RESEARCH PAPER

Evaluation of Knowledge, Attitude and Practice on Adopting Biopsycosocial-Spiritual Health Care Model in Physiotherapy Practice: Survey-Based Scoping Review

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ABSTRACT
Medical education and practice have undergone many reforms throughout the decades for their upgradation and excellence. The ideology of present study research is to put forth the fact about knowledge and attitude about the recent WHO called in 2023 for a vision of health that integrates physical, mental, psychological, emotional, spiritual, and social wellbeing. The present cross-sectional trial protocol combined short review study which was carried out within 6-month period on knowledge, attitude and practice on adopting biopsychosocial-spiritual health care model. Sample of 1000 academic background and clinical practice physiotherapist were selected. Subjects were randomly selected for interview for a pre validated questionnaire and data extracted was coded and arranged in positive and negative feedback. Filtered data was then analysed with SPSS based on the analysis plan. Study results showed that 85.4% had good knowledge on the topic with proper understanding. 57.6 % of subjects' attitude were on the positive side were 26.2 % had no comments regarding the attitudinal open-ended questions. The practice section explored 50.9 % good response in explaining biopsychosocial-spiritual health care model practice and participation within, and among communities of all cultures, religions, and educational backgrounds. The study concluded that the inclusion of a greater understanding of spirituality would have definite significance in treating medical conditions.

Keywords (Index terms): *Knowledge, Attitude, Biopsychosocial- Spiritual Health care Model, Physiotherapy, Medical Practice*
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The Medical Background: Medical health discipline is a unique profession that needs continuously upgradation with its concept and practice. Emphasizing on its assessment and treatment it has reframed its definition from "health meaning as absence of disease" to the WHO 1948 definition "A state of complete physical, mental and social well-being and not merely absence of disease or infirmity". Recently WHO called a reform in the definition of health that integrates physical, mental, psychological, emotional, spiritual, and social wellbeing[1]. It has been seen in national and international level that now researches are showing interest in the application of this concept at ground level. Different studies have explained the biopsychosocial-spiritual health care model over the standard biopsychosocial model, spirituality and health relation[2]. Spirituality mostly defined as one's religious belief and practice as well as one's sense of purpose and meaning of life[3]. Though some researches in medical concept explains term religion as organized and or shared faith practice or belief, spirituality term is distinct as it's the way of the people to relate the transcendent, including traditional practice[1]. A researcher David Vermette explained in detail that spirituality has been defined as an individual's relationship with the transcendent, which can take many forms, including but not limited to organized religion. Researchers further added in their original research writing importance and inclusion of biopsychosocial-spiritual health care model in the present and future health care strategies. Studies also demonstrated positive effects of illness when assessed in the integrated approach of biopsychosocial-spiritual health care model.

The biopsychosocial-spiritual health care model: Researcher David Vermette in 2022 has put focused note on the importance of the present time to move towards actual holistic medical education and how much the

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biopsychosocial-spiritual health care model is important in the patient care to the educators, trainees along with the patient and its family care takers. Studies illustrated effectiveness of the biopsychosocial-spiritual health care model over the standard biopsychosocial model in different conditions. Here spirituality is studied and tried to manage in terms of interactive and communication strategies on each patient. A study by Yi-heng Chen in the year 2023 have shown positive effects of biopsychosocial-spiritual group therapy on quality of life among institutionalized older adults with disabilities where he used separate sessions of building trust in patients, assessing ADLs, harmonizing relationship with self, exercise and mental health self-management with developing positive meaning of life[4].

Reviving the new concept of spiritual model in health care system there is the need of implementing the same in physiotherapy assessments and management. As there is dearth in the research of intervention using the new concept of health, the present study is focused to find out the present knowladge, attitud and current practicing facts on Biopsychosocial-spiritual wellness belief health care model in physiotherapy management. The present study has the objective to find the insight of how much the physiotherapy communituy is aware of Biopsychosocial-spiritual model in Community based patients medical assessement and clinical practice. Also the present study will focus on facts about the attitude and practicing strategies in physiotherapy community in terms of biopsychosocial -spiritual health care model. This will play a very important role in understanding further biopsychosocial -spiritual interventions in health system. This is also expected to understand and reduce further economic burden in health system.

