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Brazilian Physiotherapists' Perceptions on Spirituality, Religiosity and Health: A Cross-sectional Study

Percepções dos Fisioterapeutas Brasileiros sobre Espiritualidade, Religiosidade e Saúde: Um estudo transversal

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ABSTRACT

A cross-sectional qualitative-quantitative study was conducted to outline the profile of physiotherapists in terms of their own spirituality and to analyze their perception of the effect of spirituality or religiosity on patient recovery. A self-administered Google Forms questionnaire, including the Spiritual Well-being Scale and the Duke University Religion Index, as well as two open questions was applied in 374 physiotherapists. Women exhibited higher non-organizational and intrinsic religiosity, while men showed higher intrinsic religiosity ($p=0.005$). Those living with partners also had a higher level of spirituality ($p<0.005$). Brazilian physiotherapists believe that the level of spirituality interferes with treatment outcomes, often encourage faith, hope, optimism, meditative practices, relaxing music and breathing exercises, and the search for significance in health problems.

KEYWORDS

Spirituality; Religiosity; Physiotherapy; Traditional and integrative medicine; Complementary Therapies.

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RESUMO

Foi realizado um estudo transversal quali-quantitativo para traçar o perfil do fisioterapeuta brasileiro quanto à sua própria espiritualidade e analisar sua percepção sobre o efeito da espiritualidade ou da religiosidade na recuperação do paciente. Um questionário autoaplicável do Google Forms, incluindo a Escala de Bem-Estar Espiritual e o Índice de Religião da Duke University, além de duas questões abertas foi aplicado em 374 fisioterapeutas. As mulheres apresentaram maior religiosidade não organizacional e intrínseca, enquanto os homens apresentaram maior religiosidade intrínseca (p=0,005). Aqueles que viviam com companheiros também apresentaram maior nível de espiritualidade (p<0,005). Os fisioterapeutas brasileiros acreditam que o nível de espiritualidade interfere nos resultados do tratamento, muitas vezes incentivam a fé, a esperança, o otimismo, as práticas meditativas, as músicas relaxantes e os exercícios respiratórios e a busca de significado nos problemas de saúde.

PALAVRAS-CHAVE

Espiritualidade. Religiosidade. Fisioterapia. Medicina tradicional e integrativa. Terapias Complementares.

Introduction

The profession of Brazilian physiotherapists is regulated by Decree-Law number No. 938 of October 13, 1969.[6] Physiotherapeutic intervention encompasses the use of therapeutic techniques and approaches to promote recovery, improve physical function, mobility, and quality of life for individuals with various health conditions. Professional actions focus on assessment, diagnosis, prevention, treatment, and rehabilitation of human movements and functionality. As members of multidisciplinary teams in the health area, these professionals have higher education training, allowing them to carry out their activities with ethical responsibility and autonomy, in accordance with the regulations of Brazil's federal and regional councils.[7]

In their diverse fields of professional activity, physiotherapists are systematically confronted with patients' suffering caused by pain, fear of death, and malaise. Moreover, moments of personal crisis often bring intrinsic psychological and physical factors as sources of suffering. This daily exposure to others' suffering, as well as their own, leads to existential questioning and the search for subjective dimensions that transcend it, offering meaning and a broader purpose to human existence.

Given its role in fulfilling this existential need, the dimension of spirituality in health has been the subject of numerous studies in contemporary science.[8] Spirituality and religiosity are multidimensional constructs that involve the self-perception of an ability to transcend the material

[6] Brasil. Decreto-lei n. 938, de 13 de outubro de 1969. Provê sobre as profissões de fisioterapeuta e terapeuta ocupacional e dá outras providências [on-line]. Brasília (DF): Diário Oficial da União, 1969; 197 (Seção 1): 3658.

[7] SILVA, Coffito/GLEDSON, Luciano da. n.d. "COFFITO". COFFITO. Accessed February 27, 2024. Disponível em: https://coffito.gov.br/.

[8] CUNHA, V.F.; SCORSOLINI-COMIN, F. A Dimensão Religiosidade/Espiritualidade na Prática Clínica: Revisão Integrativa da Literatura Científica. *Psicologia: Teoria e Pesquisa,* v. 35, e35419, p. 1-12, 2019.

world and connect with higher forces.[9] In times of crisis, pain, and illness, spirituality can make a significant difference.[10]

In medicine and nursing fields, the spirituality of both professionals and patients has been extensively studied.[11] Recent studies have confirmed the impact of spirituality levels on the physical and mental health of both the professionals themselves and the patients they care for.[12] However, regarding physiotherapists, there have been few studies on the spirituality of these professionals and their beliefs about patients' spirituality.[13] Therefore, the general aim of this study was to outline the profile of physiotherapists in terms of their own spirituality and to analyze their perception of the effect of spirituality or religiosity on patient recovery.

Method

Study design and ethical aspects

This is a cross-sectional study with a qualitative-quantitative approach (Minayo, 2012). The research project was submitted to and approved by the Research Ethics Committee of the Bahiana Foundation for the Development of Sciences (CAAE: 53587321.4.00005544). All the ethical recommendations of Resolution 466/2012 of the National Health Council were followed, which are in line with the Helsinki declaration on ethics in research involving human beings.[14]

Place and period of the research

The research was carried out in a virtual environment using a self-administered form developed by the researchers with the help of the Google Forms tool (https://docs.google.com/forms/d/1aTuYBQcHC4c2B9N5OtTSn2CLyXEgxMI1fmby3lHar1Y), which included the collection of general data, the application of two validated instruments – the Spiritual Well-being scale (SWS) and the Dukel University Religious Index (DUREL) – as well as two open questions. Access to the form link was sent by email or WhatsApp to potential participants. After reading the informed consent form (ICF), which presented the objectives and procedures of the study, those who wished to take part signed it digitally and proceeded to answer the closed and open questions.

