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Article

The Overlooked Dimension: Physiotherapists' Perceptions of Spirituality and Religion in Older Person Care

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Abstract

Despite growing recognition of holistic care in gerontology, the role of spirituality and religion in physiotherapy practice remains underexplored. This study examines Maltese physiotherapists' perceptions and awareness of religious and spiritual care in the treatment of older persons, contributing to an untapped area in local research and adding to the limited international literature, particularly within Mediterranean and predominantly Catholic healthcare contexts. A questionnaire was distributed via SurveyMonkey to government sector physiotherapists in Malta. Findings revealed that while physiotherapists recognised the importance of incorporating spiritual and religious considerations into older persons' care, they often viewed such care as outside their clinical responsibilities. Key barriers included limited training, insufficient knowledge, and time constraints. Notably, physiotherapists with personal religious or spiritual beliefs were more inclined to integrate these aspects into their practice compared to their atheist or agnostic counterparts. The study underlines the need for enhanced training at both undergraduate and postgraduate levels and advocates for qualitative research to deepen understanding of the barriers and facilitators to spiritual care. Addressing these gaps will promote holistic, person-centred care that respects individual beliefs, ultimately enhancing outcomes for older persons.

Keywords: spiritual care; religious beliefs; religion; beliefs; older persons; quantitative research design

1. Introduction

Healthcare professionals are generally proficient in addressing patients' physical, psychological, and social needs, which are essential components of holistic care. However, studies indicate that many healthcare professionals lack sufficient knowledge and training in providing spiritual care, which is increasingly recognised as a vital dimension of comprehensive healthcare [1,2]. This gap is especially pertinent for older persons, whose religious needs, such as access to faith-based rituals, prayer, sacred texts, dietary customs, and pastoral support, often play a central role in coping with illness, preserving identity, and finding meaning in later life. Research shows that unmet religious and spiritual needs among older persons can contribute to distress, diminished well-being, and reduced satisfaction with care [3,4].

It is important to distinguish between religion and spirituality: religion typically refers to organised belief systems, doctrines, and communal practices associated with a particular faith tradition, whereas spirituality denotes a broader, more personal search for meaning, purpose, connection, and transcendence, which may or may not be linked

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to formal religious affiliation [5]. Despite growing recognition of these dimensions, the integration of spiritual and religious support into clinical settings remains limited and is often treated as optional rather than an essential component of person-centred care. This highlights the need for enhanced education, institutional policy development, and interdisciplinary collaboration to ensure that spirituality and religion, particularly for older persons, are appropriately addressed as integral aspects of health and healing.

Despite the growing awareness of spirituality's importance, there is a notable dearth of research both internationally and locally regarding how healthcare providers, including physiotherapists, incorporate spiritual care into treatment sessions, especially for older populations. Previous international studies have indicated that healthcare workers often feel unprepared or unsure about addressing spiritual issues [6–8]. Compared with some other healthcare professionals, physiotherapists tend to demonstrate a more moderate level of engagement in spiritual care. Research across healthcare disciplines indicates that spirituality is increasingly recognised as an important component of holistic patient care, particularly in nursing and end-of-life contexts [6,8]. Nevertheless, healthcare professionals frequently encounter barriers when attempting to integrate spiritual care into clinical practice, including limited training, uncertainty about professional roles, and time constraints [7,9]. Although many clinicians acknowledge the relevance of spirituality for patient well-being and coping, its integration into routine practice remains inconsistent. In rehabilitation settings, physiotherapists often recognise that spiritual beliefs may influence patients' motivation, coping strategies, and adherence to treatment; however, the focus tends to remain on the practical implications of these beliefs for functional recovery rather than on direct spiritual care interventions [3,5]. In Malta, research on spirituality in healthcare remains limited, especially with regard to the perceptions and practices of physiotherapists in providing spiritual care to older persons. Building on Baldacchino's work on spiritual-care education, which identified common challenges in delivering this aspect of care among healthcare professionals but focused primarily on nursing, this study addresses the relative neglect of allied-health professionals such as physiotherapists [9]. Indeed, physiotherapists merit particular attention because their practice centres on intensive, long-term functional rehabilitation, where patients' spiritual beliefs may influence coping strategies, which in turn can affect exercise motivation, pain management, and adherence to lifestyle changes amid chronic issues such as post-stroke recovery or musculoskeletal disorders.

Older persons face complex health challenges that can be compounded by spiritual distress or unmet spiritual needs, which influence coping strategies, adherence, and quality of life [10,11]. Recognising and addressing spiritual needs aligns with holistic, patient-centred approaches in healthcare, particularly in geriatrics, where individual values and beliefs significantly impact satisfaction and outcomes. Nonetheless, health professionals vary widely in their understanding and willingness to integrate spiritual care, often hindered by personal, professional, and systemic barriers [12,13].

Given these gaps, this study explored the perceptions, awareness, and readiness of Maltese physiotherapists regarding religious and spiritual care, particularly within the context of older-person care. By identifying knowledge gaps, attitudinal differences, and potential barriers, this research seeks to inform strategies that enhance education, practice, and policy. Understanding these perspectives is essential, as integrating spiritual care into physiotherapy has the potential to improve holistic patient outcomes and foster more meaningful therapeutic relationships, aligning with the evolving paradigm of patient-centred healthcare [3,14].

Malta is a small, densely populated Mediterranean island nation with a population of approximately 574,250 as of 2024, of whom 18.4% are aged 65 and over [15].

