Spiritual History Assessment and Occupational Therapy: Students Using the FICA©

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Committee Chairperson: Kay Robbins, MSOT, OTR/L

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Reader: Yvonne Swinth, PhD, OTR/L, FAOTA

__________________________
Director, Occupational Therapy Program: George Tomlin, PhD, OTR/L

__________________________
Dean of Graduate Studies: Sarah Moore, PhD
Abstract

The purpose of this study was to examine students’ perceptions of spiritual history assessment and/or the experience of administering the FICA© with an adult client in an on-campus clinic. A retrospective survey was completed by 13 second year occupational therapy students enrolled in a clinic class. Of the 13 respondents, ten were able to implement the FICA©. Data collection included: demographic information; Likert scaled questions; and open and close-ended questions. Quantitative data were analyzed and the results indicated an increase in respondents’ confidence in administering a spiritual history assessment and discussing a client’s spiritual history. Seven of ten respondents noted increased rapport. A phenomenological framework was used to analyze the qualitative data. Qualitative topics that emerged from the data included: Increased understanding of their client; holistic care; scope of practice; increased confidence broaching the subject of spirituality; understanding client motivation; rapport; time constraints; respondent apprehension about religion; difficulty with spiritual history assessment due to client limitations; and lack of client interest in engaging in a spiritual history discussion. This study suggests when occupational therapy students are given an opportunity to consider and/or implement a spiritual history assessment those students become confident with such assessments. More importantly, they gain experience with the dilemmas of dealing with client spiritual history in practice which could help them become more client-centered, holistic occupational therapy practitioners.
Whether or not people explicitly express it, spirituality is the essence of their humanity and worldview (Hodge, 2006; Koenig, 2007). Existential questions abound throughout life. When clients are most vulnerable and dealing with disease (or dis-ease), questions naturally arise about what matters most and can lead clients on a spiritual journey or into a spiritual crisis. Occupational therapists work with clients during these extremely sensitive times (Stratton, 1995). In 2001, after an exploration of relationships between spirituality, occupational therapy and occupational therapy curricula, Kirsh et al. concluded that spirituality is “inextricably intertwined with holism, meaning, and client-centeredness” (p. 119).

Occupational therapy engages clients in meaningful activities and views the client as an amalgamation of mind, body, and spirit. Understanding the embedded meaning of activities to each person is crucial for effective intervention. Occupational therapists have a unique opportunity to discover exactly what activities are meaningful to clients and to support them in those occupations. Spirituality is intrinsic to the human experience and can motivate a person and give meaning to life’s occupations (Johnston & Mayers, 2005) leading to better outcomes. The importance of discerning the spiritual needs of clients to promote occupational therapy as a client-centered and holistic practice was further noted by Farah and McColl (as cited by Bouthot & Wells, 2010). More importantly, what occupational therapy practitioners discover about their clients’ spiritual nature may strengthen the therapeutic relationship (Johnston & Mayers, 2005).

During the 61st World Health Assembly of the World Health Organization (WHO) Archbishop Desmond Tutu stated “health not only encompasses the physical, mental and social well being, but must be inclusive of spiritual well being” (Tutu, 2008). The WHO included spirituality in their preamble in 1997 acknowledging the importance of spirituality in clients
SPIRITUAL HISTORY ASSESSMENT: OT STUDENTS’ USE OF THE FICA©

(Khayat, n.d.). Many occupational therapy principles follow the WHO’s healthcare vision. Spirituality is an important aspect of healthcare and thus important to occupational therapy.

In 2008 the American Occupational Therapy Association included spirituality in the Occupational Therapy Practice Framework: Domain and Process, 2nd Edition (OTPF-II) under client factors. The OTPF-II states “client factors reside within the client and may affect performance in areas of occupation” (p. 634). Therefore, any disease in the spiritual nature of a person could diminish occupational performance and undermine quality of life. Additionally, Moyers and Dale (2007) concluded that occupational therapists understand occupational performance and how to intervene when clients experience decreased function. Billock (2009) argued that everyday experiences facilitated through the participation in meaningful occupation give clients and practitioners a deeper understanding of themselves and/or spiritual motivation.

Occupational therapy research in the U.S. is lacking in regards to the concept of spirituality, how to apply it in practice, and assessment. Occupational therapy researchers in the U.K., Australia, and Canada have published the majority of the research in this arena (Dallal, 2005). Healthcare researchers and practitioners have rediscovered an enmeshed history between medicine and spirituality. Physicians, nurses, and social workers are rediscovering the importance of a client-centered approach to care. Thus spiritual history assessments are being integrated into their practice standards (Puchalski & Romer, 2000).

There seems to be a conflict for occupational therapists between being part of an evidence-based profession and occupational therapy’s holistic roots (Billock, 2009). Clinicians are constantly reminded of time constraints for reimbursement (Watling, 2011). This constraint may come at the cost of a quality client-therapist relationship. Johnson and Mayers (2005) and Hasselkus (2002) proposed that the potential for meeting the spiritual needs of clients exists
within the very nature of meaningful occupations in everyday practice. If this is the case, then occupational therapists and students must acquire the tools to feel knowledgeable and confident to address the spiritual well being of clients.

**Background and Significance**

**History of holism including spirituality.** Holism and its relationship to health and well being of the mind, body and spirit have been traced to Plato, Hippocrates, and the Old Testament of the Bible (Bouthot & Wells, 2010; Dallal, 2005; Siegel, 1986). One could argue that the history of medicine is the history of all health related professions; therefore many of the same principles of holism can be applicable in those fields (Smith, 2008). The ancients understood that health and well being concerned the whole person, not simply the disease.

