There is limited evidence to support inclusion of spirituality in occupational therapy interventions in older adult populations with physical disabilities

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There is limited evidence to support inclusion of spirituality in occupational therapy interventions in older adult populations with physical disabilities

Disciplines
Occupational Therapy | Rehabilitation and Therapy

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There is limited evidence to support inclusion of spirituality in occupational therapy interventions in older adult populations with physical disabilities.

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Date: November 28, 2009
Review date: No date has been established for re-evaluation of this topic

Why this topic is important to clinical practice:
- Religious observance is included in the current version of the Occupational Therapy Practice Framework (AOTA, 2008) under instrumental activities of daily living (IADLs). Spirituality is listed as a client factor within the person category (AOTA, 2008).
- Interventions which address the spiritual orientation of the client would reflect holistic and client centered collaboration, if included in treatment.
- It is possible that a client's spiritual orientation has the potential to support optimal well-being of the physical, social and cognitive dimensions of self contributing to desirable health outcomes.
- Client's spiritual orientation may also have the potential to support the feeling of hope which can contribute to desirable health outcomes in older adults and other populations.
- To date there is no evidence that suggests the inclusion of spirituality in treatment with older adults is warranted.
- To date there is no evidence to suggest that inclusion of spirituality in treatment creates harm to patients or that inclusion creates undue financial burden for the rehabilitation department/occupational therapist.
- To date the effects of inclusion or exclusion of spirituality in occupational therapy interventions have not been extensively researched with older adults with physical disabilities or other populations.

FOCUSSED CLINICAL QUESTION:
Do older adults with physical disabilities benefit from occupational therapy interventions which support their spiritual orientation?

SUMMARY of Search, ‘Best’ Evidence appraised, and Key Findings:
- Searched professional peer reviewed journals – American Journal of Occupational Therapy, British Journal of Occupational Therapy, Annals of Pharmacotherapy, Journal of Palliative Medicine, Effects of Religion on Health, Oncology Nursing Forum, and Disability and Rehabilitation
- Individual topic, age range and condition searches of listed professional journals
- Limited date range of search to 2002-2009, 7 years
- 15 articles were located, 5 articles were selected to support critically appraised topic

CLINICAL BOTTOM LINE:
Participants of this study demonstrated that there may be an intrinsic human need to perceive oneself as being of worth, as part of something greater than oneself, and as concurrently constant and continuous. A health model and clinical practice that incorporates interventions and treatments which supports the patient’s core sense of self and worth contributes to perceptions of health and wellbeing, improving coping skills and engagement in meaningful, purposeful occupations. Religious observance (instrumental activity of daily living – OTPF. p 631) and spirituality (client factor – OTPF. p 633) are both within the domain of occupational therapy (Occupational Therapy Practice Framework).
Limited evidence demonstrates that treatments that incorporate patient's religious observance routines, spirituality objects do not harm and are easy to implement. More ongoing research is needed to understand barriers to clinicians regarding this client factor and how effective is incorporation of spirituality client factors on health outcomes.

Limitation of this CAT: This critically appraised topic has been peer-reviewed by a faculty member, however, author does not claim this to be a complete nor exhaustive review of the evidence. Preparer is a novice practitioner and does not claim expertise in this area.

SEARCH STRATEGY:

Terms used to guide Search Strategy:

- **Patient/Client Group:** older adult, physical disabilities
- **Intervention (or Assessment):** treatment, spiritual orientation of client, benefit, occupational therapy
- **Comparison:** no treatment, no spirituality, health, outcomes
- **Outcome(s):** evidence, spirituality, health, outcomes, benefit

<table>
<thead>
<tr>
<th>Databases and sites searched</th>
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<tr>
<td>MEDLINE</td>
<td>Health, spirituality, religion, older adults, conditions</td>
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<tr>
<td>CINAHL(EBSCOhost)</td>
<td>older adults, treatments, physical disabilities, spirituality, religion</td>
<td>occupational therapy</td>
</tr>
<tr>
<td></td>
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<td>health outcomes</td>
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</tbody>
</table>

INCLUSION and EXCLUSION CRITERIA

- **Inclusion:**
  1. older adult – persons over 50 years of age
  2. condition - physical disabilities, serious illness
  3. role of spirituality and intervention
  4. peer reviewed articles
  5. not older than 7 years (2002-2009) publication

- **Exclusion:**
  6. adults under 50 years of age
  7. condition – no physical disabilities or serious illness
  8. focus of intervention other than spirituality
  9. not peer reviewed articles
  10. older than 7 years, prior 2002 publication
RESULTS OF SEARCH

5 relevant studies were located and categorised as shown in Table 1

<table>
<thead>
<tr>
<th>Study Design/ Methodology of Articles Retrieved</th>
<th>Level</th>
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BEST EVIDENCE

The following study/paper was identified as the ‘best’ evidence and selected for critical appraisal. Reasons for selecting this study were:

- Age of participant sample: 36 to 82 (mean = 56)
- Condition: physical disabilities
- Participants’ articulation of their personal spirituality habits and routines
- Impact of personal spirituality habits and routines on health outcomes
- Study was conducted within the past five years (in 2004)
- Researchers articulated via graph dimensions which contribute to perception of health and wellbeing
- Goal of study: draft multidimensional definition of health and patient's perception of health and wellbeing
- Outcome detailed the importance of clinicians providing support for patients' core self
- Outline possible interventions, for example “connecting with natural world” facilitated strengthening patients sense of place and purpose.