It is the most densely populated country in the European Union, with approximately 1795 inhabitants per square kilometre [16]. Approximately 83% of the population identifies as Roman Catholic [17], and religion continues to play a significant cultural and personal role. The country operates a publicly funded universal healthcare system, which forms the primary framework for physiotherapy services. However, individuals may also choose to access private physiotherapy care [18]. This distinctive demographic and religious context makes Malta a particularly relevant setting for examining the integration of spirituality and religion into older persons' care.

2. Materials and Methods

Following a comprehensive review of the existing literature [19–22], a significant gap was identified in research examining how physiotherapists integrate spirituality and religiosity into the care of older persons. To address this gap, the researcher employed a quantitative survey approach using a questionnaire, selected for its ability to capture individual perspectives and facilitate data analysis [23]. The research was guided by the following questions as labelled in Figure 1:

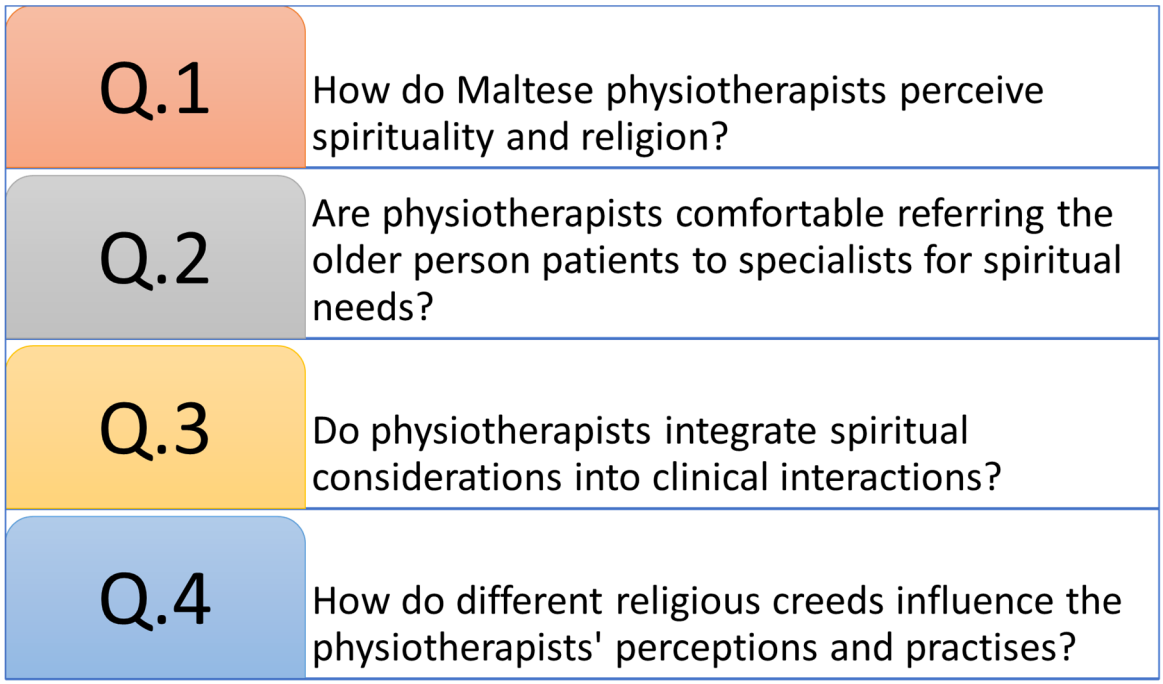


Figure 1. The research questions guiding the study.

These questions were designed to explore and critically examine prevailing perspectives and practices within the Maltese physiotherapy community.

To address this, the study explored the following three core areas as shown in Figure 2.

A positivist paradigm was adopted, grounded in scientific realism and guided by the hypothetico-deductive approach [24]. This paradigm relies on quantifiable data to examine relationships between independent variables (e.g., religious creed) and dependent variables (e.g., perceptions of spirituality), allowing measurement and analysis of patterns across participants.

The ontological stance was critical realism, acknowledging that personal, cultural, and subjective factors influence perceptions, while the epistemological stance focused on generating knowledge deductively through analysis of responses [25,26]. This approach enabled meaningful interpretation of how personal beliefs shape professional roles in older-person care.

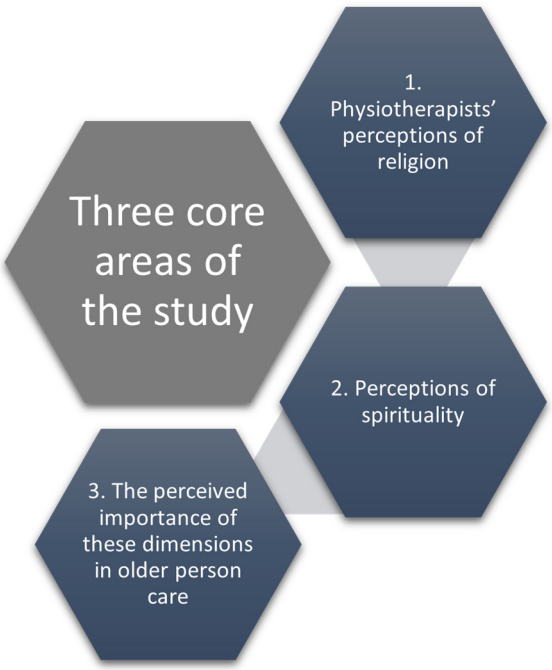


Figure 2. The three core areas of the study.