One of occupational therapy’s founders, Eleanor Clarke Slagle, commented in 1927 that occupational therapy must consider the spiritual nature of clients or therapy would fail. Slagle implied that spirituality is an integral concept to the occupational therapy profession. As the profession grew and healthcare changed to the biomedical, insurance reimbursement model, many healthcare professions, including medicine, nursing and occupational therapy lost touch with the idea of client-centeredness and holism (Smith, 2008).

In the 1990’s interest in the connection between spirituality and health returned throughout medical, nursing, and social work literature (Belcham, 2004). Discussions about spirituality and religiosity and their interconnectedness were found in occupational therapy literature (Collins, 2007). Stratton (1995) concluded that a “conceptual ambiguity” about spirituality’s definition existed in both occupational therapy and nursing literature in the U.S. Furthermore, having no working definition of spirituality may have made it difficult for occupational therapists to address it directly with clients.
The World Health Organization acknowledged the connection between health and spiritual well being on an international level by adding the following to their preamble: “Health is a dynamic state of complete physical, mental, spiritual and social well being and not merely the absence of disease or infirmity” (“WHO Definition”, 1997). Spirituality was simultaneously addressed in the occupational therapy literature of the U.K., Canada, and Australia (Beagan & Kumas-Tan, 2005). The Canadian Association of Occupational Therapy was the first to include spirituality in its practice domain “as an essential component of a person performing occupation” (Csonto, 2009, p. 443).

Hodge (2006), a social sciences researcher, noted in 2001 the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) stipulated that healthcare practitioners conduct a brief spiritual assessment with clients upon intake at most facilities. In 2011, Joint Commission mandated inclusion of a spiritual history assessment in their Advanced Certification Program for Palliative Care facilities. Joint Commission is the leading healthcare accreditation agency in the U. S. This acknowledgement of the critical importance of spiritual history assessment is noteworthy. As occupational therapists work in many Joint Commission accredited facilities, it is the profession’s responsibility to ensure that practitioners and students have time to consider spirituality and have practice with the assessment tools.

Occupational therapists are well versed in the practice of incorporating issues of diversity in client care. Spirituality is embedded within the concepts of diversity, yet some occupational therapists do not consider a client’s spirituality in care (Billock, 2009). “Occupational therapy scholars have described diverse attitudes and beliefs of occupational therapists, including how spirituality is addressed in practice” (Collins, 2007, p. 504). Hooper (1997) wrote “interrelatedness of sociocultural context, worldview, and clinical reasoning” (p. 334) is present
in clinical settings where holism including spirituality is integrated. There appears to be a conflict between knowing spirituality is important to clients and not knowing how to assess it or include it in intervention.

Lesley Wilson is an internationally recognized researcher of spirituality and occupational therapy. She authored the chapter in *Occupational Analysis in Practice* titled “Analyzing the Occupational Components of Spirituality.” In 2010, Wilson wrote:

> The general consciousness across the globe is moving towards an esoteric awareness. The materialism of the last few decades is increasingly rejected and lessons from popular explorations and positive psychology (for example, Frey and Stutzer 2001, Seligman 2002) suggest that people are not necessarily made happier by wealth or even health but by doing things that have meaning to them…. A loss of such meaning in life’s occupations may cause a person to become ‘dispirited’, which could eventually lead to illness and disease, both physical and psychological. It is for this reason that the nature of spirituality and its connection to wellbeing is worthy of ongoing consideration by occupational therapists (p. 437).

If occupational therapy is to be a client-centered, outcome based, holistic profession, then understanding client spirituality is essential. Additionally, occupational therapists and students should have assessment tools allowing for the integration of client spirituality while meeting the practical and philosophical needs of clinical practice.

**Occupational therapy practice models & frames of reference**

**incorporating spirituality.** There are two occupational therapy practice models known by this researcher which guide practitioner clinical reasoning when incorporating the spiritual nature of clients into interventions, the Canadian Model of Occupational Performance (CMOP) and the Model of Human Occupation (MOHO). Additionally, some clinicians incorporate the Psychospiritual Integration frame of reference (PSI) or the OTPF-II practice framework when integrating spirituality into client care.
The Canadian Model of Occupational Performance (CMOP) places “client spirituality at the center of its model” (Egan & DeLaat, 1994, p. 4). Spirituality lies in the center of the model in relationship to the person, environment, and occupation. The diagram of the model places spirituality in a center circle at the heart of a triangle, which represents the person and their cognitive, physical, and affective aspects. The triangle is surrounded by the circle of occupation, including productivity, leisure and self-care. The outermost circle houses the physical, institutional, cultural, and social, representing the environment of a person. Canadian occupational therapy scholars identified the concept of spirit as essential to the person and this model combines a philosophical concept with a way to practice occupational therapy with clients. Clarke (2003) concluded that the strength of the CMOP is connection between spirituality and client-centeredness.

Model of Human Occupation’s (MOHO) “major focus for practice is on the person and how the environment contributes to one’s source of motivation, patterns of behavior, and performance…according to Kielhofner’s view, a person reflects how motivation, behavior, and performance are integrated” (Cole & Tufano, 2008, p. 95). There are three interrelated parts that exist within each person according to Cole & Turfano:

- **Volition** is the motivation for occupation.
- **Habituation** refers to the process by which occupation is organized into patterns and routines.
- **Performance capacity** refers to the physical and mental abilities that underlie skilled occupational performance. This subsystem is also called mind-brain-body performance.

The volitional subsystem is defined as a source of motivation that guides individuals to anticipate, choose, experience, and interpret what they do. It is comprised of personal causation, values, and interests. MOHO “does not address spirituality directly, but the volition subsystem comprising
personal causation, values, interests, choices, and volitional subsystem narrative comes close” (Kang, 2003, p. 94).

Kang introduced the psychospiritual integration frame of reference (PSI). PSI acknowledges the challenges occupational therapists face when “trying to understand and apply spirituality in the many contexts of their work” (Kang, 2003, p. 93). PSI focuses on:

- The nature of spirituality.
- The expressions of spirituality in everyday occupational behavior.
- The nature of spiritual occupation.
- The influence of spirituality and spiritual occupations on health and wellbeing.