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[9] THIENGO, P.C.S. *et al*. Espiritualidade e religiosidade no cuidado em saúde: revisão integrativa. *Cogitare enfermagem*, 24, e58692, p. 1-12, 2019.

[10] ALTOÉ, K. Religião e saúde: a espiritualidade no tratamento de fisioterapia dos pacientes idosos. *Revista Foco,* 16(12), e3867, p. 1-19, 2023.

[11] REGINATO, V.; DE BENEDETTO, M.A.C.; GALLIAN, D.M.C. Espiritualidade e saúde: uma experiência na graduação em medicina e enfermagem. *Trabalho, Educação e Saúde,* 14 (1), p. 237-255, 2021.

[12] KOHLS, N. *et al*. Spirituality: An Overlooked Predictor of Placebo Effects? Philosophical Transactions of the Royal Society of London. Series B, *Biological Sciences*, 366(1572), p. 1838-1848, 2019.

[13] ALTOÉ, 2023.

[14] SCHMIDT, U.; FREWER, A.; SPRUMONT, D. *Ethical Research*: The Declaration of Helsinki, and the Past, Present, and Future of Human Experimentation. Oxford: Oxford University Press, 2020.

Participants

Participants were recruited using the snowball sampling method, whereby initial participants referred new participants through their contact networks. Eligible participants were physiotherapists duly registered with any Regional Physiotherapy Council (CREFITO) in Brazil, spanning various specialties and fields of clinical practice, of both genders, and with at least one year of professional clinical practice. The exclusion criteria included participants who withdrew from the study and any forms that were not fully completed (100%).

Variables

In the quantitative analysis, the dependent variables included the Spiritual Well-Being Scale (SWS) score and its subscales: Religious Well-Being (RWB) and Existential Well-Being (EWB). Additionally, the Duke University Religion Index (DUREL) subscales -Organizational Religiosity (OR), Non-Organizational Religiosity (NOR), and Intrinsic Religiosity (IR) – were evaluated. The independent variables comprised sociodemographic data and questions related to the physiotherapists' professional activities. For the qualitative analysis of data from open-ended questions, Bardin's content analysis method was employed.[15]

Outcome measures

The data collection instrument was structured into three sections: [1] sociodemographic and professional information; [2] validated instruments assessing levels of spirituality and religiosity; and [3] open-ended questions exploring the subjective perceptions of personal and patient spirituality. The first section collected data on variables such as gender, age, marital status, family income, Federative Unit of residence, area of practice, year of graduation, length of clinical practice, weekly workload, and perception of professional fulfillment.

The Spiritual Well-being Scale (SWS) and the Duke University Religiosity Index (DUREL) were administered in accordance with the guidelines set forth by their respective developers. The SWS, developed by Paloutzian and Ellison in 1982 and later adapted and validated for the Brazilian population by Marques *et al*[16], comprises 20 items divided into two subscales: [1] Religious Well-Being (RWB), which assesses satisfaction with one's personal connection to God or to something perceived as absolute; and [2] Existential Well-Being (EWB), which evaluates the individual's sense of life purpose independent of religious affiliation. Responses are provided on a six-point Likert scale ranging from "totally agree" to "totally disagree". The overall SWS score is interpreted as follows: 20 to 40 points indicate low well-being, 41 to 99 points indicate moderate well-being, and 100 to 120 points indicate high well-being. For the RWB and EWB subscales, the scoring categories are defined as 10 to 20 points for low, 21 to 49 for moderate, and 50 to 60 points for a high level of well-being.

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[15] BARDIN, L. *Análise de conteúdo*. Trad. Luís Antero Reto. Lisboa: Edições 70, 2016; YEARY, K.H.K. *et al*. Considering Religion and Spirituality in Precision Medicine. Translational Behavioral Medicine, 10(1), p. 195-203, 2020.

[16] MARQUES, L.M.; SARRIERA, J.C.; DELL'AGLIO, D.D. Adaptação e validação da Escala de Bem-estar Espiritual (EBE). *Avaliação psicológica*, 8(2), p. 179-186, 2009.

The Duke University Religiosity Index (DUREL) was translated into Portuguese[17] and validated for the Brazilian context.[18] This brief and user-friendly instrument evaluates three dimensions of religiosity across five items. Item 1 assesses Organizational Religiosity (OR), which is the frequency of participation in religious gatherings such as masses, services, ceremonies, study or prayer groups.

Item 2 evaluates Non-Organizational Religiosity (NOR), which is the frequency of private religious practices including prayer, meditation, reading religious texts, and listening to or watching religious programs on television or radio. For these items, respondents select from six options on a Likert scale ranging from "more than once a week" to "rarely/never".

Items 3 to 5 measure Intrinsic Religiosity (IR), reflecting the extent to which an individual internalizes religiosity as a primary life goal. Responses for IR are indicated on a Likert scale from "Totally true for me" to "Not true". According to the developers of the DUREL, the scores for the three dimensions – OR, NOR, and IR – should be analyzed independently. It is advised against combining these scores into a total score, as the dimensions represent distinct aspects of religiosity.

To delve deeper into the relationship between spirituality/religiosity and the clinical practices of physiotherapists, as well as their perceptions of how patients' spirituality/religiosity influences the health and illness process, two open-ended questions were posed at the conclusion of the form. These questions aimed to gather qualitative insights into the practical integration of spiritual and religious considerations within physiotherapy settings. The questions asked were:

> "Do you discuss spirituality or religiosity with your patients? If so, how do you incorporate this information into your clinical practice?"
> "How do you perceive your patients' spirituality or religiosity as influencing their health and illness process?"

These questions were designed to encourage physiotherapists to reflect on and articulate their experiences and observations regarding the role of spirituality and religiosity in both therapeutic interactions and patient outcomes.