SUMMARY OF BEST EVIDENCE

Aim/Objective of the Study/Systematic Review:

Study Design: Qualitative study using inductive methods. It was driven by grounded theory and ethnology as it applies to health processes and definition of health in New Zealand older adults with physical disabilities. Subjects were randomly assigned to 8 focus groups which met for a maximum of 5 hours each.

Setting: Queen Elizabeth Hospital, Rotorua, New Zealand.

Participants: Sample size of 30 adults ages 36 – 82 with physical disabilities and no history of major intellectual, psychological or emotional dysfunction, recruited from inpatient database.

Intervention Investigated: The aim of this study was to draft a definition of health from this population's perspective and construct a model of health change using focus group discussion of two guiding questions: what is health for you and what has helped, or would help you achieve this health? Focus groups were facilitated by trained clinical researchers (CR). CRs were selected for their ability to maximize rapport, trust and empathy with study subjects (thus supporting data validity of study). Principal researcher (PR) developed training manual specific to this study and conducted a two day training of CRs to develop focus group facilitation, recording, transcription, qualitative data collection skills and grounded theory analysis techniques.

Main Findings: Participants identified four categories that contributed to perception of health. These categories were instrumental in the perception of wellbeing, not as single categories but combined to support individual's core self. The four categories participants identified were:

- Primary (reflection, interaction, strength of identity, bearable pain)
- Secondary (time for self, acceptance, beliefs)
- Tertiary (attitude, knowledge of self, friendship/love, worth of self)
- Quaternary (self responsibility, goal setting, humor)

Original Authors' Conclusions: A health process model that integrates the four primary categories of personal perception of health supports the client's core sense of self and being and is the foundation upon which health can be built. More research is needed to understand the possible link between spirituality and health attainment in individuals who face challenging health circumstances.

Critical Appraisal: Clinical researcher (CR) lead focus groups to draft health process model. Participants were randomly selected from hospital database and randomly assigned to focus groups. CRs were trained by principal researcher. Consensus was used to identify key themes. Delphi technique and grounded theory/ethnology principles guided analysis process.

Validity

Methodology: 1:1 interviews, participant-observation, panel expert, and a series of cyclical rounds of data analysis by panel members (Delphi technique). Participants randomly assigned to 8 focus groups which met for a maximum of 5 hours each.

Rigour: Established by triangulation. It was achieved by CRs comparing commonalities and coding categories with fellow CRs, then with PR (as whole group, followed by individual 1:1 session). This process was repeated for both questions until consensus was reached and a draft of health concept model was created.

PEDro score: this study satisfied criterion levels 4-6 of PEDro scale.
Interpretation of Results:
Study participants identified four categories that contribute to personal perception of health. Together, not individually these categories support client's ability to achieve health inspite of adversity and physical disabilities.

Summary/Conclusion:
Health process model is comprised of four categories that enable client to develop a strong core perception of self, self worth, and resiliency.


Aim/Objective of the Study/Systematic Review:

Study Design: case reports, literature review

Setting/Participants: 200 Canadian and 210 American occupational therapists randomly chosen to complete survey focusing on addressing spirituality in their clinical practices

Intervention Investigated: Canadian and 210 American occupational therapists complete survey focusing on addressing spirituality in their clinical practices.

Main Findings: Therapists are unclear on billing protocol for interventions that include spirituality; therapists are unclear on working definition of spirituality and therapist experience barriers to addressing spiritual needs of clients (lack of awareness/skills).

Original Authors’ Conclusions: Therapists are able to express opinions on spirituality and the need to address client needs in this area, but face challenges regarding how to implement treatments with spirituality focus, lack of assessment tools and conflicting definitions of religion and spirituality. More research is needed to understand the relationship between spirituality and occupational performance.

Critical Appraisal: Survey of clinical practices of occupational therapists reveal uneven occupational therapy service delivery that address the client factor of spirituality. Limited availability of occupation based spirituality focused assessment tools creates barriers to practitioners’ ability to accurately assess benefit of this type of treatment intervention. More research is needed to understand this client factor and occupational health outcomes.

Validity
Methodology: Literature review and survey of Canadian and American occupational therapists.