Donica’s (2008) qualitative study focused on the PSI and its use with a post-stroke individual. She concluded that PSI is a “preliminary framework to organize our thinking regarding spirituality and its impact on occupational performance and development” (Donica, 2008, p. 119).

In 2002 the American Occupational Therapy Association’s Commission on Practice submitted recommendations to move spirituality from “Context or Contexts” into a more prominent position in the Framework (Schulz, 2004). The 2008 OTPF-II placed spirituality under client factors. The inclusion of spirituality at this level illustrates an understanding of the importance of spirituality to clients. OTPF-II (2008) defined spirituality as the “personal quest for understanding answers to ultimate questions about life, about meaning, and the sacred” (p. 633). It is important to note that spirituality was defined in terms of secular meanings rather than any one religious meaning to include the diverse understandings of spirituality to clients and occupational therapists alike (Egan & Swedersky, 2003). This is the working definition for the current study.
Spiritual history assessments in use by other healthcare professionals. There are many spiritual history assessments currently in use by physicians, nurses, and social service practitioners, including HOPE, FACT, SPIRIT, CSI-MEMO, and FICA©. All are similar in that they guide healthcare professionals through non-judgmental, unbiased, open-ended spiritual history discussions. Physicians developed the FICA© and its intended use is for any healthcare professional who understands the importance of spirituality to clients. It is a tool that gives a platform from which to establish holistic, client-centered care. The FICA©, an acronym for Faith, Importance, Community, and Address, was chosen for the current study because it is the only spiritual history assessment tool that occupational therapists have thus far evaluated. FICA©’s creators emphasize that its design is intended to foster ease of use allowing clients and clinicians to discuss spiritual occupations or beliefs and meet the time constraints many clinicians face.

Bouthot and Wells, occupational therapy students, conducted the first known pilot study of occupational therapists and their implementation of the FICA© in 2009. In the study, five occupational therapists administered the FICA© to between one and eight clients in a skilled nursing facility and then completed a survey. The occupational therapists in that study reported that their clients appeared to be open and willing to talk about their spirituality (Bouthot & Wells, 2010).

Lack of spiritual history assessment in occupational therapy. As described, spiritual history assessment is a brief, dynamic, narrative exploration of a client’s spiritual life. It can expose a client’s rituals, beliefs, practices and discover how any of these might potentially impact the client’s medical care. To date, occupational therapy does not have its own spiritual history assessment. LaRocca-Pitts (2009) concluded that a spiritual history assessment could be
performed at appropriate intervals throughout a client’s life and pertinent details noted in his/her chart. Occupational therapist researchers, Johnston and Mayers (2005) found that addressing client spirituality was important to occupational therapy practitioners yet the practitioners stated that they lacked specific assessments tools to address clients’ spiritual occupations and beliefs.

In 2009, Csonto discovered that occupational therapy students sometimes lack the knowledge, confidence, or a means of addressing client spirituality. Teo, a beginning occupational therapist, wrote about the complexity of understanding spirituality in a palliative care setting when she was just out of school. In 2009, Teo wrote:

For a young therapist such as myself, the idea of spiritual care provision has always been daunting. Coupled with a general lack of literature and no detailed role-description that addressed a client’s spirituality, working as an OT[sic.] in a PC[sic.] setting posed great challenges to me…explicit education and training in spirituality at university can serve to equip OTs [sic.] with the skills to attend to this area of care (p. 2).

In another study regarding students and spirituality, Enquist et al. found that 82% of the student-therapists felt that their academic training had not adequately prepared them to address the spiritual needs of their clients (as cited in Kirsh, et al. (2001). The need for students to experience what happens when the topic of spirituality is introduced to clients, in a way that respects diversity, ethical boundaries, and to simply practice potential dialogues is an essential component of understanding holistic and client-centered care.

Dallal (2005) determined that occupational therapy “program directors (70%) agreed that spirituality should be a required topic of study and included in accreditation standards” (p. 2).

Current Accreditation Council for Occupational Therapy Education (ACOTE) standards have recently been updated and specifically state that occupational therapy students be able to perform “…evaluation of occupational performance using standardized and nonstandardized assessment tools including… client factors, including values, beliefs,
spirituality…” (B. 4.4). Likewise, ACOTE standards assert that “intervention plans and strategies must be culturally relevant…and based on available evidence. Interventions should address the following the following components... client factors, including values, beliefs, and spirituality…” (B. 5.1). Therefore, students ideally have exposure to the assessment tools available and opportunity to use them.

**Benefits to including spirituality and assessment in education and practice.**

Occupational therapists and students need not question the value of incorporating spirituality in their discussions with clients. Udell and Chandler (2000) concluded the role of occupational therapy does not infringe on spiritual counseling “but, rather, the acknowledgement and recognition of spiritual needs and how they might be affecting function in the individual” (p. 492). Additionally, Borneman, Ferrell, and Puchalski’s (2010) qualitative research found “most clients rated faith or beliefs as very important in their lives with mean of 8.4 [sic.]” (p. 163). Anandarajah and Hight (2001), Koening (2007) and Siegel (1986) identified that spiritual discussions increase clients’ ability to cope with the disease or illness. They concluded that the health professional/client relationship is strengthened by the inclusion of a spiritual discussion. Additionally, they discussed client compliance and overall course of a medical outcomes are positively affected by upholding clients’ spirituality, beliefs, and rituals.

If addressing clients’ spirituality increases functional outcomes, enhances client quality of life/care, and/or supports the therapist/client relationship, then the occupational therapy profession has an obligation to educate its students and familiarize them with the concept of spirituality and spiritual history assessment. Students ought to be given opportunity to explore and use spiritual history assessments during their occupational therapy education. The purpose of
this study was to examine students’ perceptions of spiritual history assessment and/or the experience of administering the FICA© with an adult client in an on-campus clinic.

