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The purpose of this study was to explore recreational therapists' status and perceptions of incorporating spirituality into the field of Therapeutic Recreation (TR). The literature indicates that healthcare is moving to treat individuals more holistically and is evidenced by the Joint Commission for Accreditation of Healthcare Organization's (JCAHO) mandating that all of their accredited agencies conduct a spiritual assessment on their clients (Hodge, 2006). Recent studies in TR specifically have found that some recreational therapists (RTs) are already applying spirituality in practice and interested in receiving additional education on how to assess and treat individuals' spiritual needs. However, no comprehensive study has been conducted on RTs' perceptions and the status of spirituality in TR services.

An online questionnaire was developed through Qualtrics and sent out to 6,200 full-time Certified Therapeutic Recreation Specialists (CTRSs) practicing in the US and Canada. Data were collected and analyzed using SPSS Statistical Software, version 26. A total of 411 CTRSs responded to the survey. The results of this study indicated that respondents not only thought addressing clients' spirituality needs is important, but also that they are currently doing so throughout the TR therapeutic process. Results also indicated that spirituality has a role in TR practice and that there is a need for more training on addressing clients' spiritual needs. Several recommendations were made for the inclusion of spirituality in the TR scope of practice, education, and future research.

RECREATIONAL THERAPISTS' STATUS AND PERCEPTIONS OF INCORPORATING SPIRITUALITY IN THERAPEUTIC RECREATION

by

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CHAPTER I

INTRODUCTION

Statement of Problem

Patient-centered care has grown in healthcare practices, to include the treatment of not only individuals' health but their overall well-being as well (Shea, 2000). Fain and Lewis (2002) stated that, "wellness is the holistic approach to health" (p. 7) where holistic care is meant to involve the treatment of all domains of human functioning. The domains necessary for an individual to obtain holistic wellness, however, are not commonly agreed upon across healthcare disciplines. Four domains are consistent throughout the literature: physical, social, emotional, and cognitive (Fain & Lewis, 2002; World Health Organization [WHO] 1948; Wolfe, 2017). Additional domains discussed in the literature include occupational, spiritual, and leisure (Anderson & Heyne, 2012; Fain & Lewis, 2002; Van Andel, 1998; Wolfe, 2017). There is a lack of clarity and consensus regarding which, if any, of these three additional domains belong in holistic care. This study specifically explores the domain of spirituality in recreational therapy (RT).

In the early 2000s, governing healthcare organizations such as the WHO and Joint Commission on Accreditation of Hospitals (JCAHO) issued changes to standards of care and operations of intake assessments in an effort to move towards a more holistic approach to health (Fleck & Skevington, 2007; Hodge, 2006). WHO defines health as, "a state of complete physical, mental and social well-being and not merely the absence of

disease or infirmity" (WHO, 1948, para. 1). Since the enactment of the WHO's constitution in 1948, when this definition was first established, numerous articles have been published in defense of the need for a more holistic definition, and thus the need to incorporate spirituality into the WHO's definition of health (Chirico, 2016; Larson, 1996; Nagase, 2012). In defense of a revised definition, it was argued that the cultural climate of the world is currently more receptive to spirituality than it once was and furthered that a person's health and well-being not only involve the mental, physical, and social, but also include the spiritual (Chirico, 2016). Although the WHO's definition remained the same, in 2002 their Department of Mental Health and Substance Dependence developed an instrument that was an extension of their pre-existing Quality of Life Instrument. The extension addressed spirituality, religiousness, and personal beliefs. It was created in response to professionals who work in mental health and substance dependence who felt that the existing Quality of Life Instrument did not accurately capture patient quality of life, specifically because of the absence of spirituality, religiousness, and personal beliefs (Fleck & Skevington, 2007).

In addition, in 2001, Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the largest healthcare accrediting body in the United States, implemented a requirement for spiritual assessment of patients (Hodge, 2006). Agencies accredited by JCAHO that now mandate spiritual assessment include hospitals, home care organizations, long-term care facilities, and some behavioral health care organizations (Hodge, 2006). This change to accreditation standards has created an assessable patient care need within the healthcare system; however, it is not currently

housed within any one healthcare discipline (e.g., sociology, psychology, physical therapy, occupational therapy, recreational therapy), and the only guidance that JCAHO provides in regards to spiritual assessment is, "your organization would define the content and scope of spiritual assessments and the qualifications of the individuals(s) performing the assessment" (JCAHO, 2020, para. 1).

Beyond the exploration of spirituality's role in patient-centered care by healthcare governing and accreditation bodies, patients themselves have expressed that spirituality is beneficial to their recovery process (Daly et al., 2019; Groff et al., 2009). Patients reported having a spirituality and wanting it to be addressed to improve their health and well-being (Daly et al., 2019; Park, 2013). Despite this identified need, there is discrepancy in the literature regarding how to assess patient's spirituality and who is responsible for doing so (Engquist, et al., 1996; Hunt, 2014; Oakley et al., 2010). As support of holistic treatment grows among healthcare professions (Bremault-Phillips et al., 2015; Egan & DeLaat, 1997; Hodge, 2011; Krageloh et al., 2015; Oakley et al., 2010), more research is needed for understanding and identifying reliable and meaningful ways to treat the whole person (i.e., mind, body, and spirit).

Significance and Rationale

This study is important to the growth of therapeutic recreation (TR) as a healthcare profession since it would provide a rich understanding of the current and potential role of spirituality in the practice of recreational therapy (RT). Exploring spirituality through research and practice would set TR apart from other healthcare disciplines, while simultaneously building the field's body of knowledge and evidence-

based practice. In addition, according to Sylvester (2015), exploring spirituality in research is one way in which we can assure that the field continues to remain current by expanding into domains of human functioning that are not considered within the scope of practice of other healthcare disciplines (e.g., physical therapy and occupational therapy)(Engquist et al., 1996; Oakley et al., 2010). Furthermore, as a discipline that already works holistically with patients in many functional domains (i.e., physical, social, emotional, and cognitive), the field of TR is uniquely suited to incorporate spirituality into patient care.

As a healthcare service, the field of TR has a stake in the discussions among other healthcare professions about whether to incorporate spirituality into practice and, if so, how? Further, the experience of RT professional uniquely lends itself for recreational therapists (RTs) to lead the charge in addressing the spiritual needs of clients focused on a strength-based patient-centered care approach (Anderson & Heyne, 2012; Wozencroft et al., 2012). Unfortunately, there is limited available literature or research about the use of spirituality in RT and why it is or why not it is not being incorporated. In addition, TR Standards of Practice and Code of Ethics, as outlined by the American Therapeutic Recreation Association (ATRA), make no mention of spirituality in practice. It is difficult to join a conversation and "sit at the table" when there is a lack of clarity regarding where the field stands on the topic of spirituality in practice.

Purpose Statement and Research Questions

The purpose of this study was to explore recreational therapists' status and perceptions of addressing clients' spiritual needs. Through this study, the following questions were addressed:

1. What is the status of incorporating spirituality in RT service provision?
2. What are the perceptions of Certified Therapeutic Recreation Specialists (CTRSs) in regard to addressing the spiritual needs of clients?
3. To what extent do CTRSs' intrinsic spirituality influence their perceptions of addressing clients' spiritual needs?

The research questions guided the researcher's exploration of addressing spirituality in RT.

Definitions of Key Terms

Holistic. Treatment of all parts of a person (i.e., physical, cognitive, social, emotional, spiritual).

Leisure. "The condition of having one's time free from the demands of work or duty" (Veal, 1993, p. 2).

Recreational Therapy (RT). The practice of therapeutic recreation is, "designed to restore, remediate, and rehabilitate a person's level of functioning and independence in life activities, to promote health and wellness, as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition" (ATRA, 2015, para. 6).

Religion. Doctrinal in nature and, "relates to systems of worship" shared among a given group of people (Engquist et al., 1996).

Spirituality. Can be "secular or sacred," and it cultivates transcendence, connectedness, and purpose within one's life (Unruh & Hutchinson, 2011, p. 567). "Spirituality is that which gives meaning and purpose to one's life and connectedness to the significant or sacred" (Bremault-Phillips et. al., 2015, p. 477).

Therapeutic Recreation (TR). Field of practice in which RTs are the practitioners (ATRA, 2015).

Well-Being. Where one experiences productive, satisfying, and successful engagement with one's life in a resource rich environment, it leads to a flourishing life (Anderson & Heyne, 2012).

Wellness. A holistic approach to health (Fain & Lewis, 2002).

Limitations and Delimitations

Limitations include the effects of conducting this study during a pandemic outbreak. At the onset of developing the questionnaire and administering it, the virus COVID-19 broke out and led the researcher to having a smaller time frame for study completion. The original plan was to complete an internship for course credit in the summer and devote the full fall semester solely to thesis research. Rather than having four months over the summer and no other obligations other than to design, administer, and complete the study, the researcher had to develop, administer and complete the study within three months over the summer since her internship was moved to the Fall

semester. These events changed how the researcher was able to access resources and faculty.

The survey sample was delimited to full-time practicing CTRSs registered with the National Council for Therapeutic Recreation Certification (NCTRC). According to the US Bureau of Labor Statistics (2020), in 2018 there were 19,800 employed RTs in the United States. According to the NCTRC, there are "currently 18,000 certificants who hold active, inactive, or eligible for re-entry status on the registry" (NCTRC, 2020, para. 6). This discrepancy shows that not all of the RTs accounted for by the Bureau of Labor Statistics hold the status of CTRSs; therefore, for the purpose of this study, the researcher chose to sample only CTRSs from NCTRC's registry. Furthermore, only full-time practicing CTRSs were included in the sample because the researcher wanted to gather data from practitioners who were participating within the field of TR and practicing RT as their sole career. In addition, since this research was conducted by a master's candidate, the researcher did not want to acquire more responses then was manageable given the limitations listed above.

CHAPTER II

REVIEW OF THE LITERATURE

The importance of spirituality to the wellness of an individual transcends basic understanding of the human condition. Holocaust survivor, neurologist and psychiatrist, Viktor Frankl et al. (2006) reported that, "psychological observations of the prisoners have shown that only the men who allowed their inner hold on their moral and spiritual selves to subside eventually fell victim to the camp's degenerating influences" (p. 69). He was speaking on the well-being and quality of life of his fellow inmates at four different concentration camps during the Holocaust. In his book, *Man's Search for Meaning*, Frankl et al. (2006) wrote at length on the essential role that one's spirituality played in their adversity and inevitable survival from the conditions of concentration camps.

> Seen from this point of view, the mental reactions of the inmates of a concentration camp must seem more to us than the mere expression of certain physical and sociological conditions. Even though conditions such as lack of sleep, insufficient food and various mental stresses may suggest that the inmates were bound to react in certain ways, in the final analysis it becomes clear that the sort of person the prisoners became was the result of an inner decision, and not the result of camp influences alone. Fundamentally, therefore, any man can, even under such circumstances, decide what shall become of him – mentally and spiritually. (p. 66)

In his above statements, Frankl et al. (2006) suggested that one's state of mind and spirituality are the fundamental elements of one's quality of life which determines their understanding of

well-being. However, Frankl et al. (2006) was not the first to identify spirituality as a concept with deep interplay between a person and the world within which they exist.