Sample size

With the help of the G Power calculator, considering the Mann-Whitney test as the main outcome, for an effect size of 0.30, alpha of 5%, beta of 80%, for a two-tailed hypothesis and an allocation rate of 1:1; the need for 368 participants was found in the sample estimate.

Treatment of bias

To avoid selection bias, due to the fact that sampling was voluntary using the Snowball method and carried out on the Internet, the sample estimate was calculated with more demanding parameters for the expected effect size between the groups of 0.30. In order to reduce

[17] TAUNAY, T.C.D. *et al*. Validação da versão brasileira da escala de religiosidade de Duke (DUREL). *Archives of Clinical Psychiatry* (São Paulo)*,* 39(4), p. 130-135, 2012.
[18] TAUNAY, 2012.

the influence of socio-cultural factors, an attempt was made to include professionals from all Brazilian regions, although it was not possible to respect the regional distribution found in the professional registers.

In order to avoid the selection bias of non-response, forms without 100% completion were not included. However, it was not possible to control for association bias, which may have been influenced by the fact that naturally spiritualized people were interested in taking part, while less spiritualized people did not volunteer for the study. The anonymity guaranteed when filling in the form sought to avoid response bias. To avoid measurement bias, only instruments validated for Brazilian Portuguese were used and the statistician responsible for the analyses was a professional from another area of knowledge with no conflicts of interest involved with the results.

Statistical methods

Initially, the numerical variables were separated from the qualitative ones. To process the quantitative data, it was tabulated using Microsoft Excel and analyzed using R software (version 4.2.2). Quantitative data was expressed as mean and standard deviation for normal distributions and as median and interquartile ranges for asymmetric distributions. Categorical variables were expressed as absolute numbers and proportions. The Shapiro-Wilk test was used to check the normality of the data distribution, together with an analysis of the symmetry and flatness of the distribution.

The quantitative analysis used the correlation of the numerical variables from the questionnaires on spirituality and religiosity with the variables gender, marital status, region of the country, and area of work. To identify significant associations between the categorical variables, the Chi-square or Fisher's exact test was used, and between the quantitative variables, according to the groups of interest, the non-parametric Mann-Whitney or Kruskal-Wallis tests were used. The study's significance level was 5%.

To analyze the physiotherapists' marital status, the variables were categorized into two groups: [1] "together" for those who declared themselves married, partnered, or in a relationship; and "not together" for those who declared themselves single, separated, or widowed. The physiotherapists' specialties were grouped as follows: [1] Cardiopulmonary (intensive care, respiratory, and cardiovascular physiotherapy); [2] Neuromuscular (neurofunctional physiotherapy for children and adults, and gerontology); [3] Musculoskeletal (occupational physiotherapy, osteopathy, trauma-orthopaedic physiotherapy, chiropractic, and sports); and [4] other (physiotherapy in women's health, dermato-functional, acupuncture, and oncology).

Qualitative analysis method

The analysis of the qualitative data from the answers to the open questions was subjected to Laurence Bardin's content analysis (2008). After exhaustive readings of the answers, the data was analyzed in terms of the nexus and coherence of the content, and categories and subcategories were defined. The letter F and the number following the sequence of answers in the Forms (F01...F02...) were used to identify the participating physiotherapists. The content analysis was structured in three phases: pre-analysis, exploration of the material and treatment of the results.

Pre-analysis systematized preliminary ideas in four stages: [1] floating reading; [2] selection of documents; [3] reformulation of objectives and hypotheses; and [4] formulation of indicators.

The material was then explored in order to categorize its content. The categories were defined by identifying the constituent elements of an analogy significant to the research. At this stage, two researchers analyzed the content separately to ensure greater reliability. Categorical analysis involved breaking down the text's recording units and then grouping or regrouping them. The repetition of words and/or terms was used as a strategy for the coding process and the creation of recording units, and subsequently, initial analysis categories.

The third phase involved processing the results, inference, and interpretation. The aim was to give meaning to the messages through reflective and critical analysis. In this phase, the contents contained in all the material collected through the instruments were constituted and captured. Once the data had been revised several times and a consensus reached between the researchers, the results were compiled and a matrix describing the most representative themes was created in the results section.

Results

The initial sample comprised 386 physiotherapists who completed the form. However, 10 could not be included in the study because they had not graduated for at least one year and two because they did not work in clinical practice, leaving 374 records that met the research eligibility criteria.

Regarding the sociodemographic profile of the study participants, 303 (81%) of the physiotherapists were female, with an average age of 38.1 ± 8.8 years. There was a predominance of individuals living alone, represented by 210 (56%) participants. The average length of professional experience was 12.4 ± 8.4 years, with a weekly workload of approximately 35.3 ± 14.9 hours. The family income of the majority of participants (57%) is above 5 minimum wages (U$1221.11). In terms of the country's regions, there was a greater participation of professionals from the Northeast (56%), followed by the South (18%) and Southeast (10%) (Table 1).

Insert Table 1

When asked about their level of professional fulfillment, 66 (17.8%) physiotherapists described themselves as 'very fulfilled', 164 (44.2%) as 'well fulfilled', 25 (6.7%) as 'reasonably fulfilled', 107 (28.8%) as 'not very fulfilled', and 9 (2.4%) as 'very poorly fulfilled'. With regard to physiotherapists' specialties, 150 (40.7%) work in the musculoskeletal area, 92 (24.9%) in the cardiopulmonary area, 48 (13%) in the neuromuscular area and 79 (21.4%) in other fields.

Regarding the level of spirituality, the total EBE score shows that 235 (62.8%) of the physiotherapists have a positive score and 139 (37.2%) a negative score. As for the BER subscale, 269 (72%) of the physiotherapists were classified as having a high score, 90 (24%) as having a moderate score and 15 (4%) as having a low score. For the BEE subscale, 175 (46.8%) had a high score, 195 (52.1%) a moderate score and 4 (1.1%) a low score (Table 2).