**Method**

**Research Design**

A descriptive study design using a retrospective survey was chosen for this study. According to Kielhofner (2006), descriptive studies have an exploratory quality. Kielhofner wrote, “…sometimes basic descriptive information is needed in order to indicate norms, trends, needs, and circumstances that inform and guide practice” (p. 58). Additionally, this study allowed student participants practice using a spiritual history assessment tool in order to engage their client in a spiritual history discussion.

**Participant**

A convenience sample was taken from thirty-two final year occupational therapy students acting as student-therapists in the adult on-site clinic course during their final semester. Participation in clinic requires that these students are academically prepared following to the ACOTE standards.

**Instrumentation**

**Retrospective questionnaire.** A literature review prompted the researcher to create a retrospective questionnaire (RQ) (See Appendix A) to capture the depth and breadth of the student participants’ experience and/or perceptions of spiritual history assessment and the experience implementing the FICA©. Additionally, the researcher adapted questions from Bouthot and Wells’ 2010 study. Thus, the RQ was comprised of basic demographic, fixed response, Likert scaled and open-ended questions. The open-ended questions were integrated throughout the RQ to give participants the opportunity to articulate responses that the fixed
responses could not capture. They were also intended to give students’ the opportunity to discuss their perceptions of spiritual history assessments and/or of implementing the FICA©.

**FICA©.** The FICA© is a spiritual history assessment tool designed in 1996 by a collective of physicians, including the copyright holder, Dr. Christina Puchalski. This tool comes in the form of a 2x4 inch plastic card with four labeled domains (Faith, Importance, Community, and Address in Care) with example questions, which prompt and guide healthcare practitioners as they inquire about a client’s spiritual history.

**Instructional PowerPoint.** An instructional PowerPoint (IP) was designed by the researcher to orient the student participants to the FICA© and its implementation, and to clearly define the parameters to which the participants were to adhere. This tool was created after consulting with Dr. Pulchalski to ensure that the IP accurately reflected the essence of the FICA©. The IP described the FICA©; explained implementation; and defined the parameters of its use. The IP was posted on Moodle.

**Moodle.** Moodle is an open source community based software program used by the School of Occupational Therapy (moodle.org). Using Moodle, students access resources ranging from class assignments to lectures, making it the most logical place to “house” the IP. Content on Moodle can only be accessed by students or faculty associated with a particular course, thereby increasing security of the information dispersed.

**Setting.** The on-site student clinic is pro-bono and draws pediatric and adult clients from the University’s diverse community. Students are under direct supervision of licensed occupational therapists, also known as clinic instructors (CI), from initial evaluation through final treatment session eight weeks later. Students perform all evaluations; develop treatment plans; and implement treatment. Clinic sessions are fifty minutes and it was during one of the
first four sessions, the initial evaluation period of the course, when student participants implemented the FICA© as they were able.

**Procedures**

**Pilot use of the FICA© and RQ.** There were two parts to the piloting the FICA© and RQ. The researcher conducted three mock clinic client FICA© assessments. The researcher acted as a study participant and volunteers acted as clinic clients, in order to determine the most accurate estimate of time required to administer the FICA© in student clinic. Two out of three assessments took less than five minutes, confirming what Puchalski claimed about the time it takes to administer the FICA© in a clinical setting (personal communication, Puchalski, 2011).

Two occupational therapists were queried; by interview about (1) ease of use (2) clarity of the FICA© and the RQ after review of each. Dr. Puchalski was also consulted about the RQ via interview. Consult was further sought from the researcher’s faculty regarding appropriateness, accuracy, and design of the RQ, to further ensure validity and reliability of the tool. Changes were carefully considered and integrated based upon feedback.

**Participant protocol.** Approval of the research protocol for this study was sought from the university Institutional Review Board (IRB). Approval for students’ use of the FICA© with clinic clients was sought from the clinic coordinator. Upon receiving approval from the above mentioned parties, the researcher invited students to participate in the study via the second year cohort email list upon completion of the fall semester, and again at the beginning of the spring semester.

The tool used was a survey in the form of a RQ. Consent was assumed when the RQ was returned. Student participant identities were not listed on the RQ produced for this study. The
RQs produced for this study will be destroyed when they are no longer necessary for research or future presentations.

**Distribution of RQ, the FICA©, and IP.** FICA© tools were procured prior to the implementation of the study and were ready for distribution upon approval from the aforementioned parties. Student participants received the FICA© tool in person before or after classes. They were asked, in person and via cohort email, to view the IP on Moodle prior to the first day with clinic clients. Students were asked to email the researcher upon viewing the IP. A reminder email was sent to the student participants to view the IP two days prior to beginning their work with clinic clients.

Student participants had the researcher’s email address in order to ask specific questions about the FICA© and/or its implementation. They were directed away from the topic of spirituality to reduce any confounding of the data.

Student participants implemented the FICA© with their adult clinic client during the first two weeks of the clinic course assessment period while gathering the occupational profile. Upon completion of the clinic course assessment period, the researcher provided the participants with the retrospective questionnaire in person before or after classes. Participants were asked to return the RQ within three days of issuance in person or via the researcher’s on campus student mailbox.

**Data Analysis**

As a survey, this study was intended to yield mostly quantitative data with qualitative data coming from six supplemental questions and one entirely open-ended question. While the quantitative data produced results for analysis, the qualitative data, unexpectedly yielded rich results as well. The researcher was then compelled to apply some degree and method of rigor to
the analysis of the qualitative data, which most closely followed a phenomenological approach. As defined by Lester (1999), “A phenomenological approach is to illuminate the specific, to identify phenomena through how they are perceived by the actors in the situation” (p. 1). The data was analyzed using a multi-strategy method “to fill in the gaps that were left by the quantitative approach” (Bryman, 2003, p. 1).