Spirituality is a notion philosophers and scientists alike have attempted to grasp in their works as they try to make sense of humanity's meaning. One such example can be found in hermeneutics. Hermeneutics is a philosophical discipline that began during the transition from oral history to written texts (Freidman, 2014). Its roots are religious in that scholars would interpret biblical texts and translate their interpretations into understanding of their current world. These interpretations involved subjective critique and cultural context. In hermeneutics, understanding is the whole of life, and engagement and interpretation of the phenomena is the parts of that whole. Similarly, the practice of healthcare began to transition from a purely medical model that only recognized a couple parts of the human condition (i.e., physical and cognitive) to a more holistic approach of patient care that takes into consideration all parts of the human condition (Heintzman, 2008; O'Keefe, 2001; Sylvester, 2017). As cited by Anderson and O'Keefe (2020), Shae (2000) captures this sentiment stating, "healthcare and the spirituality have always been closely related, in part because health care attends to people as they suffer, and suffering is often a time of spiritual invitation…By its very nature, health care lives at this juncture of human suffering and spiritual search" (Slide 14).

Spirituality and Religion

Spirituality and religion are often referred to interchangeably; therefore, it is important to discuss how spirituality and religion are two distinctly different concepts. Religion is, "primarily social" and a term that is a distinctly different construct from

spirituality (Hodge, 2003, p. 42). Oakley et al. (2010) further states that, “religion provides a firm set of beliefs, rituals and worship patterns within a faith community for the expression of particular spirituality” (p. 46). On the other hand, spirituality is a broad construct that can contain religion, but is not limited to existing and being developed only within religion (Hodge, 2003). Although there is no one definition of spirituality, studies within other healthcare disciplines (e.g., physical and occupational therapy, social work) have defined spirituality in the following ways. Sargeant (2009) described spirituality as, “the fundamental life process through which wellness is experienced. It involves a connectedness to oneself, others, nature, and to a larger meaning or purpose” (p. 29). Similarly, Oakley et al., (2010) stated that, “spirituality is a broad concept that includes the attributes of the following: search for meaning and purpose in life, connecting with oneself, others, or a higher power; and cherished beliefs and principles such as love, compassion, truth, and justice” (p. 46). Unruh and Hutchinson (2001) describe spirituality as being able to be “secular or sacred,” and to cultivate transcendence, connectedness, and purpose within one’s life (p. 567). Lastly, spirituality is the source from which people derive their inspiration and motivation and thus hoping to discover purpose and meaning in life (Engquist et al., 1996; Hodge, 2003).

The root of spirituality is spirit, “the force that animates life” (C. O’Keefe, personal communication, November 17, 2019) or spiritus, meaning “breath of life” (Heintzman, 2010). For the purpose of this study and based on a thorough review of spirituality as defined by the literature, spirituality was defined as a, “state of the heart that animates one’s life and how individuals cultivate meaning-making, purpose, hope,

transcendence and connectedness." The five components listed within the definition were chosen to define spirituality since they were the five most recurring terms in the literature regarding spirituality (Chandler et al., 1992; Heintzman & Mannell, 2003; Unruh & Hutchinson, 2011).

Thus, for the sake of drawing distinctions, one's spirituality can include religion, but one's spirituality is not dependent on a subscription to any religious beliefs. The importance of this cannot be overstated. Some literature shows that professionals are still conflating the concept of spirituality with the necessity of being religious (Lyons & Lopez, 2015; Park, 2013). One does not have to be religious, however, in order to have or develop a spirituality. Religion is rooted in doctrines, higher power(s), and communal organizations, while spirituality is rooted in, "strong and coherent beliefs about the higher purpose and meaning of life" (Anderson & Heyne, 2012, p. 74), which does not necessitate the requirement for understanding the "work of God" as suggested by Lyons and Lopez (2015, p. 222).

Spirituality in Healthcare

The discussions surrounding spirituality's role in the WHO's quality of life assessment instrument increased researchers' awareness of spirituality as playing a role in wellness in a wide variety of healthcare disciplines (Daly et al., 2019; Heintzman, 2008; Hodge, 2006; Oakley et al., 2010). Over time, healthcare disciplines began to adopt the paradigm shift, towards treating patients holistically and incorporating spirituality into treatment (Bremault-Phillips et al., 2015; Egan & DeLaat, 1997; Krageloh et al., 2015). The healthcare literature consistently refers to the benefits of incorporating spirituality

into patient care such as improved physical health, coping skills, client-healthcare provider rapport, stress management, well-being, connectedness, meaning-making, and hope (Bremault-Phillips et al., 2015; Daly et al., 2019; Iwasaki et al., 2015; Oakley et al., 2010; Park, 2013).

Within the healthcare system, disciplines that RTs often interact with include physical therapists (PT), occupational therapists (OT), speech and language pathologists (SLP), social work (SW), pain and palliative care (PPC), and nursing. Each of these disciplines has begun exploring the importance of spirituality in their respective fields and individualized care. For example, a study within the field of PPC sought to assess the use of spirituality in patient care. They reported that spiritual assessment was an effective means for establishing rapport with patients as it increases patients' trust and comfort (Gomez-Castillo et al., 2015). Spirituality was also found to create stronger patient-therapist connections (Bremault-Phillips et al., 2015). Bremault-Phillips et al., (2015) explored the roles of spiritual assessment in palliative care patients. They noted the importance, challenges, and opportunities of gathering a spiritual history from patients and incorporating it into care. They found that, though considered a non-essential piece of patient care at the time of the study, over 73% of healthcare professionals strongly agreed that the inclusion of spirituality in patient care was important (Bremault-Phillips et al., 2015).

The fields of PT and OT also recognize the importance of spirituality in patient care but have not made any notable strides towards incorporating it into practice (Engquist et al., 1996; Hunt, 2014; Milliken, 2020; Sargeant, 2009). Oakley et al. (2010)

found that PTs perceived that the largest barrier to incorporating spirituality into practice was a lack of experience or lack of experience in taking a spiritual history (i.e., assessing or collecting information regarding an individual's spiritual history). This finding defends the need for discussions on spiritual well-being within the classroom curriculum as discussed in previous studies conducted by Morris et al. (2014) and Sargeant (2009). Sargeant (2009) discussed how as contact with patients experiencing "life-altering circumstances" (p. 29) increases, there is an apparent need for spirituality in PT curricula, so that the practitioners are equipped to incorporate and advocate for the spiritual and religious needs of their clients. Similarly, Morris et al., (2014) found a lack of spirituality in OT curricula, yet an expressed acknowledgement by OTs of the importance incorporating spirituality in care.

Despite PTs and OTs reporting that spirituality is important for clients and should be incorporated into practice more, some studies showed that they did not see it as their role to respond to patients' spiritual needs (Engquist et al., 1996; Oakley et al., 2010). For example, Engquist et al. (1996) found that 84.3% of therapists thought spirituality is a very important dimension of health and rehabilitation, however 91.9% of therapists reported that a pastoral care department or hospital clergy is responsible for heling clients with spiritual needs, thus addressing spirituality is not within their scope of practice as OTs. Similar in Oakley et al.'s (2010) study on PTs' perceptions of spirituality and patient care, findings showed that 96.3% of respondents reported spiritual well-being as an important component of health, 51.5% responded that spiritual questions should be referred to the hospital chaplain or other spiritual leader. Furthermore, 40.8% responded

that spiritual questions should not be addressed by PTs. This raises the question, what role does spirituality play in healthcare professions and how can healthcare professionals help clients use their spiritual strengths to meet their therapeutic outcomes? Since PTs and OTs do not regard addressing spirituality in patient care within their scope of practice, spirituality might have potential within TR service provision.

Beyond education, some disciplines have expressed concerns that bringing spirituality into practice could lead to crossing ethical boundaries with patients; however, research shows this not to be the case (Blair, 2015; Wozencroft et al., 2012). Blair (2015) conducted interviews with nine mental health professionals regarding how their own personal spirituality informs their professional practice. The study found that the respondents' spirituality helped them to develop better self-care practices, which in turn helped them to better serve their clients. Meanwhile Wozencroft et al. (2012) offers similar implications for spirituality in TR specifically. The study showed that 73.6% of respondents reported, "spirituality impacted the way that they performed their jobs" (p. 47).

Benefits and Barriers to Incorporating Spirituality in Healthcare

Several key benefits and barriers to incorporating spirituality into healthcare practices have been found in the exploration of spirituality in practice. Findings show that spirituality is beneficial to both patients and therapists for various reasons (Daly et al., 2019; Groff et al., 2009; Iwasaki et al., 2015). From the patient's perspective, research shows that spirituality is central to one's identity (Daly et al., 2019). Further, patients have reported the following to be benefits of having spirituality incorporated in patient

care: an increase in coping skills and transcendence (Daly et al., 2019; Groff et al., 2009), an increase in one's ability to make-meaning of their life and purpose (Iwasaki et al., 2015), fostered connectedness, further spiritual growth (Bremault-Phillips et al., 2015), individualized treatment, reduction of distress, and restored personhood (Daly et al., 2019). Finally, patients report that engaging with spirituality is helpful in "finding a new normal" when faced with life altering diagnoses (Groff et al., 2009, p. 353).

Benefits for therapists include increased job satisfaction, and greater interdisciplinary collaboration (Bremault-Phillips et al., 2015). Benefits shared between therapists and patients include an increase in rapport and stronger patient-therapist connections (Bremault-Phillips et al., 2015; Daly et al., 2019), opportunities for enhanced patient and family satisfaction, and enhancement of patient experiences (Bremault-Phillips et al., 2015). More specifically, in regards to building rapport, Austin et al. (2017) argue that, "…rather than prescribe activities, RTs are much more likely to engage in a therapeutic relationship with clients…" (p. 60). This statement further attests to the importance of client-therapist rapport and research shows that bringing one's spirituality into treatment can help create rapport faster and on a deeper level (Bremault-Phillips et al., 2015; Groff et al., 2009; Park, 2013). Beyond rapport, the benefits that patients receive are helpful to the recovery process (Bremault-Phillips et al., 2015). In one study by Bremault-Phillips et al. (2015), it was reported that over 73% of the healthcare professional involved in the study selected strongly agreeing that the inclusion of spirituality in patient care through conversations, care planning, and overall care was important to patient care, healing and patient experience. The authors concluded that

"addressing the spiritual domain of individuals in care clearly has a positive influence on patient care, IP team members, and overall organization culture…therefore important when considering ways to effectively deliver high quality healthcare services" (Bremault-Phillips et al., 2015, p. 494).

While there is an increasing amount of discussion in the literature surrounding the benefits of incorporating spirituality into patient care, there is little mention of the barriers to addressing spirituality in healthcare. Several barriers have been presented in the literature that could explain the lack of addressing clients' spiritual needs. Barriers include lack of clarity on how spirituality is to be defined (Daly et al., 2019), lack of support and/or understanding from other members on the treatment team (Bremault-Phillips et al., 2015), fear of the incorporation of spirituality deterring patient participation (Groff et al., 2009), lack of knowledge on spirituality, lack of experience or skills to address spiritual needs, and lack of available resources or lack of knowledge regarding available resources (Daley et al., 2019).

Spirituality in TR

Models of Practice

It is important to note the unique interplay between spirituality and leisure as domains of human functioning. TR in and of itself is about helping individuals with disease or disability identify and access their leisure interests for recovery and well-being (ATRA, 2015). The literature in TR discusses the role of leisure as providing "a space or outlet" (Iwasaki et al., 2015, p. 548) for people to find their purpose/meaning in life through the leisure they chose to participate in, as well as "using leisure experiences to

grow, realize their potentials, and to become healthier than they were prior to encountering their initial health concerns" (Austin et al., 2017, p. 62). According to these descriptions the relationship of spirituality and leisure is analogous to a boat and to travel, where leisure is merely the vehicle or vessel for expression of spirituality. These comparisons of the relationship between spirituality and leisure suggest TR is the appropriate healthcare discipline to assess, treat, and evaluate the spiritual needs of clients as part their holistic, strength-based treatment process.