Since no single validated tool suitable for the study could be identified, a descriptive, quantitative methodology was employed using a questionnaire adapted from three validated instruments developed by Ellis et al. [27], Oakley et al. [28], and Sargeant and Newsham [29]. This questionnaire assessed demographic characteristics, beliefs, perceptions, and barriers related to the inclusion of spiritual care in physiotherapy. A descriptive, quantitative methodology was used. Sections A to E were derived from the instrument developed by Sargeant and Newsham [29], titled 'Physical Therapists' Perception of Religion and Spirituality', which formed the primary basis of the questionnaire. The final section of the questionnaire, 'Barriers to Addressing Spirituality with Clients' (Section F), was adapted from the instrument developed by Ellis et al. [27] and subsequently modified for physiotherapy practice by Oakley et al. [28]. The rationale for including this section was that the original validated tool did not address knowledge of the barriers influencing physiotherapists' practice in relation to spiritual care. Without this section, the researcher would have been unable to identify what can and cannot be done to inform future recommendations in this area.

A pilot study was conducted with 10 physiotherapists who worked with older persons to test the questionnaire and determine whether any modifications were needed. Following this, the questionnaire was distributed via SurveyMonkey to all 307 physiotherapists working in Malta's government sector. The Director of Allied Health Services Malta acted as a gatekeeper and distributed the link to all physiotherapists working within the government sector. Participants were given 35 days to fill in the questionnaire (5 November 2022 until 10 December 2022). Two reminders were sent two weeks apart by the gatekeeper. A target minimum sample size of 108 (95% confidence level, 5% margin of error) was calculated. Ethical approval was granted by the University of Malta Faculty Research Ethics Committee (REDP No. SWB-2022-0718), and permissions were obtained for all validated measures. Participants received an information sheet outlining the study's purpose, and anonymity was assured.

The study hypothesised that physiotherapists generally lack awareness of the importance of spirituality and religiosity in older person care and often confuse or interchange these concepts. It was further proposed that this gap results from limited training,

knowledge, and professional barriers such as time constraints and colleagues' attitudes, factors which may ultimately impact treatment outcomes. To explore these hypotheses, the questionnaire included sections on perceptions of religion and spirituality, comfort levels in addressing spiritual needs, and barriers to providing spiritual care. Figure 3 presents an overview of the questionnaire structure with the complete version presented in Appendix A.

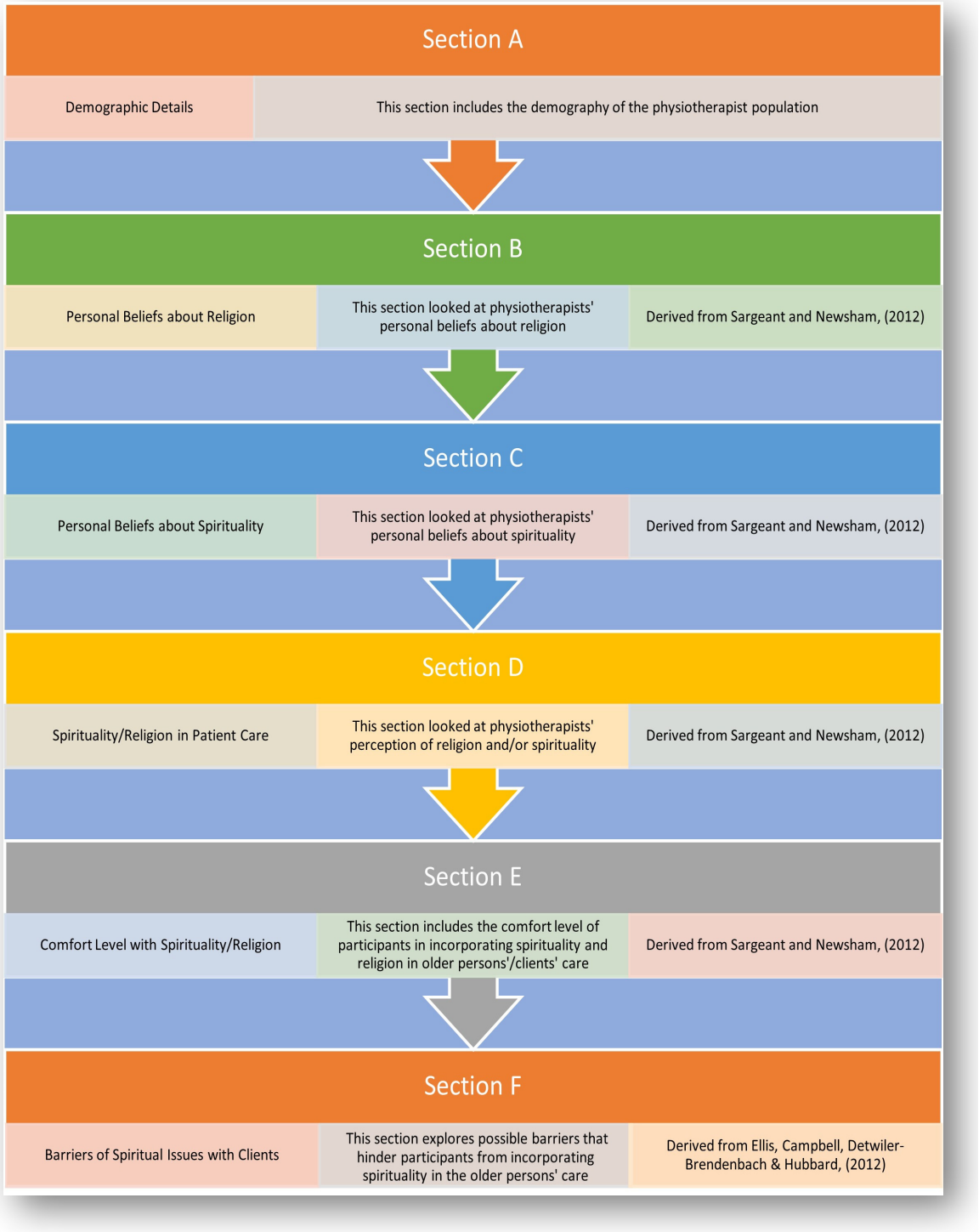


Figure 3. Overview of the Questionnaire Sections [27,29].