Insert Table 2

The highest agreement scores on the RWB subscale involved 290 (77.7%) individuals in the sample who 'Totally agree' with item 3, corresponding to 'I believe that God loves and cares for me'. There was also high agreement among participants who 'Strongly disagree' with item 1 'I don't find much satisfaction in personal prayer with God', item 9 'I don't receive much personal strength and support from my God', item 12 'I don't enjoy life very much', and item 18 'Life doesn't have much meaning'.

When examining the association between the gender variable and EWB, the study found a significant difference between genders. Among the participants, 202 (68.0%) women exhibited a higher religiosity score compared to men, with 35 (51.5%) cases showing a moderate difference ($p < 0.05$).

Upon evaluating the correlations between gender and the subscales of the SWS, it was observed that 77.5% of females demonstrated greater relevance for Religious Well-Being (RWB), indicating a connection with God or the divine ($p = 0.001$), in contrast to males (55.1%). Regarding the correlation between gender and Existential Well-Being (EWB), reflecting individuals' perception of their life's purpose regardless of religious reference, males scored higher (65.7%) ($p = 0.031$). No significant differences were found between regions ($p = 0.245$) or specialties ($p = 0.695$)

When examining the association between marital status and SWS, it was found that 149 (71.3%) of the physiotherapists who reported being not together and 86 (55.1%) of those who reported being together had a high score for spirituality. Concerning the subscales, 163 (77.6%) of those not together and 106 (67.5%) of those together had a high score for RWB. However, regarding the EWB subscale, 118 (56.5%) of those not together had a high score for existential spirituality, while 104 (64.2%) of those together had a moderate score, indicating a difference between the groups ($p = 0.005$)

In the assessment of religiosity using the DUREL index, it was observed that 131 (35%) participants attend a church, temple or other religious meeting more often than not a few times a year, 187 (50%) of the participants dedicate their time to individual religious activities such as prayers, meditations or reading the Bible or other religious texts on a daily basis, 239 (63.9%) expressed that they feel the presence of God (or the Holy Spirit) in their lives, considering it totally true, 155 (41.4%) reported that their religious beliefs generally dictate the way they live, with 147 (39.3%) considering it totally true, 182 (48.7%) participants mentioned that they generally strive to live their religion in all aspects of life, with 101 (27%) considering it totally true.

When analyzing the DUREL scores with the participants' gender variable, the sample showed a similar distribution in the OR score, with both genders reporting attending churches or temples a few times a year: 107 (35.3%) females and 24 (33.8%) males ($p = 0.506$). In the NOR follow-up, the response pattern was similar, with both genders reporting daily dedication to individual religious activities: 163 (53.8%) females and 24 (33.8%) males ($p = 0.005$) (Table 3).

Regarding the dimension of the IR subscale, both genders varied more frequently between answers 1 ('totally true for me') and 2 ('generally true'). Females showed a higher representation of answers 1 for questions 1 (N = 205, 67.7%) and 2 (130, 42.9%), while for males, there was a higher frequency of answers 1 for question 1 (N = 34, 47.9%). A significant difference between the groups was observed for the IR subscale ($p < 0.001$). (Table 3).

Insert Table 3

In terms of marital status, 65 (31%) individuals reported being together, while 66 (40.2%) reported not being together, answering that they go to church or temple a few times a year, with a significant difference ($p = 0.002$). However, in the NOR subscale, both those together (N = 114, 54.3%) and those not together (N = 73, 44.5%) reported practicing individual religious activities daily ($p > 0.05$). Regarding marital status, a statistical difference in the response pattern between groups was observed for OR ($p = 0.012$) and IR ($p = 0.007$), but all options demonstrate a high level of religiosity. No associations were found for regions and specialties ($p > 0.05$).

Concerning the IR subscale, both individuals together and not together varied more frequently between answers 1 ('totally true for me') and 2 ('generally true'). Individuals together had a higher representation of answers 1 for questions 1 (N = 151, 71.9%) and 2 (87, 41.4%), while for those not together, there was a higher frequency of answers 1 for question 1 (N = 88, 53.7%), with a significant difference between the groups for the IR subscale only for the first question ($p < 0.04$)

No associations were found between Brazilian regions and DUREL in the OR ($p=0.651$), NOR ($p=0.323$) and IR ($p=0.066$) subscales. The same occurred in relation to the SWS total score ($p=0.638$), and the RWB ($p=0.444$) and EWB ($p=0.497$) subscales.

In the qualitative analysis of the research, regarding responses to the question 'Do you talk about spirituality/religiosity with your patients? If so, how do you use this information in your clinical practice?', 217 (58%) of the sample answered 'Yes' to addressing the subject of spirituality with patients. However, 118 (31.6%) stated they didn't discuss the subject with their patients, while 24 (6.4%) mentioned 'sometimes / a few times / sometimes / some of the time', as depicted in the excerpts of statements in Box 1 (Supplement 1).

A content analysis was carried out of the answers to the question of how physiotherapists use information from the conversation about spirituality or religiosity in their clinical practice. Three main categories emerged from the analysis: 1) Encouragement to have faith, hope and optimism; 2) Meaning, significance and overcoming; 3) Use of tools to approach spirituality or religiosity in clinical practice.

According to more than half of the participating physiotherapists, talking about spirituality or religiosity in clinical practice appears to be a way of maintaining faith and belief in treatment, recovery, improvement of symptoms and the possibility of a cure, according to clippings from participants F13, F37 and F67.

> **F13** – "Yes. More precisely, about spirituality. In general, patients who cultivate some faith are more involved in treatment, more hopeful and positive..."
> **F37** – "Yes, I always tell my patients that God is in control of everything and has plans for everyone, that life is made up of phases and that they have to have faith in God that everything will work out..."
> **F67** – "Yes. About the patient's perspectives on spirituality/religiosity, on the possibilities of faith and healing and how to better deal with the situation based on faith".