In the field of TR, models are meant to guide practice, and typically include the domains of human functioning. The physical, social, emotional, and cognitive domains are consistently found in TR models, while spirituality is found in only some (Park, 2013; Anderson & Heyne, 2012; Heintzman, 2008; Van Andel, 1998). The most common models found in TR include: Leisure Ability Model (Gunn & Peterson, 1984), Therapeutic Recreation Accountability Model (Stumbo & Peterson, 2009), Health Protection/Health Promotion Model (Austin, 2011), Optimizing Lifelong Health and Well Being Through TR (Wilhite, et al., 1999), TR Service Delivery and Outcome Model (Van Andel, 1998), Leisure and Well-Being Model (Carruthers & Hood, 2007), and Self-Determination and Enjoyment Enhancement Model (Datillo et al., 1998).

Of the above seven models, only the TR Service Delivery and Outcome Model, and Leisure and Well-Being Model includes spirituality. Anderson and Heyne (2012) wrote an extension of the Leisure and Well-Being Model to focus more emphasis on flourishing through leisure. Their extension explicitly outlines spiritual well-being as an outcome of the participant experience. The TR Service Delivery and Outcome Model,

developed by Glen Van Andel (1998), was the earliest model to refer to spirituality. The TR Outcome Model offers a comprehensive outline for the scope and nature of TR services and expected outcomes. Van Andel's model (1998) addresses all functional domains (i.e., cognitive, psychological, physical, spiritual, social, and leisure), and how they interact for optimal quality of life and well-being.

As the field of TR grew (c. 2007 to present), so did the available models that account for leisure and spiritualty as integral components of the therapeutic process. Since 2007, the Leisure-Spiritual Coping Model (Heintzman, 2008) and the Meaning-Making Model (Park, 2013) have surfaced as practical models that defend the importance of spirituality in RT practice. The Leisure - Spiritual Coping Model (Heintzman, 2008) is the newest model in TR and was based on Van Andel's (1998) TR Outcome Model and Gall et al.'s (2005) Spiritual Framework for Coping. This model asserts that spirituality is an integral part of our coping process when introduced with new or consistent life stressors. Finally, there is the Meaning-Making Model (Park, 2013) which highlights the importance of spirituality in clients' quality of life and ability to make meaning in their lives. It is important to note that the Meaning-Making Model was developed as a guide for those practicing in the discipline of psychological health and not TR specifically. The field of TR, however, often adopts theories and models that have already been established by other disciplines, thus this model speaks greatly to the impact one's spirituality can have on their ability to find meaning in their lives. Park (2013) defends that spirituality plays a crucial role in how people make meaning in their lives, especially in times of great stress or difficult situations. She also contended that, "people generally report fairly

high levels of spirituality" (p. 42) and that 85% of people worldwide, "report having some form of religious beliefs" (p. 42). Thus, the need for a model that attends to an individual's spirituality.

The above summary of available models demonstrates how the field of TR has grown to recognize the importance of spirituality in the treatment of the whole person. However, there is little research available regarding the current status of spirituality in TR and recreational therapists' perceptions about incorporating spirituality into practice. Though the current study is not guided by any one model, it is important to note the important influences models have in practice, as well as demonstrate how TR models have developed over time to recognize an individual's spirituality as playing an essential role in well-being.

Scope of Practice

RTs work within the following settings: hospitals, skilled nursing facilities, residential care, community-based parks and recreation, community-based human/social services, assisted living, education and others (NCTRC CTRS Professional Profile Overview, 2019). The diversity of settings in the professional profile conducted by NCTRC demonstrates that RTs work in a wide variety of settings, many which are JCAHO accredited, yet receive little guidance on the content and scope of spiritual assessment, as well as who the qualified provider is.

Despite the lack of guidance and unlike research findings in PT and OT (Engquist et al., 1996; Oakley et al., 2010), TR research shows that spirituality is not only a topic of interest to RTs, but a competency that RTs are, at least, moderately utilizing (e.g., Porter

et al., 2020; Wozencroft et al., 2012). In their recent study, Porter et al. (2020) collected information regarding competencies in RT practice. The purpose of the study was to help RT academic programs, the NCTRC, and the Commission on Accreditation of Recreation Therapy (CARTE) utilize the results to ensure that curricula, accreditation standards, and the certification exam reflect the findings. The findings were grouped into categories of high, moderate, and low. Porter et al. (2020) recommended RT academic programs, NCTRC, and CARTE "reflect on, and give moderate attention, to the extent these items are being incorporated and threaded throughout academic programs, accreditation standards, and the national credentialing exam" (Porter et al., 2020, p. 431). Findings showed that in non-activity specific competencies and techniques, spirituality and spiritual support were considered to be moderately used by RTs. Further, RTs were moderately interested in receiving additional education on spirituality.

Currently, the NCTRC Job Task Survey Report (2014) makes no mention of spirituality as part of the TR job tasks and knowledge areas (i.e., tasks done by RTs and knowledge areas that a TR student should know). Six knowledge areas are necessary for credentialing (i.e., foundational knowledge, assessment, documentation, implementation, administration of services, and advancement of the profession), and none of them includes competency in spirituality or spiritual support. Furthermore, despite the evidence that RTs are utilizing spirituality in practice, there is no reference to spirituality in TR standards of practice nor code of ethics.

In summary, additional research regarding the status of spirituality in RT practice and RTs' perceptions of incorporating spirituality in practice, could demonstrate a need

for changes to the documents that define TR scope of practice (i.e., job task and knowledge areas, standards of practice, code of ethics). There is little research, however, on the status of spirituality in TR and recreation therapists' perceptions of its role. This research could help gain valuable insight into how RTs already are or are failing to tailor their client care to not just the health of their client, but their overall well-being too. As seen in today's cultural climate, holistic (i.e., treatment of the mind, body, *and* soul) approaches to medicine are becoming increasingly popular (Engquist et al., 1996; Hodge, 2003; Oakley et al., 2010; Park, 2013; Van Andel & Heintzman, 1996), thus exploration of spirituality could help grow and strengthen the field as a way of improving and expanding TR's research base.

CHAPTER III

METHODOLOGY

Design

The design of this study was survey research. Since this study explored the status and perceptions of recreational therapists' beliefs and practices, quantifiable data were the best approach to gathering the desired information. The information needed for this study was not reflective in nature, but rather specific and measurable, thus the researcher chose to use a questionnaire for data collection.

Sample

Participants were full-time practicing CTRSs registered with the NCTRC. A sort function was conducted by NCTRC from the total pool of 18,000 certified RTs in the US and Canada. CTRSs practicing full-time were identified resulting in a sample pool of 6,200. An online questionnaire was the most effective way to reach the sample pool since participants were located in areas across the US and Canada. A response rate around 20% was expected, since recent studies (2015-2019) that used the NCTRC members as subjects consistently saw a return rate of around 20% (CTRS Professional Profile, 2019).

Instrument

For the purpose of this study, an online questionnaire was developed using Qualtrics software. The Qualtrics questionnaire was a survey instrument designed to provide a foundational understanding of recreational therapists' status and perceptions of

addressing clients' spiritual needs (See Appendix A). Content of the instrument questions was divided into five sections (elements of quality of life, addressing spiritual needs, training and education, the Intrinsic Spirituality Scale, and demographics). Each item on the questionnaire was carefully designed based on the researcher's review of the available literature across healthcare disciplines. Specific items were developed that addressed the gaps in the literature regarding the recreational therapists' perceptions of addressing spirituality in patient care as well as their status of doing so. In addition, in-depth semi-structured interviews were conducted to gather information for item content. Four professionals in the field considered to be experts in TR and spirituality in practice were interviewed. The interviews not only guided the researcher's literature review but also helped with developing questionnaire items. The instrument consists of 41 Likert scale items, three polar questions, two check-all-that-apply (CATA) questions, one drop-down question, and six demographic questions.

Content for the first three sections came from the literature across various disciplines on domains utilized in practice (Anderson & Heyne, 2012; Fain & Lewis, 2002; Van Andel, 1998; WHO, 1948;Wolfe, 2017), components of spirituality (Chandler et al., 1992; Heintzman & Mannell, 2003; Oakley et al., 2010 Unruh & Hutchinson, 2011), and training and education regarding spirituality (NCTRC Job Task Analysis, 2014; Oakley et al., 2010; Sargeant, 2009). The first three sections contain 35 Likert scale items on a scale of 1-6 (1=strongly disagree, 2=disagree, 3=slightly disagree, 4= slightly agree, 5=agree, 6=strongly agree). The items on elements of quality of life came from the WHO's definition of health (WHO, 1948) and RT models (Austin, 2011; Carruthers &

Hood, 2007; Datillo et al., 1998; Gunn & Peterson, 1984; Stumbo & Peterson, 2009; Van Andel, 1998; Wilhite et al., 1999) on the functional domains. Addressing spiritual needs came from the literature on benefits of incorporating spirituality into practice and definitions of spirituality. These items were created to explore participants' perceptions and identify possible outcomes for future research. The items regarding training and education came from a similar study conducted by the discipline of OT (Engquist et al., 1996) and were designed to explore the status of spirituality in practitioners' training and areas practitioners would like to see future training.

The remaining items came from the Intrinsic Spirituality Scale (ISS) (Hodge, 2003) and were on response options were on a scale of 0-10. The original ISS was contained more questions and explicit reference to religion. The ISS, as it is used in this questionnaire, was modified by Hodge (2003) due to low reliability and the references to religion. The current ISS is a 6-item scale used to address one's intrinsic motivations to be spiritual that are based in spirituality alone and has a high reliability score (r=.80). This scale was chosen based on its reliability, number of questions, and ability to report the level to which one is spiritual. Including the ISS allows the researcher to report one's spirituality more accurately than having the participants self-report their level of spirituality. In addition, the ISS was included so that participants' ISS composite score could be compared with other questionnaire items in order to respond to research question three: to what extent does a CTRSs intrinsic spirituality influence their perceptions of addressing clients' spiritual needs?

The literature suggests that one's spirituality can be influenced by age (Black & Hannum, 2015), gender (Reid-Arndt, 2011), and race and ethnicity (Paredes-Collins, 2011). For this reason and for the purpose of collecting basic demographics on participants, age, gender, race, and ethnicity were questions included in the demographic section. In addition, years of practice, and primary setting of practice were included in order to determine whether or not the participants in this study were consistent with the population as outlined in the NCTRC CTRS Professional Profile (2019).

Data Collection

This study was approved by the Institutional Review Board (IRB) at the University of North Carolina Greensboro and deemed to involve little to no risk/harm to participants. Following IRB approval, an application was submitted to and approved by NCTRC for the purchasing of email labels. As a result, NCTRC sent out a pre-scripted email message and a link to the online questionnaire to all full-time, practicing CTRSs requesting that they participate in the questionnaire. This process was completely anonymous and confidential. CTRSs had one week from the date the questionnaire was sent out to complete the questionnaire. Responses were recorded by the Qualtrics survey system. Participants were not identifiable and IP address collection was turned off in Qualtrics during data collection. At the end of five days, a follow-up email was sent to remind participants to complete the questionnaire by the provided date. At the close of the week and after all of the responses had been collected, the data were input into SPSS, version 26, for data analysis. Four hundred and eleven valid responses were received and used for data analysis.