Figure 3 provides an overview of the questionnaire sections. The first column presents the section name, the second column provides a description of each section, and the third

column identifies the original source instrument from which each section was derived. Sections A to E were adapted from [29], and Section F was adapted from [27] as modified by [28].

Given the dearth of research both locally and internationally on the topic, this research followed the analytical approach of Sargeant & Newsham [29], whereby the main analysis was organised by creed. Questionnaire items were transformed into analytical variables prior to statistical analysis. Demographic details were coded as nominal variables to classify respondents into sub-groups. A 4-point Likert scale (1 = Strongly Disagree; 2 = Disagree; 3 = Agree; 4 = Strongly Agree) was utilised across the majority of items (Sections B to D), whilst a 5-point Likert scale incorporating an Unsure/Neutral response option was employed for the remaining items (Sections E and F). Likert scale responses were assigned numerical rank values and treated as ordinal data, preserving response granularity and avoiding dichotomisation that would otherwise reduce statistical power.

Given the ordinal nature of the data, parametric tests such as ANOVA and the T-test were deemed inappropriate. Consequently, the non-parametric Kruskal-Wallis H test was employed for inferential analysis, with Dunn's post hoc comparisons used to examine statistically significant differences across religious creeds, qualifications, and demographic sub-groups. Descriptive statistics were used to summarise demographic data, and all quantitative data were computed using IBM SPSS Statistics (Version 27). The internal consistency of the questionnaire was verified through Cronbach's alpha ($\alpha = 0.902$), confirming strong reliability across all items and sections.

Overall, this study sought to address a vital research gap by providing empirical insights that may inform policy, professional training, and future research aimed at integrating spiritual care into physiotherapy practice, ultimately contributing to the enhancement of holistic care for older persons.

3. Results and Discussion

This study analysed quantitative data from the 88 physiotherapists who chose to participate out of the 307 eligible individuals. The final sample included 88 physiotherapists (including the 10 physiotherapists who participated in the pilot study) aged 20–60 years, most of whom were female (68.2%). The largest age group was 31–35 years (23.9%), and participants had an average of 10.10 years of clinical experience (SD = ±8.012). Over half held a BSc in Physiotherapy (52.3%), while 38.6% had a Master's degree. Participants worked mainly at the local general hospital (26.1%), in Community & Residential Services (25.0%), and in Outpatient Clinics. Regarding personal beliefs, 36.4% identified as religious, 19.3% as both religious and spiritual, 18.2% as spiritual, and smaller proportions as atheist, agnostic, or humanist.

Section A of the questionnaire collected the demographic characteristics of the study participants, which are presented in Table 1.

Table 1. Demographic characteristics of physiotherapist participants.

Demographic Profile of Participants	Details
Sample Size	88 physiotherapists (after excluding incomplete responses)
Age Range	20–60 years
Gender Distribution	68.2% female, 31.8% male
Largest Age Group	31–35 years (23.9%)
Average Years of Clinical Experience	10.10 years (Standard Deviation = ±8.012)

Table 1. *Cont.*

Demographic Profile of Participants	Details
Highest Qualification	Doctorate: 0% Bachelor of Science in Physiotherapy: 52.3% Master's Degree: 38.6% Post-graduate Diploma: 5.7% Diploma (equivalent to BSc): 3.4%
Work Settings	Mater Dei Hospital: 26.1% Community & Residential Services: 25.0% Outpatient Clinics
Religious Creed	Religious: 36.4% Religious & Spiritual: 19.3% Spiritual: 18.2% Atheist: 9.1% Agnostic: 8.0% Humanist: 6.8%

The study's main key findings are tabulated in Table 2 below and the summary of the results can be found in Table 3:

Table 2. Main key findings.

Domain	Key Findings and Significance
Section B—Personal Beliefs	Religious respondents linked religion to spirituality; agnostics/atheists disagreed. Significance: $p < 0.001$
Section C—Personal Spirituality	Spiritual participants valued spirituality as central to life's meaning. Significance: $p < 0.001$
Section D—Spirituality in Care	Religious respondents saw spirituality improving client relations. Significance: $p < 0.05$
Section E—Comfort Level	Moderate comfort: low confidence integrating spirituality. Significance: $p < 0.05$
Section F—Barriers	73% lacked training, 64%time constraints; 47% feared offending clients. Significance: $p = 0.017–0.034$

Table 3. Summary of the results below outlines the main themes, perceptions, and statistical results.

Theme	Findings	Statistical/Key Data
General Awareness & Perception	Most physiotherapists were unaware of the distinction between spirituality and religion. The two terms were often used interchangeably. Spirituality seen as an integral part of religion and personal faith.	74% agreed spirituality is part of religion. 80% linked spirituality to personal faith; 90% defined spirituality as a search for meaning/purpose.
Influence on Care	Awareness of a client's spirituality strengthens the therapeutic relationship. Spirituality considered more central to health than religion. Spirituality viewed as aiding coping, hope, and holistic healing.	89% agreed spirituality improves therapeutic relationships; 82.6% viewed spirituality as part of health and 67.4% viewed religion as part of health.