Methods: The study is primarily a cross-sectional qualitative analytical short review study, on Knowledge, Attitude and practice on adopting the newest Biopsychosocial spiritual health care belief model in physiotherapy practice. The study was conducted in accordance with the Helsinki Declaration ethical principles and an Institutional Ethical Clearance committee approval was taken.

Extensive literature review and review of the standardized KAP questionnaire was undertaken before the survey study. Four phases criteria to construct the questionnaire was undertaken. In Phase 1 generating items that suit the study purposes by reviewing the relevant literature were carried out. In Phase 2, evaluating content validity of the instrument was done from the panel of expert reviewers and modifying accordingly of the raw draft was done. In Phase 3, assessing face validity by conducting a pilot test of the modified instrument was done at local institutes and in Phase 4, further modification of the instrument was done based on the results of exploratory factor analysis (EFA), examining construct validation and reliability of the final version of the tool biopsychosocial - spiritual health care model.

For the present study survey sample was selected from a 1000 large population (comprised of academic and or clinical physiotherapist experienced more the two years) to be used to generalize the population frame. The study was carried out drawing the participants randomly from various government registered universities, institutes, schools and clinics. All study participants were then informed about the study's purpose and benefits, and were asked to provide informed consent before participating in the self-administered questionnaire. Participants were also informed that the study was voluntary, and participants had the right to withdraw at any time without penalty. First details were collected of the eligible participants from valid source and invitation and consent formalities were cleared via email or telephonic communication. Target population was calculated to estimate population proportion and be 95% certain that the survey estimates below 5 % point of the true population proportion.

A multifaceted logistic regression analysis was carried out to identify factors associated with varying knowledge levels, attitudes, and practice experience on biopsychosocial - spiritual health care model. The present study used SPSS 23.0 to analyse the data.

RESULTS:

In the current study overall gender distribution had no significant difference. Descriptive statistics were used to analysed the background characteristics of the participants. Categorical variables were summarized using frequencies and percentages. The detailed distribution of gender, age, religion, qualification, years of practice, and specified experience is presented in **Table 1**.

Age categories were classified for simplification

Table 1: Detailed distribution of Gender, Age, Religion Qualification, years of Practice and specified Experience

Background Characteristics (P = 1000)	Proportion	Percentage
Gender		
Male	660	66.0
Female	340	34.0
Age		
25 to 40 years	825	82.5

41 to 50 years	123	12.3
51 to 60 years	32	30.2
60 years and above	20	20.0
Religion		
Hindu	640	64.0
Muslim	140	14.0
Christian	28	2.8
Others	192	19.2
Qualification		
BPT complete	362	56.2
MPT in musculoskeletal/ OMT/ Sport/ Biomechanical physiotherapy	150	15.0
MPT in Neurology / paediatric physiotherapy	114	11.4
MPT in Cardio respiratory Physiotherapy	188	18.8
MPT in community rehabilitation / Geriatric / OBG Physiotherapy	152	15.2
PhD in Physiotherapy	34	3.4
Practice in years		
2 to 3 years	420	42
4 to 6 years	216	21.6
7 to 10 years	153	15.3
10 to 15 years	103	10.3
15 to 20 years	66	6.6
above 20 years	42	4.2
Specified experience		
Clinical	259	25.9
Academic	236	23.6
Clinical plus academic	505	50.5