Data Analysis

Data analysis included descriptive statistics, reliability analysis and interpretive statistics such as Cronbach's alpha and crosstabulations with chi-squares. All descriptive analyses were based on all cases with valid data. Respondents were removed from the study if they did not complete any questions, if it was apparent that they had started the questionnaire but failed to complete it in its entirety, or if they left any whole sections incomplete except the demographic section.

Since a large part of this study was about gathering data on the current status of RT practice, descriptive analyses were run for all individual items. Mean scores were collected for each of the Likert scale items in the elements of the quality of life section. The means were used to rank how essential each element is to one's quality of life. Similarly, mean scores were collected for each of the Likert scale items in the addressing spiritual needs section. The higher the agreement for each item, the larger the role spirituality played in that area of RT service provision. Descriptive statistics for the polar questions indicate where RTs are being trained in addressing the spiritual needs of clients. Descriptive statistics for the CATA question regarding the application of spirituality in RT service provision will indicate the degree to which therapists believe that spirituality's role in TR is a process; an outcome; an intervention; a process and outcome; a process, outcome and intervention; or not necessary in recreational therapy services. Similarly, descriptive statistics for the CATA question regarding the model used in practice were utilized to indicate which models are being used in practice and whether

those models contain components of spirituality. Knowing which model is used more than others, if any, could help describe the role spirituality has in RT service provision.

Crosstabulations with chi-squares were run between a variety of items. Items for which crosstabulations with chi-squares were run include participants' ISS score and elements of the quality of life section, ISS scores and importance of addressing spirituality, training/education and age, training/education and years of practice, identified models of practice and importance of addressing spirituality, and finally, importance of addressing spirituality and age.

A Cronbach's alpha reliability analysis was conducted for the items of question four (i.e., I think that it is important for RTs to address their clients' spiritual needs because doing so…) in the section on addressing spiritual needs. The items in this question were identified in the literature as both benefits of addressing clients' spiritual needs and elements of spirituality that could be treated as client outcomes. A reliability analysis would show which items in this section stand together and how the removal of each individual item impacts the overall reliability level since there are no pre-existing measures for these particular outcomes of addressing clients' spiritual needs.

CHAPTER IV

RESULTS

Descriptive statistics, reliability analysis and cross tabulations were run on the collected data in order to respond to the three research questions. Specifically, descriptive statistics were used to answer research question one, "What is the status of incorporating spirituality in RT service provision?," as well as research question two, "What are the perception of CTRSs regarding addressing the spiritual needs of clients?" N sizes varied based on the number of respondents, since not all respondents responded to all questions.

A total of 483 practitioners responded to the questionnaire; 72 were removed for reasons stated above, which left the researcher with 411 usable respondents. The response rate was 6.6%. The majority of participants identified as White (85.7%) and female (90%). The primary settings in which respondents practiced were identified as behavioral health (32.7%), long-term care (22.4%), and community (e.g., adaptive, inclusive, specialized) (15%). The demographic findings for race, gender, and primary setting were similar with the latest CTRS Professional Profile (2019) conducted by NCTRC. See Table 1 for descriptive data. Respondents' ages ranged from 22-79 (M=43.146, SD=13.143) and years of practice ranged from 0.50-46 (one respondent reported practicing 2011 years, which was an outlier and not considered for any analyses with years of practice).

Table 1

Percentages of Identity, Race, Ethnicity, and Primary Setting

	N out of 411	Percentage
Identity		
Female	341	90
Male	34	9
Prefer not to answer	4	1.1
Race		
Asian	4	1.1
Black or African American	25	6.6
White	324	85.7
Mixed Race	9	2.4
Other	5	1.3
Prefer not to answer	11	2.9
Of Hispanic, Latinx, or Spanish Origin?		
Yes	14	3.7
No	360	96.3
Primary Setting		
Behavioral Health	124	32.7
Community	57	15.0
Corrections	18	4.7

Hospitals	26	6.9
Long Term Care	85	22.4
Pediatrics	6	1.6
Physical and Medical Rehabilitation	39	10.3
University/College	13	3.4
Other	11	2.9

Research Question One: What is the Status of Incorporating Spirituality in RT Service Provision?

There were four areas of concentration within research question one: service provision through the Assessment, Plan, Implementation and Evaluation process (APIE), obstacles to incorporating spirituality into practice, models of practice ascribed to, and training and education in spirituality. In the following sections, results for each area of concentration are reported individually.

Service Provision Through the APIE Treatment Process

There were six items that addressed the extent to which practitioners addressed spirituality in each of the components of the treatment process. Participants reported on a Likert Scale with a range of 1 (strongly disagree) to 5 (strongly agree) for each question. Results showed that the majority (55% and above) of respondents addressed (agreed or strongly agreed) the spiritual needs of their clients through all six of the treatment process components (i.e., assessments, goals and objectives, treatment plans, interventions, evaluation, and discharge planning). The largest majority of respondents (83.3%)

reported agreeing or strongly agreeing to addressing spirituality in interventions (*M*=4.04, *SD*=.896). See Table 2 for all remaining response options and percentages.

Table 2

Distribution of Percentages of Service Provision Through the APIE Treatment Process

		Valid Percent				
Treatment Area	N	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Assessment	386	2.8	10.4	17.4	46.6	22.8
Goals & Objectives	386	2.8	11.1	24.1	45.6	16.3
Treatment Plan	387	2.8	10.3	18.1	50.6	18.1
Interventions	390	2.6	4.4	9.7	53.3	30.0
Evaluation	387	2.8	10.9	27.9	44.4	14.0
Discharge Planning	384	3.1	12.8	28.4	38.5	17.2

Obstacles to Addressing Clients' Spiritual Needs

Seven items about obstacles to incorporating spirituality in RT services (lack of support, lack of personal knowledge, lack of experience, lack of resources, lack of knowledge regarding available resources, fear of deterring patients, and other) were presented on a Likert Scale ranging from 1 (strongly disagree) to 5 (strongly agree). Mean responses to these items were relatively low (ranging between 2.69-3.40) with

"lack of resources" having the highest response average (*M*=3.38, *SD*=1.138). Specifically, just over half (57.7%) of respondents reported that they agreed or strongly agreed that they experienced a lack of resources as an obstacle to incorporating spirituality into their patient care. For each of the remaining items, the majority (>50%) of respondents remained neutral, disagreed or strongly disagreed that the items were an obstacle to incorporating spirituality into patient care. Table 3 shows the distribution of percentages regarding all variables for this item.

Table 3

Distribution of Percentages for Obstacles to Incorporating Spirituality in RT

		Valid Percent				
Obstacle	N	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Lack of Resources	388	6.4	20.4	15.5	44.6	13.1
Lack of Knowledge Regarding Available Resources	387	7.8	25.8	18.3	38.5	9.6
Lack of Experience	388	13.9	31.4	18.6	29.6	6.4
Lack of Support	388	11.1	37.9	21.9	22.9	6.2
Lack of Personal Knowledge	388	13.9	36.9	20.9	22.9	5.4
Fear of Deterring Patient	386	16.6	40.7	22.5	16.6	3.6
Other	58	6.9	5.2	44.8	27.6	15.5

The option of "Other" followed by a text box was offered to respondents in this item and 58 respondents indicated "Other." The researcher reviewed the text entries and recoded any responses that fit the categories above so that they went into the categories there were already codes for such as lack of resources, lack of support, and lack of time.

Then, the researcher recoded the remaining 35 text entries into one word or phrase that was common among responses. Response topics were as follows: agency philosophy, another discipline's domain, appearances, boundaries of patient care, culture, the pandemic, patient education, patient understanding, fear of proselytizing, rapport, and separation of terminology. Out of the remaining 35 responses to this variable, the most common response (n=12) was that spirituality is the domain of another discipline (e.g., chaplaincy or social work). One text entry contained multiple of the listed areas and is as follows, "time, patients feeling other goals are more important, patients thinking spirituality and religion are the same. Our hospital had spiritual health therapists so I can just refer to them, I deal with more spiritual engagement whereas they deal with more the psychotherapy side of spirituality."

Models of Practice

Participants were asked to indicate which of eight practice models was the primary model that guided their practice of RT. Findings showed that most participants (33.2%) did not use a formal model to guide practice. After that, the most common models were the Leisure Ability Model (Gunn & Peterson, 1984) (25.4%), and the Leisure and Well-Being Model (Carruthers & Hood, 2007) (11.8%). The least used models in RT practice were the Therapeutic Recreation Accountability Model (Stumbo & Peterson, 2009) (2.4%) and the Therapeutic Recreation Service Delivery and Therapeutic Outcome Models (Van Andel, 1998) (2.4%). See Table 4 for all models and percentages.

Table 4

Percentages of Models Used in TR

Model	*N* out of 411	Percentage of Respondents
Do not use a formal model to guide my practice	110	33.2
Leisure Ability Model	84	25.4
Leisure and Well Being Model	39	11.8
Health Protection/Health Promotion Model	27	8.2
Other	19	5.7
Self-Determination & Enjoyment Enhancement Model	17	5.1
Optimizing Lifelong Health and Well Being Through TR	15	4.5
TR Service Delivery & TR Outcome Models	10	3.0
Therapeutic Recreation Accountability Model	10	3.0

Training and Education

In this section, participants reported on RT training and education in spirituality. Respondents were prompted to answer yes or no to the three items provided: "I received training in coursework about spirituality in TR/RT practice," "I received training at my internship about spirituality in TR/RT practice," and "I would like to receive additional training on spirituality to help me address the spiritual needs of my clients." Responses were coded 1 for yes and 2 for no. The majority (68.1%) of participants reported not having received any training and education on the topic of spirituality in their

coursework. The majority (80.3%) of respondents also reported not receiving any education and training on the topic of spirituality during their internship. Meanwhile, 80% of participants responded yes to wanting to receive additional training on the topic of spirituality.

If respondents selected "yes" to wanting additional training, then they were branched to an additional item that inquired how respondents would like to receive additional training. The majority (65.5%) of respondents indicated wanting to receive additional training through webinars (*n*=269). Conferences were the second most common way respondents wanted to receive additional training (59.1%, *n*=243). Published material was the third most common way respondents wanted to receive additional training (56.7%, *n*=233). Fewer than half (30.4%) of respondents indicated wanting to receive additional training through coursework (*n*=125) and only 19.7% indicated wanting to receive additional training through internships (*n*=81).

A crosstabulation with chi-square was run between training in coursework and the ages of respondents, as well as years of practice. A crosstabulation with chi-square was run between training in internship and age of respondents, as well as years of experience. Years of practice was categorized into three groups based on the distribution of the descriptive results (nine years or less = 1, 10-25 years = 2, and 25 years or more = 3). Similarly, age was categorized into three groups based on the distribution of the descriptive results (30 or less = 1, 31-50 = 2, more than 51 = 3). A relationship was found between training in coursework and age of respondents, X^2 (2, N = 376) = 17.656, p<.01, as well as between training in coursework and years of practice, X^2 (2, N = 367) = 22.492,

$p<.01$. The younger respondents were and the less time they have been practicing the more likely they were to have received training and education in spirituality in coursework. A relationship was also found between training in internship and years of practice, X^2 (2, N = 367) = 7.070, $p<.05$. The fewer number of years respondents were practicing, the more likely they were to have received training and education in spirituality during an internship. No relationship was found between training in internship and age of respondents, X^2 (2, N = 376) = 3.670, $p>.160$.

Research Question Two: What Are the Perceptions of CTRSs Regarding Addressing the Spiritual Needs of Clients?