Table 3. *Cont.*

Theme	Findings	Statistical/Key Data
Differences by Creed	Significant differences across religious creeds: Religious/spiritual physiotherapists more likely to integrate spiritual care; atheist/agnostic less likely to address spirituality; no significant differences in barriers by creed.	$p < 0.05$ for Sections B–E (beliefs, perceptions). No sig. difference in Section F (barriers).
Barriers to Spiritual Care	Lack of time, confidence, and training. Spiritual issues viewed as lower priority; some perceived clients uninterested in discussing spirituality. Organizational/systemic barriers dominate.	64% cited time constraints; 73% lacked training/confidence; 50% said spirituality is a lower priority; 43% believed clients not interested.
Personal Beliefs & Comfort Level	Many physiotherapists felt unprepared or uncomfortable addressing spirituality. Fear of offending clients was common. Comfort linked to personal faith.	$p = 0.035$ between religious/spiritual vs. atheist participants. Only 23% wanted spirituality included in their own treatment.
Demographics & Other Factors	Age and qualification had limited effect. Small group differences noted (e.g., 41–45 vs. 20–25 years).	Kruskal–Wallis H tests: minor significance in select age bands.
Overall Conclusion	Physiotherapists recognise spirituality's importance but struggle with unclear boundaries, lack of training, and time pressures. Variation in beliefs and comfort levels affects integration in practice.	

The findings demonstrate that although most physiotherapists acknowledged spirituality as an important dimension of holistic health, conceptual understanding remained limited, with many respondents using the terms spirituality and religion interchangeably. This reflects similar trends in international physiotherapy literature [14,30]. More than 80% associated spirituality with personal faith and life meaning, and 89% believed it strengthens therapeutic relationships. Willingness to address spirituality, however, varied significantly across belief systems ($p < 0.05$); physiotherapists identifying as religious or spiritual were more inclined to integrate spiritual care than those identifying as atheist or agnostic. Although this specific pattern is not widely reported within physiotherapy literature, allied-health research suggests that personal worldview influences practitioners' comfort levels and motivation to provide spiritual care, offering partial support for these findings [31]. Lower personal religiosity among healthcare professionals may emoved contribute to under-recognition of patients' spiritual needs, particularly among older persons, where faith often remains central to well-being [4,11]. This highlights the need for cultural competence and spiritual care education to support objective engagement with patients' beliefs [8,9]. Acknowledging patients' spiritual perspectives demonstrates respect for their worldview, fostering trust, empathy, and open communication, which can strengthen therapeutic relationships and support adherence in rehabilitation [10,20] even when the healthcare professional and the patient hold different views.

Barriers identified by physiotherapists, such as time constraints (64%), lack of training and confidence (73%), and uncertainty around professional roles, align closely with international studies highlighting similar systemic and educational challenges [14,19,32,33]. A recent descriptive review of sociocultural and spiritual influences in physiotherapy also emphasised the limited development of spiritual competence within the profession and the need for clearer guidance [34]. Overall, while the emerging global evidence supports the perception that spirituality is valued but poorly understood and insufficiently integrated into practice, the findings contribute novel insight into this issue. They highlight

the influence of personal belief systems and the specific barriers experienced by physiotherapists working with older persons. Integrating structured spiritual-care education into physiotherapy curricula and continuing professional development may therefore enhance practitioners' competence and confidence, ultimately promote more patient-centred, relationship-focused rehabilitation and improve quality of life for older persons [34].

A visual summary of the main findings is shown below in Figures 4–7. Figure 4 illustrates physiotherapists' conceptual understanding of the relationship between spirituality and religion, showing how the majority of respondents (approximately 90%) recognised spirituality as relating to personal meaning and purpose. A substantial proportion viewed spirituality as part of religion (approximately 78%). In contrast, only a minority of respondents (approximately 28%) viewed spirituality as independent from religion. These findings suggest that while physiotherapists acknowledge the broader, personal dimensions of spirituality, many continue to associate it closely with religious belief, with a notable tendency to conflate the two concepts.

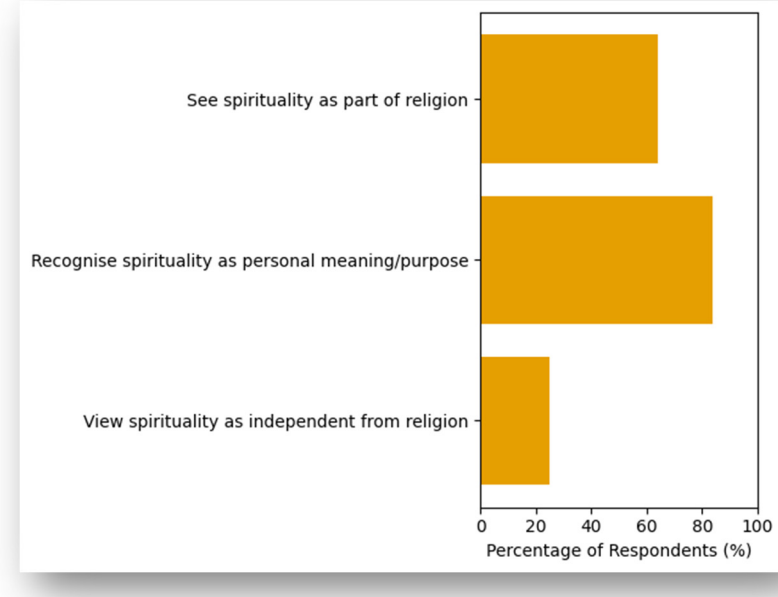


Figure 4. Conceptual understanding of spirituality.