After the surveys were returned, the researcher and her faculty chair assigned a number to each survey in order to delineate respondent one’s answers from respondent two’s answer and so on. A preliminary content analysis was conducted on respondents’ answers. Peer debriefing was employed two times with the data; once with the researcher’s faculty chair and once with the researcher’s colleagues. During both sessions, topics were identified and defined by the researcher and her peers. Peer debriefings were used to enhance the rigor including the validity, accuracy and truth value (Krefting, 1991) of the results. The researcher then re-immersed herself in participants’ responses to the six supplemental questions and one open-ended question another five times.

All quantitative data was entered into SPSS for descriptive analysis. Frequency, percentages, and chi-square tabulations were tabulated on the RQ’s questions.

**Results**

**Respondent Demographics**

Question one and two regarding age and gender were discarded due to respondents’ misinterpretation of the questions. Twenty-nine students out of a possible 32 students indicated interest in participating in the study. Thirteen surveys were returned for a 44.8% response rate. Of the surveys returned, 3 (23.1%) of the surveys returned noted that student participants were unable to implement the FICA© due to lack of clinic client interest in the assessment or time
constraints during their assessment period. These respondents’ data were still included in the study as they still met inclusion criteria. Of the respondents, 3 of 13 (23.1%) had worked in another healthcare profession (nursing assistant, counselor, medical assistant, and hypnotherapist). Chi-Square revealed no statistically significant results.

**Student Perceptions of Spirituality in Occupational Therapy**

When queried about spirituality being addressed in their occupational therapy education, 10 of 13 (76.9%) of the respondents recalled at least one class. According to the data, the FICA© helped 9 of 10 (90%) of the respondents at least somewhat address client spirituality. When asked if they consider spirituality to be a topic that occupational therapists should address with clients, 13 (100%) of the respondents responded yes. When asked why, the topics identified were; scope of practice, importance to client, holism, and client-centeredness.

**Student Perceptions and Experiences of Spiritual History Assessment in Occupational Therapy**

None (n=13) of the respondents had ever implemented a spiritual history assessment before. Approximately 8 of 10 (80%) of the respondents felt at least somewhat confident administering the FICA©. Of the 10 respondents who implemented the FICA©, five (50%) had at least a one-step confidence level increase; one (10%) reported a two-step confidence level increase; and one (10%) reported a three-step confidence level increase in addressing client spiritual history after using the FICA©. Three respondents (30%) had no change in confidence. Therefore, seven (70%) of participants had at least a one-step confidence level increase.

Three of ten respondents (30%) reported the FICA© helped them address topics other than spirituality. The topics they reported and topics identified were: understanding a client’s
social system, client’s social participation, and addressing client’s feelings around having a CVA.

When asked about client/therapist rapport, 8 of 10 (80%) noted an improvement. Five of ten respondents (50%) found the FICA© to be a useful tool for clinic, and five of ten (50%) did not. According to the data, 9 of 10 (90%) responded that the FICA© did not help clients identify treatment goals. When asked, “Do you think the information you gained from implementing the FICA© will help you with intervention planning?” 4 of 13 respondents (30.8%) replied yes and 5 of 13 (38.5%) replied no. When queried how intervention planning might be influenced the topics were: Alternative methods for social participation, client/student-therapist rapport and client motivation.

When respondents were asked if they would continue to use the FICA© with future clients, 12 of 13 (92.3%) of the participants said they would. The topics identified and reasons participants gave for answering yes to this above question included: increased understanding of client and understanding client motivation.

The student experience was reflected when they were asked “Are there any additional insights, opinions, or comments you would like to share about your experience?” multiple topics emerged including: Client/student-therapist rapport, time constraints, student-therapist apprehension about religion/faith, difficulty with client communication due to client limitations and lack of client interest in engaging in a spiritual history discussion.

**Discussion**

The results from this study are consistent with what literature has previously described, (see Appendix B). The conclusions about spirituality in occupational therapy by Csonto (2009),
Egan and Swedersky (2003), Kirsh et al. (2001), Udell and Chandler (2000), Wilding (2002), and Wilson (2010) are mirrored in the following quote:

It was difficult to use at first because my client has dysphonia. I felt silly repeating myself when he and his wife didn’t understand my questions. However, after we made it through the few questions I felt I knew my client much better than before. I think that insight will prove invaluable in my treatment with him.

(R12)

Kirsh et al. (2001) wrote, “…holism, meaning, and client-centeredness become intertwined with spirituality” (p.120). Rapport and confidence combined with experience afforded these student-therapists insights into themselves and their clients.

In 2001 Kirsch et al. found over ninety percent of respondents (who were occupational therapy students) believed that spirituality was within the scope of the occupational therapy profession. As in the Kirsch et al. study, the occupational therapy students in this study did not question whether spirituality was within the occupational therapy scope of practice. They resoundingely replied that spirituality is important to the practice. A respondent in this study wrote “spirituality is about meaning” (R12), similar to the American Occupational Therapy Association’s working definition of spirituality. Several respondents noted that it helped them with planning interventions because it helped in understanding their client’s motivation and values (R2, R4, R6, R12, and R13).

Scope of practice, importance to client, holism, and client-centeredness were the topics that emerged when respondents were questioned about whether spirituality should be addressed with clients. Respondents wrote:

First, it is part of practice framework. Smarter people than I have deigned it important so it only makes sense to follow. Secondly, and most importantly spirituality is about meaning. Although it may not be OT’s role to create meaning for their clients, it is always our role to help them imbue meaning in their lives.
through occupation. Understanding a client’s spirituality is a powerful tool for doing so. (R12)

“It is a part of holistic care-truly understanding the parts of the person and their context and meeting them where they’re at.” (R4) These occupational therapy students appeared to understand the importance of holistic care as it relates spirituality in practice. What might be challenging for these future practitioners is if they can uphold those views when they are in practice.