Research question two explored elements of quality of life, importance of spirituality in practice, and the role of spirituality in practice.

Elements of Quality of Life

Respondents indicated the extent to which they agreed or disagreed that the six elements contributed to one's quality of life (i.e., cognitive, emotional, leisure, physical, social, and spiritual). Items were on a Likert scale ranging 1 (strongly disagree) to 5 (strongly agree). The vast majority of respondents agreed or strongly agreed that all six elements contributed to one's quality of life (89.9% to 96.5%). Findings showed that the leisure element had the highest agreement (96.5%) among respondents (M=4.63, SD=.765). The element of spirituality had the lowest level of agreement (M=4.44, SD=.888), but the majority of respondents (89.9%) still agreed or strongly agreed that spirituality is an essential element of one's quality of life. Next to leisure, emotional was

the second most agreed upon, followed by social, then cognitive, and then physical. See Table 5 for the distribution of percentages.

Table 5

Distribution of Percentages for Elements of Quality of Life

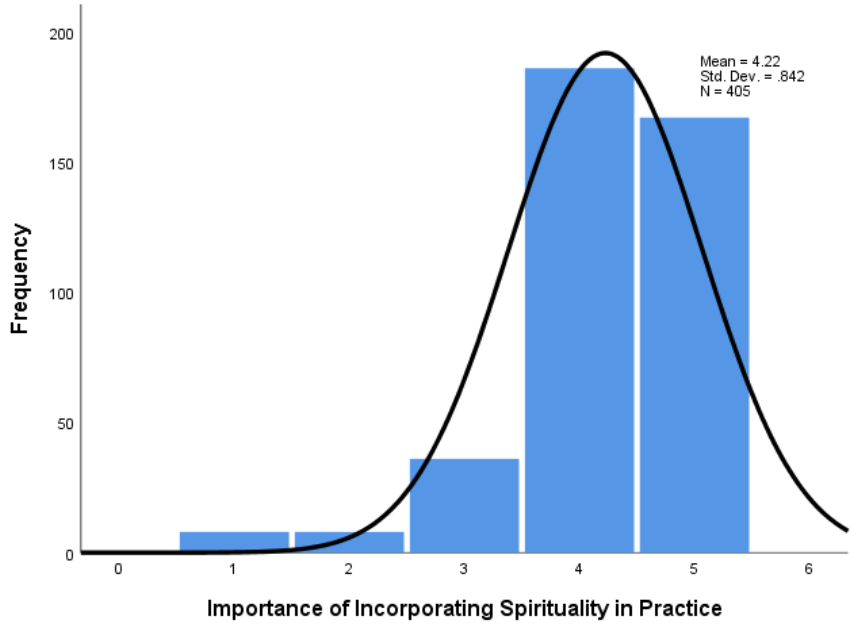
		Valid Percent				
Element	N	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Emotional	407	3.2	0.2	0.2	20.9	75.4
Leisure	405	2.7	0.2	0.5	24.2	72.3
Social	408	2.9	0.2	1.2	23.8	71.8
Cognitive	408	2.9	0.7	5.6	28.9	61.8
Physical	408	2.7	1.2	5.6	29.4	72.3
Spiritual	407	3.2	0.5	6.4	28.5	61.4

Importance of Addressing Clients' Spiritual Needs

Respondents were asked to report the level to which they agreed or disagreed that it was important to address clients' spiritual needs. Findings showed that 97.1% of respondents agreed or strongly agreed that it is important to address clients' spiritual needs (*M*=4.22, *SD*=.842). Figure 1 depicts the distribution of this finding.

Figure 1

Likert Scale Responses to the Importance of Addressing Spirituality



Importance of Addressing Spirituality and Models

For further statistical analysis, a crosstabulation with chi-square was run to explore the relationship between each of the main models used in practice and the importance of incorporating spirituality in practice. The researcher chose to only use the three models with the highest frequency of responses and the item "do not use a formal model" since the percentages of other models were quite small in comparison and thus would not work in statistical analysis. No relationship was found between any of the top three selected models or use of no model with and importance of spirituality, X^2 (16, N = 327) = 22.335, p>.01.

Importance of Addressing Spirituality and Demographics

Crosstabulations with chi-squares were also run between importance of spirituality and years of practice, as well as with age. No relationship was found between the importance of spirituality and years of practice, X^2 (8, N = 365) = 5.621, p>.01. No relationship was found between the importance of spirituality and age, X^2 (8, N = 372) = 5.666, p>.01.

Outcomes of Addressing Spiritual Needs

This variable contained 11 items for respondents to indicate the level to which they agreed or disagreed that these were options to be incorporated as outcomes of addressing clients' spiritual needs. Each item was on a 5-point Likert scale 1 (strongly disagree) to 5 (strongly agree). At least 70 % of the respondents agreed or strongly agreed that all 11 options are important outcomes of addressing clients' spiritual needs. They ranged from awe at 69.9% (M=3.93, SD = .958) to both hope (M=4.40, SD=.820) and purpose at 92.4% (M=4.40, SD=.803). Even though awe had the lowest level of agreement, 69.9% or more of respondents indicated agreeing or strongly agreeing to each outcome as contributing to the importance of addressing spirituality. See Table 6.

Table 6

Distribution of Percentages for Outcomes Addressed

		Valid Percent				
Outcome	N	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Hope	407	2.0	1.5	5.4	37.3	53.8
Purpose	406	2.2	0.7	4.7	39.7	52.7
Coping	408	2.5	0.5	3.4	43.6	50.0
Connectedness	409	2.4	0.5	7.6	37.9	51.6
Gratitude	407	2.5	1.2	7.1	41.0	48.2
Peace of Mind	404	2.5	1.5	7.4	41.6	47.0
Optimism	404	2.0	1.0	8.2	46.3	42.6
Meaning-Making	404	2.2	1.7	8.4	45.3	42.3
Transcendence	409	1.7	2.0	9.0	47.2	40.1
Awe	408	2.5	3.4	24.3	38.0	31.9
Other	74	4.1	0.0	29.7	28.4	37.8

A Cronbach's alpha reliability analysis test was run on this item to determine the reliability of variables. The overall Cronbach's alpha shows an internal consistency of .954. All additional alphas for if an item were deleted can be found in Table 7.

Table 7

Cronbach's Alpha if Item Deleted for Outcomes of Addressing Spirituality

Outcome	Cronbach's Alpha if Item Deleted
Transcendence	.950
Hope	.949
Meaning – Making	.949
Purpose	.949
Connectedness	.949
Optimism	.949
Gratitude	.947
Peace of Mind	.947
Awe	.954
Coping	.948

An "Other" category with a text box was offered to respondents in this item to gather any additional outcomes of addressing spirituality that was not found in the literature. Initially there were 74 respondents who indicated "Other." The researcher coded any text entries that was the same or closely related to the above options, such as connectedness, coping, and transcendence. Then the researcher went back through the text entries and recoded the longer entries into one word or phrase and 36 text entries were left. Finally, the entries were reviewed for any similarities and recoded accordingly.

Responses are as follows: acceptance, awareness, endurance, healing, helps with transition from hospital to home, individual specific, joy, perceived control, population specific, resilience, resources, spirituality/religion, trust in the process, valued, well-being, wholeness, and yoga therapy and nature. Out of the 36 respondents to this variable, the most frequently noted outcome of addressing spirituality was resiliency (5 respondents).

Role of Spirituality in Practice

Respondents were asked to select all parts of the RT process in which they perceive the role of spirituality to exist. Roles included as an outcome, a process, an intervention or no role in RT services. A majority of respondents (53.3%) selected that spirituality is part of the RT process (i.e., APIE). The second largest percent of respondents (47.7%) selected spirituality's role as an intervention (i.e., RT tool used to work towards a given outcome). Less than half (41.8%) of respondents reported spirituality's role being as an outcome (i.e., functional area that is improved or worked on through RT). Lastly, only 2.9% of respondents selected spirituality as not having a role in RT services.

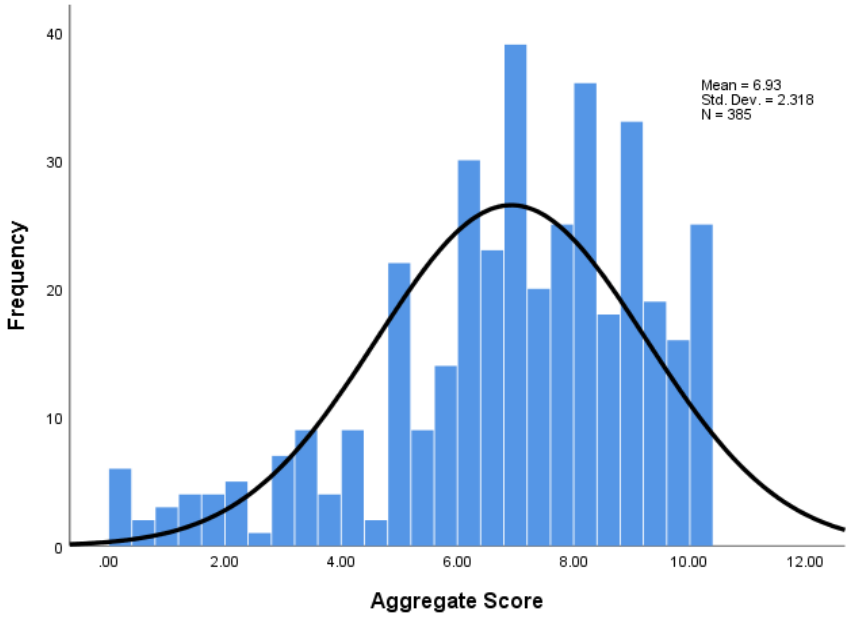
Research Question Three: Influence of Intrinsic Spirituality on Perceptions

All individual responses for each item of the Intrinsic Spirituality Scale (ISS) were collected and an aggregate score was computed for the reported scores of the ISS by averaging each respondent's response to the ten items of the ISS resulting in one mean score for each respondent. ISS scores ranged from 0.00 to 10.00. Due to the widespread distribution, the aggregate scores were further grouped into ten whole number categories

(e.g., 0-.99 =0, 1-1.99=1, 2-2.99=2, etc.). Over three quarters (78.4%) of respondents, had a score of 6 or higher on the ISS with 10 being the most intrinsically spiritual. The distribution of the mean scores can be found in Figure 2.

Figure 2

Intrinsic Spirituality Scale Aggregate Scores



ISS and Practitioner Perceptions

Research question three aimed to explore the extent to which one's intrinsic spirituality influenced their perceptions of addressing clients' spiritual needs. Correlations and crosstabulations were run for each respective item to determine whether there was a relationship between practitioners' level of intrinsic spirituality and their perceptions regarding spirituality in practice (i.e., items relating to elements of quality of

life, importance of addressing spirituality in practice, outcomes of addressing spiritual needs, and the role of spirituality in TR). For these tests, the researcher ran a crosstabulation with a chi-square on the aggregated ISS scores grouped into whole numbers and level of importance respondents gave to addressing clients' spiritual needs (i.e., strongly disagree, disagree, neutral, agree, strongly agree). A positive relationship was found between respondents' ISS and the level of importance, X^2 (40, N = 380) = 141.656, p<.01. Those with higher ISS scores tended to agree that it is important to address the spiritual needs of clients.