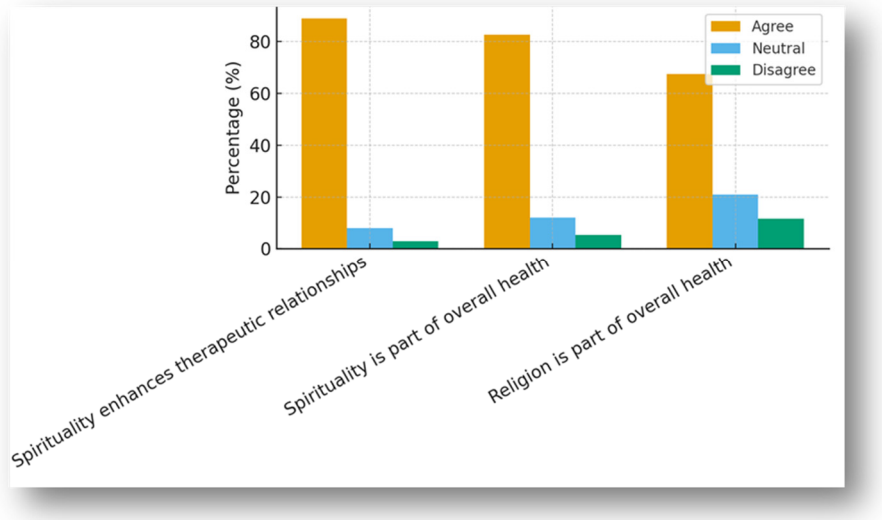


Figure 5. Perceived role of spirituality in physiotherapy.

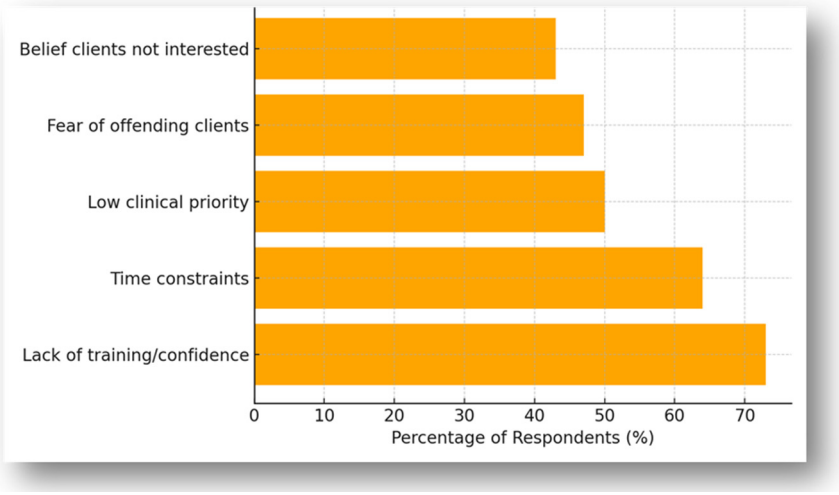


Figure 6. Barriers to integrating spiritual care.

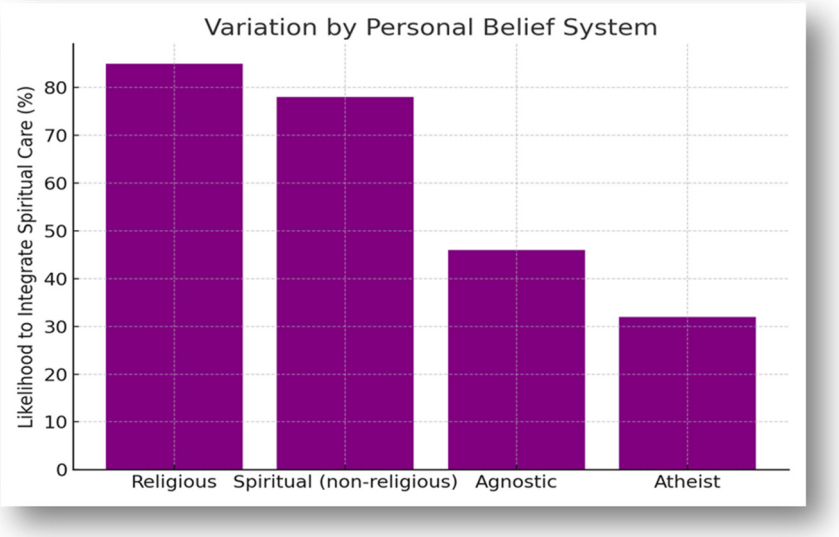


Figure 7. Variation by personal belief system.

Figure 5 demonstrates physiotherapists' perceptions of the role of spirituality in clinical practice. A large majority agreed that spirituality enhances therapeutic relationships, with close to 90% selecting "agree," while only a small minority (under 5%) disagreed. Similarly, around 85% agreed that spirituality is part of overall health, with fewer than 10% expressing neutrality and very few disagreeing. Views on religion as part of overall health were slightly more varied: approximately 70% agreed, around 20% were neutral, and just over 10% disagreed. Overall, the data show strong support for spirituality as a meaningful component of physiotherapy practice, although attitudes toward religion are somewhat more divided.