Meaning, sense and overcoming

In the category of meaning, sense, and overcoming, it was observed that physiotherapists associate spirituality or religiosity with improved treatment results. Trust in higher forces that aid in treatment enhances the bond between the professional and the patient, facilitating better adherence to the therapeutic plan, acceptance, resilience, and disease management. This analysis was drawn from statements made by participants F23, F27, F39, and F41, who emphasized spirituality as a means of strengthening the bond with patients and assisting them in finding pathways to improvement and healing:

> **F23** – "Yes. I try to emphasize spirituality as a way of seeking resilience, acceptance of the illness and overcoming it".
> **F27** – "Yes, if the patient uses this language to signify their life process. I identify the spiritual/religious elements on which they rely and allow myself to immerse myself in this web of meanings in order to establish a deep connection with the patient".
> **F39 –** "Yes. First I find out about the belief, whether it exists or not. If so, I seek acceptance through faith, so that they know they are not alone and that everything has a purpose".
> **F41** – "Yes, I use spirituality/religiosity to encourage patients to seek their own improvement, so that they accept what has gone before and try to achieve future improvement".

Use of tools to approach spirituality or religiosity in clinical practice.

Regarding the tools utilized to address spirituality or religiosity in physiotherapists' clinical practice, it is evident that professionals believe and affirm the benefits of employing prayer/prayers, relaxing music, meditation, breathing techniques, massages, readings on the subject, and conversations about God. These insights are drawn from excerpts provided by F13, F68, F22, and F110.

> **F13** – "...I don't usually go into each person's religion, but I do use tools that favor the patient's encounter with themselves and what they believe in (relaxing music, breathing, meditative practices)".
> **F68** – "Yes!!! In most of my counseling sessions I start with a prayer and take time to talk about God and his deeds. As well as talking about God, I bring the Bible as a tool of hope for this time".
> **F22** – "I usually ask patients to connect with their spirituality through prayer and/or meditation".
> **F110** – "Yes, I don't focus on a religion, because I'm against preaching, but I do seek spiritual help or a religious basis. I believe that daily prayers are a way of meditating, sharing problems with God, Jesus, protective angels or whatever the belief may be, can help relieve baggage".

Chart 2 shows the codifications established on the basis of the answers to the question about the conversation with patients on the subject of spirituality, taking into account the repetition of words (Supplement 2).

Chart 3 displays the coding of thematic units and grouping of themes for the second question: "How do you perceive your patients' spirituality/religiosity interfering in the health and illness process?" (Supplement 3).

Based on this survey, three categories were identified, regarding how patients' spirituality/religiosity interferes in the health and illness process: [1] It facilitates coping with illness: Patients believe in and adhere better to treatment, exhibit more resilience, positivity, optimism, and willpower, leading to better outcomes; [2] Hope, faith and the belief in improvement aid the healing and rehabilitation process; [3] Negative interference: Some patients perceive illness as punishment or divine trial, leading to pessimism, somatization, limiting beliefs, and therapeutic limitations.

It facilitates coping with illness: Patients believe in and adhere better to treatment, exhibit more resilience, positivity, optimism, and willpower, leading to better outcomes

The majority of physiotherapists say that spirituality or religiosity enables patients to cope better with illness, believing in and adhering to treatment, maintaining resilience, positivity, optimism, and willpower, and consequently achieving better therapeutic outcomes. This interpretation is based on F67, F78, F194, F241, F261 and F304.

> **F67** – "People with greater spirituality/religiosity generally receive bad news better, and consequently cope better with the health/illness situation they are going through. In addition to maintaining faith and optimism, they often have more frequent healing processes".
> **F78** – "Belief in 'Something Greater' makes the patient understand and face the process they are going through in a more positive and optimistic way".
> **F194** – "I realize that people with greater spiritual development have more resilience to deal with illness".
> **F241** – "Patients who believe in something, regardless of religion or belief, improve their clinical condition, they start to make more of an effort to get better, sometimes what seemed so bad is no longer so bad. And then you start to see progress within the established activities and improvement in the quality of life of these individuals".
> **F261** – "Those with spirituality/religiosity are better able to accept the conditions they are faced with and adapt as best they can in search of positive results".
> **F304** – "I can clearly see that individuals who have a well-resolved spiritual connection have positive attitudes and thoughts and consequently have different results to those who don't have an alignment between spirituality and the physical".

Hope, faith and the belief in improvement aid the healing and rehabilitation process

Participants understand that their patients' spirituality or religiosity can be a source of hope, faith and belief in improvement, and that they can also help with healing, better results and healing itself, as seen in the statements of participants F122, F219 and F270.

> **F122 –** "I see that people are more confident, have more faith and hope in getting better... They are also more dedicated and take more care of themselves, so they heal faster".
> **F219** – "Those who have faith tend to have more satisfactory results, facilitating progress in rehabilitation".
> **F270** – "Patients who have faith are more willing and eager to make the treatment work, so I think it helps speed up recovery".

Negative interference: Some patients perceive illness as punishment or divine trial, leading to pessimism, somatization, limiting beliefs, and therapeutic limitations

For some physiotherapists, spirituality or religiosity can have a negative, pessimistic impact on treatment, on therapeutic conduct, brought about as a punitive idea, as a punishment, summarizing the condition, often limiting the therapy instituted and presenting a certain limiting belief, as we can see in the statements F37, F107 and F280.