As seen in the literature, spiritual history discussions increase client/therapist rapport. The current study found increased rapport between student-therapists and their clinic clients. Bouthot and Wells’ 2010 study concluded that occupational therapy clients were willing to discuss their spiritual histories with their therapists and that the FICA© was an effective tool of occupational therapists. The willingness on the part of the client to discuss spiritual history was also seen in this study and most of the students appeared to think it was a useful tool. However, the student-therapists that had clients communication issues found the FICA© difficult to use.

Previous literature mentioned that some practitioners fail to address client spirituality due to the lack of confidence in broaching such a complex topic (Csonto 2009, Egan & Swedersky, 2003). This study found that basic exposure to a spiritual history assessment tool and the opportunity to implement it increased student-therapist confidence. For example:

In my circle, the older people are much more spiritual than the young. So, it stands to reason that adult clients (particularly the geriatric crowd) will find motivation and inspiration in their beliefs. It’s important they know we (care providers) recognize and respect that. (R8)

Another respondent wrote:

My client communicates by signing letters, so communication of such a complex topic is difficult. I felt comfortable bringing spirituality because he alluded to God being responsible for his successful movement. The other interesting thing I
gleaned was that although he attends church, he does not feel connected to that group. (R1)

It could be inferred that when given the opportunity to consider spirituality as it relates to practice and the opportunity to apply a spiritual history assessment, students and therapists alike may experience greater confidence and rapport with their clients. Additionally, one may conclude that client outcomes could be increased with the use of a spiritual history assessment. Ultimately, this allows for a better informed and equipped occupational therapy practitioner, who is able to remain client-centered and promote interventions that are holistically appropriate for their clients.

In the current study, some student-therapists felt uneasy about spirituality and spiritual history assessments initially, but wrote that with practice, including the IP and using the FICA© tool, they began to feel at ease and identified what was meaningful to the client. Likewise, some clients were not willing to discuss their spiritual history and the student-therapist then moved on, as seen in R10’s response, “he is not spiritual so I won’t consider it for tx [sic] because it won’t affect outcomes.” This quote shows student understanding of client-centered care, sound clinical reasoning and the therapeutic dilemma. When respondents were queried about their overall experience with administering the spiritual history assessment, a respondent replied:

I think it is a great tool, but really I doubt we will get to use it much. The push for productivity and short patient stays eliminate time for non medical items. (R7)

This quote reflects what the literature states about the dilemma of addressing spirituality and using a spiritual history assessment in practice. Respondents in this study appear to understand the external and internal dilemmas of addressing client spiritual history even while still students.
In 1994, Mattingly and Fleming wrote *Clinical Reasoning: Forms of Inquiry in a Therapeutic Practice*, a result of a longitudinal study of psychosocial occupational therapists and students and their clinical reasoning in treatment. In the book, Mattingly and Fleming identified several dilemmas that permeate occupational therapy practice which resulted in what they defined as the “underground practice” and enhanced clinical reasoning. They defined the underground practice as having double binds where knowledge and values silently conflict within the occupational therapist as the therapeutic relationship grows. The current study suggests students, as well as the profession overall, experience dilemmas when acknowledging client spirituality and assessing it. For example, how are the new ACOTE standards going to be interpreted and incorporated into occupational therapy school curricula?

Kirsh et al. (2001) wrote, “…how to prepare occupational therapy students to address this issue [spirituality] remains a challenge” (p.120). Internal dilemmas might arise for student-therapists or their clients, as can be seen in the following quote: “He said his faith was strong and good and in OT we should do our OT work” (R11). The client thinks that “OT work” does not include a spiritual history assessment. One might speculate that the student-therapist then took a more biomedical approach to the client after this discussion in order to best meet the client’s needs. It seems that student-therapists in this clinic appear to be experiencing the dilemma of “whole person” vs. medical model even before they are practitioners. Mattingly and Fleming (1994) wrote;

*Occupational therapists often find themselves torn between a concern to “treat the whole person” and a concern to be credible within the medical world that pushes the therapist to redefine problems and treatment goals in biomedical terms. (p. 296)*
Interestingly, the same respondent (R11) wrote that spirituality is “part of the person!” Aligning with the previous quote from Mattingly and Fleming. This experience may help this student-therapist be more client-centered in the future. When something is important to a client but minimalized for the sake of productivity or third party payers’ demands for documentation of functional outcomes, occupational therapy practitioners may naturally feel a dilemma and conflict. Minimization of clients’ needs goes against many principles occupational therapy students are taught. Students and clinicians are experts in task analysis and understanding the interconnected parts of the whole of a client. The aforementioned therapeutic dilemma may be reason for the lack of a spiritual history assessment designed by occupational therapists.

**Implications for Occupational Therapy**

The student-therapists in the study clearly understood spirituality to be an integral to their clients’ lives and a part of the profession’s domain. Since clients appreciate and are typically open to discussing their spiritual history with their healthcare providers as a part of holistic and client-centered healthcare, occupational therapy curricula have the obligation to expose students and encourage practitioners to consider implementing spiritual history assessments. In 1998, Couch et al., concluded that anything that is not assessed is also not considered in treatment. The current study showed that when given the opportunity to implement a spiritual history assessment, students gain confidence and client understanding. Overall, the student-therapists in this study demonstrated willingness and readiness to commence with a spiritual history discussion with clients and gained professional experience through the process.
Future Research

The depth and breadth of research for this topic provides a foundation from which future research could be based. The current study could be replicated in other occupational therapy programs with student-therapist clinics around the U.S. and around the world. Due to the lack of research on spiritual history assessment in U.S. occupational therapy literature, a meta-analysis of the recent literature from Canada, U.K. and Australia might prove beneficial for scholars. A longitudinal study focusing on therapeutic outcomes in relationship to integrating a spiritual history assessment in intervention is indicated. An in-depth qualitative research project could be implemented using a focus group with occupational therapists/student-therapist(s) and their clients together to discuss their feelings, experiences, and beliefs about spiritual history assessment as it pertains to their sessions.