A crosstabulation and chi-square were also performed between the ISS and respondents' perceptions of the elements that contribute to quality of life. There was a positive relationship found between ISS and the element of spirituality, X^2 (40, N = 381) = 123.133, p<.01. Findings showed no other relationships between the ISS and the other elements of quality of life, cognitive element, X^2 (40, N = 382) = 28.787, p>.01; emotional element, X^2 (40, N = 381) = 30.895, p>.01; leisure element, X^2 (40, N = 379) = 24.425, p>.01; physical element, X^2 (40, N = 382) = 32.091, p>.01; and social element, X^2 (40, N = 382) = 28.297, p>.01.

CHAPTER V

DISCUSSION

Based on the results, it is clear that RTs find addressing spirituality in RT practice important and are utilizing spirituality in practice. Further, respondents currently address their clients' spiritual needs in the treatment process. These findings offered encouraging results for practical application regarding recreational therapists' status and perceptions of spirituality in TR. The findings also demonstrated a need for updated pedagogy and practice, as well as careful consideration of how to best care for individuals while minimizing harm done to the greatest extent possible.

Limitations

Several limitations of this study became evident throughout the research process. Limitations include poor response rate, question wording, and the literature review. These limitations are discussed below.

The response rate for this study was low. Though responses were enough to start developing an idea of recreational therapists' status and perceptions regarding spirituality in practice, the researcher hoped for a higher response rate. The response rate was 6.6%, thus it is difficult to generalize the findings to all practitioners. Past research studies with this population yielded an approximate response rate of 20% (e.g., Kinney, 2019; NCTRC CTRS Professional Profile, 2019). It is unknown whether respondents of this study are an accurate depiction of the larger population of CTRSs. It is the researcher's

belief that higher volumes of people working from home, due to COVID, influenced the response rate. With more therapists working from home, adjusting to a new normal, and juggling work and family responsibilities, it is possible that despite the provided reminder email, respondents forgot to complete the questionnaire or prioritized other responsibilities.

Response bias is also of concern due to the nature of the topic and influence of personal beliefs on openness to spirituality in RT practice (Blair, 2015). It is difficult to say whether respondents responded because this is a topic that they feel strongly about thus biasing results. Response rate and possibility of bias compromised the analyses in that it was difficult to determine what to attribute statistical significance to. Findings that were significant, while significant for these respondents, does not necessarily mean that the finding was true of all CTRSs.

Question wording also resulted in some limitations. Despite a pilot test with some peers and faculty as respondents, some structural limitations based on question wording were not found until after all data of the current study had been collected. For example, the "select all that apply" questions made it difficult in SPSS to determine whether respondents had selected more than one of the options. Specifically, in regards to the item on the role of spirituality, it would have been more beneficial to offer this question as a drop down option, since only half of the respondents appeared to have responded to the variables in this item and it was difficult to determine whether respondents chose more than one option. A multiple choice, polar question, or Likert Scale option would have been a better question format for descriptive and statistical analysis. In addition, in

retrospect, the researcher would have worded some questions differently. For example, the phrasing of "TR/RT" may have been confusing or overwhelming to respondents. The researcher could have chosen either TR or RT and kept it consistent throughout questions.

Finally, the literature review offered some limitations to question development. After reviewing the results, it became clear that this study could have benefitted from adding a question that specifically asked who was responsible for addressing clients' spirituality. This would have been helpful for clarity on whether respondents thought spiritual needs should be addressed by RTs as well as pastoral care or spiritual leaders. In addition, the researcher also found data regarding the professional profile of CTRSs after the questionnaire had been developed and administered. This information would have been helpful in developing the demographic section.

Research Question One: What is the Status of Incorporating Spirituality in RT Service Provision?

Overall, respondents noted the use of spirituality in all areas of the RT treatment process. They also noted a general lack of obstacles preventing them from addressing the spiritual needs of their clients. In regard to education and training, most respondents reported the use of a model to guide practice, though almost a third of the respondents did not use a model at all. In addition, respondents reported wanting to receive additional training on spirituality in TR.

Service Provision Through the APIE Treatment Process

When asked the following question, "As a Recreation Therapist, I address the spiritual needs of my clients through…", it was surprising to find that over 55% of respondents agreed or strongly agreed to addressing spirituality in each of the six components of the treatment process. Addressing spiritual needs through interventions had the highest agreement among respondents. According to these results, respondents indicated that they are actively addressing spirituality in interventions, however, there is little available research in TR to support this nor how they are specifically addressing spirituality. With the lack of research on evidence-based practice regarding spirituality, this raises the questions of how RTs are addressing the spiritual needs of their clients and where are they learning to do so. This is especially concerning due to the indication by respondents that they have not received education on spirituality in coursework nor an internship. Further, RTs have reported moderate competency in the use of spirituality in TR (ATRA, 2015). These findings are important to consider when educators, professional organizations, and the certification board are determining the required knowledge areas for professional competency. Most importantly, if RTs are utilizing spirituality in practice, but not learning how to do so in curricula or from continuing education opportunities, then there is the potential of doing harm to clients since there is no standard of practice or formal education in place for how to do so. In order for RTs to address the spiritual needs of their clients consistently and ethically, guidance from curricula, professional organizations and/or the certification board needs to be offered.

Obstacles to Addressing Clients' Spiritual Needs

This study found that the obstacles presented to respondents were inconsistent with results from the previous studies that addressed obstacles to incorporating spirituality into practice. Six obstacles discussed in the literature were provided as variables in this item: lack of support from other therapists on a treatment team, lack of personal knowledge on spirituality, lack of experience/skills to address clients' spiritual needs, lack of available resources, lack of knowledge regarding available resources, and the fear of deterring patient participation from RT treatment. According to the literature and practitioners in other disciplines (e.g., palliative care, PT, OT), the listed seven items were commonly reported obstacles to incorporating spirituality in their respective practice (Bremault-Phillips et al., 2015; Daly et al., 2019; Groff et al., 2009; Hunt, 2014; Milliken, 2020; Oakley et al., 2010). The majority of responses in the current study were either neutral, disagree, or strongly disagree meaning that respondents did not agree or had no opinion regarding the provided items as obstacles to addressing clients' spiritual needs. This raises the following questions: could this question have somehow confused respondents, which led to the low level of agreement, or is it possible the listed items within this question are no longer obstacles? On the other hand, on average respondents agreed that lack of resources was more of an obstacle than any other of the provided options. Additional research would be beneficial in exploring what type of resources are necessary for addressing clients' spiritual needs.

Noted barriers such as a lack of available resources or lack of knowledge regarding available resources or a lack of knowledge regarding spirituality (Daly, et al.,

2019) were surprisingly low for the respondents in the current study. This means that the majority of respondents did not agree with these being barriers to incorporating spirituality in practice. If these are not barriers and respondents are addressing clients' spiritual needs in the APIE process, then where are RTs receiving the knowledge and/or resources to address spirituality? Further research is indicated.

Training and Education

Findings showed that respondents had received little to no training in coursework and internships regarding spirituality in RT. However, respondents also reported addressing clients' spirituality in practice and spirituality as important in practice. These findings display an interesting juxtaposition. It shows that despite the lack of training and education, respondents are still incorporating spirituality in practice and regard doing so as important. As noted above, this finding raises a concern for the ethical conduct of RTs. There is no discussion in the literature or knowledge of where RTs are receiving their training and/or education for addressing spiritual needs. This would be important for governing bodies of the fields' standards of practice and code of ethics to further explore in order to ensure that their professionals are not practicing in any way that could harm their clients.

Furthermore, respondents indicated a desire to gain more education and training regarding spirituality. This means that not only do respondents think it is important to incorporate spirituality into practice, but they would like to receive education and training on spirituality as well. This leads the researcher to believe that, based on the high level of importance the majority of respondents ascribe to addressing clients' spirituality, it is

possible that respondents want more training because they recognize the importance of spirituality in practice and wish to develop more proficient competencies in addressing clients' spiritual needs. Further research is necessary to determine where respondents are getting the knowledge on how to address the spiritual needs of clients in order to minimize potential harm in services provided to clients.

The majority of respondents did not receive training on spirituality during their internship, yet out of those who responded, very few respondents wished to receive training in internships. This finding could be explained by the reality of respondents having already completed their internship for credentialing, thus no need for training in spirituality on internship. This also suggests that respondents either felt prepared for credentialling with any formal education or training on spirituality or didn't need it at all; however, given these findings it would seem they do. This suggests that spirituality should be discussed in coursework and on internships. Given the need for RTs to obtain continuing education credits, it was expected that respondents that report a desire for additional training would want to receive additional training through conferences and/or webinars. Findings showed this to be the case, with the highest percent of respondents reporting that they would like to receive additional training through webinars.

Lastly, findings showed a relationship between respondents' training in course work and age, as well as years of practice. Younger respondents having been more likely to receive training in coursework then their older counterparts suggest a generational shift towards the use of spirituality in practice. This shows that to some extent spirituality has been incorporated in the curricula of younger respondents. Topics and trainings on

spirituality in webinars and at conferences would be beneficial for the older respondents who may not have received education or training in their coursework. National and state professional organizations should welcome and encourage the topic of spirituality to be discussed in continuing education opportunities. However, surprisingly, the younger the respondents were, the less likely they were to have received training in their internship. This may be explained if their supervisors have been practicing for over 10 years, but further research is indicated. Further research is indicated. It could be that supervisors have not received any education or training in spirituality themselves.

Models in Practice

The highest percentage of respondents reported not using any formal model in practice. However, it should be noted that two thirds of respondents indicated using a model in practice. This finding demonstrates a good opportunity for educators to encourage the use of models to guide practice, while simultaneously educating TR students on spirituality in practice. There are several available models that include spirituality as a domain or component of holistic well-being (Carruthers & Hood, 2012; Heintzman, 2008; Park, 2013; Van Andel, 1998) that can be used as educational tools and visualizations of spirituality as part of the RT scope of practice.

Meanwhile, two thirds of the respondents indicated using a model to guide their practice. Of the other models that respondents used, only one of them contains any reference to spirituality, the Leisure-Well Being Model, and findings showed that it was not highly used. Also, further analysis found no connection between respondents' model of choice and how important they perceived addressing spirituality. The lack of

connection would suggest that one's spirituality does not influence which model respondents ascribe to as a guide for their practice.

Findings showed that the Leisure Ability Model, the oldest model in TR, is still widely used today. From this finding, it can be concluded that perhaps educators are not teaching a lot of the newer models that contain spirituality. For TR to continuously grow and evolve, as suggested by Sylvester (2015), educators should be exposing students to a variety of models. This finding raises concerns similar to that of training and education, that despite the lack of use of models as a guide, respondents reported that spirituality is being used in TR and that they perceive doing so is important. While it seems RTs are doing more with spirituality then PTs and OTs (Engquist, et al. 1996; Oakley et al., 2010), it is concerning that it is unknown where RTs are receiving their training to do so. Educators and TR governing bodies (i.e., NCTRC, ATRA) should work to build training and education on spirituality into curricula, standards of practice, and the TR Code of Ethics.

Research Question Two: What Are the Perceptions of CTRSs Regarding Addressing the Spiritual Needs of Clients?

Elements of Quality of Life

Findings regarding elements that contribute to quality of life were quite surprising, although showed some consistency with the literature. The literature suggested that the most widely used elements of practice include clients' physical, cognitive and social domains (e.g., Fain & Lewis, 2002; WHO, 1948; Wolfe, 2017). However, findings from this study showed that the emotional and leisure elements were

identified as most essential by the respondents. That said, all items in this question (i.e., cognitive, emotion, physical, leisure, social, spiritual) had a high level of agreement. These findings suggest that the majority of respondents agree with holistic, individualized care, which is consistent with the literature that suggests healthcare disciplines are moving to a more holistic approach to care (Bremault-Phillips et al., 2015; Egan & DeLaat, 1997; Hodge, 2006; Krageloh et al., 2015).