> **F37** – "Some religions limit certain therapeutic behaviours, which end up interfering with the patient's treatment and chance of life. In addition, faith in God is often so great that many choose not to start treatment. Looking to God for the power to cure without carrying out the necessary treatment..."
> **F107** – "The fanatical and extreme ideas of some religions limit health actions!!! I respect them, but I don't agree with some of them. I've had patients tell me that they're going to die because the value they were giving the pastor was too low to save their lives (patient's comments on pastor's speech)".
> **F280** – "Most people associate painful experiences with 'divine punishments/permissions/proofs' or when they are in very serious situations, they cling to the hope of improvement based on spiritual help. I believe that this transfer of responsibility most often prevents patients from taking responsibility for their treatment and therefore hinders the process of clinical evolution".

Discussion

The study, which aimed to delineate the profile of physiotherapists concerning their spirituality and analyze their perceptions regarding the impact of spirituality or religiosity on patient recovery, yielded results that, to our knowledge, are unprecedented both in Brazil and globally. Employing a triangulation of quantitative and qualitative methods, we observed that the religious beliefs and spiritual behaviors of physiotherapists influence the approaches adopted and expectations for treatment outcomes.

Most of the study participants were women, a trend commonly observed among physiotherapy professionals globally. These individuals were of working age, with an average clinical practice experience exceeding 10 years and an income consistent with the standards set by the Federal Physiotherapy Council in Brazil. The majority expressed fulfillment in their profession,

primarily specializing in musculoskeletal and cardiorespiratory areas. These findings align with similar studies by Melo[19] and Cruz.[20]

Female participants tended to have higher overall spirituality scores than males on both the Spiritual Well-being Scale (SWS) and the Duke University Religiosity Index (DUREL). While both genders displayed limited interest in organizational religiosity, they exhibited more significant engagement in non-organizational and intrinsic religiosity. However, men appeared to demonstrate a heightened interest in intrinsic religiosity, whereas women exhibited high frequencies in both non-organizational and intrinsic religiosity. This phenomenon of heightened spiritual openness among women has been noted in previous studies.[21] Women seem to seek elevated spirituality levels, often subconsciously, as a coping mechanism for mental distress.[22] By turning to a religious group, women can share their painful experiences, thus functioning as a support group.

Men in distress, on the other hand, tend to isolate themselves and talk less about their problems with others. It seems that men seek individual reflection and a more direct relationship with the sacred, without the need for mediation. That's why IR is higher in men and NOR and IR in women, both in the present sample and in the study by Jordán[23] carried out with medical residents. In any case, Brazilian health professionals of both genders consider it important and pertinent to include the dimension of spirituality or religiosity in their lives and in the therapeutic context. This fact seems to reinforce the need to include subjects and debates on the subject during academic training.

Those in cohabitating relationships demonstrated greater non-organizational and intrinsic religiosity compared to those living alone. This association suggests that shared living arrangements may naturally foster a mutual pursuit of spirituality. Marriage, characterized by shared commitments and responsibilities, not only safeguards the physical and mental well-being of spouses but also fosters healthy social relationships.[24] Spiritual practices within the family environment can strengthen marital bonds and equip couples to navigate the challenges of contemporary professional and social life.

Most of the participants in the study believe that God loves them and cares about them, as well as finding satisfaction with their spiritual and religious practices. Spiritual well-being is more positive than negative, and religious well-being is higher than existential well-being, although both have high to moderate scores. The fundamental difference between the two subscales of the SWS is that religious well-being refers to practical and objective activities, while

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[19] MELO, N.G. *et al*. Perfil de Formação e Produção Científica do Fisioterapeuta Pesquisador no Brasil. *Fisioterapia E Pesquisa,* 28(1), p. 60-69, 2021.

[20] CRUZ, A.P. da *et al*. Análise comparativa do perfil do fisioterapeuta, como parte integrante da equipe de saúde nos núcleos ampliados de saúde da família e atenção básica. *Revista Contexto & Saúde,* 22(45), e12329–e12329, p. 1-13, 2022.

[21] MARTINS, A.M.; Nascimento, A.R.A. Gender and Its Implications for Religious Practices: Exploratory Study among Brazilian Universities. *Psicologia – Teoria E Prática*, 24(3), p. 1-20, 2022.

[22] RASSOULIAN, A.; GAIGER, A.; LOEFFLER-STASTKA, H. Gender Differences in Psychosocial, Religious, and Spiritual Aspects in Coping: A Cross-Sectional Study with Cancer Patients. *Women's Health Reports* (New Rochelle, N.Y.)*,* 2(1), p. 464-472, 2021.

[23] JORDÁN, A.P.W. *et al*. Avaliação Da Espiritualidade/religiosidade E Opinião de Residentes Sobre a Participação Em Um Módulo de Espiritualidade E Integralidade. *Interdisciplinary Journal of Health Education,* 6(1), p. 1-17, 2021.

[24] BHATTACHARYYA, K.K. The Sacred Relationship between Marriage, Spirituality and Healthy Aging in Hinduism. *Journal of Religion, Spirituality & Aging,* 32(2), p. 135-148, 2020.

existential well-being involves a more subjective relationship with higher forces. Many instruments have been used to assess the level of spirituality in contemporary times, but some are too long or not comprehensive enough.[25] For this reason, we chose to use two short instruments with high sensitivity and specificity, and to include open-ended questions. Physiotherapists with moderate to high levels of spirituality believe that this dimension affects treatment outcomes, both through their own spirituality and that of patients. It was also observed by Jones[26] that rehabilitation professionals have a high awareness of the nature of spirituality, high perceptions of its importance for patients and the ability to incorporate spirituality into their clinical practice as personally meaningful.

