and cultures.[28]

- <u>Individualistic</u>

Participants echoed the subcategory of individualistic/client-centred intervention with words like "self-choice", "client needs", "holistic", and "unique identity".

Hemphill[8] and other authors mention that spirituality means many things to many people, it is subjectively expressed, and, thus, participant's expression of the need for intervention to be individualistic resonates with this understanding.[6,8,45] Furthermore, this uniqueness conveys that clients bring their own perspective to intervention. They are experts in their own occupational functioning and uniquely understand the impact of the condition on their everyday life. Thus, providing choice in client-centred care should address individual needs and values.[22] Consistent with this, our participants articulated self-choice as promoting individual and client-centred intervention. This concurs with previous literature, which explains that choice is a basic need of human beings. Other basic needs include purpose, meaning, self-worth, and control and occupation.[29]

The findings of this study are consistent with that of Mthembu et al.[28] whereby participants articulated that spirituality is personal and expressed and experienced differently. Their participants highlighted that the spiritual being distinguishes an individual from other individuals. These authors also note that in OT, clients should be considered as occupational beings with inner drive when it relates to occupational performance.[28] Moreover, spiritual care has been found to be unique to every individual with their relationship with God, nature and other.[29]

- <u>Safe space</u>

Participants did not refer to this in literal terms, however, they did feel a necessity to mention that clients should feel that they are in a space with their practitioners that is free from bias, conflict and criticism.

By creating this safe space for service users, participants suggested that it allowed the clients the opportunity to be who they really are and communicate openly, thus facilitating the integration of spirituality. Puchalski et al.[43] expressed this as 'compassionate presence', whereby this presence refers to creating a safe space where the client feels they can express their deepest and greatest concerns. Furthermore, these authors argue that the experience of compassionate presence by the clinician facilitates a sense of healing within the milieu of the relationship with the clinician.[43] Similarly, Mthembu et al.[62] recommend that a safe and supportive

environment be created by educators in a classroom situation to facilitate the teaching of spirituality and spiritual care.[62]

5.2.2.2. Category b) Spirituality as expressed through the therapeutic relationship

Participants articulated that the therapeutic relationship with their clients was vital when wanting to facilitate spirituality in their current practice successes.

This is consistent with the findings of Jones et al.[26] that effective therapeutic relationships have facilitated client's spiritual needs. However, they do conclude that development of these relationships can be challenging and unrealistic within healthcare environments.[26]

The importance of the therapeutic relationship has also been highlighted with the provision of spiritual care. Spiritual care "is person-centred care which seeks to help people (re)discover hope, resilience and inner strength in times of illness, injury, transition and loss".[54]. Spiritual care is "exemplified in the health professional's respect for patient's dignity, display of unconditional acceptance and love, honest health professional-patient relationship, and the fostering of hope and peace".[25] It is advocated in literature that the therapeutic relationship is a catalyst for change and a crucial aspect in the OT process.[1]

A study by Mthembu et al.[29] expressed that spiritual care attributes were inclusive of spiritual awareness, empathy and building trusting relationships.[29] This provision of spiritual care and building a relationship with clients has genuinely interested healthcare professionals.[8,11,88]

Hemphill[8] suggested five reasons why spiritual assessment is crucial in a therapeutic relationship: to understand a patient's worldview to facilitate more empathy and sensitivity; to broaden the therapist's perception of how healthy or unhealthy a patients spiritual orientation is and how it influences the clients problem; to ascertain whether the patient's beliefs and the community can be used as assets for coping methods and growth; to establish which spiritual interventions may be advisable for the client; to determine if there are any unresolved spiritual issues.[8]

Misiorek and Janus[11], in their study, found that most therapists considered the client's spirituality as vital for developing a therapeutic relationship founded on partnership.

Their respondents also highlighted the significance of being familiar with the patient's spirituality and the ensuing choice of therapy to be carried out.[11]

The subcategories relevant to the above-mentioned category will now be discussed.

- Acknowledgement

Participants echoed that they work with an array of diverse cultures and religions. Acknowledging their clients as spiritual beings irrespective of their different beliefs facilitates current successful integration of spirituality.

This lends itself well to the growing literature amongst therapists and other health care professionals, that the spirit component of the client's needs should be acknowledged.[6,39] It is also consistent with affirming the holistic approach, whereby mind, body and spirit is attended to.[27] Acknowledgement of the philosophical journey together with the physical journey is imperative in ensuring truly holistic care.[45]

Similarly, Duncan[22] mentions that client-centred therapists accept their clients from all viewpoints namely who they are, what they are and where they are at.[22] This finding of acknowledgment also corroborates with Maley et al's.[63] systematic literature review, whereby acceptance and acknowledgement from family, friends and groups were found to be vitally important in the face of adversity, thus finding meaning and purpose in the situation.[63]

Conversely, Mathisen et al.[45] mention in their paper that speech and language pathologists (and other healthcare professional) rarely, if ever, acknowledge the significance of spiritual and religious beliefs in intervention.[45,89] Reasons for this disregard of spirituality in the client-therapist relationship could be varied, nevertheless Thompson et al.[39] mention that their participants expressed that religion and spirituality are sensitive topics to broach with their clients. However, in order for clients to comfortably voice their religious and spiritual concerns, it remains imperative that therapists overcome their possible discomforts.[39] Lambie et al.'s[13] findings expressed similar views, as their participants expanded on these potential sensitivities extending it to the teaching and learning environment. Most of the participants interviewed expressed that when discussing spirituality with clients, caution should be taken, as this could potentially harm clients if expressed in an insensitive and inexpert way. Some extended this cautiousness to deliberating the subject with students, and cited that

students bring such a wide array of cultural, personal and experiential backgrounds to their learning.[13]

Participants in our study also stated that it is important to *acknowledge* the uniqueness of clients. This is consistent with other findings, which reveal that spirituality is uniquely and subjectively expressed, thus indicating the diversity of views and is not only applied to religion.[29] Similarly Maley et al.[63] recommend that when utilising spirituality to address major life events, occupational therapists should be sensitive to the uniqueness of their clients.[63]

- Open and non-judgemental to cultures and religion

Participants also reiterated that in their current successes with respect to spirituality, one needs to refrain from making judgements on clients narratives.

Moreira et al.[60] suggest that as a practical guideline in the intervention of mental healthcare clients regarding spirituality and religiosity, the healthcare professional displays open-mindedness with sincere interest in and respect of the patient's beliefs, values, and experiences.[60] This finding also corroborates with the OTASA position statement which states that a non-judgemental approach to clients and their communities be adopted as this is innately spiritual.[27]

Furthermore, Duncan[22] mentions that when a therapist is non-judgmental, it enhances communication and the therapist is able to listen to the client better.[22] Our participants also expressed that the health care professional should be open to and comfortable with discussing spirituality with their clients. Similarly Lambie et al.[13] mentioned that openness to discussing spirituality lends itself well to better patient health and improved physician-patient relationship.[13]

Conversely, a considerable amount of literature mentions that most clients would prefer that their spiritual concerns be addressed.[51] However, the clinicians tend to be hesitant and reluctant to discuss spirituality with their clients.[6,28,39,60]

- Respect the clients beliefs and values

Respect refers "to due regard for the feelings, wishes, or rights of others".[22] Participants expressed respect as another subcategory enabling their current successes in

spirituality. Participants articulated that respecting the client referred to respecting them as an individual with their specific qualities and attributes as well as respecting them within their context (community)

Similarly, Duncan[22] mentions that respect entails demonstrating value for the individual's views and opinions, as well as the therapist not imposing their views on the client. Duncan[22] further argues that respect of the individual extends beyond their opinions, beliefs and values and is inclusive of respecting their limitations and capabilities.[22]

Lambie et al.[13] mention that within healthcare there has been substantial dialogue about the importance of understanding and respecting the diverse cultural views of illness.[13] These findings are consistent with Mthembu et al.'s[29] study, which revealed that OT students in their study perceived that the client's dignity, religious and cultural beliefs needs to be respected. Additionally, it was believed that occupational therapists provide spiritual care by doing so.[29] Within the Constitution of South Africa, the right to have a person's dignity respected is of paramount importance.[27]

This finding also corroborates with the definition of client-centred practice, where respect is one of the key elements of the approach.[22,70] Misiorek and Janus[11] mention that showing respect for the client's spiritual beliefs facilitates a healthier patient-therapist relationship, as the client is more willing to share about their true aims and motivations. These authors also mention that when these spiritual needs are respected, patients' contentment with emotional aspects of care is high.[11] Similarly, Balboni et al.[88] note that patient's healthcare outcomes are enhanced when their values and beliefs are respected and incorporated into their care. These authors also advocate for professionals to respect the expertise of others and recognise the limitations of their professional expertise in certain areas.[88]

- <u>Listen and understand</u>

In the context of this study participants referred to listening as the process of being attentive. Participants' apparent view was that listening attentively has facilitated a better understanding of the client's spirituality.