A total of 1,000 Physiotherapy practitioners were included in the final analysis, with complete data available for all variables. Outcomes were analysed using descriptive statistics and effect estimates expressed as odds ratios (OR) with 95% confidence intervals (CI), comparing good responses with poor/not-related responses. Good knowledge distinguishing spirituality from religion was reported by 98.9% of participants. Knowledge regarding the influence of spirituality on assessment, diagnosis, and treatment was significantly high (84.5%; OR = 5.45, 95% CI 4.35–6.82). Positive attitude toward inclusion of spirituality during therapeutic intervention was strongly associated with acceptance (91.7%; OR = 12.6, 95% CI 9.4–16.9). Attitude toward spirituality in health assessment and diagnosis showed moderate acceptance (57.6%; OR = 1.36, 95% CI 1.14–1.63). Support for inclusion of spirituality in health-care education was observed in 66.7% (OR = 1.99, 95% CI 1.66–2.38). However, favourable attitude toward the biopsychosocial-spiritual model was low (25%; OR = 0.42, 95% CI 0.35–0.51). Practice of the model was reported by 50.9% of practitioners. Overall, results demonstrate strong knowledge and attitudes but limited clinical implementation. Detailed in table 2.

Table 2: Detailed demonstration on Knowledge, attitude and Practice on Biopsychosocial- Spiritual Health care model in Physiotherapist

Characteristics	Good	Poor	Not related
Knowledge on Health definition	1000		
Knowledge on Spirituality v/s religion	989	10	1

Knowledge on Spirituality affects diagnosis and treatment	845	141	14
Attitude toward Spirituality in diagnosing health condition	576	162	262
Attitude toward Spirituality in intervention in treating health condition	917	70	13
Attitude toward Understanding for trainees on spirituality inclusion in health	897	83	20
Attitude toward Need of inclusion of spirituality learning in health system	667	250	83
Attitude toward on prior understanding on spirituality	800	10	10
Attitude toward use of Biopsychosocial-Spiritual model in Physiotherapy	250	167	583
Practicing Biopsychosocial-Spiritual model in Physiotherapy	509	102	382

DISCUSSION:

Upgradation in the term Health: The recent development in medical health is the upgradation in the discussion of the term "health" itself by the WHO meet in 2023 with a vision of health that integrates physical, mental, psychological, emotional, spiritual and social wellbeing dimensions. Handful studies have published on the different concepts of practicing health of which biopsychosocial spiritual health care model has come under the lime light of the health professionals and practicing researchers. We undertook the current study to assess the knowledge, attitude, and practice of the Biopsychosocial spiritual health care model in Physiotherapist practicing in India.

Knowledge of Physiotherapy oh Health updates and inclusion of spirituality: Overall, in the current study we found that 100 percent of the physiotherapist practicing in India that participated in our study acknowledged possessing general knowledge about health definition and that the knowledge about health was aligned with their attitude and clinical practice. In the study 1000 participants were actively enrolled of the age group 25 to 71 years and above. The study considered bachelors in physiotherapy to all specialities in the physiotherapy stream currently recognised by academic institutions in the country. In the current study 25.9 % participates were clinicians, 23.6 were purely acclamations and researchers and 50.5 % were clinical with academic and research experienced physiotherapist of the country. Thise gave a good clinical exposure expertise review of the practicing and academic physiotherapist of the country in the study.

It was found by the survey in the present study that though all the participants had good knowledge about the definition health and common terms used in health system, it was foggy response on the integrated term biopsychosocial spiritual health care model and other health care models practiced in the health system. When asked spirituality, religion and culture terms mean almost the same or different the answer was into splits. Were 10 % where of the view that all the terms were almost the same 90 % said its different, but were not able to convince how it's different on health profession ground. Most participants were of the view the term spirituality means meaning and purpose of life or holistic understanding and approach towards wellbeing or happy filling, super consciousness of the individual with unique positive approach toward individuals life events. It is a moral support for the life activities and work as an enzyme in healing internally form any life situations. It was also put forth that it's a global concept to interconnect the proceeding of life events of different culture and continents. 14 % of the participates could not relate how spirituality can be related to medical health concept, however demonstrated that spirituality is meaning and purpose of life.