Although still quite high overall (89.9%), spirituality as an essential element contributing to an individual's quality of life was the lowest reported element. Furthermore, when compared with respondents' intrinsic spirituality scale (ISS) score, results showed that the more intrinsically spiritual a respondent was, the more likely they were to consider spirituality an essential element of quality of life. This finding suggests that practitioners who are less intrinsically spiritual are less likely to prioritize spirituality as an element necessary for a clients' quality of life. Despite this finding, it is important to note that this does not mean that one has to have intrinsic spirituality in order to address the spiritual needs of clients. Other findings in this study would suggest that this is possibly a matter of gaining more training and education on spirituality and how to incorporate it, thus the need for spirituality to be addressed in curricula and the scope of practice as outlined by professional organizations and the certification board.

Importance of Addressing Clients' Spiritual Needs

Results showed that the majority of respondents agreed that addressing clients' spirituality was important, although further indication as to who is professionally responsible for addressing spiritual needs would have been beneficial. In similar studies,

results showed that while OTs and PTs found spirituality an important aspect of client care, they did not in reality think that it was the responsibility of their discipline but rather that of pastoral care or a spiritual leader (Engquist et. al., 1996; Oakley et al., 2010). Further research would be beneficial for exploring the differences between the outcomes RTs achieve by addressing the spiritual needs of their clients and how pastoral care or spiritual leaders address spirituality. For example, a professional from a spiritual care department may address an individual's expression of spiritualty through religious practices or engage in discussions regarding an individual's ability to connect to a higher power. Meanwhile, RTs can systematically identify and address the spiritual needs of their clients through the APIE process which would involve an intervention (i.e., journaling, walk in nature) that produces measurable outcomes such as the ones identified in this study (i.e., hope, transcendence, optimism, etc.).

Outcomes of Addressing Spiritual Needs

Responses to outcomes of addressing clients' spiritual needs highlight some interesting possibilities for future research. The literature suggested that transcendence, purpose, connectedness, meaning-making, and hope were the main components of spirituality (Chandler et al., 1992; Heintzman & Mannell, 2003; Oakley et al., 2010; Unruh & Hutchinson, 2011). The remaining outcomes listed on the questionnaire came from the informal interviews with experts in the field of TR. Findings showed that all outcomes had a high mean (ranging 3.93–4.40), as well as high inter-item internal consistency (.954). These findings show that all the items in this variable are concrete and reliable outcomes of addressing clients' spiritual needs through assessment, goals and

objectives, and interventions (i.e., journaling, walking in nature, meditation). For example, if RTs were to ask their clients, "what gives your life meaning" then their client's response could be incorporated into treatment planning and possibly used as a modality of treatment. These identified outcomes and their uses could offer professionals a powerful strength-based approach to integrating holistic care and establishing rapport with their clients. Further research is recommended to explore what interventions RTs are utilizing to work towards these outcomes of addressing clients' spirituality.

Role of Spirituality in Practice

Respondents were asked to select all of the roles that spirituality has in RT. Respondents could choose from outcomes, process, interventions, and/or not belonging in TR. The highest reported role of spirituality within RT practice was the process. This means that the majority of respondents indicated the role of spirituality as being more than just in interventions or outcome, but rather part of the whole treatment process. The lowest response rate for this item was found for the option, "spirituality does not belong in TR/RT services." This defends that respondents do perceive spirituality as having a role in RT practice; however, based on the question set up and low sample size, it is difficult to be sure that this is the truest depiction of practitioners' perceptions regarding spirituality in RT.

Research Question Three: Influence of Intrinsic Spirituality on Perceptions

The majority of respondents had an ISS score above 6 which means that the majority of respondents were intrinsically spiritual. As previously discussed, it is difficult to know if this finding is an accurate depiction of the larger population due to the

possibility of response bias. It could be that the majority of respondents had a high ISS score for the same reason they responded to the survey and agreed to addressing clients' spiritual needs as important – because spiritualty is important to them. This is consistent with the findings from studies conducted by Blair (2015) and Wozencroft et al. (2012) who found intrinsic spirituality is not only important to healthcare professionals, but a leading factor in being the best professional they can be for their patients. That said, findings showed a relationship between respondents' response to importance of spirituality and ISS score, as well as between ISS scores and level to which respondents agreed that spirituality is an element of quality of life. This shows that to some degree individuals' intrinsic spirituality influences how they perceive spirituality in practice. This is not to be confused with a causal relationship. No causal relationship has been established. These findings merely suggest that there is some sort of relationship between an individuals' intrinsic spirituality and the importance they give to addressing spirituality in practice. Further, out of four items on respondents' perceptions of spirituality in practice, only one variable of one item (i.e., spirituality as an element of quality of life) showed a significant relationship to their ISS score. This shows that even if an individual's personal spirituality is important to them as a professional, it does not necessarily mean that it will influence their beliefs and practice as a professional.

Recommendations

The findings of this study create a foundation for many more studies on spirituality in TR. Some expectations were upheld, some useful information was gathered, and some questions were identified for further exploration.

This study brought to light that the majority of respondents agreed spirituality is important to address with clients. Despite what was expected based on previous studies in other disciplines (Engquist et al., 1996; Oakley et al., 2010; Wozencroft et al., 2012), respondents did report spirituality played a role within TR's scope of practice. Furthermore, respondents reported already incorporating spirituality throughout the APIE process and in interventions. These findings leave it unclear, however, what RTs are actually doing when they incorporate spirituality in the APIE process and where they are receiving their training to do so, for that matter. These findings indicate the need for further research on the topic of spirituality and in what ways practitioners are incorporating it into the therapeutic process. Further research to determine the specific uses of spirituality in the APIE process of RT would be beneficial for the development of curricula and competencies in spirituality.

The findings of this study also suggest the need for further research regarding client's perspectives, differences in beliefs based on setting of practice, and outcomes of addressing spirituality. Research into client's perspectives would offer a useful comparison to the current study that explores status and perceptions of the professionals. A similar study based on the status and perceptions of the clients would be beneficial for ensuring that clients are receiving the best care possible. In reference to differences based on setting of practice, the findings regarding obstacles would suggest that respondents' ability to address spiritual needs varies based on setting of practice. If an agency has a religious foundation or access to a spiritual care department, then RTs may experience less obstacles to addressing spirituality then those in an agency that does not have similar

resources available. Therefore, further research is needed to explore if differences in status and perceptions exist based on setting of practice. Lastly, further research is indicated for the item regarding outcomes. Outcomes showed a strong internal consistency. Further analyses such as a factor analysis may be beneficial to exploring the outcomes in this study, as well as explain why these outcomes would be useful.

It would be beneficial to take a more in-depth look at obstacles to incorporating spirituality in practice and the outcomes of addressing clients' spirituality. Qualitative data would be useful in further exploring why so many respondents were neutral, disagreed or strongly disagreed with the listed obstacles. In addition, qualitative data would be useful in helping to understand and develop measurable outcomes for assessing and treating the spirituality of clients.

Based on the findings regarding status of spirituality in TR, further implications for practice and education include improvements to the TR scope of practice. The field of TR Standards of Practice and Code of Ethics were established by the American Therapeutic Recreation Association (ATRA) and they make no mention of spirituality. Principle four (Justice) of the TR Code of Ethics (2009) has potential to include spirituality. It states,

> "recreation therapy personnel are responsible for ensuring that individuals are served fairly and that there is equity in the distribution of services. Individuals should receive services without regard to race, color, creed, gender, sexual orientation, age, disease/disability, social and financial status." (para. 5)

As it is currently written, neither spiritualty nor religion, for that matter, is mentioned as the ethical responsibility of recreational therapy personnel. It would be important for ATRA to provide some clearer guidance on the ethical obligations of RTs addressing spirituality in client care. Further, in a recent study by Porter et al. (2020), data were collected regarding the competencies of RT practice. In their study, Porter et al. (2020) suggested that RT academic programs, NCTRC, Council on Accreditation of Parks, Recreation, and Tourism (COAPRT) and Commission on Accreditation of Recreation Therapy (CARTE), use the findings to ensure that curricula, the certification exam material, and accreditation standards are most up to date with current practices. Based on the findings of the current study, the researcher recommends that ATRA, as well as RT academic programs, NCTRC, CARTE, and COAPRT should all review the extent to which accreditation, credentialing, curricula, and the scope of practice reflect the incorporation of spirituality in practice. Upon review, ATRA, NCTRC and CARTE should develop guidelines for spirituality in practice that will hold practitioners accountable to ethical and educational standards. Furthermore, JCAHO should develop some clearer guidelines regarding available spiritual assessments.

The findings regarding intrinsic spirituality and respondents' perceptions of spirituality in practice indicate the need for further research. The way this study was set up made it difficult to explore and establish any casual relationships; however, the relationships found can inform future research. Blair (2015) discussed a professional's spirituality as an aid for self-care, thus enabling better client-care. The current study showed that the majority of respondents were spiritual, thus it would be important to

further explore in what ways RTs' personal spirituality informs their perceptions of practice. From an ethical and educational standpoint, these findings offer unique opportunities for updated curricula and continuing education for current professionals. Spirituality, and its role in TR, is something that can be taught and developed. As evidenced by the ISS scores, this is not a matter of one is either intrinsically spiritual or they are not. There are degrees and levels to cultivating spirituality, just like any other skill. Further, for those who may be uncomfortable with the topic of spirituality, curricula should be careful to present spirituality as a professional competency that is no different than competencies such as relaxation techniques or journaling in that they are not dependent on subscribing to any religious beliefs.

Porter et al. (2020) found that RTs are utilizing spirituality in techniques and consider it a non-activity specific competency. Findings of the current study showed that respondents are incorporating spirituality throughout the APIE process as well as in interventions yet have not received any formal training on spirituality. It is important from both an ethical and educational standpoint that spirituality is addressed in coursework and/or continuing education opportunities. Offerings of additional training and education in addressing clients' spiritual needs could improve the incorporation of spirituality into internship programs and the classroom.

As for the practical implications of this study for professionals, it is recommended that RTs strive to be informed about how to address the spiritual needs of their clients, and begin incorporating their clients' spiritual needs in the treatment process. Until there is further guidance from educators, professional organizations, and the certification

board, RTs should be cautious when addressing the spiritual needs. When addressing the spiritual needs of clients, RTs should carefully check the sources of their education and training to ensure that they are offering sound evidence-based practices. Furthermore, professionals currently in the field offer potential resources and access to populations for building evidence-based practices. The researcher encourages RTs to begin exploring the outcomes identified in this study as measurable goals and objectives for client treatment, and as a strength-based approach to consider when assessing clients.

In conclusion, this study opens up a lot of opportunities for additional research. More specifically, in replication of this study or future research, it would be of value to further explore why respondents are not using formal models. Is it a lack of available models? Does the use of models have to do with the setting of practice? Also, additional research on the topic of spirituality in TR could help build an evidence-based foundation for practitioners and educators alike so that spirituality is included in education and training. It is evident that respondents were addressing the spiritual needs of their clients, with little indication of where they are gaining the know-how to do so. Without further research and evidence-based practices, this could become an ethical concern. Victor Kestenbaum (2005), in his article on professionalism, ethics and unity, writes "in those matters, about which a profession knows something, failure to obey its recommendations is not simply a failure of common-sense; it is a failure of prudence, judgment, responsibility, i.e., a moral failure" (p. 43).