This finding of listening and understanding to facilitate spirituality is clearly echoed in the definition of spiritual care, whereby spiritual care is described as "the connection

between healthcare professionals and their clients, thereby listening to their fears, dreams, and pain; collaborate with their clients as partners in their care; and provide, through the therapeutic relationship".[53]

Piret et al.[54] mention that spiritual care is much more "about attending the patient by being present and listening than delivering the message".[54] Similarly Duncan[22] mentions that listening is essential to understand what is said and what is not said.[22]

Listening was also articulated by Cobb et al.[12] and Puchalski et al.[43] as vital to the communication process when discussing spirituality. These authors advocate that the health care professional listens, firstly, to how important spirituality is in the client's life and its influence on his or her health. Additionally the therapist listens for themes of spiritual distress.[12,43]

The importance of listening in spiritual care was also conveyed in a previous study by Mthembu et al.[29], whereby participants expressed that spiritual care involves listening to and allowing patients time to discuss their worries.

Puchalski et al.[51] mention that a clinician gives the patient's distress a voice when they is able to practice deep non-judgmental listening. It is further stated that a compassionate listener aids in the patient feeling less alone, less afraid, as well as may facilitate healing and hope.[51]

The essence of listening was echoed in another study whereby therapists prioritised listening and considered the clients' perceptions in order to facilitate spiritual occupations. These fundamental elements reverberate the essence of client-centredness.[20]

5.2.2.3. Category c) Spirituality as expressed through beneficence to the client

When describing their current successes of spirituality in their practice, many participants voiced the value its implementation had on their clients. Some participants also articulated spirituality to be 'nourishment' for the soul.

Likewise, a myriad of studies report the benefit of addressing spirituality in healthcare.[1,12] The reported benefits include the positive effects on social, mental and emotional health.[64] Additionally, reviewed literature mentions the vital role spirituality has on how the patients perceive and manage their health and illness, face challenges

and ultimately choose to die. It's reported contribution to healing and recovery in various conditions has also been noted in literature.[28]

Misiorek and Janus[11] mention nine similar benefits when using spirituality in therapy. Spirituality may generate a source of strength, solace, empowerment and control, social support, and the sense of belonging. Moreover, it enables meaning, leads to the acceptance of oneself, illness, and assists in dealing with the fear of death.

This category was conveyed through the following subcategories:

- Instil hope

Participants voiced that this inner hope allowed clients in difficult circumstances to move towards healing and better handling of their situation. Instillation of hope in clients were twofold: Firstly, participants were of the understanding that by bringing hope to the situation they are addressing spirituality, and, secondly, participants felt that engaging in spiritual activities facilitated hope.

Consistent with this finding, Mthembu et al.[28] mentions that spirituality inspires hope when faced with adversity.[28] Likewise hope was described in another study as a spiritual belief that enables people to believe that "things are going to work out somehow". Other synonymous descriptions of hope included "hope was expressed in reference to a better future, as a way to live, as recognition of God's support, and as a mantra to overcome hardship".[63]

This finding is also compatible to another study by Mthembu et al.[29], whereby respondents were in agreement that "spirituality provides sense of hope" and "occupational therapists can provide spiritual care by enabling a patient to find meaning and purpose in their lives".[29]

- Motivation

Participants also used spirituality as a vehicle to enhance the client's motivation. Here participants voiced this as intrinsic motivation, which refers to behaviour that is determined by internal needs and/or rewards. Participants also felt that this was crucial to comply with and adhere to treatment.

This finding concurs with the finding of Misiorek and Janus[11], where a majority of the therapists noted the relationship between spirituality and motivation in their clients. Moreover, the therapists expressed that spirituality affects the quality of the patient's day, their choice of everyday activities and goals, the sense of self-fulfilment, willingness to make key decisions and the sense of agency.[11]

This corroborates with another study on OT students and their perceptions of spirituality, where spirituality appeared to be responsible for students' motivation and coping skills, bringing calm and contentment in their lives.[28]

- Gives meaning

Spirituality gives meaning. Meaning was understood by participants as the client making sense of their current situation. It refers to how the client defines and understands their current situation.

This finding is consistent with that of Jones et al.'s concept analysis, which concluded that occupational therapists utilise spiritual coping strategies to engender meaning and purpose when addressing a disturbance in wellbeing and quality of life. Additionally, these authors mention that the search of the meaning of personal illness or disability is inherent to OT practice.[26] Furthermore, dimensions of meaning and purpose have been emphasised as a means for integrating spirituality in OT practice.[1,26]

Similarly, a review by Maley et al.[63] found that when people are confronted with a major life event or transition, they continue to attempt to make sense of it. Pertinent questions of why, for what purpose, and what the event signifies or implies are prevalent during the process of sense-making. Moreover, these authors argue that this process of sense-making inevitably provides people with motivation to advance in the spiritual experience.[63]

The present finding of spirituality facilitating meaning was expressed in another study by Bremaut et al, [50] whereby healthcare professionals expressed that their patients valued when the professional acknowledged what was meaningful to them. Healthcare professionals taking into cognisance what is meaningful to a patient allows patients to better cope with their circumstances.[50]

This finding, likewise, concurred with the views of Gall et al.[46], whose participants explored the function of spirituality in coping with life stress. Their participants conveyed that spirituality held various meanings in response to stressful events. These included: "(a) taking a greater perspective: seeing self as part of creation, a larger reality, or as in unity with world; having lessons to be learned and providing a life focus; (b) seeing a link to a higher power: believing God as present and that one is not alone, God has empathy, a higher being is in control, has answers, and has some life purpose, God is not punishing; (c) accepting that the passage of time is important: time will help in that healing will occur/everything will be fine/all must pass, importance to focus on the now, acceptance; and (d) person has purpose: a person's work is not done, obstacles will be overcome".[46] Most significantly Gall et al.[46] conclude that spirituality makes available a framework from which to develop a sense of meaning or understanding of the events that happen in one's life.[46]

5.2.3. Theme 3: Envisioned practice enablers of spirituality

When exploring aspirations of participants regarding the use of spirituality in practice, the theme of 'envisioned practice enablers of spirituality' emerged. This theme encompasses all that participants wished for, i.e. to enable spirituality in practice and to move towards excellence. This also included what more participants could do and how they could do better. With this being said, there has been a repetition of two categories, namely:

- Maintaining the therapeutic relationship
- Spirituality as expressed through therapeutic intervention

The remaining categories that emerged are:

- Development of spiritual tools
- More consultation time
- Increased education and awareness

As the first two categories of maintaining the therapeutic relationship and therapeutic intervention were discussed in detail earlier and no new information emerged, the

researcher will not discuss them again, and will only discuss the new emerging categories.

Participants expressed these subcategories similarly to the Discovery phase, however, in statements participants expressed these categories and subcategories as aspects they wished they could implement more and perform better in. Here one should take cognisance that in AI the Discovery phase is taken as the building blocks for the Dream phase.

5.2.3.1. Category a) Development of spiritual tools

- Spirituality Guide

Participants articulated the need for a tool to guide spirituality in OT practice. As spirituality is conveyed as an intangible component of the client, participants concurred on the importance of developing such a tool. A tool to assess as well as to be used in intervention was the echoed wish of participants. According to one participant, this tool could be a vehicle to incorporate spirituality in a practical manner.