When asked if they talk to their patients about the subject, most said they did. The physiotherapists in the sample assumed their beliefs in a general way, trying not to influence patients' religious choices. This ethical behavior has been recommended when approaching the subject of spirituality in health.[27]

Regarding discussions with patients, most physiotherapists in the sample acknowledged their beliefs in a general manner, striving not to influence patients' religious choices – an ethical approach endorsed in addressing spirituality in health. Despite religious diversity, the sample collectively recognized the value of fostering faith, hope, and optimism, as well as encouraging spiritual practices to enhance treatment effectiveness.[28] While some attribute spiritual practices to the placebo effect, healthcare professionals worldwide acknowledge the role of spirituality/religiosity in coping with illness, fostering adherence to treatment, and improving recovery outcomes. Although incipient, the studies that have tested the association between biomarkers and spirituality or religiosity have confirmed the hypothesis of the beneficial impact of spiritual practices in human health.[29]

However, participants cautioned against negative religiosity, which can exacerbate treatment challenges by promoting resignation to pain and illness or perpetuating erroneous beliefs of divine punishment. Health professionals must monitor the intrinsic concepts of religious and spiritual practices to prevent health-detrimental misconceptions. There has been an association between negative religiosity and anxiety[30] and domestic violence.[31] Nevertheless, health professionals should not just recommend religious and/or spiritual practices to patients, but should monitor the

[25] LUCCHETTI, G.; LUCCHETTI, A.L.G.; VALLADA, H. Measuring Spirituality and Religiosity in Clinical Research: A Systematic Review of Instruments Available in the Portuguese Language. *Revista Paulista de Medicina,* 131(2), p. 112-122, 2013.

[26] JONES, K.F. *et al*. Spirituality Is Everybody's Business': An Exploration of the Impact of Spiritual Care Training upon the Perceptions and Practice of Rehabilitation Professionals." *Disability and Rehabilitation,* 44(8), p. 1409-1418, 2022.

[27] TOLOI, D.A. *et al*. Spirituality in Oncology – a Consensus by the Brazilian Society of Clinical Oncology. *Brazilian Journal of Oncology,* 18, p. 1-18, January-December 2022.

[28] KØRUP, A. *et al*. Health Professionals' Attitudes toward Religiosity and Spirituality: A NERSH Data Pool Based on 23 Surveys from Six Continents". *F1000Research* 10(June), 2021.

[29] SHATTUCK, E.C.; MUEHLENBEIN, M.P. Religiosity/Spirituality and Physiological Markers of Health. *Journal of Religion and Health,* 59(2), p. 1035-1054, 2020; FERGUSON, M. A. *et al*. (2022). A Neural Circuit for Spirituality and Religiosity Derived from Patients With Brain Lesions. *Biological Psychiatry*, 91(4), p. 380-388, 2022.

[30] ABDEL-KHALEK, A. M.; NUÑO, L.; GÓMEZ-BENITO, J.; Lester, D. The Relationship Between Religiosity and Anxiety: A Meta-Analysis. *Journal of Religion and Health,* 58(5), p. 1847-1856, 2019.

[31] GONÇALVES, J.P.B. *et al*. The Role of Religiosity and Spirituality in Interpersonal Violence: A Systematic Review and Meta-Analysis. *Revista Brasileira de Psiquiatria,* 45(2), p. 162-181, 2023.

intrinsic concepts of such practices, avoiding erroneous beliefs that are harmful to health. In any case, addressing the issue seems to be recommended within the health promotion model.

A relevant factor for the emergence of spirituality issues in healthcare includes the era of precision medicine. Individual, environmental and lifestyle factors have been included in the optimization of treatments. In the opinion of researchers, spirituality or religiosity can support and reinforce health beliefs and behaviors that affect therapeutic results.[32] The data on physiotherapists' view of their own spirituality or religiosity confirms the hypothesis that Brazil is a predominantly religious and secular country. The different religious beliefs and dogmas coexist with a certain harmony. Religious intolerance has been combated by public authorities and the media, which increases the freedom to talk about the subject, even in scientific contexts.

Limitations

The study has some limitations. It was not possible to achieve proportional representation for the regions of the country, with a greater representation of physiotherapists from the northeast, which does not correspond to the Brazilian reality. This can be explained by the limitations of the sampling method adopted. The sample may not be representative of the target population in terms of the level of spirituality either, tending to represent more individuals with a greater interest in the subject and requiring caution when generalizing the results.

Conclusion

In conclusion, the perspectives of Brazilian physiotherapists on spirituality and health converge and diverge in various aspects. While recognizing spirituality's therapeutic role, as a facilitating element in the treatment and rehabilitation process, practitioners also acknowledge the potential harm of negative religiosity, emphasizing the need for evidence-based curricula addressing spirituality in physiotherapy practice. Further research is warranted to validate these findings across diverse fields, regions, and countries.

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Table 1

Table 1 – Socio-demographic data of the sample of physiotherapist respondents (N=374).

Variables	N	%
Gender		
Women	303	81.0
Men	71	19.0
Age (years)		
23 to 37	182	49.0
38 to 52	155	41.0
53 to 66	37	10.0
Marital status		
Not together	210	56.1
Together	164	43.9
Family income (minimum wage)		
Less than 1	4	1.1
Between 1 and 2	38	10.2
Between 3 and 4	120	32.2
Above 5	210	56.5
Country region		
North	30	8.0
North-East	209	55.9
Centre-West	29	7.8
South-East	39	10.4
South	67	17.9

Table 2

Table 2 – Description of the results of the SWS and the RWB and EWB sub-scales, applied to physiotherapists in Brazil (N=374).

CLASSIFICATION	SCORE	N	%
SWS	Positive	235	62.8
	Negative	139	37.2
RWB	High	269	72.0
	Moderate	90	24.0
	Low	15	4.0
EWB	High	175	46.8
	Moderate	195	52.1
	Low	4	1.1

Legend: SWS – Spiritual Well-being Scale; RWB – Religious Well-Being; EWB – Existential Well-Being.