Limitations

The generalization of this study should be considered with caution due to the small sample size (n=13) and the fact that this study was conducted at a single university. At least three student-therapists queried the researcher about the FICA’s© use with clients who have aphasia or dysphonia, which may have affected client interpretation of the questions and/or their responses. The student-therapists were told to adapt the FICA© as they saw fit. They reported asking their client’s primary caregiver the FICA©’s questions or adapting the questions in such a way that their client was best able to respond. Since the FICA© is not standardized assessment, its use can be adapted as the administrator sees fit. Because the FICA© is a verbally based assessment it may not be appropriate for every client.
Conclusion

When occupational therapy students are provided with basic education and are afforded opportunities to use of a spiritual history assessment, they better understand its incorporation into their future practice. With exposure to a spiritual history assessment tool, they may be able to integrate spirituality into their intervention plan and gather meaningful information from their clients. Moreover, the opportunity to implement a spiritual history assessment may increase student-therapist (and future practitioner) confidence when addressing client spirituality. This type of inquiry may increase client/student-therapist rapport. With enhanced rapport client outcomes likely increase, thereby improving the client’s quality of care. In addition, exposure to the external and internal dilemmas of spiritual complexities might develop a well prepared clinician.
References


About WHO: Definition of Health: https://apps.who.int/aboutwho/en/definition.html


www.who.int/mediacentre/events/2008/wha61/desmond_mpilo_tutu_speech/en/


Appendix A:

_Spiritual History Assessment and Occupational Therapy:
Students Using the FICA_

_A study conducted by: Patricia Kelso-Wright_
_Undersity of Puget Sound_
_School of Occupational Therapy_
By answering this questionnaire, you are giving your consent to participate in this study and to having your data used for research purposes. Please answer the following questions:

1. **Age**
   - 18-25 ___
   - 26-35 ___
   - 36–45 ___
   - 46-55 ___
   - 56–65 ___

2. **Gender** ________

3. Do you have any previous experience as a healthcare practitioner? What type? Number of years?

4. Have ever administered a spiritual history assessment before?
   - ___ Yes
   - ___ No
   If yes, which one?

5. Do you consider spirituality a topic occupational therapists should address with clients?
   - ___ Yes
   - ___ No
   Why or why not?
Please choose one answer for the following questions.

6. Has spirituality been a topic addressed in your occupational therapy education to date?
   ___ Yes
   ___ No
   If yes, which course or context?

7. Were you able to watch the instructional PowerPoint on the FICA?
   ___ Yes
   ___ No

8. Did you implement the FICA with your adult clinic client?
   ___ Yes
   ___ No

9. If no, please select the reason(s) why:
   ___ I did not think the assessment would be useful
   ___ I did not feel confident having a spiritual discussion with my client
   ___ My CI did not think it was appropriate
   ___ I did not have enough time
   ___ None of the above
   ___ Other, please specify_____________________________________________________

10. Did you feel confident administering the FICA?
    ___ Yes
    ___ Somewhat
    ___ No

11. Do you think use of the FICA helped you feel more confident addressing your client’s spirituality?
    ___ Yes
    ___ Somewhat
    ___ No
12. Do you feel that implementing the FICA increased rapport with your client?
   ___ Yes
   ___ Somewhat
   ___ No

13. Do you believe the FICA helped your clinic client identify treatment goals?
   ___ Yes
   ___ No
   If yes, why or in what way?

14. Do you think the information you gained from implementing the FICA will help you with inter-vention planning?
   ___ Yes
   ___ No
   If yes, how? If no, why not?

15. Did the FICA help you address other topics besides spirituality?
   ___ Yes
   ___ No
   If yes, what topic(s)?

16. Do you think you will continue to use this assessment with future clients?
   ___ Yes
   ___ No
   If yes, why? If no, why not?
For the following questions, please rank your answer on a scale of 1-5, where 1 = no, definitely not/not much/not at all useful and 5 = yes, definitely/very much/extremely useful.