This finding is supported by a report by Balboni et al.[90] where palliative care providers classified spiritual screening tools as the number one priority for spiritual care research.[90]

The dialogue of spiritual and religious issues has been cited as a highly advanced communication skill. Hence, a tool to facilitate such a discussion may be helpful, and could improve the health care professional's confidence in discussing spiritual issues with patients.[50]

This finding is also confirmed by Mthembu et al.[62] and Morris et al.[6] where participants in their studies expressed that a lack of spiritual assessments was impeding spiritual integration. The majority of the therapists in a study by Morris et al.[6] indicated that they are not aware of and are not applying assessments of spirituality to assess their clients' spiritual needs. This possibly indicates that from an OT standpoint there is a scarcity of assessment instruments to assess the client's spirituality. Hence, occupational therapists cannot claim that their treatment is holistic if spiritual assessment is absent.[6,62] Similarly, Mathisen et al.'s[45] review of literature found that consideration of

spiritual assessment and screening in clinical practice was found to be timely, thus ensuring holism.[45]

Bremault et al.[50] and Jones et al.[26] note that spiritual history-taking and assessment are increasingly vital activities in modern-day healthcare practice and a means to meet spiritual needs.[26,50] Moreira et al.'s[60] review of evidence found that the most widely acknowledged and agreed-upon application of religiosity/spirituality to clinical practice is the need to take a spiritual history. This could possibly improve patient compliance, satisfaction with care, and health outcomes.[60] Likewise, the OTASA Position Statement highlights spiritual history-taking as part of a routine history assessment of individuals, families and communities.[27] Mthembu et al.[29] suggest that OT practitioners need to be comprehensively educated on spiritual assessments.[29]

The findings of Bremault et al.'s[50] study, whereby health care professionals were trained on a spiritual history-taking tool (namely the FICA), revealed that integration of spiritualty, via the use of the FICA tool, positively facilitated spiritual discussions with their clients.[50] Hemphill[8] and Misiorek and Janus[11] argue that a spiritual history assessment should occur at admission and during the initial OT evaluation process.[8,11]

Participants in the current research study were also of the opinion that a possible tool that could be utilised is the VdTMoCA. Given that this model is a client-centred model, participants' envisaged use of this model as a tool is understandable. However, at present, to the researcher's knowledge, there is no literature to substantiate the use of this tool for the integration of spirituality in OT.

Notably, as spirituality is a multidimensional and multifaceted definition, many authors contend it is difficult to assess and intervene, which could make the consideration of clients' spirituality a subjective assessment, rather than an objective analysis.[6,48]

5.2.3.2. Category b) Consultation time

Additional time with clients was envisaged by our participants to be a facilitator of integrating spirituality in practice. Time is essential in establishing an authentic understanding of clients' spirituality, their spiritual needs, including their spiritual activities and occupations. However, according to participants, this is apparently hindered by busy schedules and high workloads.

Having time for introspection and reflection allows for deep thought and consideration, may counteract the practitioner's narrow worldviews, and, thus, consequently guide the use of spirituality. The client having time for introspection and reflection may facilitate the spiritual orientation of OT intervention.

- Time to address

Consistent with findings of Bremault et al.[50] and Mthembu et al.[62], the present study found time as an enabler to spiritual integration. Bremault et al.'s[50] findings revealed that therapists' lack of time was an inhibiting logistical factor of going into patients' spiritual concerns in detail. Mthembu et al.[62] found that time was identified by educators and students as a barrier in the classroom situation, as minimal time was given to addressing the topic of spirituality in OT practice. Additionally, Mthembu et al.[62] argue that OT educators and clinicians should develop an innovative curriculum to address this issue.[50,62]

The infusion of spirituality in fieldwork settings by OT students was hindered by time constraints with high turnover of clients. Educators also perceived that understanding of conditions by students took time as well as precedence, and spirituality was negated. This was confirmed by participants, and they stated that there was no time or space within hospital settings to address spirituality. These participants also expressed that discussing spirituality takes time.[62]

The finding of additional consultation time, which is hindered by participants' workloads and busy schedules, is also supported by Jones et al.[26], who mentions that in clinical practice it is imperative to develop an effective relationship, but this requires time. The patient should be allowed time to communicate their spiritual and religious issues, as well as share knowledge on their values, dreams and desires. However, this may be challenging and unrealistic within the demands of a busy healthcare environment. Therefore, these authors suggest that the culture within healthcare organisations needs addressing.[26]

Similarly, an earlier study by Edwards et al.[91] found that barriers, such as shortage of time, influence the integration of spiritual care, as time is needed for patients to open up, develop and maintain relationships with healthcare providers.[91] Likewise, a literature review by Mathisen et al.[45] found that time impedes the healthcare

professional's ability to broach the topic of religion and spirituality in clinical practice.[45] Hence, time constraints on an institutional and educational level are identified as key barriers to the integration of spiritual care.[60,62]

Lack of consultation time, as expressed in all the above studies, was echoed by the participants in the present study. It also determines how much time will be awarded to reflection on intervention by therapists, as well as the client having time to reflect on the spiritual orientation of their therapy. Reflection has emerged as a category in the next theme and will be discussed in detail there.

The researcher suggests that introspection and reflection about the spiritual orientation of their therapy could be facilitated by the means of the Canadian Occupational Performance Measure (COPM). It is a client-centred measure whereby the client determines priority occupations and scores themselves for performance and satisfaction in these priority occupations. On reassessment, the client scores each occupation again, thus facilitating reflection and introspection into their occupations**.**[22]

5.2.3.3. Category c) Awareness and increased education on the understanding of spirituality

The need for more awareness and increased education was voiced strongly by participants in two different ways, namely the therapist's spirituality and the client's spirituality. In the Design and Destiny phase, the participants also articulated the need for having an awareness of and being educated on the concept of spirituality in South Africa.

- <u>Therapist's spirituality</u>

Participants felt the need to journey into their own spirituality and become more aware of their own spirituality. This finding resonates with the notion mentioned by Meredith et al.[65] "by seeing our own spirituality we become better equipped to recognize spiritual things in others".[65] Furthermore, these authors mention that the evolution of one's own spirituality comprises a multifaceted journey. Nevertheless, embarking on this experience equips us to grasp the spiritual lives of individuals with whom we work. These researchers implemented a longitudinal study designed to improve awareness, confidence and spiritual knowledge of palliative care workers. Findings revealed that

the aim of these workshops were met and there was significant improvement in the above-mentioned aspects amongst the multidisciplinary participants.[65]

Hemphill[8] suggests that it is vital that occupational therapists be aware of their own spiritual beliefs and practices and how those might impact on their clinical practice. Furthermore, she mentions that a successful spiritual discussion is aided by self-understanding and spiritual self-care. The therapist's understanding of their own spiritual beliefs, values and biases allows the therapist to be client-centred and non-judgmental when dealing with the client's spiritual concerns. This is pertinent when the therapist has differing beliefs from the patient.[8]

Consequently, a lack of self-understanding and the implications thereof was clearly demonstrated in a literature review by Mathisen et al.[45], where occupational therapists found it challenging considering and conveying their own religiosity and spirituality, let alone enquiring about another person's beliefs.[45]

The findings of the current study also corroborates with findings of Mthembu et al.[29] and Piret et al.[54] who emphasised the importance of self-awareness before addressing the spiritual care of clients.[29,54] Self-awareness and education in one's personal spirituality has been highlighted in literature as a means of facilitating spiritually and culturally sensitive OT practitioners and students.[62]

In a different study, Mthembu et al.[64] found that the community fieldwork setting facilitated the OT students' understanding of their spiritual beliefs. Moreover, practitioners may learn to converse with community members by being empathetic, non-judgmental, open to, and aware of the spiritual dimension of communities.[64]

Other reported benefits of self-awareness and thus education of personal spirituality have been highlighted in a study by Misiorek and Janus[11]. The postgraduate occupational therapists in their study articulated their spirituality as a source of support and a coping mechanism with stress. The majority of these therapists expressed that their own spirituality influences how they treat others and their acceptance of patients.[11] This finding is echoed in another study where participants used prayer to guide them through their intervention with clients. Spirituality was also reported to bring stability and a sense of calm for these participants.[28]

The present study findings are also consistent with a 2018 study that recommends that teaching and learning about spirituality should include self-awareness. It is recommended that prior to understanding the client's spirituality, educators and students should be cognisant of their own spirituality. This awareness may promote personal and professional development.[53] Directed study and reflection of personal spirituality was also found to lead to increased awareness and confidence in delivering spiritual care to clients.[41]

- Understanding the concept in South Africa

Participants indicated that understanding spirituality within a South African context was viewed as an essential strategy to integrate spirituality in practice.