In the present study were 57.6 % participants think that the distinct term spirituality affects the assessment process in diagnosing medical condition and treatment rehabilitation of the same, 26.2 were of the view that the term spirituality does not relate to the term health and both are independent. On further investigation less than 50 participants of 1000 were of the view that spirituality term means healthy mind and or psychological health with peace in relation to medical health concept. Most participants were of the view the term spirituality means meaning and purpose of life or holistic understanding and approach towards wellbeing or happy filling, super consciousness of the individual with unique positive approach toward individuals life events. It is a moral support for the life activities and work as an enzyme in healing internally form any life situations. It was also put forth that it's a global concept to interconnect the proceeding of life events of different culture and continents. Some focused spirituality as it's a positive energy happy good going inside and holistic understanding of super conscious of individual with balanced faith in all systems.

Attitudinal response on inclusion of spirituality in health as assessment, diagnostic and treatment factor: When specified on effects on diagnosis on intervention participants responded, inclusion of spirituality can work on controlling anxiety and stress with rule out cultural or religious backdrops. It can also give clear vision on diagnosis and treatment without wasting energy on multiple association unidentified. It could focus and build healthy perspective of patients if properly introduced to spirituality and heath relation. More information can be pulled by the therapist on Insight behaviour and attitude of the patients in regards to culture and health condition that can help in diagnosis and treatment. can have positive attitude and profession relation in improving internal health. It can give resting period efficient for recovery and influence copping mechanism. It will give motivation and willingness to continue the battle of rehealing health in vulnerable groups and health issues. Yet very minimal response was of no effects on inclusion of spirituality in

assessing and diagnosing health condition and on interventions of the same.

Inclusion of spirituality in academic learning in medical students: There was good response seen when asked about inclusion of spirituality in academics and should it be thought for trainees. Participants pointed that it can be additional pathway for effective students' concentration and batter understanding on human behaviour and cultural aspects of individual as an integral part of health and faster recovery. Student will also have clear concept on handling patients on spiritual and cultural background. Inturn therapist's spiritual, cultural, behaviour and attitude affect the assessment and treatment process. Thise will build a clear knowledge on recent health updates and positive mindset in the students, reducing stress and fear of failure in goal achievements. Yet some said detailed spiritual concept should be thought at postgraduate level only.

Overall, when asked about the professional knowledge about the spirituality and integration of spirituality as a factor interrelated with health, more than half participants had good knowledge and congruency with knowledge, attitude and practice with the term Biopsychosocial spiritual health care model. In the present study participants were of the opinion that spirituality should be considered at every level of health from history taking to goal setting and patient education for maximum positive input.

Overall inclusion and adaptation of health concept with the new version "The biopsychosocial-spiritual health care model" and its Implications for Behavioural Health: As discussed upgradation is a continues process and the need of new era, all disciplines of medical al well as other branches working with health should be going hand in hand. Inclusion of change in old concepts of health in necessary to meet the Morden challenges of health and behavioural growth. Therefore, the latest version of health that is The biopsychosocial-spiritual health care model is very important to understatd befor application. In terms of behavioral health inclusion of spirituality will show a gret positive changes in the practice and tecniques of assessement, diagnosis and speciallly in rehabilitive phase. Inclusionof spiritual in accdmic learning will make students, interns and prifessionals understand and cooprate professionaly with root behavior of the patient, relatives as well as medical athiorities. Conlicts in processes will be decreased due to greater understanding.

Strengths and Limitations: This research represents a pioneering endeavour, scrutinizing the knowledge, attitude, and practice of Physiotherapists on Biopsychosocial-spiritual health care model. Participant were randomly select from Indian region having experience of more than 2 years after completing Bachelors of Physiotherapy. Participants were polled from all background like academic to clinical, private practice to employed. Primarily, the study was cross-sectional designed, investigation of temporal relationships among variables associated with disconnected areas was not feasible. Furthermore, the self-administered nature of our online questionnaire may have possibility that the pressures of the healthcare or culture environment influenced the professionals' responses of the individual; hence, the completeness and accuracy of their responses cannot be unequivocally guaranteed.

Conclusion: Overall, knowledge, attitude, and practice of Physiotherapy professionals about Biopsychosocial-spiritual health care model was found to be adequate in the current study. However, results demonstrate strong knowledge and attitudes but limited clinical implementation in current scenario.

Conflict of Interest Statement

The authors have no conflict of interests to declare

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