Rigour: All relevant articles retrieved from database search were read, reviewed and critically appraised. Coding was done to identify key themes.

Selection: Key terms were used for database search (Medline, AMED, CINAHL) for example: occupation/health, spirituality, and spiritual needs.

Interpretation of Results:
Therapists face a variety of barriers to addressing spiritual needs of clients include:
- discomfort with addressing topic with clients.
- unclear of appropriate working definition of spirituality.
- unclear of difference between religiousness and spirituality.
- unclear of appropriate billing protocol.
unaware of appropriate assessment tools – no occupational therapy specific assessment tools addressing spirituality practice domain.

- lack or limited development of therapeutic skills/awareness to address spirituality practice domain.

**Summary/Conclusion:**
Therapists support addressing spirituality with their clients but face a variety of barriers to incorporating this client factor into treatment interventions, for example limited occupation based assessments for spirituality, limited experience in addressing this client factor and billing concerns.

| Table 4: Effects of spirituality in breast cancer survivors. Meraviglia, M. Oncology Nursing Forum, 33(1) E1-7.(2006) |

**Aim/Objective of the Study/Systematic Review:**

**Study Design:** Quantitative, cross-sectional and descriptive study: Examine the effects of spirituality (meaning in life and prayer) on a sense of wellbeing among women who have had breast cancer.

**Setting:** Mail-in questionnaires, participants were from urban and rural communities in Texas, USA.

**Participants:** 84 women aged 34-80 years of age, able to read and write English and were in fair health at the time of the study.

**Intervention Investigated:** Supportive coping behaviours such as spirituality and the cancer lived experience and.

**Main Findings:** A strong relationship may exist between meaning in life and spirituality, findings support healthcare providers encouraging patients to explore their spirituality as an effective resource for dealing with physical and psychological challenges of cancer.

**Original Authors’ conclusions:** Outcomes suggest spirituality might have mediating effect on quality of life for women breast cancer survivors. More research is needed in this area using a larger sample size.

**Critical Appraisal:** Questionnaires were analysed correlational analysis, mediation, statistical analysis and comparison of mediator variables. Three step analysis followed to test for mediation for spiritual variable, meaning of life. Multivariate delta method was used to confirm findings of mediation for meaning in life. Five tables were produced to describe cancer characteristics of sample, spiritual characteristics of sample, mediating model of meaning in life on psychological responses, mediating model of meaning in life on physical responses, and mediating model using multivariate Delta Method.

**Validity**
Methodology: Questionnaires were mailed to sample participants. Returned questionnaires constituted consent to participate in study. Six instruments were used to establish cancer lived experience and supportive coping behaviours such as spirituality: Background Information Survey, Characteristics of Cancer, Life Attitude Profile-Revise, Adapted Prayer Scale, Symptom Distress scale, and Index of Well-being. Questionnaires were analysed correlational analysis, mediation, statistical analysis and comparison of mediator variables. Three step analysis followed to test for mediation for spiritual variable, meaning of life. Multivariate delta method was used to confirm findings of mediation for meaning in life. Five tables were produced to describe cancer characteristics of sample, spiritual characteristics of sample, mediating model of meaning in life on psychological responses, mediating model of meaning in life on physical responses, and mediating model using multivariate Delta Method.
Rigour: Established by correlational analysis, mediation, statistical analysis and comparison of mediator variables. Two powerful mediation tests (Olkin and Finn (1995), Bobko and Rieck (1980)) was used for psychological wellbeing and physical wellbeing.

Selection: Self selection via returned questionnaires.

Interpretation of Results:
Women breast cancer survivors can draw on a variety of coping behaviors to support quality of life and satisfaction. Individuals with lower stages of cancer and who are higher functioning tend to be successful in using spirituality as a coping behavior.

Summary/Conclusion:
Women with lower stage cancer might experience some benefit using spirituality as a coping behavior. A small sample size might limit the effect of the mediating variable. More research is needed in this area to understand if a possible link exists between spirituality as a coping behavior and health outcomes.


Aim/Objective of the Study/Systematic Review:

Study Design: Literature review: 9 RCTs and 25 non-RCTs.

Participants: 9 RCTs and 25 non-RCTs literature review conducted by the authors at Department of Medicine, Virginia Commonwealth University, and Hunter Holmes VA Medical Center, Richmond, Virginia, USA.

Intervention Investigated: Effects of occupational activities of intercessory prayer on health outcomes.

Main Findings: Review of RCT studies suggests that intercessory prayer might have an impact on health outcomes. Client's occupational involvement in religion and/or religious activities may promote mental and physical health. Therapeutic engagement in religious activities does not add financial cost. Providers are encouraged to investigated treatments that support the occupational activities of religion in the care of patients.