This is supported by the OTASA Position Statement that mentions that every effort must be made to comprehend spirituality from the viewpoints of the individual or community within our multicultural diverse population of South Africa. Moreover, this understanding is vital to comprehensive and culturally competent healthcare in South Africa.[27]

The importance of understanding spirituality within the South African context is also highlighted in the fact that spirituality has a variety of cultural and individually influenced meanings.[41]

A review on spirituality in speech and language pathology mentions that caring for a growing number of people who are from diverse religious/spiritual backgrounds has the potential to present substantial challenges.[45]

Our findings agree with findings of a study by Mthembu et al.[28] whose participants expressed that spirituality is a sensitive topic to be discussed and addressed in practice, as their participants at times interacted with clients from different religions and cultures. Moreover, these participants reported a challenge in comprehending the contextual aspects, as there are many different cultures in South Africa.[28]

Similarly, Thompson et al.'s.[39] findings imply that, in order for therapists to integrate religious observation in practice, it may comprise being informed of anticipated behaviours of different religions.[39] Mosirek and Janus[11] and Hemphill[8] explain that an individual's faith community may be a source of therapeutic aid, hence our participants

understanding and awareness of spirituality within a South African context will seemingly assist their integration of spirituality in practice.[8,11]

Consistent with this, in another South African study, therapists recognised cultural or religious organisations as one of the pertinent sources for information when determining the nature of spiritual occupations in mental health care settings. These participants highlighted people as a resource during this process. The value of people as web-like resource and their interconnectedness could be explained by the Ubuntu philosophy, prevalent in South Africa.[20]

The appreciation and acknowledgement of history, culture, and tradition as part of spirituality could enhance and deepen the experience of life.[62] Furthermore, Fang et al.[89] and Moreira et al.[60] reported that effective therapeutic relationships tend to be established when health care professionals are culturally and spiritually sensitive, consequently assisting in providing effective care to clients and their family members.[60,89]

A scoping review by Fang et al.[89] revealed that facilitators of culturally and spiritually holistic care expressed the need for active efforts to: “involve family members; integrate diverse cultural and spiritual values; discuss with family members the changing needs of the patient and improve as well as sustain culturally- and linguistically-effective communication between heath care professionals and service users”.[89]

A systematic review by Roman et al.[25] exploring the teaching content and teaching strategies on spirituality in health care education found that content knowledge may include, amongst other aspects, cultural beliefs, diversity and social justice. Consistent with our findings, cultural beliefs were considered as a vital component of teaching spirituality in health sciences education. Moreover, these studies reported that people seem to have varied cultural beliefs and values that have an impact on dietary requirements and birth and death rituals. When considering diversity and social justice in the review, these studies suggested that spirituality be included in topics such as diversity and social justice.[25]

- Client’s spirituality

Awareness and education were articulated as a vital empowering strategy to enabling the client’s spirituality. Learning strategies participants mentioned were expressed as

learning through enquiry (with client), learning through understanding, learning through introspections and reflections with clients and learning through research. Additional training in this aspect of spirituality was also highlighted.

Various studies identify a theory-practice divide.[6,29,41] This could be attributed to a lack of understanding of spirituality in OT or a lack of confidence in practice. Participants highlighting the need of education and awareness of client spirituality is thus justified.

The importance of awareness and education on the client's spirituality, as echoed by participants, resonates with the holistic and humanistic approaches adopted by educators, clinicians and students to guide client intervention. However, the spiritual element in education seems to be annulled.[53]

The results of the current study align with the findings of Morris et al.[6], whereby OT practitioners found their formal OT syllabi insufficient with regard to integrating spirituality in treatment.[6] Consistent to this, another study found that even though occupational therapists acknowledge the significance of religious observance and its place in the OTPF, participants did not address this in therapy. Further education was indicated on how to do so. These authors stated that it is vital that therapist overcome any discomfort surrounding the topic of spiritual and religious activities so that clients may share their spiritual concerns with the therapist. Further training for practitioners and the addition of spirituality in the curriculum of the undergraduate programme was recommended.[39]

A review of literature by Mathisen et al.[45] found that occupational therapists alleged that there was no or inadequate academic training during their university education exploring religion/spirituality issues, consequently having an impact on their clinical education and subsequent clinical practice.[45]

The findings of the current study also corroborate with a study on OT students, where participants indicated less agreement on education adequately preparing them to address spirituality. The authors confirm this lack of adequate academic training resulting in the therapists being unprepared to intervene and act on patient's spiritual needs. It was, thus, recommended that spirituality be integrated into OT education, consequently enhancing the holistic approach.[29]

Conversely, findings from a study that explored the "barriers impeding the integration of spirituality and spiritual care in OT education in a South African context," found that educators questioned whether spirituality should be taught in OT education, as it seems not to be given focus in theory. OT students in this study also felt unprepared to address spirituality due to the ambiguous nature of the topic within the classroom.[62]

Lambie et al.[13] and Roman et al.[25] argue that, given the apparent ambiguity regarding the meaning of spirituality, it comes as no surprise that there was no agreement on how spirituality should be taught. Hence, these variations impede the infusion of spirituality in healthcare education and practice.[13,25]

A qualitative study by Lambie et al.[13] revealed explicit methods for teaching spirituality which included "small group tutorials, opportunistic teaching (e.g. as relevant issues emerge in the care of particular patients), teaching by example, mentoring and role modelling." Many of their participants suggested that the concept of spirituality could be presented along one or more of the following topics: empathy, self-reflection and cultural sensitivity. Several participants in their study indicated that spirituality should not become another 'box to tick." Didactic lectures were found to be inadequate and not the most appropriate.[13] Consistent with this, participants in a study by Meredith et al.[65] found that a custom-designed workshop significantly improved knowledge and confidence of healthcare professionals when providing spiritual care to clients.[65]

Likewise, a systematic review of teaching methods and teaching content on spirituality revealed teaching content to include "concept analysis, self-awareness, cultural beliefs, diversity and social justice, ethics, spiritual competence, person-centred attributes and barriers, evidence-based practice, and possible areas where spirituality and spiritual care may be covered". Teaching strategies should include educator's teaching strategies in the classroom, collaborative learning and practice learning".[25]

5.2.4. Theme 4: Nurturing spirituality within the therapist

Participants also expressed that nurturing their own spirituality is imperative to developing strategies on how to implement, sustain and address spirituality in daily OT practice. This theme was derived from the following two categories, namely, reflection and awareness and increased education. The category of awareness and increased education has already been discussed in detail.

5.2.4.1. Category a) Reflection

Reflection was identified as pertinent to sustain and further develop participants' ability to address spirituality. This was voiced in the following three subcategories, namely, journaling, discussions and creating time for reflection. Previously, under the theme of envisioned enablers, time for reflection emerged, and here time for reflection has been embedded in the subcategories of journaling and discussion.

The value of reflection is confirmed in a study by Barry and Gibbens[41]. Their participants expressed greater confidence in their ability to address the spiritual needs of their clients after completion of directed study (reading about spirituality) and personal reflection. Additionally, participants were in agreement that this would improve their ability to meet the spiritual needs of their clients in practice.[28,41]

Furthermore, Barry and Gibbens[41] cite earlier studies that sought to identify the best methods of preparing OT students to address clients' spiritual needs. These studies also utilised reflection on personal spirituality. One of these studies found that reflection on personal spirituality improved awareness of self and others. The second study reported changes in participants' attitudes towards spirituality as a consequence of self-reflection. It is argued that these findings should be addressed with caution due to a lack of information on methodological aspects. Nevertheless, these studies suggest that confidence in addressing clients' spiritual requests are facilitated through education and reflection about spirituality.[41]

The findings of this study also corroborate with a review carried out by Roman et al.[25], which found that reflection increased the awareness of spirituality and participants were more confident in addressing spiritual needs of clients.[25]

Fang et al.'s[89] findings reiterate the value of reflection, whereby studies found that a critical challenge for healthcare professionals is the capacity to reflect on their own unrecognised anxieties, prejudices, biases and fears about other cultural and spiritual practices, beliefs and values that are dissimilar to their own. This suggests that engagement in self-reflection and reflexivity should support a more profound understanding and empathy towards individuals of different cultural and spiritual backgrounds.[89]

- Journaling

Participants were of the opinion that keeping a reflective journal on spirituality, would enrich their development of spirituality. Reflections should also be shared weekly to sustain further development.