17. Please describe your confidence level in addressing this topic BEFORE using the FICA.
   
   1  2  3  4  5

18. Please describe your confidence level in addressing this topic AFTER using the FICA.

   1  2  3  4  5

19. To what degree do you believe the FICA helped you address spirituality with your clinic client?

   1  2  3  4  5

20. How useful was this tool for you in clinic?

   1  2  3  4  5

21. Are there any additional insights, opinions, or comments you would like to share about your experience?

   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

Please return this survey to me or UPS mailbox 4761 on or before February 14, 2012.
THANK YOU FOR YOUR TIME AND EFFORTS!!!
<table>
<thead>
<tr>
<th>Q5: Do you consider spirituality topic occupational therapists should address with clients? Why or Why Not?</th>
<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
<th>R5</th>
<th>R6</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Spirituality is important to a client, it will influence their behaviors in therapy.</td>
<td>Part of the alternative tx section in policy class.</td>
<td>CAM in mental health</td>
<td>600, 606, Healthcare systems</td>
<td>SAW- sociocultural awareness workshop.</td>
<td>It’s in our scope of practice.</td>
<td>It’s in the OTPF care-truly understanding the parts of the person + their context and meeting them where they’re at.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q6: Has spirituality been a topic addressed in your occupational therapy education to date? If yes, which course to context?</th>
<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
<th>R5</th>
<th>R6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part of the alternative tx section in policy class.</td>
<td>CAM in mental health</td>
<td>600, 606, Healthcare systems</td>
<td>SAW- sociocultural awareness workshop.</td>
<td>It’s in our scope of practice.</td>
<td>It’s in the OTPF care-truly understanding the parts of the person + their context and meeting them where they’re at.</td>
<td>It can be a very large part of someone’s roles, habits, &amp; routines and we would be remiss to ignore it, especially in the older population.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Q13: Do you believe that FICA© increased rapport with your client? If yes, why or in what way?</th>
<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
<th>R5</th>
<th>R6</th>
</tr>
</thead>
<tbody>
<tr>
<td>I already know he goes to church and he had a limited social network,</td>
<td>Helped me think of alternative methods for him to increase his social participation.</td>
<td>Helped me think of alternative methods for him to increase his social participation.</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q14: Do you think the information you gained from implementing the FICA© will help you with intervention planning? If yes, how? If no, why not?</th>
<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
<th>R5</th>
<th>R6</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Appendix B: Participants’ Written Responses to Six Supplemental & One Open-Ended Question**
<table>
<thead>
<tr>
<th>Q15: Did the FICA© help you address other topics besides spirituality? If yes, what topic(s)?</th>
<th>Social participation.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q16: Do you think you will continue to use this assessment with future clients? If yes, why? If no, why not?</td>
<td>I would be inclined to use this to increase my understanding of a client’s philosophy.</td>
<td>This may be much more important for others.</td>
</tr>
<tr>
<td>Q21: Are there any additional insights, opinions, or comments you would like to share about your experience?</td>
<td>My client communicates by signing letters, so communication of such a complex topic is difficult. I felt comfortable bringing spirituality up because he had alluded to God being responsible for his successful movement. The other interesting thing I gleaned was that although he attends church, he does not feel connected to that group.</td>
<td>This wasn’t very important to my client. He was not very interested in talking about spirituality.</td>
</tr>
</tbody>
</table>
### Appendix B: Participants’ Written Responses to Six Supplemental & One Open-Ended Question

<table>
<thead>
<tr>
<th>Q5: Do you consider spirituality a topic occupational therapists should address with clients? Why or Why Not?</th>
<th>R7</th>
<th>R8</th>
<th>R9</th>
<th>R10</th>
<th>R11</th>
<th>R12</th>
<th>R13</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is part of their occupational profile. If they are religious or spiritual a practitioner can use that knowledge to relate or offer comfort to the client.</td>
<td>Any topic that inspires motivation within the client should be explored. However, I’d probably be more uncomfortable with porn…</td>
<td>If I think it seems to be important in my client’s life.</td>
<td>If my client feels strongly about it, OT could tie it together in treatment.</td>
<td>It is part of the person!</td>
<td>First, it is part of our practice framework. Smarter people than I have deigned it important so it only makes sense to follow. Secondly and most importantly, spirituality is about meaning. Although it may not be OT’s role to create meaning for their clients, it is always our role to help them imbue meaning in their lives, through occupation. Understanding a client’s spirituality is a powerful tool for doing so.</td>
<td>Find out if it is a meaningful activity.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Q6: Has spirituality been a topic addressed in your occupational therapy education to date? If yes, which course to context? | Intro to healthcare, alternative practices | Briefly in healthcare systems (CAM) | Anytime the framework was mentioned 600, health systems | Complementary in Mental Health. | Extremely briefly in a course on mental health… I think. | Can’t remember. If it’s yes, it is brief not a major topic. |
| Q 14: Do you think the information you gained from implementing the FICA© will help you with intervention planning? If yes, how? If no, why not? | Because he is not spiritual, so I won’t consider it for tx because it wouldn’t affect outcomes. | Understanding a little about what is important to my client and where he feels a greater connection to things larger than himself allows me to understand better his motivation and what activities may appeal to him. | To continue to build rapport, understand, &amp; may use to help evaluate thinking, beliefs that help/hinder tx goals, motivation, etc. |
| Q15: Did the FICA© help you address other topics besides spirituality? If yes, what topic(s)? | Support systems | Touched on feelings around CVA |</p>
<table>
<thead>
<tr>
<th>Q16: Do you think you will continue to use this assessment with future clients? If yes, why? If no, why not?</th>
<th>In my circle, the older people are much more spiritual than the young. So, it stands to reason that adult clients (particularly the geri. crowd will find motivation and inspiration in their beliefs. It’s important they know we (care providers) recognize and respect that.</th>
<th>Easy- could be beneficial.</th>
<th>I think it is a credit to our clients to bring up an issue that underlies so many other things. I am interested in not hiding spirituality.</th>
<th>Ask them about if faith important, helpful-won’t pursue if sense if not comfortable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q21: Are there any additional insights, opinions, or comments you would like to share about your experience?</td>
<td>I think it is a great tool, but really I doubt we will get to use it much. The push for productivity and short patient stays eliminate time for non-medical items.</td>
<td>He said his faith was strong and good and in OT we should do our OT work.</td>
<td>It was difficult to use @ first because my client has dysphonia. I felt silly repeating myself when he and his wife didn’t understand my questions. However, after we made it through the few questions I felt I knew my client much better than before. I think that will prove invaluable in my treatment with him.</td>
<td>I noticed feeling apprehensive about asking about religion/faith because I am gunshy about born-agains “sharing their faith” trying to convert me, shoving it down my throat- and their curiosity about my [religion]. Very tiring. Also, the connections to extreme Right wing politics. Did NOT want to hear it.</td>
</tr>
</tbody>
</table>
Acknowledgements

I am grateful to Dr. Christina Puchalski for her insights on the design of my survey and PowerPoint as well as her generous donation of 25 FICA© cards for the purposes of this study. I am also grateful to Jacqueline Bouthot for her time and input. I thank Mer Manson, who was my grammatical editor and confidante throughout the process. To my many friends, who read this or simply gave me encouragement when I needed it most, thank you.