Table 3

Table 3 – Description of the results of the DUREL, applied to physiotherapists in Brazil (N=374)

CLASSIFICATION	SCORE	N	%
OR	More than once a week	35	9.4
	Once a week	64	17.1
	Two to three times a month	39	10.4
	A few times a year	131	35.0
	Once a year or less	63	16.8
	Never	42	11.2
NOR	More than once a week	37	9.9
	Daily	187	50.0
	Two or more times a week	60	16.0
	Once a week	–	–
	A few times a month	57	15.2
	Rarely or never	33	8.8
IR question 1	Totally true for me	239	63.9
	Generally true	83	22.2
	Generally true	30	8.0
	Generally, not true	7	1.9
	Not true	15	4.0
IR question 2	Totally true for me	147	39.3
	Generally true	155	41.4
	Generally true	46	12.3
	Generally, not true	–	–
	Not true	26	7.0

IR question 3	Totally true for me	101	27.0
	Generally true	182	48.7
	Generally true	39	10.4
	Generally, not true	–	–
	Not true	50	13.4

Legend: OR – Organizational Religiosity; NOR – Non-Organizational Religiosity; IR – Intrinsic Religiosity.

SUPPLEMENT 1

BOX 1: Group of answers and clippings from the answers to the question "Do you talk about spirituality/religiosity with your patients?

GROUP OF ANSWERS	EXTRACTS FROM THE SPEECHES
Yes	***F13 –*** *"Yes. More precisely, about spirituality. In general, patients who cultivate some faith are more involved in their treatment, more hopeful and positive. [...] the patient's encounter with himself and what he believes in (relaxing music, breathing, meditative practices)."* ***F40 –*** *"Yes. I talk about spirituality, the meaning of life, support networks, welcoming and listening, serving others..."* ***F67 –*** *"Yes, about the patient's perspectives on spirituality/religiosity, about the possibilities of faith and healing and how to better deal with the situation based on faith."* ***F110 –*** *Yes, I don't focus on a religion, because I'm against preaching, but I do seek spiritual help or a religious basis. I believe that daily prayers are a way of meditating, sharing problems with God, Jesus, guardian angels or whatever the belief may be, can help relieve baggage.* ***F277 –*** *"Yes, making them understand that they are a physical, mental and spiritual being and that this contributes to their improvement."* ***F281 –*** *"Yes. I use it as an emotional/psychosocial assessment profile within the evolving context of the clinical complaint and to get to know my patient better."* ***F299 –*** *"Yes, when treatment progresses, because of optimism, hope, motivation and forgiveness."*
No	***F56 –*** *"I avoid this kind of subject because I understand that religiosity and spirituality are personal issues and an individual perception of the world..."* ***F101 –*** *"I don't usually talk about religion because it's extremely personal and I've experienced unpleasant situations with patients of a certain religion. I go more for dialogue about energy and/or faith in something because it's more neutral among religious practices."* ***F134 –*** *"I don't talk, because I don't have the knowledge to do it, but I'd like to."* ***F194 –*** *"Not yet, but I feel I need to!"*

	F263 – *"No. That's not what clinical practice is for"* ***F287 –*** *"I don't talk. Only if the patient is very depressed and starts talking about spirituality or God."* ***F316 –*** *"No, I think it's unethical"* ***F296 –*** *"I don't like to talk too much about religion, but I make it as comfortable as possible for the patient to express themselves or lean on what they believe in."* ***F321 –*** *"I don't talk, but I always light a small candle and have a place to pray. I have a greater sense of guidance and security in my care."*
Sometimes / a few times / sometimes / some of the time	***F138 –*** *"Not often. Most of the dialogue is along the lines that the spiritual part should also be dealt with"* ***F204 –*** *"Sometimes! I try to get him to believe in his recovery and find the strength to dedicate himself to the treatment!"* ***F247 –*** *"Sometimes, when the subject brings up this issue. I see it as a way of strengthening the bond, optimizing attachment and encouraging therapeutic adherence."* ***F328 –*** *"Sometimes. I use it to see if my patient sees meaning in life"*
Rarely	***F200 –*** *"Rarely. If the patient takes a stand on their religiosity, I encourage them to look to their faith for support in overcoming adversity."* ***F280 –*** *"Rarely. In general, I try to lead the conversation based on the patient's limits. But I'm never the one who initiates a conversation on these subjects."*
Only when the patient initiates	***F231 –*** *"Only when the patient initiates the subject."* ***F260 –*** *"Only if they propose the subject. I never initiate a conversation on this subject."*

Source: Research data (2022)

SUPPLEMENT 3

BOX 2. Coding of the thematic unit that emerged from the answers to the first open question: "Do you talk about spirituality/religiosity with your patients? If so, how do you use this information in your clinical practice?"

Grouping of Thematic Units	**Total**
Strengthening religious belief	44
Stimulating faith	21
A tool used	19
Talking (the physiotherapist) about S/R	12
Adherence to treatment	10
Talking positively	10
Conversations around the physiotherapist's own beliefs	09
Listening and/or talking to (the patient) about S/R	09
Connecting with what one believe	09
Encouraging hope	08
Encouraging belief in improvement	08
Comfort	07
Connection/bond with the patient	07

SUPPLEMENT 3

BOX 3. Coding of the Thematic Units that emerged from the answers to the second open question: "How do you perceive your patients' spirituality/religiosity interfering in the health and illness process?"

Grouping of Thematic Units	**Total**
Copes better with illness / health and disease process / More resilience	69
Positive / Optimistic / More attitude / positive thinking / willpower	63
Believe in / adhere (better) to treatment / better outcome / results	67
Helps in the healing and/or rehabilitation process/ Hope for improvement/ Faith and belief in healing	54
Sadder, depressed, pessimistic, and discouraged people / More negative / Suffer more / Greater somatisation	17
Don"t adhere to treatment/ more difficult to treat/ hinders therapeutic management / Less tolerance to the process of becoming ill/ Therapeutic limitation	16
Sense of punishment/abandonment/punishment/probation/divine proof / Limiting belief / Fanatical idea	12
Less response to treatment / less progress towards improvement	10
Complains less/less	8

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