The use of reflective journals were also supported by Meredith et al.'s[65] findings, which showed that resources utilised in a workshop for teaching and learning about spirituality by health care professionals, may include reflective journals poems, music, quotes, movie clips and photo montages. Thus, it appears that these resources could improve insight regarding spirituality. Hence, it seems apparent that these resources demonstrate that spirituality is not only a cognitive process.[28,65]

Similarly, in a community fieldwork setting OT students conveyed that journaling was an effective approach for improving the student's understanding of spirituality in community settings. The participants also noted that there was an improvement in students' abilities to write journals. Journaling, in this setting, was viewed as an enabler to enhance self-reflective abilities. Moreover, these participants stated that writing the journals improved their personal and professional developments.[64]

Our findings are consistent with a study that explored educators' and students' needs regarding teaching and learning strategies for integrating spirituality and spiritual care. Reflective journaling emerged as one of the pertinent categories in this study and was a platform for integrating spiritualty in practice. Participants expressed that journaling could assist in their own spiritual journeys, as well as facilitate understanding of the spiritual journey of others.[53]

- Discussions

Participants highlighted that when religious holidays are celebrated, this should be communicated as this can bring about awareness. Dialogue with peers around the topic of spirituality was another idea. Sharing thoughts about spirituality with colleagues at practice placements during regular time slots was also identified as a way to develop spirituality.

The importance of discussions and thereafter intermittent discussions was supported by a study in which healthcare professionals gathered together to reflect on clinical

practice and discuss spiritual matters. Findings reveal that this may nurture one's own spirituality and replenish the ability to provide personalised care. However, this effect is not lasting, thus these authors suggest that holding gatherings intermittently for staff may prove beneficial.[65]

An editorial by Bremault[49] supports our findings, as it is mentioned that it is imperative to open up dialogue among occupational therapists regarding spirituality and its place with the conception of the occupational human – both therapist and client. This dialogue can also assist in providing therapists with a vision that makes spirituality more obtainable to themselves and their clients.[49]

Similarly, Mthembu et al.[53] found that OT students were of the opinion that spirituality cannot be imparted through lectures alone. Engaging in discussion about spirituality and culture as part of social participation was highlighted to contribute significantly to their learning about spirituality in the OT classroom. Interactive learning was expressed as a suggestion for incorporating spirituality into OT education. Hence, these authors recommend that strategies that may foster learning in spirituality should entail group discussions and case studies as part of interactive learning. Furthermore, debates, brainstorming, group presentation, photographs and documentaries may be used as strategies to enable awareness and critical reflection about spirituality within the classroom.[53]

5.3 CONCLUSION

This chapter presented a discussion of the relevant themes of this study namely, understanding spirituality as a construct, client centred practice/approach, envisioned enablers of spirituality, and nurturing of spirituality in the therapist. The next chapter will address the conclusion of this study, its recommendations and the limitations.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1. INTRODUCTION

Chapter 5 presented a corroboration of study findings with the available literature. This chapter encompasses the conclusions in relation to the objectives of the study. The limitations are discussed and recommendations for education and curricula, clinical practice, and further research of spirituality in occupational therapy (OT) practice are proposed.

6.2. AIMS AND OBJECTIVES

This study aimed to explore how spirituality is being addressed in occupational therapy practice by clinicians and educators by means of an appreciative inquiry (AI) approach. The objectives formulated to achieve this purpose are outlined in the Table 6.1. below.

Table 6.1. AI phases linked to Aims and Objectives

Discover Phase: (the best of what is)
• To explore and describe spirituality in OT practice through the generation of experienced successes in spirituality.
Dream Phase: (what might be)
• To explore the aspirations/wishes of OT clinicians and educators regarding spirituality in occupational therapy practice.
Design and Destiny Phase (What should be and will be)
• To develop strategies on how to implement, sustain and address spirituality in daily OT practice

The conclusions of each of the objectives will now be discussed.

6.2.1. Objective 1: Discovery Phase *(Discover the best of what is)*

This phase was facilitated through two questions that allowed participants to share their ideas about what spirituality in OT practice is and to describe how they use spirituality in their current practice. Two themes emerged, namely 1) understanding spirituality as a construct, and 2) client-centred practice/approach.

Participants showed that spirituality as a construct was expressed in the categories of meaning of life and connectedness. Meaning of life was correlated with *motivation* and *hope.* Connectedness was also pivotal in understanding spirituality from the perspective of the participants, and they were of the opinion that connecting on a deeper level with clients as well as connecting with the client's community remains instrumental when facilitating spirituality from an OT perspective.

Moreover, participants expressed spirituality in OT practice to be an intangible component that can be made tangible when expressed through occupation. Participants acknowledged the importance of spirituality and its influence on mind and body. Finally, the participants expressed that spirituality is a concept beyond religion and culture and not just religion and culture.

Experienced current successes of spirituality were not only attributed to the participants' understanding of spirituality, but also to participants being client-centred in their practice. Client-centred practice in this study pertained to the categories of spirituality as expressed through the therapeutic relationship, spirituality as expressed through beneficence, and spirituality as expressed through the therapeutic intervention.

Participants highlighted that respecting the client's beliefs and values, acknowledging their uniqueness, as well as acknowledging clients as spiritual beings, being open and non-judgmental to cultures and religion, and to listen and understand were essential in their therapeutic relationship to facilitate spirituality in their current practice.

Participants indicated that benefits of addressing spirituality in OT practice included motivating the clients, instilling hope and giving meaning to clients' current understanding of their situation. When expressing spirituality through therapeutic intervention, participants emphasised that client-centred practice should entail individualistic and holistic intervention, culture- and God centred-intervention, meaningful activities/occupations, as well as creation of a safe space.

6.2.2 Objective 2: Dream Phase *(What might be?)*

When exploring the aspirations and wishes of participants regarding spirituality in OT practice, the theme of 'envisioned enablers of spirituality' emerged. In this phase participants shared what they could do more of, what they could do better, and how they could move towards excellence.

Five categories were highlighted under this theme, two of which were repeated from the first theme of client-centred practice, namely spirituality as expressed through the therapeutic relationship and spirituality as expressed through therapeutic intervention.

Participants' expression of these categories and subcategories were conveyed similarly to the Discovery phase, however, in statements participants expressed these categories and subcategories as aspects they wished they could implement more of and perform better in. Here one should take cognisance that in AI the Discovery phase is regarded as the building blocks for the Dream phase.

Novel emerging categories were:

- time to address
- need for a spiritual tool
- increased awareness of and education on spirituality

Firstly, participants valued extra time in practice to address spirituality with OT students and clients. Additional time with clients was foreseen by participants to be a facilitator of integrating spirituality in practice. Time is essential in establishing an authentic understanding of client's spirituality, their spiritual needs, including their spiritual activities and occupations. However, according to participants, this is often hindered by busy schedules and high workloads. This time constraint also impacts on time for introspection and reflection. Likewise, having extra time for introspection and reflection was also envisioned.

Secondly, participants articulated a need for a spiritual tool for assessment and intervention in OT. This tool was envisaged to be a vehicle to incorporate spirituality practically. Participants were also of the opinion that a possible tool that could be utilised is the Vona du Toit's Model of Creative Ability (VdTMoCA).

Thirdly, the clinicians and educators of this study valued increased education and awareness of spirituality. This was communicated in two different ways, namely the therapist's spirituality and the client's spirituality. Participants conveyed that it is essential to journey into and become more aware of their own spirituality. This was seen as a means of coping and preventing burnout of practitioners. Participants indicated that raising awareness of the significance of spirituality amongst therapists is essential. Participants also expressed that having an increased awareness and understanding of the client's spirituality will assist them to hone into the spiritual needs of the clients better.