Original Authors’ Conclusion: Healthcare providers may be uncomfortable in addressing religious needs of their patients. Intercessory prayer activities may improve health outcomes. More ongoing research in this area is warranted to understand possible link between intercessory prayer and health.

Critical Appraisal: Through review of 9 RCTs and 25 non-RCTs conducted by the authors at Department of Medicine, Virginia Commonwealth University, and Hunter Holmes VA Medical Center, Richmond, Virginia, USA.

Validity
Methodology: Literature review of 9 RCTs and 25 non-RCTs

Rigour: Established by studies being randomized control type.

Selection: Database search (MEDLINE) based on key words (religion, intercessory prayer, prayer therapy, faith, medicine, traditional, psychology) and published between 1966 and 1999.
Interpretation of Results:

Literature review of 9 RCTs and 25 non-RCTs suggest that intercessory prayer might promote mental and physical health outcomes. Engagement in occupational activities based on client's religious habits and routines might support occupational performance and health outcomes.

Summary/Conclusion:

Healthcare providers are encouraged to address client's religious occupational activities to promote health outcomes.


Aim/Objective of the Study/Systematic Review:

**Study Design:** Quantitative/longitudinal study - purpose of this study is to describe demographic and clinical factors associated with the importance of religiousness and spirituality among patients with HIV infection in the U.S.

**Setting:** Mail in questionnaire from national HIV database source.

**Participants:** Participants (male, female, gay, heterosexual) from urban and rural locations were randomly selected (2266 HIV patients) to complete survey.

**Intervention Investigated:** The importance and/or relevance of religiousness and spiritual activity in their perception of health and well-being.

**Main Findings:** Persons at all levels of HIV illness indicated strong importance and relevance of religiousness and spirituality in their perception of health and wellbeing.

**Original Authors’ Conclusions:**
Religiousness and spirituality is more important to individuals with HIV than general American population. Religious organizations may be under-used community resources of support for persons with HIV. Providers are encouraged to investigate the value of incorporating client's religious and spiritual occupations into treatment at all stages of HIV.

**Critical Appraisal:** Themes were developed using questionnaires returned by randomly selected participants identified using national HIV database source via baseline survey response tabulation, follow-up survey tabulation, 1:1 interview and multivariable linear regression models.

**Validity**
Methodology: 2266 HIV patients completed survey/questionnaire, followed by tabulation, interview and multivariate linear regression analysis.

Rigour: Random selection using national data base of HIV patients (credibility, transferability, dependability, conformability).

Selection: Random selection using national data base of HIV patients

Bias: National data base of HIV patients was primary source for sourcing participants for this study resulting in 50% gay male, 29% female and 21% heterosexual male.
Interpretation of Results:
Clinicians are encouraged to investigate the value in incorporating client's religious and spiritual occupations into all levels of HIV treatment. Community religious and spirituality organizations are under-used resources of support for individuals with HIV.

Summary/Conclusion:
This study suggests that a majority of individuals with HIV affirm an importance and relevance to religiousness and spirituality in their perception of health and wellbeing.

IMPLICATIONS FOR PRACTICE, EDUCATION and FUTURE RESEARCH
Although the studies included in this CAT suggest the value of addressing the client factor of spirituality and IADL of religious observance many occupational therapy practitioners face a variety of barriers, for example:
- discomfort with addressing topic with clients.
- unclear of appropriate billing protocol.
- unaware of appropriate assessment tools – no occupational therapy specific assessment tools addressing spirituality.

The limited body of knowledge on this topic suggests that incorporating occupation based interventions which focus on client's spirituality orientation and religious objects do not harm the client and are easy to implement into treatment, for example when the occupational task of engaging in prayer is submitted to task analysis a variety of treatment areas can be addressed – postural control, language, cognition, motor planning, fine and gross motor, grip/grasp – release, visual tracking, trunk control, balance, AROM, sequencing and the list could go on.

Another example of incorporating spirituality into treatment intervention would be to engage the client in the task of walking to the in-house (hospital) chapel – when submitted to task analysis again a variety of treatment areas can be addressed – fine and gross motor, grip/grasp – release, visual tracking, sequencing, memory, object relationships, language, sensory motor, proprioception, kinematics, balance, trunk control, social interaction...etc.

Future clinicians and current practicing clinicians are encouraged to seek innovative occupation based treatment interventions which tap into this client factor and instrumental activity of daily living as a means to deliver collaborative client center service. If utilizing this client factor and instrumental activity of daily living is easy to implement into practice and does not harm the client, why not investigate the possibilities? If the clinician suspects that their client would be receptive to treatment intervention based on a client identified spirituality orientation, the evidence presented in this CAT suggests doing so might have a positive impact on health outcomes on a variety of populations and conditions.

More research is needed to build a body of knowledge on occupational performance in the areas of spirituality and religious observance activities and create occupational therapy based assessments that address this IADL area and client factor.

REFERENCES