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APPENDIX A.

QUALTRICS QUESTIONNAIRE

Status and Perceptions of Spirituality in TR/RT Questionnaire

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Start of Block: Consent and Information Sheet

Q1 Greetings Certified Therapeutic Recreation Specialists:

The World Health Organization (WHO) identifies the elements of quality of life as physical, social, emotional, cognitive, and spiritual. However, traditionally, the field of therapeutic recreation/recreation therapy (TR/RT) consistently treats only the physical, social, cognitive, and emotional. Within the field, there is little available literature or research about the use of spirituality in TR/RT practice. Therefore, the purpose of this questionnaire is to understand Recreation Therapists' status and perceptions of addressing clients' spiritual needs in TR/RT.

You have been selected for this study because you are a full-time practicing CTRS. This online questionnaire should take less than 10 minutes to complete. All information from this study is anonymous and confidential. Please note, however, that absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished. NCTRC's agreement to distribute this survey on behalf of the researchers does not imply or convey direct endorsement by NCTRC.

The Institutional Review Board at UNC Greensboro has determined that participation in this study poses no risk to participants. Your participation is entirely voluntary. You do not need to complete the survey if you do not want to or are uncomfortable doing so. If you have questions, want more information, or have suggestions, please contact Ms. Kaitlyn Powalie at UNC Greensboro at knpowali@uncg.edu, (843) 222-5253 or her advisor, Dr. Leandra Bedini, at bedini@uncg.edu. If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at (855) 251-2351.

By completing the survey, you are giving your consent to participate in this study. Please click the button below that states, "I do consent" and you will be directed to the survey. Please answer all questions to the best of your ability, remembering that your answers are confidential

and anonymous. Your input is valuable, so please complete the survey by the closing date of **August 3rd, 2020** so your responses will be included in the study.

Thank you for your participation in this study. Your input may contribute greatly to the field of TR/RT. -Kaitlyn Powalie

End of Block: Consent and Information Sheet

Start of Block: Purpose

Q2 **Definition of Spirituality:** As a practicing full-time CTRS, you will be prompted to answer a series of questions regarding your perspectives of spirituality and its application in the field of TR/RT, your intrinsic spirituality, and a few demographics. For the purpose of this study, **spirituality** is defined as "that which gives meaning and purpose to one's life and connectedness to the significant or sacred" (Bremault-Phillips, et. al., 2015, p.477). Please keep in mind that this study is solely about spirituality, noting that it differs from religion in that spirituality is a state of being and religion is a doctrinal set of beliefs.

End of Block: Purpose

Start of Block: Section A

Q3 SECTION A - PERCEPTIONS OF SPIRITUALITY IN PRACTICE: The purpose of this section is to explore CTRSs perceptions of spirituality in practice. More specifically, your perceptions of the elements of quality of life, as well as the role and importance of spirituality in TR/RT.

Q4 The following have been identified as essential elements of one's quality of life. For each of the following statements, please indicate the extent to which you disagree or agree these elements are essential to one's quality of life:

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Cognitive (1)	○	○	○	○	○
Emotional (2)	○	○	○	○	○
Leisure (3)	○	○	○	○	○
Physical (4)	○	○	○	○	○
Social (5)	○	○	○	○	○
Spiritual (6)	○	○	○	○	○

Q5 What do you perceive as the role of spirituality in TR/RT practice? (please select all that apply)

- [ ] Spirituality is a process (i.e., involved in every part of APIE) (1)
- [ ] Spirituality is an outcome (i.e., functional area that is improved or worked on through TR/RT) (2)
- [ ] Spirituality is an intervention (i.e., TR/RT tool used to work towards an outcome) (3)
- [ ] Spirituality does not belong in TR/RT services (4)

Q6 For each of the following statements about the importance of spirituality in TR/RT practice, please indicate the extent to which you disagree or agree.

Q7 It is important for Recreation Therapists to address their clients' spiritual needs.

- ○ Strongly Disagree (1)
- ○ Disagree (2)
- ○ Neutral (3)
- ○ Agree (4)
- ○ Strongly Agree (5)

Q8 “I think that it is important for Recreation Therapists to address their clients’ spiritual needs because doing so increases clients'…”	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
transcendence (i.e., ability to look beyond any current situation or disabling condition) (1)	○	○	○	○	○
hope (i.e., looking forward to a better future) (2)	○	○	○	○	○
meaning-making (i.e., making sense of a current situation or disabling condition) (3)	○	○	○	○	○
purpose (i.e., finding they have something to contribute) (4)	○	○	○	○	○
connectedness (i.e., ability to connect with others, nature and/or a higher power) (5)	○	○	○	○	○

optimism (i.e., ability to see any current situation or disabling condition positively) (6)	○	○	○	○	○
gratitude (i.e., appreciation for life) (7)	○	○	○	○	○
peace of mind (i.e., comfort in knowing that they are safe and in control) (8)	○	○	○	○	○
awe (i.e., feeling of amazement and wonder) (9)	○	○	○	○	○
ability to cope with stress (i.e., sense of tension or burden) (10)	○	○	○	○	○
Other (11)	○	○	○	○	○

End of Block: Section A

Start of Block: Section B

Q9 SECTION B - STATUS OF ADDRESSING SPIRITUAL NEEDS: The purpose of this section is to explore the current status of CTRS addressing the spiritual needs of their clients. This includes how and where CTRS are addressing clients' spiritual needs.

Q10 For each of the following statements about how you address spiritual needs, please indicate the extent to which you disagree or agree.

Q11 "As a Recreation Therapist, I address the spiritual needs of my clients through…"

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
assessments (1)	○	○	○	○	○
goals and objectives (2)	○	○	○	○	○
treatment planning (3)	○	○	○	○	○
interventions (4)	○	○	○	○	○
evaluation (5)	○	○	○	○	○
discharge planning (6)	○	○	○	○	○

Q12 For each of the following statements about the barriers to addressing the spiritual needs of your clients, please indicate the extent to which you disagree or agree.

Q13 “As a Recreation Therapist, the following has been an **obstacle** to addressing the spiritual needs of my clients…”

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
lack of support from other therapists on a treatment team (1)	○	○	○	○	○
lack of personal knowledge on spirituality (2)	○	○	○	○	○
lack of experience/skills to address clients’ spiritual needs (3)	○	○	○	○	○
lack of available resources (e.g., time, evidence-based research, conferences, and training) (4)	○	○	○	○	○
lack of knowledge regarding available resources (5)	○	○	○	○	○
fear of deterring patient participation from TR/RT treatment (6)	○	○	○	○	○
Other (7)	○	○	○	○	○

Q14 Which of the following is the primary model that guides you in your practice of TR/RT? (please select one option from the drop down menu below)

▼ Leisure Ability Model (Peterson & Gunn, 1984) (1)
Therapeutic Recreation Accountability Model (TRAM) (Stumbo & Peterson, 2009) (2)
Health Protection/Health Promotion Model (Austin, 1991) (3)
Optimizing Lifelong Health and Well Being Through TR (Wilhite, Keller, & Caldwell, 1999) (4)
TR Service Delivery & TR Outcome Models (VanAndel, 1998) (5)
Leisure and Well-Being Model (Hood & Caruthers, 2007) (6)
Self-Determination & Enjoyment Enhancement Model (Datillo, Kleiber, & Williams, 1998) (7)
Other (8)
Do not use a formal model to guide my practice (9)

End of Block: Section B

Start of Block: Section C

Q15 SECTION C - TRAINING AND EDUCATION: The purpose of this section is to explore CTRSs' experiences of receiving training and more knowledge on spirituality.

Q16 I received training about spirituality in TR/RT practice through my coursework.

- Yes (1)
- No (2)

Q17 I received training about spirituality in TR/RT practice at my internship .

- ○ Yes (1)
- ○ No (2)

Q18 I would like to receive additional training on spirituality to help me to address the spiritual needs of my clients.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Block If I would like to receive additional training on spirituality to help me to address the spiritual n... = No

Q19 Please indicate where you would like to see more on the topic of spirituality (select all that apply).

- ☐ Conferences (1)
- ☐ Webinars (2)
- ☐ Coursework (3)
- ☐ Internships (4)
- ☐ Published material within TR/RT (5)

End of Block: Section C

Start of Block: Section D

Q20 SECTION D - THE INTRINSIC SPIRITUALITY SCALE: The purpose of this section is to gain an understanding of how intrinsically spiritual CTRSs are. Each of the following six items are on a scale 0-10, with 0 having the least impact and 10 having the most impact.

Q21 In terms of the questions I have about life, my spirituality answers -

- 0 (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 (7)
- 8 (8)
- 9 (9)
- 10 (10)

Q22 Growing spiritually is -

- ○ 0 (0)
- ○ 1 (1)
- ○ 2 (2)
- ○ 3 (3)
- ○ 4 (4)
- ○ 5 (5)
- ○ 6 (6)
- ○ 7 (7)
- ○ 8 (8)
- ○ 9 (9)
- ○ 10 (10)

Q23 When I am faced with an important decision, my spirituality -

- ○ 0 (0)
- ○ 1 (1)
- ○ 2 (2)
- ○ 3 (3)
- ○ 4 (4)
- ○ 5 (5)
- ○ 6 (6)
- ○ 7 (7)
- ○ 8 (8)
- ○ 9 (9)
- ○ 10 (10)

Q24 Spirituality is -

- ○ 0 (0)
- ○ 1 (1)
- ○ 2 (2)
- ○ 3 (3)
- ○ 4 (4)
- ○ 5 (5)
- ○ 6 (6)
- ○ 7 (7)
- ○ 8 (8)
- ○ 9 (9)
- ○ 10 (10)

Q25 When I think of the things that help me to grow and mature as a person, my spirituality -

- 0 (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 (7)
- 8 (8)
- 9 (9)
- 10 (10)

Q26 My spiritual beliefs affect -

- ○ 0 (0)
- ○ 1 (1)
- ○ 2 (2)
- ○ 3 (3)
- ○ 4 (4)
- ○ 5 (5)
- ○ 6 (6)
- ○ 7 (7)
- ○ 8 (8)
- ○ 9 (9)
- ○ 10 (10)

End of Block: Section D

Start of Block: Demographics

Q27 **DEMOGRAPHICS:**

Q28 How many years have you been a practicing CTRS?

_____

Q29 What is the primary setting in which you practice?

- ○ Behavioral Health (1)
- ○ Community (adaptive, inclusive, specialized) (2)
- ○ Corrections (3)
- ○ Hospitals (4)
- ○ Long Term Care (assisted living, skilled nursing) (5)
- ○ Pediatrics (6)
- ○ Physical and Medical Rehabilitation (7)
- ○ Schools (8)
- ○ University/College (9)
- ○ Other (10) _____

Q30 How do you identify?

- ○ Identify as female (1)
- ○ Identify as male (2)
- ○ Identify as gender neutral (3)
- ○ Other (4) _____
- ○ Prefer not to answer (5)

Q31 Are you of Hispanic, Latinx or Spanish origin?

- Yes (1)
- No (2)

Q32 What is your race?

- American Indian or Alaskan Native (1)
- Asian (2)
- Black or African American (3)
- White (4)
- Mixed Race (5)
- Other (6) _____
- Prefer not to answer (7)

Q33 What is your age? (please fill-in number of years below)

_____

End of Block: Demographics

APPENDIX B.

INSTITUTIONAL REVIEW BOARD APPROVAL