6.2.3. Objective 3: Design and Destiny Phase *(What should be and will be)*

In this phase, participants developed strategies on how to implement, sustain and address spirituality in daily OT practice. The study findings of this objective yielded two main themes. Firstly, client-centred practice was highlighted again as one of the emerging themes, however, now expressed as a strategy to implement and address spirituality in OT practice. Yet again the VdTMoCA was highlighted as a subcategory of client-centred practice and a strategy for implementing spirituality. The second theme for this phase was 'nurturing of spirituality within the therapist and educator'. This theme was divided into two categories, namely reflection and enhanced education and awareness.

Reflection was identified in this study as pertinent to sustain and further develop participants' ability to address spirituality. This was expressed in the following three subcategories, namely: journaling, discussions, and creating time for reflection.

The category of education and awareness of spirituality emerged again and was expressed as a strategy to enable the practice of spirituality. This category had the following subcategories: education and increased awareness of the therapist's own spirituality, education and increased awareness of the client's spirituality, and understanding the concept of spirituality from a South African perspective. Learning strategies were expressed as learning through enquiry, learning through increased understanding, learning through introspections and reflections with clients, and learning through research.

6.3. IMPLICATIONS OF THE STUDY

This study set out to explore how spirituality is being addressed in OT practice by clinicians and educators by means of an AI approach. Overall, the findings reveal that this aim was achieved. Through the use of AI, participants identified their strengths, aspirations, and developed strategies on how to implement, address and sustain spirituality in OT practice. Utilisation of this approach also found that participants view spirituality in OT practice and education positively, amidst the various other challenges occupational therapists experience on a daily basis.

Conceptual ambiguity of spirituality was not evident in this study. The participants in this study expressed that spirituality is a concept beyond religion and culture and not just religion and culture. Findings suggest that the concept of spirituality in OT could be defined as meaning of life and connectedness, with meaning of life relating to motivation and hope, and connectedness referring to being connected to the individual and their community. Spirituality was also expressed as essential to OT and could not be ignored, and that this intangible aspect of the human could be made tangible through the use of meaningful occupations.

Client-centred practice was highlighted as a strength to addressing spirituality in OT practice. An authentic therapeutic relationship, based on respect, acceptance, being non-judgmental and being able to listen and understand, is vital to addressing spirituality in practice. In addition, therapeutic intervention should entail God-centred and/or culture-centred therapy, individual/client-centred focused intervention and meaningful activities and occupations, and finally the creation of a safe space to explore spirituality. VdTMoCA was highlighted as a possible vehicle to address spirituality. Participants suggested that the possible benefits of addressing spirituality in practice were that this motivates clients, instils hope and gives meaning to therapy.

Participants indicated that envisioned enablers of spirituality could possibly be additional time to address spirituality, a tool to assess and include spirituality in treatment, and an increased awareness of and education on spirituality. The need for a spiritual tool, as well as the need for increased awareness and education on spirituality articulated by educators and clinicians, highlight the perceived theory-practice gap mentioned in literature. Importantly, this study found that without attending

to one's own spiritual beliefs, needs and values, meeting spiritual needs in clients will not be forthcoming.

6.4. CLINICAL RELEVANCE

The findings of this study identify the extent to which spirituality is already incorporated into OT practice amongst participants. It recognises the need and value of spirituality in OT practice. Findings can likewise inform guidelines to integrate spirituality in OT.

In keeping with the study findings, occupational therapists' utilisation of meaningful activities and occupations indicate that they possess the opportunity to initiate conversations with clients around spirituality. Spirituality should be considered as part of a routine history assessment. Spiritual and religious occupations could be used as a means and as an end in OT. Moreover, the use of individualist culture-centred therapy could facilitate spirituality in OT practice. Deciphering whether their patients relate to spirituality through a traditional religious discipline or through unconventional practices is pertinent for the OT clinician. Thereafter, the therapist can assist their clients in their spiritual process. A therapeutic relationship imbued with respect, acknowledgement, a non-judgmental approach, as well as a relationship in which the therapist listens actively to the client, is a catalyst for the client to open up and share their spiritual needs. Participants suggested that the VdTMoCA could potentially be utilised to address spirituality in clinical practice.

Ultimately, the spiritual self-care and self-awareness of the therapist is vital to addressing spirituality in practice. Discussions with peers and reflections are instrumental in developing the OT practitioner's ability to address the spiritual needs of their clients.

6.5. RELEVANCE FOR EDUCATION AND CURRICULUM

The theory-practice divide is evident in literature, similarly to the findings of this study. Participants expressed increased awareness and education as an enabler of spirituality in OT practice, as well as a strategy to develop the ability to address

spirituality in practice. Learning content needs, as expressed by participants in this study, include better understanding of the client's spirituality, better understanding their own spirituality, as well as understanding the concept of spirituality within the multicultural and, thus, diverse South African context. A spiritual tool to facilitate spirituality practically was also envisaged by participants.

6.6. LIMITATIONS

Due to the specific purposive sampling of OT educators and OT clinicians practicing in the Gauteng region of South Africa, a limitation of this study lies in its lack of generalisation to other areas. However, it must be noted that the findings of this study are similar to other studies conducted in South Africa, as illustrated in the discussion. Therefore, findings may be applicable to similar settings in South Africa. In spite of this limitation, the findings contribute to the growing body of knowledge on spirituality in OT.

6.7. RECOMMENDATIONS

6.7.1. Clinical practice

It is essential for OT clinicians to be aware of different cultural, religious and diverse values of their clients, thus enabling them to be sensitive and address the spiritual needs of their clients. Creation of a safe and supportive environment is imperative when addressing spirituality in OT practice.

It is recommended that a balance be kept between occupational therapists using and developing a patient's spiritual strengths and remaining attentive to treatment goals. Therapy should continually be the main focus. The multidisciplinary team approach should be applied, and occupational therapists should not assume the role of spiritual expert, but rather refer their clients to their own spiritual leaders. Practical spiritual needs, like having access to scriptures, prayer beads or clothing, or time for prayer must be acknowledged and met. Hemphill[8] proposes further suggestions to be culturally and spiritually sensitive:

- Uphold patient requirements for same-sex providers whenever possible.
- There should be respect for patients' religious beliefs and needs, even when these are different from your own.
- Allow patients privacy for prayer.
- Beware and acknowledge diverse religious holy days, namely Friday for Muslims, Saturday for Jews, and Sunday for Christians.
- Study religious symbols that are sacred to those who are being treated and show respect to these.

Nationally, practicing occupational therapists belong to a regulatory body, namely, the Occupational Therapy Association of South Africa (OTASA). Recently OTASA published a Position Statement on spirituality in OT. As part of its strategies for implementing their position statement, this paper explicitly explains that spirituality needs to be assessed, as it is regarded integral to the concept of holism. It is recommended that the routine history assessment of the individual, their families and communities include spirituality. This paper makes known that limited practice guidelines in health facilities do exist. The researcher advocates that these guidelines be developed, based on literature included in Chapter 4. This may include addressing the barrier of having adequate time to integrate spirituality in clinical practice, thus the culture within hospitals needs to change.[26]

Ethical standards should be maintained when discussing and addressing spirituality with patients.[51] The researcher recommends that the universal ethics suggested by Hemphill[8] be considered when clinicians are interacting with clients that are experiencing a spiritual crisis (See Box 1).

Box 1: Hemphill's Universal ethics[8]

- *"Be human, be real, and be honest.*
- *Be present and listen, with an emphasis on being with the patient, not doing.*
- *Include spiritual concerns in treatment planning.*
- *Respect the patient's belief system, regardless of your own feelings about religion and spirituality.*
- *Provide access to spiritual resources by referring to spiritual healers, such as chaplains, priests, ministers, rabbis, and imams.*
- *Be a caring professional; encourage patients and their family members to give voice.*
- *Explore, but do not probe; help people to feel heard.*
- *Avoid judging beliefs, practices, or emotional responses; refrain from proselytizing or imposing your own beliefs. Be aware of your beliefs and the influence they have on the health care process.*
- *Be careful if you and a patient share the same religious traditions; beliefs and practices vary widely.*
- *Avoid discussions of doctrine, dogma, and complicated theological questions. Patients usually do not want or need intellectual discussions; they need comfort and reassurance. Avoid clichés, such as "It is God's will" or "God never gives you more than you can bear." Do not use this language unless the patient and family members have used these phrases themselves.*
- *Respect the patient's and family's spiritual traditions and practices, as well as their privacy in this area.*
- *Do not initiate participation in the patient's religious observances. Let the family do the inviting.*
- *Finally, follow the plan for spiritual care agreed upon by the patient, family, and health team."*

Ultimately, it is recommended that OT clinicians take heed of their own spiritual self and spiritual self-care. This is integral to dealing with the multicultural demands and multiple needs of patients in the current health care system. Thus, healthcare settings should make provision and encourage the healthcare professional's consideration to their self-care, reflection and attention to stress management.