Figure 6 presents the reported barriers to integrating spiritual care within physiotherapy practice. Participants most identified a lack of training or confidence as a significant barrier, with approximately three-quarters of respondents indicating this concern. Time constraints were also widely acknowledged (around 65%), suggesting that workload pressures may limit opportunities for addressing spiritual needs. In contrast, fewer physiotherapist respondents considered spiritual care to be a low clinical priority (approximately 50%) or reported concerns about offending clients (about 45%). The belief that clients are not interested was the least frequently endorsed barrier (roughly 45%). Collectively, these

findings indicate that perceived deficits in competence and available time present more substantial challenges to the integration of spiritual care than client-related factors.

Figure 7 depicts the extent to which the likelihood of integrating spiritual care varies according to respondents' personal belief systems. Physiotherapists participating in the project, identifying as religious, reported the greatest likelihood of incorporating spiritual care (approximately 85%), with similarly high levels observed among those identifying as spiritual but non-religious (around 78%). In comparison, markedly lower likelihoods were reported by agnostic (about 45%) and atheist respondents (approximately 32%). These findings indicate that the physiotherapists with defined spiritual or religious identities demonstrate a stronger inclination to integrate spiritual care into their practice than those with non-theistic or uncertain belief orientations.

4. Limitations

The study's limitations included a relatively small sample confined to government sector physiotherapists, excluding those working in private practice. This may limit the generalisability of findings to the wider physiotherapy profession in Malta. At the time of data collection, there were 637 registered physiotherapists, 307 of whom worked within governmental entities in Malta and Gozo. Of the 307 participants who met the eligibility criteria, 88 completed and returned the questionnaire, yielding a low response rate. This low response rate may be attributed to several factors, including participant disengagement, time constraints, lack of interest in the topic, or the voluntary nature of participation. Non-response bias may therefore be a limitation of this study. It is noteworthy that none of the participants who took part in the pilot study (n = 10) reported on the length and/or the complexity of the questionnaire. Future studies could still test even shorter versions to maximise response rate.

Despite these constraints, the findings underline the need for enhanced education, policy support, and organisational integration to fortify spiritual care in physiotherapy. Conclusively, while physiotherapists acknowledge the significance of religion and spirituality in health and recovery, actual incorporation into practice remains limited due to various barriers. These include a lack of training and education, uncertainty about professional boundaries, time constraints, limited policy or guideline support, personal discomfort or lack of confidence, concerns about imposing personal beliefs, and challenges arising from cultural and religious diversity.

5. Conclusions

This study highlights that while physiotherapists recognise the importance of addressing religious and spiritual needs, they often view such care as beyond their responsibilities, mainly due to limited knowledge and training. Despite awareness, many avoid integrating spiritual care into practice, citing barriers like a lack of clear guidelines, confidence, and time constraints. These findings highlight the need for sustained investment in research and continuous monitoring to ensure that the formal inclusion of spiritual and religious care competencies in ethical codes, undergraduate curricula, and professional training programs is thoroughly evidence-based; thereby equipping all practitioners with skills in neutral assessment and referral, and thereby improving competency, comfort, and holistic care without requiring personal belief. Implementing brief spiritual assessments would also facilitate better identification of the older person patient's needs. It is suggested that future research pilot the following questions within physiotherapy assessment forms for older persons, whether in acute or rehabilitative settings, community services, or residential care.

Are there any religious practices or obligations that are important to you, such as attending religious services, prayer times, or fasting, that we should take into account when planning your physiotherapy sessions?

Do you have any spiritual beliefs or practices that influence how you cope with your current condition?

Are there any religious activities, such as attending a place of worship, performing prayer, or participating in religious rituals, that you would like to be able to return to or maintain as part of your rehabilitation goals?

Are there any spiritual practices, such as meditation, mindfulness, or engaging in activities that give you a sense of meaning and purpose, that you would like to be able to return to or maintain as part of your rehabilitation goals?

Moreover, qualitative studies involving diverse sectors and creeds within Malta, to develop tailored strategies that empower physiotherapists to provide holistic care, should be undertaken. Promoting awareness and training would help bridge existing gaps, enabling practitioners to more confidently integrate spiritual care into their work. It has been reported that addressing religion and spirituality in physiotherapy improves healthcare by enhancing patient motivation, exercise adherence, and resilience during long-term rehabilitation for chronic conditions like post-stroke recovery, ultimately yielding better functional outcomes [28]. It strengthens therapeutic trust through empathy even when beliefs differ, aligning care with patients' values in religious contexts like Malta. Strengthening education, policy guidelines, and research will ultimately support physiotherapists in delivering truly holistic care, especially for older persons, while honouring their beliefs, values, and overall. Additionally, organisations should provide time slots for spiritual screening during physiotherapy sessions and develop clear policies with referral pathways to spiritual support services, addressing systemic barriers like time pressures and lack of clear protocols.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the University of Malta Faculty Research Ethics Committee. The Research Ethics and Data Protection form code (SWB-2022-00718) approved on 22 September 2022.

Informed Consent Statement: Informed consent was obtained from all participants involved in the study.

Data Availability Statement: The data presented in this study are available in this article. Additional raw data are available upon request from the corresponding author.

Conflicts of Interest: The authors declare no conflicts of interest.

Appendix A

Physiotherapists' Perception of Spirituality and Religion in Older Person Care

Cover Page

Dear Participant,

This questionnaire explores physiotherapists' perceptions of spirituality and religion in the care of the older person. Participation is voluntary and anonymous.