The interdisciplinary team together with the OT should be allocated time on an ongoing basis to examine and reflect on their spiritual interactions with patients. The benefits of spiritual and reflective practices are consolidated when these practices occur regularly and are foundational in one's life.[92] Some examples of these practices include

participation in a faith- or spiritual community, using spiritual mentors to guide our spiritual journey and inquiry, meditation, the arts (poems, drawings etc.), prayer or reading scriptural texts, gratitude practices, reflective practices (reviewing how the encounter with the client made us feel spiritually and emotionally), journaling can help bring closure to a day with our patients, or even simply taking a walk in nature can be reflective practice.[92]

6.7.2. Education and training

Most participants expressed that there is a need for increased education and awareness of the client's spirituality, their personal spirituality, as well as understanding the concept of spirituality in a multicultural and diverse South African context. Thus, it goes without saying that undergraduate and postgraduate education needs attention. This study also highlighted a need for a spiritual tool that could guide spiritual discussions with clients.

6.7.2.1. Undergraduate level of training

Spirituality should feature across the various OT modules in the undergraduate curriculum. Some of the content knowledge found in literature that embraces the topic of spirituality could include concept analysis, self-awareness, cultural beliefs, diversity and social justice, ethics, spiritual competence, person-centred attributes and barriers, and evidence-based practice. Additionally, learning objectives should encompass enhancing the knowledge, skills, and attitudes-based learning when incorporating this topic in education. Pedagogic strategies should include classroom-, collaborative- and practice learning.[25] These self-awareness activities could enhance the educator's and student's professional growth, consequently resulting in an OT practitioner that is better equipped to address the spiritual needs of clients. The value of experiential learning and reflective practice has been well-documented in literature and the researcher recommends that reflective journals during practice placements will foster critical thinking.

The OTPF[3] guides OT practice and education nationally and internationally, and, in its third edition, this framework presents spirituality as a client factor and mentions spiritual and religious activities as an instrumental activity of daily living. Even though the

framework defines these activities, it lacks guidelines to address this occupation in practice. Thus, the researcher recommends that additional training of students and focus on this occupation is necessary to ensure that spirituality is given attention in practice and not negated due to the lack of practice guidelines.

The researcher also recommends that, in an overloaded curricula, and not having the luxury of extra time to address spirituality in education, educators need to be creative when addressing spirituality in training.

It is also recommended that an interdisciplinary team approach to learning about spirituality is adopted, as this could facilitate OT students' understanding of other team members and their specific roles with respect to spirituality. The clergy or traditional healer should also be part of this team.

Occupational therapy students and educators should also be trained in spiritual history-taking and screening. Educators should advocate that these spiritual assessments should be part of practice placements. This can facilitate that students will feel competent to assess the client's spiritual needs, and that the educator can guide the students in the field with regards to this aspect.

Educators should also be creative in their assessment methods with respect to spirituality. Students' assessments should be designed to motivate critical reflection about content area and skills, and incorporate personal reflection about their own spiritual and professional commitments. Assignments recommended to facilitate this could be a spiritual blog whereby students' journal their own spiritual issues via an online e-learning platform, a personal spiritual profile assignment, debates, and/or case-report presentations.

6.7.2.2. Postgraduate level of training

It is recommended that education institutions host continuous professional development (CPD) workshops on spirituality, so that educators as well as OT clinicians can equip themselves with the necessary tools to embrace the spiritual needs of clients. Topics could include cultural diversity, spiritual tools, spiritual self-care and self-awareness, and how to integrate spirituality in OT practice in a culturally diverse context.

Additional time was highlighted by participants as an envisioned enabler of spirituality. The luxury of having extra time, whether it be in practice in a demanding healthcare setup or in education, is not likely to be forthcoming, so the researcher recommends that an online course be developed to accommodate constraints in time.

6.7.2.3. Further research

As much as this study provides some practice guidelines on how participants successfully addressed spirituality in OT practice, further research on practice guidelines is still warranted. Specifically, developing practice guidelines on how to address spiritual and religious activities as IADL occupations also justifies further research in OT.

This study highlighted that a possible tool to facilitate addressing spirituality in OT could be the VdTMoCA. To the researcher's knowledge, this specific model has not been validated to address spirituality, and thus further research on this topic could be valuable.

Spiritual history-taking falls within the domain of OT. A spiritual history-taking tool is the FICA, and as much as this tool has been utilised by other healthcare professionals and found to be beneficial, to the researcher's knowledge utilising this tool and the efficiency of it in OT practice has not been researched.

This study explored spirituality using educators and clinicians as population in the catchment area of Gauteng. Conducting a study with OT students as population in this area may also prove beneficial. Also, a qualitative study involving the multidisciplinary team's (including the clergy and chaplains) perceptions of spirituality could facilitate role clarity on this concept.

6.8. CONCLUSION

The aim of this study was met by addressing the AI-formulated objectives. The findings of each of the three phases, namely the Discovery phase, the Dream phase and the Design and Destiny phase have been summarised. Limitations of the study were

presented. Recommendations for clinical practice, education and training, as well as research were also made.

This study clearly specifies how spirituality is being addressed in OT practice by clinicians and educators in Gauteng. In the Discovery phase, participants clearly expressed how they define and understand spirituality in OT practice, and their current successes were attributed to client-centred practice. In the Dream phase, educators and clinicians shared their aspirations with respect to spirituality, envisioning OTs as enablers of spirituality. Finally, in the Design and Destiny phase, participants developed strategies to address, sustain and implement spirituality in practice. Client-centred practice and nurturing of spirituality within the therapist underscored all emerging strategies.

These findings may contribute to the current discussion on spirituality in OT. Findings of the Discovery phase were depicted in a poster and presented at an international conference.[93] Further presentations of the findings of this study should be done as opportunities arise. The literature on the utilisation of the AI approach in OT is limited, thus this study serves to contribute to the existing body of knowledge.

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APPENDIX A

Consent form

TITLE OF STUDY:

The use of spirituality in occupational therapy practice: an Appreciative Inquiry

Dear Participant,

1) INTRODUCTION

You are invited to attend an ethics continuous professional development (CPD) workshop based on appreciative inquiry principles. This information leaflet will help you to decide if you would like to participate. Before you agree to take part, you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the researcher, Mrs R Balbadhur. Contact details are available on the next page.

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore and describe how spirituality is being addressed in occupational therapy practice with the use of Appreciative Inquiry.

The objectives are as follows:

- To explore and describe spirituality in occupational therapy practice through generation of experienced successes in spirituality.
- To explore the aspirations/wishes of occupational therapy clinicians and educators regarding spirituality.
- To develop strategies on how to address, implement and sustain spirituality in daily occupational therapy practice.

Therefore, you, as voluntary participant in this study, are an important source of information on understanding spirituality in occupational therapy practice.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

The research team will consist of an independent facilitator, and myself and my supervisors as assistant facilitators, who will take field notes during the workshop. The duration of the workshop will be approximately 5 hours. The workshop will comprise of paired interviews as well as discussions, thus culminating in identified emerging themes during feedback. Please take note that group discussions will be digitally recorded. Signing consent would thus also imply consent to be audiotaped.

4) RISK AND DISCOMFORT INVOLVED

There are no risks in participating in the study, however, your involvement in this study will require some of your time and effort.

5) POSSIBLE BENEFITS OF THIS STUDY

The use of Appreciative Inquiry in data collection will facilitate understanding, as well as developing, strategies on how to address spirituality in occupational therapy practice. This will then inherently positively impact on patient treatment.

6) WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the workshop without giving any reason.

7) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria (telephone numbers 012 356 3084 / 012 356 3085).

8) INFORMATION AND CONTACT PERSON

The contact person is Mrs R Balbadhur. If you have any questions about the study please contact her at the following telephone numbers: 0795111631 or 012 3561372, or via email at raashmi.balbadhur@up.ac.za

9) COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10) CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analysed the information, no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that Mrs R Balbadhur, in asking my consent to take part in this study, has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study.

I have received a signed copy of this informed consent agreement.

Participant's name: ….....(Please print)

Participant's signature: .....…… Date:.....

Investigator’s name:.....……...(Please print)

Investigator’s signature: .....…… Date:….....

Witness's Name: .....…….....(Please print)

Witness's signature: .....…….. Date:….....

APPENDIX B

Demographic Information

Please could you complete the following information about yourself. This information will not be used to identify you during the data analysis or in the final report.

Age:

_____

Gender:

_____

Full-day/Part-time practitioner:

_____

Educator or Clinician:

_____

Years in practice:

_____

Type of practice:

_____

APPENDIX C

Self-report interview schedule questions

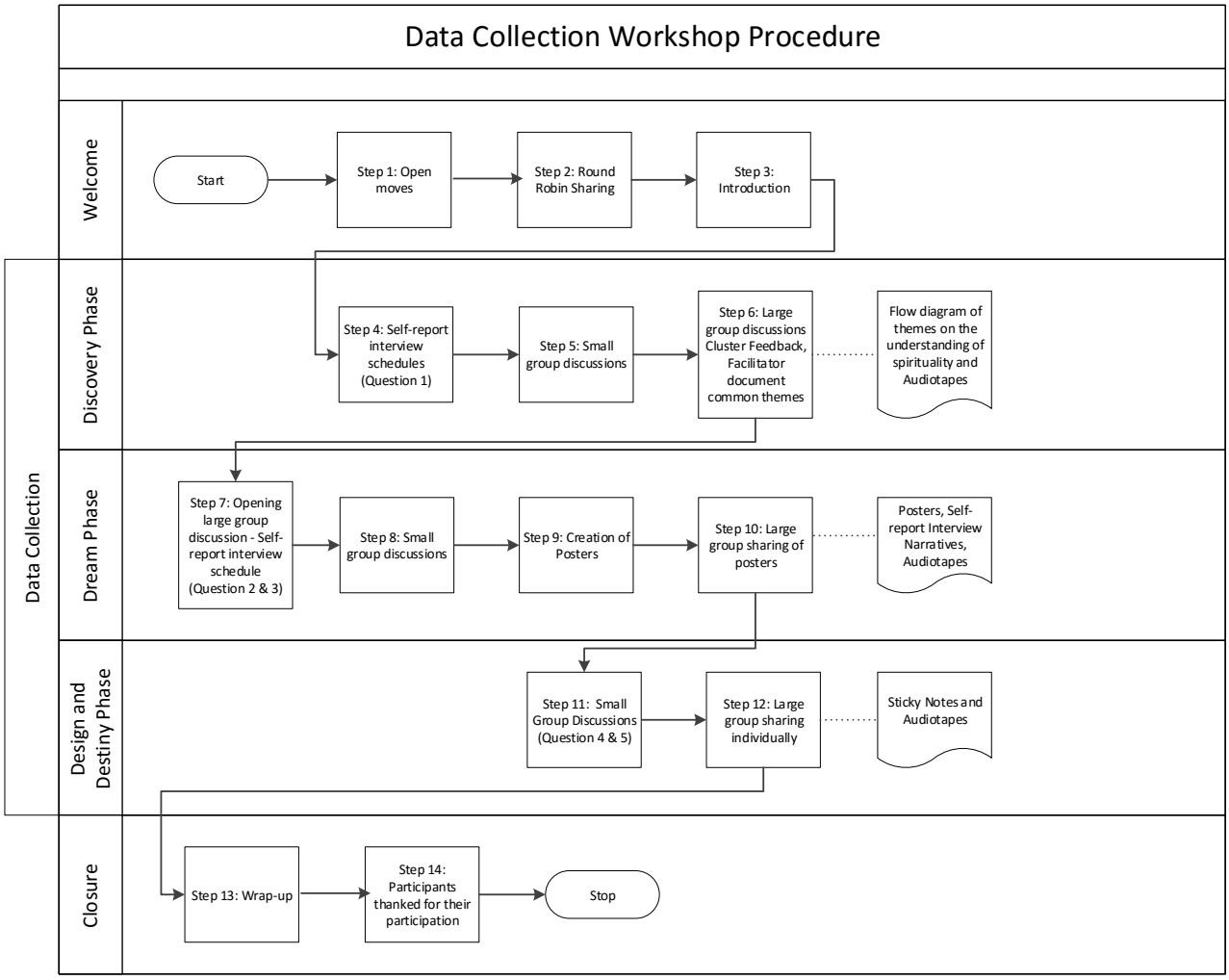
Question 1: Share your ideas about what spirituality in occupational therapy practice is.

Question 2: Describe how you use spirituality in your practice (think about what works well).

Question 3: Share your wishes regarding the use of spirituality in everyday practice (think about what we can do more, how we can do better, move towards excellence).

Questions 4 & 5: How would we develop strategies with regard to spirituality? What can we improve on now, and how will we sustain and further develop it?

APPENDIX D


Data Collection Workshop Procedure
Data Collection
Welcome
Start
Step 1: Open moves
Step 2: Round Robin Sharing
Step 3: Introduction
Discovery Phase
Step 4: Self-report interview schedules (Question 1)
Step 5: Small group discussions
Step 6: Large group discussions Cluster Feedback, Facilitator document common themes
Flow diagram of themes on the understanding of spirituality and Audiotapes
Dream Phase
Step 7: Opening large group discussion - Self-report interview schedule (Question 2 & 3)
Step 8: Small group discussions
Step 9: Creation of Posters
Step 10: Large group sharing of posters
Posters, Self-report Interview Narratives, Audiotapes
Design and Destiny Phase
Step 11: Small Group Discussions (Question 4 & 5)
Step 12: Large group sharing individually
Sticky Notes and Audiotapes
Closure
Step 13: Wrap-up
Step 14: Participants thanked for their participation
Stop

APPENDIX E

Group Rules

- Cell-phones switched off
- Have Fun
- Respect differences
- Freedom to give opinion
- Listen
- Safe Space
- Understand view of others
- Stay in

APPENDIX F

Ethics Clearance Certificate

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

26/10/2017

Approval Certificate
Amendment
(to be read in conjunction with the main approval certificate)

Ethics Reference No: 240/2017

Title: The Use of Spirituality in Occupational Therapy Practice: An Appreciative Inquiry

Dear Raashmi Balbadhur

The **Amendment** as described in your documents specified in your cover letter dated 17/10/2017 received on 24/10/2017 was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 25/10/2017.

Please note the following about your ethics amendment:
- Please remember to use your protocol number (**240/2017**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committe may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics amendment is subject to the following:
- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed; PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

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The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
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UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

29/06/2017

Approval Certificate
New Application

Ethics Reference No.: 240/2017

Title: An Exploration of Spirituality in Occupational Therapy Practice: An appreciative Inquiry

Dear Raashmi Balbadhur

The **New Application** as supported by documents specified in your cover letter dated 21/06/2017 for your research received on the 23/06/2017, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 28/06/2017.

Please note the following about your ethics approval:
- Ethics Approval is valid for 2 years
- Please remember to use your protocol number (**240/2017**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers, MBChB; MMed (Int); MPharMed,PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

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APPENDIX G

Confidentiality agreement with co-coder

Mrs R Balbadhur
19 Meadowdale
Van der Merwe Street
Eldoraigne
0159
Cell: 0795111631
raashmi.balbadhur@up.ac.za

Date

Confidentiality agreement

I am participating in this research study to verify identified themes of the data collected in the study titled 'The use of spirituality in occupational therapy practice: An Appreciative Inquiry'.

I endeavour to keep all information that is disclosed to me through this study as confidential, this includes any details of participant's identity and their practice settings at which they work. Protection of study participants will be guaranteed as I will never reveal or discuss any of the information obtained through the study with anyone except the researcher, R Balbadhur, and the supervisors of the study, Mrs E Rudman and Dr M Janse van Rensburg.

Signed by: _____ Signed by: R. Balbadhur: _____

Date: _____ Date: _____