Please answer all questions honestly.
For this study, the term "client" also refers to "older person."
Definitions:

- Atheist: Someone who does not believe in God [35]
- Agnostic: Someone who believes it is impossible to know for sure if God exists [35]
- Humanist: Someone who believes people can meet their emotional/spiritual needs without religion [36]
- Spirituality: The pursuit of existence, including questions about meaning and purpose in life [37]
- Religion: An organised system of symbols, rituals, beliefs and practices [38]

SECTION A—Demographic Information
Please tick (✓) the appropriate option or fill in as indicated.
Question Response Options

1. Gender ☐ Male ☐ Female ☐ Other
2. Age group ☐ 21–30 ☐ 31–40 ☐ 41–50 ☐ 51–60 ☐ 61+
3. Highest qualification ☐ Diploma ☐ Bachelor's ☐ Master's ☐ Doctorate ☐ Other _____
4. Area of practice ☐ MDH ☐ SVP ☐ RHKG ☐ GGH ☐ SLH ☐ MCH ☐ SAMOC ☐ CDAU ☐ AACC ☐ Other _____
5. Years of clinical experience _____ years
6. Religious creed ☐ Religious ☐ Spiritual ☐ Agnostic ☐ Humanist ☐ Atheist ☐ More than one ☐ None ☐ Other _____

SECTION B—Personal Beliefs About Religion
(Adapted from [29])
Please rate how strongly you agree with each statement.
Scale:
1—Strongly Agree 2—Agree 3—Disagree 4—Strongly Disagree
Statement 1 2 3 4
B1 Religion allows me to improve my relationship with God. ☐ ☐ ☐ ☐
B2 Religion allows me to improve my relationship with others. ☐ ☐ ☐ ☐
B3 Religion is the basis for my spirituality. ☐ ☐ ☐ ☐
B4 Religion is my belief in a higher power. ☐ ☐ ☐ ☐
B5 Religion is a negative influence in my life. ☐ ☐ ☐ ☐
B6 Religion is separate from spirituality. ☐ ☐ ☐ ☐

SECTION C—Personal Beliefs About Spirituality
(Adapted from [29])
Scale: 1—Strongly Agree 2—Agree 3—Disagree 4—Strongly Disagree
Statement 1 2 3 4
C1 Spirituality allows me to improve my relationship with God. ☐ ☐ ☐ ☐
C2 Spirituality allows me to improve my relationship with others. ☐ ☐ ☐ ☐
C3 Spirituality is a belief in a higher power. ☐ ☐ ☐ ☐
C4 Spirituality is an integral part of my religion. ☐ ☐ ☐ ☐
C5 Spirituality is an understanding of my beliefs and faith. ☐ ☐ ☐ ☐
C6 Spirituality is a negative influence in my life. ☐ ☐ ☐ ☐
C7 Spirituality is the search for meaning in life. ☐ ☐ ☐ ☐
C8 I am aware of my spirituality. ☐ ☐ ☐ ☐

C9 Spiritual development is important to me as an individual. ☐☐☐☐
C10 Spirituality is a fundamental part of each person. ☐☐☐☐
C11 Spirituality integrates body, mind, and soul. ☐☐☐☐
C12 Spirituality is a lifelong process. ☐☐☐☐

SECTION D—Spirituality and Religion in Patient Care
(Adapted from [29])
Scale: 1—Strongly Agree 2—Agree 3—Disagree 4—Strongly Disagree
Statement 1 2 3 4
D1 Knowledge of spirituality develops a physiotherapist's sensitivity toward the client as a person. ☐☐☐☐
D2 Addressing spirituality as part of total client care helps set realistic client-centred goals. ☐☐☐☐
D3 Religion can help a client adjust to chronic illness. ☐☐☐☐
D4 Awareness of clients' spiritual needs strengthens the physiotherapist–client relationship. ☐☐☐☐
D5 Awareness of clients' religious needs strengthens the physiotherapist–client relationship. ☐☐☐☐
D6 Spirituality can provide clients with hope. ☐☐☐☐
D7 Religion can provide clients with hope. ☐☐☐☐

SECTION E—Comfort Level with Spirituality/Religion
(Adapted from [29])
Scale: 1—Strongly Agree 2—Agree 3—Unsure 4—Disagree 5—Strongly Disagree
Statement 1 2 3 4 5
E1 I am comfortable talking with clients about hope. ☐☐☐☐☐
E2 I am comfortable incorporating clients' religious needs in my practice. ☐☐☐☐☐
E3 I am comfortable discussing spiritual issues when initiated by clients. ☐☐☐☐☐
E4 I am comfortable referring clients for religious or spiritual support when needed. ☐☐☐☐☐

SECTION F—Barriers of Spiritual Issues with Clients
(Adapted from [27,28])
Scale: 1—Strongly Agree 2—Agree 3—Neutral 4—Disagree 5—Strongly Disagree
Statement 1 2 3 4 5
F1 Discussing spirituality is not appropriate for a physiotherapist's role. ☐☐☐☐☐
F2 I lack training to address spiritual or religious issues. ☐☐☐☐☐
F3 I lack time during sessions to address spirituality. ☐☐☐☐☐
F4 I fear offending clients when discussing spirituality. ☐☐☐☐☐
F5 Spiritual issues take lower priority than physical needs. ☐☐☐☐☐
F6 If I were receiving physiotherapy services, I would want spirituality included in my treatment. ☐☐☐☐☐

End of Questionnaire
Thank you for your participation.

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